

## Case Study: Connecticut

# State Long-Term Services and Supports Scorecard: How One State Improved

Susan Reinhard  
Kathleen Ujvari  
AARP Public Policy Institute

Leslie Hendrickson  
*Independent Consultant*

This report presents the findings from a case study of Connecticut. The study was conducted following the release of the 2014 *State Long-Term Services and Supports Scorecard*<sup>1</sup> to understand factors that lead to improved performance on measures of long-term services and supports (LTSS) for older adults and people with physical disabilities. Case studies can provide a deeper context for understanding how some states have improved the performance of their LTSS systems over time. Connecticut is a high-performing state undertaking a systematic effort to shift its reliance on nursing homes to the use of more home- and community-based services (HCBS), and its operations are useful to study.<sup>2</sup>

### FINDINGS

Connecticut's LTSS system performance is attributed to

- Guiding principles to address LTSS reform for people of all ages and across all disabilities;
- The successful demonstration by state staff and advocates showing that LTSS programs
  - Are cost effective;
  - Provide good quality of care; and
  - Offer choice to participants;
- A decadelong effort spearheaded by a core group of state and agency staff to building strong LTSS programs that promoted inclusive participation and was instrumental in implementing new policies;
- Policy makers and elected officials that developed a clear vision of what LTSS services should be and implemented specific plans to achieve a broad transformative vision;
- Policy makers who took advantage of both state and federal funding opportunities to improve their LTSS system;
- A strong array of in-home HCBS services including a sizeable state-funded home care program for people above Medicaid income and asset levels;
- Lessons learned from continuous quality improvement evaluations of almost all LTSS programs that led to improvements across LTSS program operations;
- A multiyear vision of how technology can support LTSS services; this vision was operationalized



**Public Policy  
Institute**

*Produced with support from AARP, The SCAN Foundation, and The Commonwealth Fund. <http://www.longtermscorecard.org>*

using interlinked e-portals, web-based applications, multiple community partnerships, a consolidated assessment instrument spanning multiple programs, potential automated participant experience surveys, and planned use of personal health records; and

- A 27-percent increase in the percentage of LTSS funding spent on HCBS programs during the 5-year period from 2007 to 2012. In 2007, Connecticut spent approximately 34 percent of its LTSS dollars on HCBS. By 2012, that percentage increased to 45 percent.

## INTRODUCTION

The 2014 *State Long-Term Services and Supports Scorecard* articulates the vision of a high-performing LTSS system and operationalizes that vision with clear measures of key indicators. The *Scorecard* tracks changes over time and helps people use this information to focus on policies and programs that can improve LTSS.<sup>3</sup> The *Scorecard* uses a multidimensional approach to rank states on 26 measures across 5 dimensions of a high-performing LTSS system: (1) Affordability and Access, (2) Choice of Setting and Provider, (3) Quality of Life and Quality of Care, (4) Support for Family Caregivers, and (5) Effective Transitions. The *Scorecard* describes the goals to aim for when considering both public policies and private-sector actions that affect how a state organizes, finances, and delivers services and supports for older adults and people with physical disabilities who need ongoing help with activities of daily living (ADLs), instrumental activities of daily living (IADLs), health maintenance tasks, service coordination, and support to family caregivers.

The *Scorecard* found wide variation in state performance. Because the *Scorecard* is designed to help states improve the performance of their LTSS systems, low-performing states can examine other states that performed well in specific areas to identify potential paths for improvement. Leading states do well on multiple indicators, but even states with a low ranking scored in the top quartile for at least one indicator. Further, states that rank low can show significant improvement in their performance over time.

AARP published its first *Scorecard* in September 2011, and data from that report allow comparison with 2014 scores on 19 of the 26 indicators.<sup>4</sup> This case study focuses on Connecticut, which was the 11th highest ranking state in the 2011 *Scorecard* and the 12th highest ranking state in the 2014 *Scorecard*. The study focuses on lessons other states can learn from a high-ranking state like Connecticut and the seven indicators where Connecticut showed improvement.<sup>5</sup>

## Background

### *Connecticut Population and LTSS Providers*

In 2014, Connecticut had a population of approximately 3.6 million people, with a population density of 738 people per square mile as compared with the national average of 87 people per square mile.<sup>6</sup> In 2014, approximately 15 percent of the population was age 65 and older.<sup>7</sup> By 2030, the age 65 and older population is expected to more than double.<sup>8</sup> Connecticut is largely an urban state, with 88 percent of its population living in an urban area.<sup>9</sup> However, urban areas are concentrated and this population lives in just over one-third (38 percent) of the state's land mass. The remaining two-thirds (about 62 percent) of the state, in the northeast and northwest corners, are primarily rural. Connecticut is a wealthy state with the third-highest median income in 2013 after Maryland and New Hampshire.<sup>10</sup>

In December 2014, Connecticut had 229 nursing homes with an average size of 121 beds and an average occupancy rate of 90.1 percent.<sup>11</sup> In 2012, the state had 102 "residential care homes" with 2,780 beds. The residential care designation is a broad category of licensure covering both room and board, and homes that provide personal care from unlicensed staff. A review of their per diem rates shows wide variation, with the majority of rates varying from \$75 to \$150 per day.<sup>12</sup> In March 2014, Connecticut had 89 licensed assisted-living service agencies, 104 licensed home health care agencies, and 4 homemaker/home health care agencies.<sup>13,14</sup>

### **Connecticut Budget Issues**

The state's recurring budget problems were repeatedly mentioned in interviews conducted by AARP staff. Between fiscal years 2009 and 2014, Connecticut's total expenditures increased by approximately \$7.1 billion, from \$19.3 billion in 2009 to an estimated \$26.4 billion in 2014, a 37-percent increase.<sup>15</sup> However, the state has had difficulty funding the increases. The current governor began his first term in 2011 inheriting a \$3.6 billion budget deficit, and began his second term in 2015 with a \$1.3 billion deficit.<sup>16</sup> This backdrop of continuing budget deficits with projections of further deficits in the next 3 years led to LTSS program cuts, a lack of HCBS provider reimbursement increases, a reliance on cost-effective programs, and a concerted effort to seek federal grants to fund new policy initiatives.

### **The Governor's Rebalancing Plan**

Despite these budget travails, both the governor's office and the legislature have shown significant support for a policy stressing the importance of home- and community-based programs. In January 2013, the governor issued his "Strategic Rebalancing Plan: A Plan to Rebalance Long-Term Services and Supports that addresses the development and maintenance of a person-centered LTSS system across the lifespan for people of all ages and all disabilities."<sup>17</sup> The detailed plan describes the vision for LTSS that focuses on informed choice, least restrictive and most enhancing settings, and community inclusion and 3-year implementation strategies across five areas:

- HCBS Options;
- Workforce Development;
- Housing and Transportation;
- Hospital and Nursing Home Discharges; and
- Nursing Facility Diversification and Modernization.

The state's LTSS rebalancing plan is broadly transformative and affects all major economic and social areas affecting LTSS. Connecticut recognizes that the change in preference from institutional care to community care is increasing exponentially; thus it is calling for comprehensive statewide changes

to address consumer choice. The plan is designed as a platform on which multiple state agencies are coordinating efforts to achieve clear statewide goals.

### **Medicaid Waivers and State-Funded Programs**

Responsibility for LTSS programs for older adults and people with disabilities lies with the Department of Social Services (DSS) in coordination with multiple state agencies.

Connecticut has four Medicaid waivers that are used by older adults and people with disabilities. The Connecticut Home Care Program for Elders (CHCPE), Acquired Brain Injury (ABI), Personal Care Assistance (PCA), and Connecticut Home Care Program for Disabled Adults (CHCPDA) waivers are described below. All federal waiver applications are reviewed by the legislature's Appropriations and Human Services Committees. This provides legislative control and ownership over the number of people served on waivers and the anticipated waiver expenditures.

#### *1. Connecticut Home Care Program for Elders*

CHCPE is a Medicaid waiver and state-funded program that provides HCBS for qualifying individuals ages 65 and older who are at risk of being placed in a nursing home.<sup>18</sup> The program helps people continue to live at home but also permits those who are eligible for the program to live in adult family living and some assisted-living residences. Depending on available funding, services under this program may include care management, adult day health care, companion services, home-delivered meals, homemaker services, and personal care attendant services.

#### *2. Acquired Brain Injury Waiver*

Two ABI Medicaid waivers (ABI-I and ABI-II; collectively, ABI waivers) are available; a combined total of about 450 adults currently receive services under both waivers, each of which currently has waiting lists. The ABI waivers provide a range of nonmedical HCBS to eligible individuals ages 18 to 64 with an acquired brain injury, who would otherwise require placement in an institutional setting. Adults who are eligible for an ABI waiver are eligible for all Medicaid-covered services.

### 3. *Personal Care Assistance Medicaid Waiver*

The PCA Medicaid waiver program allows people with a physical disability who are between ages 18 and 64 and require help with at least two ADLs to be eligible to receive personal care assistance. The waiver program currently serves about 800 people and has a waiting list of 300. The average wait time to receive waiver services is about 1.5 years. Connecticut plans to implement a Community First Choice program, which will make the personal care assistance services a Medicaid State Plan benefit and should help alleviate the waiting time for services and access to additional federal matching funds.

### 4. *Connecticut Home Care Program for Disabled Adults*

CHCPDA is a pilot program that offers a package of home-based services to a maximum of 50 people, ages 18 to 64, with degenerative, neurological conditions, who are not eligible for other programs yet need case management and other supportive services.<sup>19</sup>

### **Centers for Medicare & Medicaid Services Federal Grant Initiatives**

In addition to Connecticut's use of Medicaid waivers, state LTSS policy makers have taken advantage of federal grant funding opportunities to improve LTSS services. Centers for Medicare & Medicaid Services (CMS) grants include Money Follows the Person (MFP), Balancing Incentive Program (BIP), and Testing Experience and Functional Tools (TEFT). Information about how Connecticut is using each of these grants for LTSS program initiatives is described below.

#### 1. *Money Follows the Person*

Connecticut was awarded a nursing home transition Real Choice Systems Change federal grant for community living before receiving an MFP award in 2007. The MFP program was implemented in 2008 with 5 state staff in the central office and 20 field staff, a target to transition 700 people from institutional settings, and a waiting list of 1,000 people. The MFP program provides payment for services that augment participation in other community-based support programs

such as the CHCPE and PCA waiver programs.

Today, the MFP program has about 100 contracted field staff conducting assessments and helping transition people from nursing homes. In addition, approximately 30 state staff in the central office support eligibility determinations, policy, and other administrative functions. As of calendar year-end 2014, over 2,600 people have transitioned from institutional settings back to the community.

#### 2. *Balancing Incentive Program*

BIP is a CMS initiative that offers enhanced federal funding to states that spend less than 50 percent of their LTSS budget on HCBS services. Under BIP, Connecticut will receive approximately \$72 million in additional funds that will be used to support HCBS and improve technology.<sup>20</sup> As part of its BIP implementation, Connecticut is building a consolidated assessment form that spans programs for people who are older, who have physical disabilities, or who have mental health or intellectual and developmental disabilities. This consolidated assessment form will be integrated into existing web-based platforms that Connecticut has developed. In late 2015 or early 2016, Connecticut will implement an automated No Wrong Door system that will include an online functional prescreen and application for LTSS.<sup>21</sup>

#### 3. *Testing Experience and Functional Tools Grant*

In 2014, Connecticut was one of nine states awarded a federal TEFT grant to expand the health information technology in its community-based LTSS system.<sup>22</sup>

### **Role of the University of Connecticut**

Connecticut relies heavily on the University of Connecticut Center on Aging (Center on Aging) to support administrative components of the state's long-term care program. Center on Aging staff have studied and evaluated the state's MFP and BIP programs, the TEFT grant, and family caregiver programs. Program support has typically spanned multiple years and has included conducting interviews with program participants, collecting program operations data, evaluating training programs, presenting findings, and making

recommendations for program changes. In addition, Center on Aging staff provided training to field staff, local agencies, and other parties on such topics as medication administration to facilitate in implementing new nurse delegation legislation.

### Methodology

To better understand why Connecticut's LTSS program ranks highly compared with other states, the authors reviewed relevant documents and conducted site visits and phone interviews in the first quarter of 2015.

Interviews with multiple stakeholders included the following:

- State Medicaid officials and staff in DSS, State Department on Aging (DOA), Office of Policy and Management, and Ombudsman staff;
- LTSS providers; and
- Consumer advocates in national and state-level LTSS organizations.

We focused on the *Scorecard* indicators where Connecticut ranked high historically and indicators where the state had improved on the second *Scorecard*.<sup>23</sup> We sought to understand the history and factors that accounted for Connecticut's rankings. See Table A-1 in the appendix for a list of the *Scorecard* indicators with Connecticut's scores.

## CONNECTICUT PERFORMANCE ON SCORECARD INDICATORS

### Affordability and Access

The *Affordability and Access* dimension measures the extent to which individuals and their families can easily navigate their state's LTSS system and find readily available, timely, and clear information to help them make decisions about LTSS. In a high-performing system, services are affordable for those with moderate and higher incomes, and a safety net is available for those who cannot afford services. Eligibility is determined easily and quickly, and the costs of LTSS do not impoverish the spouse of the person needing services and supports.

Overall, Connecticut ranked fourth in the nation on the *Affordability and Access* dimension. Of the six measures in this dimension, Connecticut scored in

the first quartile on four of these indicators, three of which showed improved performance since the first *Scorecard*:

- Home care private pay affordability;
- Percentage of low-income people with disabilities receiving Medicaid;
- Reach of Medicaid HCBS services; and
- Function of information and referral centers.

### Home Care Private Pay Affordability

In contrast to nursing home costs, home care private pay costs in Connecticut are low compared with the other states. Connecticut ranked ninth in the nation on home care private pay affordability. This is good for people seeking home care services, and for their families. However, the low cost of home care services may be a consequence of the lack of increases in state reimbursement for home care services. When interviewed, LTSS home care providers indicated that they received only a 1-percent increase in state reimbursement in the past 10 years and that reimbursement levels were creating financial constraints for service providers.<sup>24</sup> LTSS providers also pointed to the governor's executive orders in 2011 and 2012 that helped lay the foundation for the unionization of personal care aides, yet increased salaries have not been offset by revenue to pay for them.

### Percent of Low-Income People with Disabilities Receiving Medicaid and Reach of Medicaid HCBS Services

Connecticut improved on indicators that measure low-income adults with disabilities receiving Medicaid and low-income adults with disabilities receiving Medicaid LTSS. Although the modest improvement in percentage change over time from the 2011 and 2014 *Scorecards* did not change the state's rankings (rank of eighth and fourth in the nation, respectively), Connecticut's continued improvement in these measures are consistent with the state's emphasis on providing cost-effective HCBS programs and funding new policy initiatives with federal grants.

The CHCPE Medicaid waiver and state-funded program provides HCBS for qualifying individuals ages 65 and older who are at risk of being placed in a nursing home. As shown in table 1 below, CHCPE has three eligibility categories. Categories 1 and 2 are state-funded CHCPE components that currently serve approximately 3,500 people. Category 1 is slated for cutbacks in fiscal year 2016 due to a shortfall in the state budget.<sup>25</sup> Category 3 is a Medicaid-funded CHCPE component that currently serves approximately 11,600 people and has no waiting list.

CHCPE is noteworthy. It provides some LTSS funding for people whose assets make them ineligible for Medicaid. Current asset levels for the state-funded program are \$35,766 for an individual and \$47,688 for a couple. Serving people with higher assets is important in states with high nursing home costs. The 2014 *Scorecard* found that only two states (New York and Alaska) had higher nursing home private pay costs than Connecticut.<sup>26</sup>

Connecticut has controlled state reimbursement to home health agencies for over 10 years, providing only a 1-percent increase in state reimbursement during this period. The 2014 *Scorecard* reflects

this flat reimbursement where Connecticut ranked ninth in the country for affordable home health costs. Despite this top 10 performance ranking, home health in Connecticut is still potentially unaffordable for many people of modest means where the average annual cost of home health would consume 77 percent of median income.

The relative high-cost unaffordability of nursing home and home health care highlights the importance of the state-funded home care program. People who only have assets of roughly \$36,000 to \$48,000 will spend them rapidly if they need prolonged nursing home or home health services.

CHCPE also offers the following adult family living and four types of assisted-living services as described in table 2 (following page).

***Aging and Disability Resources Center Functions***

Connecticut increased its rank from 27th in 2011 to 10th in the 2014 *Scorecard* on the composite indicator measuring Aging and Disability Resources Center (ADRC) functions. Planning for the ADRC program began in 2007, and the program received grants in 2009 and 2010 from the Administration on Aging (reorganized in 2012 and now operating

**TABLE 1**  
**Connecticut Home Care Program for Elders Eligibility Categories**

Category Type	Description	Functional Need	Financial Eligibility	2014 Care Plan Limits	Funding Source
Category 1	Limited home care for moderately frail elders	At risk of hospitalization or short-term nursing home placement (1-2 ADLs)	Income: No limit Assets: Individual—\$35,766 Couple—\$47,688	Per-client expenditures must be less than 25% of nursing home cost \$1,450/month	State
Category 2	Intermediate home care for very frail elders	In need of short- or long-term nursing home care (3 ADLs)	Income: No limit Assets: Individual—\$35,766 Couple—\$47,688	Per-client expenditures must be less than 50% of nursing home cost \$2,900/month	State
Category 3	Extensive home care for very frail elders who would otherwise be in a nursing home on Medicaid	In need of long-term nursing home care (3 ADLs)	Income: \$2,199/month Assets: Individual—\$1,600 Couple—\$1,600 each (both as clients) \$25,444 (\$1,600 + \$23,844 as one client)	Care costs cannot exceed 100% of nursing home cost \$5,800/month	Medicaid

Source: Connecticut Department of Social Services, 2014 and 2015.

**TABLE 2**  
**Residential Programs in the Connecticut Home Care Program for the Elderly, 2015**

Residential Program	Description
Adult Family Living/Foster Care	Four levels of service are paid under the Adult Family Living program based on ADL and IADL needs of the individual. <sup>27</sup> In March 2015, two provider agencies were sponsoring 169 homes and clients. The Adult Family Living program is a fairly new program, and the state expects to see growth in the number of provider agencies, homes, and clients in the future.
Assisted-Living Demonstration Program	This was authorized by Public Act 98-239 to keep people out of nursing homes for as long as possible by providing affordable assisted-living options. Currently in four locations, the buildings were funded by the state and currently serve about 235 people, of whom 175 are state funded and the remaining 60 are Medicaid funded. Room and board are not covered, but some people qualify to receive rental subsidies from the Connecticut Housing Finance Authority. <sup>28</sup>
Private Assisted-Living Pilot Program	The pilot program serves a maximum of 125 people, who must be eligible for either the Medicaid waiver or the state-funded portion of CHCPE. Currently, 113 people are enrolled in the program, of whom 90 are state funded and 23 are Medicaid funded. The pilot program grew out of recognition that older adults were spending down assets while living in private assisted-living and required financial assistance for living expenses. <sup>29</sup>
State-Funded Congregate Care	Sixteen state-funded congregate care sites currently serve 111 clients.
Federally Funded Housing and Urban Development	Six federally funded Housing and Urban Development sites currently serve 193 clients.

Source: Connecticut Department of Social Services, March 2015.

under the Administration for Community Living (ACL) umbrella) and CMS. The state’s ADRC is a small program with only 1–2 full-time equivalents at each of roughly 12 sites. Major issues facing these programs include continued reliance on declining federal funds and how the programs will align with the state’s new information platforms such as MyPlaceCT and ConneCT. DSS is expanding the number and kinds of agencies that will be able to provide LTSS information and referral, which creates challenges for the ADRC programs. Additional challenges associated with federal funding streams from different federal agencies (ACL and CMS) to different state agencies (DSS and DOA) have caused confusion and lack of coordination between related ADRC and BIP initiatives.

**Private Long-Term Care Insurance**

Although Connecticut ranked 16th in the country on this measure (2nd quartile), it was one of the original four states in 1992 that created the Partnership Long-Term Care insurance (Partnership) option. Partnership insurance is a public-private

partnership between the private insurance industry and the Medicaid system designed to encourage residents to plan ahead for future long-term care costs. The Partnership provides dollar-for-dollar asset protection where every dollar the policy pays out on behalf of a consumer’s care equals a dollar of their assets that Medicaid must disregard (not count) when determining their eligibility for the Medicaid program should they need it in the future.<sup>30</sup> Additionally, assets protected through the Partnership program cannot be recouped by the state Medicaid agency. Medicaid policy makers agreed with this concept because the Partnership policy would be used to pay for LTSS before Medicaid had to pay, thereby saving Medicaid dollars.

Connecticut has an active partnership program that provides outreach, education, and training, and sets standards for policies.<sup>31</sup> About 41,000 of the state’s current 110,000 active long-term care insurance (LTCI) policies are partnership policies. Only 155 policyholders have accessed Connecticut’s Medicaid program after using their Partnership benefits,

which paid approximately \$31 million in long-term care benefits before policy benefits were expended.<sup>32</sup> *Scorecard* indicator performance on long-term care insurance has been flat since the start of the Great Recession in late 2007, which affected discretionary spending.<sup>33</sup>

**Choice of Setting and Provider**

Data permitting an analysis of change over time were available for three of the five indicators in the *Choice of Setting and Provider* dimension. Connecticut showed improvement on one of the three indicators, Supply of Home Health and Personal Care Aides.

**Home Health and Personal Care Aide Supply**

The *Scorecard* shows that Connecticut increased the number of home health and personal care aides (“home care workers”) from 31 per 1,000 people during the 3-year period from 2007 to 2009, to 37 workers per 1,000 people from 2010 to 2012 (an increase of 19.4 percent). Table 3 shows the number of home health aides and personal care aides and their median hourly wages for the period 2008–2014.<sup>34</sup>

In general, these data confirm the *Scorecard’s* finding that the aggregate supply of home care

workers increased substantially. An examination of the increase shows

- The number of home health aides has been declining;
- The number of personal care aides has been increasing;
- The wage differential between the two groups has been narrowing; and
- Wages of personal care aides are increasing faster than wages of home health aides.

Four factors could explain the change in the number of home care workers from 2008 to 2014:

**First** — Home care workers were added as a covered service in the CHCPE and CHCPDA programs. Home care workers are often selected as a service (instead of home health aides) because they can provide a more diverse set of services to the consumer (homemaker/companion activities as well as assistance with ADLs and IADLs).

**Second** — National data from federal records indicate that, in 2007, Connecticut spent 34.2 percent of its LTSS funds on HCBS. By 2012, LTSS spending for HCBS increased by approximately 27 percent to 43.4 percent. During this period

**TABLE 3**  
**Number and Annual Percentage Change in Home Health Aides, Personal Care Aides, and Wages, 2008-2014**

Year	Home Health Aides (HHA)				Personal Care Aides (PCA)				Total Count HHA & PCA
	Annual Count	% Change in Count	Median Wage	% Change in Wage	Annual Count	% Change in Count	Median Wage	% Change in Wage	
2008	11,730	Not applicable	\$13.23	Not applicable	7,080	Not applicable	\$9.47	Not applicable	18,810
2009	11,750	0.17%	\$13.35	0.91%	8,680	22.60%	\$9.83	3.80%	20,430
2010	11,410	-2.89%	\$13.33	-0.15%	9,450	8.87%	\$10.37	5.49%	20,860
2011	9,610	-15.78%	\$13.04	-2.18%	11,350	20.11%	\$10.71	3.28%	20,960
2012	7,860	-18.21%	\$13.34	2.30%	14,460	27.40%	\$11.30	5.51%	22,320
2013	7,580	-3.56%	\$13.37	0.22%	17,340	19.92%	\$11.68	3.36%	24,920
2014	7,390	-2.51%	\$13.14	-1.72%	19,960	15.11%	\$11.89	1.80%	27,350

Source: Bureau of Labor Statistics, Occupational Employment Statistics (OES), 2015.

and continuing into 2014, the proportion of LTSS funding for Medicaid waiver services expanded. Home health and personal care services are components of Connecticut’s Medicaid waiver services. Despite flat growth in the number of licensed home care providers over the past 10 years (104 as of March 2015), increased numbers of people receiving home care services under the expanded Medicaid waiver programs may have prompted agencies to increase hiring due to greater demand for services. For example, an increase in the number of people receiving home care services may have a multiplier effect on labor demand in that adding a single new beneficiary could mean two to three dozen home health visits.

**Third** — The governor has been raising the minimum wage, which may have directly affected home care workers.<sup>35</sup> While the hourly wage of home health aides has remained relatively flat since 2008, the more than 25-percent increase in the hourly wage of personal care aides is likely a factor that contributed to the growth in the number of people employed in this occupation. No license or certification is required for home care workers in Connecticut. Home health aides in Connecticut must complete a minimum of 75 hours of mandatory training comprising both theory and clinical practice.

**Fourth** — On September 21, 2011, Governor Dannel Malloy signed Executive Order 10 allowing unionization of personal care attendants.<sup>36</sup> In 2014, the legislature approved the first contract covering approximately 11,000 personal care attendants, which took effect July 2014. The unionization of personal care attendants is likely an element that contributed to the growth in the number of personal care aides.

**Evidence of a Shift in Spending from Nursing Homes to HCBS**

A comparison of Connecticut expenditure data for nursing homes and three Medicaid HCBS waiver programs documents the shift from nursing homes to HCBS. AARP Connecticut has advocated

**TABLE 4**  
**Expenditures for Medicaid Nursing Facility Services and the Number of Paid Medicaid Days from 2009 to 2014**

Year	Medicaid Paid Days	Total Expenditures
2009	6,373,781	\$1,222,441,696
2010	6,391,068	\$1,215,383,670
2011	6,334,254	\$1,215,603,233
2012	6,256,610	\$1,230,798,194
2013	6,036,974	\$1,216,038,278
2014	6,194,752	\$1,194,703,948

*Source: Connecticut Department of Social Services, April 2015.*

for legislation to support the shift in spending from nursing homes to HCBS. State data show that Medicaid-paid days and expenditures have declined between 2009 and 2014. Table 4 shows that Medicaid-paid days and expenditures in nursing homes have declined approximately 2.8 percent and 2.3 percent, respectively, since 2009.

The data show a drop of 179,029 days from 6,373,781 in 2009 to 6,194,752 in 2014. This drop is equivalent to 490 fewer people in nursing homes who are Medicaid recipients. The fact that the number of paid Medicaid days has decreased across the same period implies that the existing Medicaid population in nursing homes decreased, with more being accommodated in HCBS programs instead of in nursing homes.

During this same 2009 to 2014 period, Medicaid use of HCBS waiver services increased, as reflected by the number of people receiving HCBS under the CHCPE, ABI, and PCA waiver programs. Table 5 shows the trend in the number of people served and total expenditures in the CHCPE waiver program for 2009 to 2014. These data also indicate that the percentage change in annual expenditures generally exceeds the percentage change in the number of people served in the CHCPE waiver and has kept pace with the rising per-person expenditures.

**TABLE 5**  
**Number of Unduplicated People Served, Expenditures, and Annual Percentage Change in the Connecticut Home Care Program for Elders Waiver, 2009-2014**

Connecticut Home Care Program for Elders						
Year	Number of Unduplicated People	Total Expenditures	Per-person Expenditures	% Change in People	% Change in Expenditures	% Change in Per-person Expenditures
2009	11,882	\$122,805,199	\$10,335	Notapplicable	Notapplicable	Notapplicable
2010	11,981	\$130,102,171	\$10,859	0.83%	5.94%	5.07%
2011	12,286	\$142,622,103	\$11,609	2.55%	9.62%	6.90%
2012	12,542	\$158,022,563	\$12,599	2.08%	10.80%	8.54%
2013	12,776	\$181,626,528	\$14,216	1.87%	14.94%	12.83%
2014	13,186	\$212,262,607	\$16,098	3.21%	16.87%	13.23%

Source: Connecticut Department of Social Services, March 2015.

**TABLE 6**  
**Number of Unduplicated People Served, Expenditures, and Annual Percentage Change in the Acquired Brain Injury Waivers, 2009-2013**

Acquired Brain Injury						
Year	Number of Unduplicated People	Total Expenditures	Per-person Expenditures	% Change in People	% Change in Expenditures	% Change in Per-person Expenditures
2009	374	\$33,902,975	\$90,650	Notapplicable	Notapplicable	Notapplicable
2010	379	\$35,331,196	\$93,222	1.34%	4.21%	2.84%
2011	402	\$35,510,579	\$88,335	6.07%	0.51%	-5.24%
2012	425	\$37,834,295	\$89,022	5.72%	6.54%	0.78%
2013	439	\$41,021,653	\$93,443	3.29%	8.42%	4.97%
2014	Notavailable	Notavailable	Notavailable	Notavailable	Notavailable	Notavailable

Source: Connecticut Department of Social Services, March 2015.

Table 6 shows the trend in the number of people served and total expenditures in the ABI waiver programs for 2009 to 2014. These data also indicate that the percentage change in annual expenditures for the ABI waiver programs generally exceed the percentage change in the number of people served in the programs and has kept pace with rising per person expenditures.

Table 7 (next page) shows the trend in the number of people served and total expenditures in the PCA

waiver program for 2009 to 2014. As with other waivers, the data show increases over the 6-year period in both the number of people served and total expenditures. Despite periodic state fiscal crises, funding for the ABI HCBS services has been maintained. Similar to the HCBS program for CHCPE and ABI waivers, annual expenditures in the PCA waiver has kept pace with rising annual per-person expenditures.

TABLE 7

**Number of Unduplicated People Served, Expenditures, and Annual Percentage Change in the Personal Care Assistance Waiver, 2009–2014**

Personal Care Assistance						
Year	Number of Unduplicated People	Total Expenditures	Per-person Expenditures	% Change in People	% Change in Expenditures	% Change in Per-person Expenditures
2009	787	\$19,523,446	\$24,807	Not applicable	Not applicable	Not applicable
2010	798	\$20,376,747	\$25,535	1.40%	4.37%	2.93%
2011	851	\$21,939,693	\$25,781	6.64%	7.67%	0.96%
2012	958	\$24,345,225	\$25,413	12.57%	10.96%	-1.43%
2013	994	\$26,280,104	\$26,439	3.76%	7.95%	4.04%
2014	1,032	\$28,562,867	\$27,677	3.82%	8.69%	4.68%

Source: Connecticut Department of Social Services, March 2015.

**Quality of Life and Quality of Care**

The *Quality of Life and Quality of Care* dimension includes indicators for level of support, life satisfaction, and employment of working-age people with disabilities living in the community, and three indicators of the quality in nursing homes. A high-performing LTSS system promotes the quality of life that individuals *have* as well as the quality of care that they *receive*.

Connecticut’s performance in the *Quality of Life and Quality of Care* dimension was attributed to its rankings on the following indicators:

- Life Satisfaction among People with Disabilities;
- Employment of People with Disabilities;
- High-Risk Nursing Home Residents with Pressure Sores; and
- Nursing Home Staffing Turnover.

**Life Satisfaction among People with Disabilities**

While Connecticut ranked sixth in the nation on the *Quality of Life and Quality of Care* dimension, it showed improvement on one indicator in particular, Life Satisfaction among People with Disabilities. Ranked 13th overall in the nation on this measure, data for the life satisfaction indicator are based on population surveys. Although Connecticut improved on this indicator, it is not

clear how state policies directly affect the attitudes within the general population.

**Employment of People with Disabilities**

Connecticut ranked fourth in the nation on the Employment of People with Disabilities measure. This achievement stems from the state’s initiative to encourage employment opportunities and its ongoing evaluation of the effectiveness of efforts to promote and secure employment for people with disabilities.

- From 2006 to 2011, Connecticut developed projects using employment service “process maps” that outlined the processes where people with disabilities obtained employment. This was a systematic effort to study and improve employment efforts at four agencies: Bureau of Rehabilitative Services, the Department of Mental Health and Addiction, the Department of Developmental Services, and the Board of Education and Services for the Blind.<sup>37</sup>
- Advocates in Connecticut established a state chapter of the Association of People Supporting Employment First. The chapter organizes training programs for people who want to become certified as an employment support professional.
- Connecticut has a Business Leadership Network (CT BLN) comprising employers that work together to increase employment opportunities

for people with disabilities. The CT BLN organizes quarterly events such as “Tapping into the Hidden Talent Pool: Where to Find Qualified Job Applicants with Disabilities.”<sup>38</sup>

- The Connecticut Youth Leadership Project conducts a weeklong Youth Leadership Forum that includes a notable employment component.
- For approximately 12 years, Connecticut has operated the Connect Ability, a Medicaid “buy-in” program where people with disabilities that work and earn over a certain amount of wages are eligible to receive Medicaid health care services if they pay a monthly premium to purchase their Medicaid benefits. A 2012 evaluation of the Medicaid buy-in program showed that from 2002 to 2011, program enrollment more than doubled to roughly 5,000 people, and that “For some people, the program’s generous features, including high income limits, waiver eligibility, and ability to retain medical coverage through most job losses of less than a year, enable employment that would otherwise be difficult or impossible.”<sup>39</sup>
- The 2013 Vocational Rehabilitation Needs Assessment and the Department of Rehabilitation Services website shows the sustained multiyear effort that Connecticut has made on its employment work for people with disabilities.<sup>40</sup>

While Connecticut continues to address challenges associated with creating employment opportunities for people with disabilities, its sustained work over the past decade has helped create solid programs that compare well nationally.

### ***High-Risk Nursing Home Residents with Pressure Sores***

Pressure sores, also referred to as “pressure ulcers,” have been a continuing concern of CMS for over 25 years.<sup>41</sup> There is ample literature, policy analysis, information about reimbursement rates, and resources available in the public domain on prevention and treatment of pressure sores. Connecticut ranked ninth in the nation on the percent of high-risk nursing home residents with pressure sores.

All states have experience with CMS periodically urging them to focus on pressure sores.<sup>42</sup> Staff

with the Connecticut Quality Improvement Organization (QIO) described numerous actions that have been taken since 2004 to educate nursing home staff about the prevention and treatment of pressure sores. In addition to hosting web-based education sessions and conducting periodic training events with the state and nursing home associations, the QIO conducts on-site work with individual nursing homes. On-site work includes

- Participating in wound care rounds;
- Making direct observations about appropriate treatment and preventive care such as evaluating turning and repositioning practices;
- Monitoring overall patient care practices;
- Focusing on the whole person—for example, looking at continence patterns; and
- Educating staff about prevention and treatment guidelines.

QIO staff report the biggest challenge they encounter is high turnover of nursing home administrator staff. Staff changes require the QIO to build new relationships and reestablish the priorities with senior leadership.

In addition to the work of the QIO, the state’s for-profit nursing home association has encouraged its members to participate in the American Health Care Association’s Advancing Excellence program, which has placed a primary emphasis on reducing pressure sores.<sup>43</sup> As of this writing, about 74 percent of for-profit nursing homes (169 homes) in Connecticut are participating in the Advancing Excellence program.<sup>44</sup>

The result of these periodic training events and the continuous work with nursing homes is that Connecticut ranks ninth in the nation on the low percentage of nursing home residents with pressure sores.

### ***Nursing Home Staffing Turnover***

Connecticut ranked third in the nation on nursing home staff turnover. Only two states, Hawaii and New York, had lower turnover. Three factors may help explain this high performance rank.

**First** — Nursing homes in Connecticut pay high wages. In sluggish economic conditions, labor turnover could be lower in occupations that pay higher wages.

**Second** — According to an industry representative, some nursing homes offer good benefits such as paid family leave. A job with better benefits would tend to have lower turnover.

**Third** — About 75 of the 230 nursing homes in Connecticut are unionized, and it is possible that unionization may bring lower labor turnover if the union has been successful in obtaining higher wages.<sup>45</sup>

#### ***Inappropriate Use of Antipsychotic Medications***

The 2014 *Scorecard* includes a new indicator in the *Quality of Life and Quality of Care* dimension that measures the percentage of long-stay nursing home residents who are receiving an antipsychotic medication. Based on 2013 data, Connecticut ranked 33rd in the nation on the percent of nursing home residents receiving an inappropriate antipsychotic medication, with almost 22 percent of long-stay residents inappropriately receiving such a drug.

Since 2013, Connecticut has been working on psychotropic use in its nursing homes. For example, in December 2013, the Connecticut Culture Change Coalition advertised courses on inappropriate use of antipsychotic medication, and in September 2014, multiple organizations, in addition to U.S. Senator Richard Blumenthal, participated in a statewide meeting to discuss the use of psychotropic drugs.<sup>46</sup> Most recent data from Nursing Home Compare show the statewide average is 20.3 percent.<sup>47</sup> Connecticut's higher use of inappropriate antipsychotic medication, as compared with other states, is an example of where a high-performing state like Connecticut has an opportunity to improve its overall performance.

#### **Support for Family Caregivers**

Family caregivers are an important component in the care of older adults and people with disabilities.<sup>48</sup> A high-performing LTSS system supports family caregiving. Three indicators were included in the *Support for Family Caregivers* dimension. Connecticut improved its scores on two

of these indicators: Legal and System Supports for Family Caregivers and Nurse Delegation.

#### ***Legal and System Supports for Family Caregivers***

The legal and system supports indicator is constructed using measures across the following six components, each of which is individually scored, to arrive at the state's overall score on this composite indicator:

- State family medical leave laws;
- Mandatory paid family leave and sick days;
- Providing unemployment insurance for family caregivers;
- Protecting family caregivers from employment discrimination;
- Extent of financial protections for spouses of Medicaid beneficiaries who receive LTSS; and
- Conducting a family caregiver needs assessment.

In the 2014 *Scorecard*, Connecticut received credit for having legal and system supports in place on all but the family caregiver assessment measure.<sup>49</sup> This represents an improvement in change over time.<sup>50</sup> AARP Connecticut has been a strong advocate for legislation to support family caregivers. Since the release of the 2011 *Scorecard*, Connecticut has enacted legislation for the following:

#### **Statewide mandatory paid sick days** —

Connecticut is the only state to have passed a law requiring employers to provide a minimum level of paid sick leave,<sup>51</sup> sometimes referred to as earned sick time. The 2012 law extends only to broadly defined "service workers" who work in a company with 50-plus employees, and does not cover workers with elder-care responsibilities.

#### **Unemployment insurance for family caregivers** —

The 2014 *Scorecard* shows that Connecticut is 1 of 23 states plus the District of Columbia with provisions in place to provide unemployment insurance for family caregivers who voluntarily quit their job to care for a family member who is ill or has a disability.<sup>52</sup> This is an improvement over the baseline year data, which showed that only eight states had laws in place to provide unemployment insurance for family caregivers.<sup>53</sup> Following the

release of the 2014 *Scorecard*, further analysis of state laws, regulations, and practices regarding access to unemployment insurance was published in an AARP research report.<sup>54</sup> The report shows that Connecticut has granted unemployment insurance benefits to workers who voluntarily quit their jobs for compelling family reasons since at least 2008.

**Statewide protection of family caregivers from employment discrimination** — Connecticut is currently the only state to have passed a law protecting family caregivers from employment discrimination.<sup>55</sup>

#### **Nurse Delegation**

This measure is based on a count of the number of health maintenance tasks that can be delegated by a registered nurse to LTSS direct care workers. In the 2014 *Scorecard*, Connecticut received credit for allowing five health maintenance tasks to be delegated, up from one task in the 2011 *Scorecard*. Despite this improved performance, 32 states delegated more tasks than Connecticut. The Connecticut legislature passed a bill on June 12, 2012, to increase the number of tasks that could be delegated. The bill authorizes registered nurses to delegate medication administration services to home health aides after the home health aide receives certification for administration of medications.<sup>56</sup> Private pay clients were already exempt from the requirement that a nurse administer medication, so the legislation affected individuals receiving state-funded and Medicaid services.

Despite legislative authorization, state staff reported that very few home health aides have been delegated to administer medication. The legislatively authorized delegation has not occurred in practice for two reasons. First, nurses expressed concerns with liability as nurses retain responsibility if problems occur when medication is administered. Second, nurses are paid to administer medications, a revenue source they would lose if the health maintenance task was delegated to direct care workers.

#### **Effective Transitions**

Although Connecticut has experience with care transition projects, the state ranked 39th in the

nation in the overall *Effective Transitions* dimension. While the *Scorecard* used the most current publicly available data (2009–2012), these data may not reflect the state's current progress toward nursing home diversions, reducing hospital admissions and readmissions, and transitioning people from institutional settings back to the community. For example, *Scorecard* data do not take into account the Care Transitions Initiative that was instituted to address preventable hospitalizations of all patients across Connecticut.<sup>57</sup> Information about other initiatives and programs that have been implemented since the year the data were reported in the *Scorecard* is discussed in the following sections.

Of the six indicators in the *Effective Transitions* dimension, further inquiry was made about the two lowest-ranking indicators (Nursing Home Residents with Low Care Needs and Home Health Patients with a Hospital Admission) to understand the reason for the low performance.

#### **Nursing Home Residents with Low Care Needs**

States that have a high percentage of nursing home residents with low care needs are using nursing homes as a housing alternative instead of providing HCBS. Based on the most current data available (2010), Connecticut ranked 36th in the nation on the percentage of nursing home residents with low care needs. Thirty-five other states had a lower proportion of nursing home residents with low care needs. These findings are consistent with the observation that the state's HCBS programs lack a strong residential component.

According to state office staff, the key reason behind the higher proportion of nursing home residents having low care needs was that Connecticut had a history of admitting people with mental health issues to nursing homes. In 2006, the Connecticut Office of Protection and Advocacy for People with Disabilities and the Bazelon Center for Mental Health Law in Washington, DC, filed a lawsuit against the state. Plaintiffs argued that when the state closed and downsized state psychiatric hospitals years ago, officials failed to develop community services for people with mental illness. According to the lawsuit, this resulted in the

placement of several thousand people with serious mental illness in nursing homes. This suit was settled 8 years later in May 2014 with Connecticut agreeing to provide more HCBS to people with mental illness who were placed in nursing homes.<sup>58</sup>

DSS staff reported that they visit nursing homes to check on the number of mentally ill people in the homes. Visits are conducted to ensure that the proportion of people with mental illness does not exceed 50 percent of the resident population in the nursing home. Nursing homes with more than 50 percent of residents with mental illness would be considered an “institution for mental disease” and would not be eligible to receive Medicaid nursing facility reimbursement.

As result of the lawsuit, in 2012, the state implemented a mental health waiver to provide more HCBS alternatives for people with mental illness. At inception, the mental health waiver was eligible to provide HCBS services for up to 190 people, increasing to 553 by 2017. The Department of Mental Health and Addiction Services also developed a nursing home transition program. In addition, the state developed a web-based level of care determination that made it more difficult for people with low care needs to obtain admission to nursing homes.<sup>59</sup>

Due to differences in timing of the data reported in the *Scorecard* (2009–2010) and changes in state practices that address people with mental illness, the *Scorecard* does not reflect Connecticut’s most current practices related to its nursing home diversion and transition programs. The net effect of the lawsuit settlement, the mental health waiver, the nursing home transition program, and the change in nursing home admission procedures should lower the number of people with low care needs being admitted to nursing homes.

#### **Home Health Patients with a Hospital Admission**

A key way to measure effective transitions is to evaluate the relative number of hospitalizations among patients receiving home health services. A lower rate of hospitalizations would generally be expected in a high-quality setting. Preventive services, early treatment of acute illnesses, and good management of chronic conditions can help

prevent avoidable hospitalizations. Once home care begins, home health agencies should monitor patients for their overall health status and provide training to family caregivers to minimize avoidable hospitalizations and readmissions.

States with a high percentage of people receiving home health services who are admitted to a hospital have opportunities to improve their care. Connecticut ranked the lowest (51st based on 2012 data)—that is, the worst—in the nation on the indicator that measures Home Health Patients with a Hospital Admission. According to people associated with the state’s home health agencies, Connecticut has low utilization of palliative care, which could help explain higher hospital admission rates of home health patients with chronic illness.

AARP separately examined CMS state-level 2011 data on the proportion of Medicare beneficiaries receiving hospice services and the average number of days people received these services.<sup>60</sup> Based on this analysis,<sup>61</sup> Connecticut ranked 41st in the nation on the proportion of Medicare beneficiaries receiving hospice services. Forty other states had a higher percentage of Medicare beneficiaries receiving hospice care. In addition, Connecticut ranked 50th in the nation for the average number of days of hospice service per patient. In 49 states, the average patient received more hospice days of service than Connecticut. Only Alaska had fewer days of hospice service per patient. These CMS data indicate that fewer Medicare patients receive hospice services in Connecticut compared with other states, and those patients who do receive services receive far fewer days of care than people in other states.

The Interventions to Reduce Acute Care Transfers (INTERACT) program for home health agencies is being introduced by quality improvement organizations in the New England area. INTERACT is a quality-of-care approach that provides tools and best practices to nursing home and home health agency staff to reduce inappropriate transfers to hospitals.<sup>62</sup> As this education becomes more widespread, it should help reduce unnecessary hospital admissions of people receiving home health services.<sup>63</sup>

### **Connecticut's Money Follows the Person Program**

Connecticut was awarded an MFP grant in 2008 and as of calendar year-end 2014, over 2,600 people have been transitioned from institutional settings back to the community. Although *Scorecard* indicators in the *Effective Transitions* dimension reflect the most current data available (2009), as of the publication date of the report in 2014, they do not take into account the state's most current MFP program trends.

Connecticut staff who were interviewed attributed MFP's success to the program's design. The MFP budget was included in the ongoing DSS budget and was not funded as a separate grant program, thus facilitating continued funding. In addition, the MFP director reports directly to the Medicaid director, ensuring the program has the support of Medicaid. The practice of embedding LTSS innovations in the ongoing budget of DSS was essential to building a cumulative, sustained impact.

In 2009, the target for the number of transitions was increased to 800 people. In 2010, the program was reorganized based on the results of its 2008 and 2009 operations. Before the reorganization, when a referral was made to the MFP program, a transition coordinator made the first visit to the individual and then a second visit was made by a clinical staff person to do an assessment. As a result, assessments were not done timely. The reorganization changed the process so that assessments would be done first by contracted staff working on a fee-for-service basis. These changes led to more timely assessments. Changes in federal funding in 2010 helped increase the amount of funds available to reimburse administrative expenses. Following the 2010 reorganization, the Connecticut MFP program expanded significantly beginning in 2011.

In 2013, Governor Malloy's Rebalancing Plan set a goal to transition 5,000 people. During interviews with state staff, it was reported that the program has been successful in obtaining support of the legislature and governor's office because it has been able to show that the program saves money, improves quality of life, and offers choice. Cost studies by state budget units have shown that the

MFP program is cost effective. In addition, program studies conducted by the University of Connecticut report quality outcomes.<sup>64</sup> Emphasis on offering people a choice of services reverberates with policy makers and program participants.

Connecticut reorganized the program for a second time in 2014. Currently, the MFP has about 100 contracted field staff conducting assessments and helping transition people from nursing homes. In addition, approximately 30 state staff in the central office support eligibility determinations, policy, and other administrative functions. MFP contracts with Area Agencies on Aging, community-based independent living centers, and Connecticut Community Care, Inc., a care management organization.

Figure 1 shows the number of transitions that occurred each quarter from 2009 to the end of 2014. The cumulative total is 2,624 transitions, with 22 percent occurring in 2014. The majority (approximately 86 percent) of transitions are older adults and people with physical disabilities. The balance (approximately 14 percent) of transitions involved people with mental health issues and developmental disabilities.<sup>65</sup>

### **USE OF INTEGRATED TECHNOLOGY AND OTHER ADVANCES**

As part of the state's BIP implementation, Connecticut is developing an assessment tool that spans programs for older adults as well as people with physical disabilities or intellectual and developmental disabilities. This tool will be integrated into the state's existing web-based platforms.

- In October 2013, Connecticut launched Access Health CT, a web portal that Connecticut residents use to apply for health insurance through the Health Insurance Marketplace and for some Medicaid programs.<sup>66</sup> Individuals can also create and access a personal account called "MyAccount" from which updates can be made and supporting verifications can be uploaded.
- In April 2013, Connecticut launched ConneCT, which provides access to DSS programs. Through

Figure 1  
**Number of Transitions from Nursing Homes in Connecticut’s Money Follows the Person Program, 2009-2014**



Source: University of Connecticut, Center on Aging, December 2014.

ConneCT, individuals can check eligibility, apply for benefits, obtain DSS forms, and access their MyAccount.<sup>67</sup>

- In June 2013, Connecticut rolled out MyPlaceCT, a website that provides information about LTSS services that also links individuals to ConneCT.<sup>68</sup> MyPlaceCT is a comprehensive informational site for LTSS that also covers housing and transportation, has information on affordable care and service providers, and has an online chat feature to help users with questions.
- Throughout 2014, the state worked to integrate various website platforms and in second quarter 2015 is preparing to launch a new consolidated assessment instrument that will help establish eligibility for waiver programs and other services spanning older adults and people with physical and intellectual disabilities.
- In late 2015 or early 2016, the state will implement its automated “No Wrong Door” system, which will include an online functional prescreen and application for LTSS. The functional prescreen will use predictive modeling to anticipate which agency and waiver will best serve the LTSS

recipient and route the prescreen file to that agency to determine eligibility and perform a functional assessment. The state is developing a new eligibility management system (ImpaCT), which is planned for release in March 2016. When ImpaCT is operational, the state plans to integrate the functional and financial aspects of LTSS eligibility and provide the consumer with a dashboard that shows the status of both functional and financial eligibility including missing verifications, gives access to personal health records, and allows the individual to see assessment and care plan information.

- State staff are planning ongoing technology improvements over the next 3 years. Current technology projects are to be funded with a 90-percent federal match on a \$14 million expenditure. Two additional federal requests are planned for 90-percent matching. The state share of these technology projects is being paid for through the sale of bonds. Future projects will expand on what has been accomplished and bring additional partners, such as hospitals, into the system, as well as additional types of information, such as financial data.

In 2014, Connecticut was one of nine states awarded a federal TEFT grant to expand health information technology in its community-based LTSS system. The Connecticut TEFT grant will enable the state to

- Build an automated instrument to survey individuals about their experience of care;
- Test the national experience of care tools developed by CMS;
- Develop electronic health records that incorporate LTSS information; and
- Participate in the development of standards for a uniform national LTSS health record.

The TEFT grant is significant because it funds the foundation of future work in health information technology for LTSS services including the use of personal LTSS health records by individuals.

## **CONCLUSION**

There are good reasons why Connecticut ranks highly in the quality of its LTSS programs. Connecticut has made significant accomplishments despite its continual and sizeable budget difficulties. These accomplishments rest on the sustained ability of state staff and advocates to articulate a vision of LTSS and translate that vision into practical implementation steps that are then implemented. A good example of this process is the governor's 2013 3-year rebalancing plan for LTSS, which lays out a broad vision of what LTSS is, including housing and transportation, and also specifies concrete steps and budgets to achieve targets of the rebalancing plan.

APPENDIX

TABLE A-1  
**Connecticut: 2014 State Long-Term Services and Supports Scorecard Dimensions and Data**

Dimension and Indicator (Current Data Year)	Baseline Rate	Current Rate	Rank	Change	All States Median	Top State Rate
<b>OVERALL RANK</b>			<b>12</b>			
<b>Affordability and Access</b>			<b>4</b>			
Median annual nursing home private pay cost as a percentage of median household income age 65+ (2013)	345%	<b>359%</b>	<b>49</b>	↔	234%	168%
Median annual home care private pay cost as a percentage of median household income age 65+ (2013)	83%	<b>77%</b>	<b>9</b>	↔	84%	47%
Private long-term care insurance policies in effect per 1,000 population age 40+ (2011)	52	<b>53</b>	<b>16</b>	↔	44	130
Percent of adults age 21+ with ADL disability at or below 250% of poverty receiving Medicaid or other government assistance health insurance (2011-12)	57.0%	<b>60.7%</b>	<b>8</b>	✓	51.4%	78.1%
Medicaid LTSS participant years per 100 adults ages 21+ with ADL disability in nursing homes or at/below 250% poverty in the community (2009)	54.9	<b>60.7</b>	<b>4</b>	✓	42.3	85.2
ADRC functions (composite indicator, scale 0-70) (2012)	**	<b>60</b>	<b>10</b>	✓	54	67
<b>Choice of Setting and Provider</b>			<b>22</b>			
Percent of Medicaid and state LTSS spending going to HCBS for older people and adults with physical disabilities (2011)	27.5%	<b>28.5%</b>	<b>29</b>	↔	31.4%	65.4%
Percent of new Medicaid aged/disabled LTSS users first receiving services in the community (2009)	38.3%	<b>39.9%</b>	<b>30</b>	↔	50.7%	81.9%
Number of people participant-directing services per 1,000 adults ages 18+ with disabilities (2013)	*	<b>13.9</b>	<b>19</b>	*	8.8	127.3
Home health and personal care aides per 1,000 population age 65+ (2010-12)	31	<b>37</b>	<b>20</b>	✓	33	76
Assisted-living and residential care units per 1,000 population age 65+ (2012-13)	*	*	*	*	27	125
<b>Quality of Life and Quality of Care</b>			<b>6</b>			
Percent of adults ages 18+ with disabilities in the community usually or always getting needed support (2010)	70.9%	<b>72.5%</b>	<b>25</b>	↔	71.8%	79.1%
Percent of adults ages 18+ with disabilities in the community satisfied or very satisfied with life (2010)	85.4%	<b>88.4%</b>	<b>13</b>	✓	86.7%	92.1%
Rate of employment for adults with ADL disability ages 18-64 relative to rate of employment for adults without ADL disability ages 18-64 (2011-12)	30.7%	<b>30.7%</b>	<b>4</b>	↔	23.4%	37.2%
Percent of high-risk nursing home residents with pressure sores (2013)	*	<b>4.7%</b>	<b>9</b>	*	5.9%	3.0%
Nursing home staffing turnover: ratio of employee terminations to the average number of active employees (2010)	18.7%	<b>21.7%</b>	<b>3</b>	✗	38.1%	15.4%
Percent of long-stay nursing home residents receiving an antipsychotic medication (2013)	*	<b>21.9%</b>	<b>33</b>	*	20.2%	11.9%

(continued)

TABLE A-1 (continued)

Dimension and Indicator (Current Data Year)	Baseline Rate	Current Rate	Rank	Change	All States Median	Top State Rate
<b>Support for Family Caregivers</b>			<b>30</b>			
Legal and system supports for family caregivers (composite indicator, scale 0–14.5) (2012–13)	**	<b>6.50</b>	<b>5</b>	✓	3.00	8.00
Number of health maintenance tasks able to be delegated to LTSS workers (out of 16 tasks) (2013)	1	<b>5</b>	<b>33</b>	✓	9.5	16
Family caregivers without much worry or stress, with enough time, well-rested (2011–12)	60.5%	<b>59.4%</b>	<b>40</b>	↔	61.6%	72.8%
<b>Effective Transitions</b>			<b>39</b>			
Percent of nursing home residents with low care needs (2010)	15.5%	<b>15.1%</b>	<b>36</b>	↔	11.7%	1.1%
Percent of home health patients with a hospital admission (2012)	*	<b>32.3%</b>	<b>51</b>	*	25.5%	18.9%
Percent of long-stay nursing home residents hospitalized within a 6-month period (2010)	18.7%	<b>18.9%</b>	<b>25</b>	↔	18.9%	7.3%
Percent of nursing home residents with moderate to severe dementia with one or more potentially burdensome transitions at end of life (2009)	*	<b>20.9%</b>	<b>29</b>	*	20.3%	7.1%
Percent of new nursing home stays lasting 100 days or more (2009)	*	<b>18.2%</b>	<b>15</b>	*	19.8%	10.3%
Percent of people with 90+ day nursing home stays successfully transitioning back to the community (2009)	*	<b>6.7%</b>	<b>38</b>	*	7.9%	15.8%

Source: Connecticut Fact Sheet. See <http://www.longtermscorecard.org>.

\* Comparable data not available for baseline or current year. Change in performance cannot be calculated without baseline and current data.

\*\* Composite measure. Baseline rate is not shown as some components of the measure are available only for the current year. Change in performance is based only on those components with comparable prior data. See pages 73 and 83 in *Raising Expectations 2014: A State Scorecard on Long-Term Services and Supports for Older Adults, People with Physical Disabilities, and Family Caregivers* for more detail.

Please refer to Appendix B2 on page 97 of the report for full indicator descriptions, data sources, and other notes about methodology; for baseline data years, please see Exhibit 2 on page 11. The full report is available at [www.longtermScorecard.org](http://www.longtermScorecard.org).

Key for Change:	
Performance improvement	✓
Little or no change in performance	↔
Performance decline	✗

- 1 S. Reinhard, E. Kassner, A. Houser, K. Ujvari, R. Mollica, and L. Hendrickson, *Raising Expectations, 2014: A State Scorecard on Long-Term Services and Supports for Older Adults, People with Physical Disabilities, and Family Caregivers* (Washington, DC: AARP Public Policy Institute, June 2014). Available at <http://longtermscorecard.org>.
- 2 The authors would like to thank Megan Juring of The SCAN Foundation for participating in the on-site interviews for this case study.
- 3 S. Reinhard, E. Kassner, A. Houser, K. Ujvari, R. Mollica, and L. Hendrickson, *Raising Expectations, 2014: A State Scorecard on Long-Term Services and Supports for Older Adults, People with Physical Disabilities, and Family Caregivers* (Washington, DC: AARP Public Policy Institute, June 2014). Available at <http://longtermscorecard.org>.
- 4 Appendix B4 of the 2014 *Scorecard* has a complete discussion of changes to the indicators from the 2011 *Scorecard* and which indicators could be compared over time. See <http://www.longtermscorecard.org/>. p. 102.
- 5 See Exhibit A4 on p. 67 of the 2014 *Scorecard* for information on how states improved and appendix B5 on p. 105 of the report for how changes are quantified as improvements. See <http://www.longtermscorecard.org/>.
- 6 Census and population density data are available at <http://quickfacts.census.gov/qfd/states/09000.html>.
- 7 Ibid.
- 8 AARP Public Policy Institute calculations from REMI (Regional Economic Models Inc.) 2012 baseline demographic projections.
- 9 2010 Census Urban and Rural Classification and Urban Area Criteria; Lists of Population, Land Area, and Percent Urban and Rural in 2010 and Changes from 2000 to 2010; Percent Urban and Rural in 2010 by state at <https://www.census.gov/geo/reference/ua/urban-rural-2010.html>.
- 10 U.S. Census Bureau, Current Population Survey, 2012, 2013, and 2014 Annual Social and Economic Supplements. Median Household Income (in 2013 Inflation-Adjusted Dollars) by State Ranked from Highest to Lowest Using 3-Year Average: 2011–2013. Available at <http://www.census.gov/hhes/www/income/data/statemedian/>.
- 11 American Health Care Association, Nursing Facility Operational Characteristics Report (December 2014), in table 4. Available at [http://alt.ahcancal.org/research\\_data/oscar\\_data/Nursing%20Facility%20Operational%20Characteristics/LTC%20STATS\\_PVNF\\_OPERATIONS\\_2014Q2\\_FINAL.pdf](http://alt.ahcancal.org/research_data/oscar_data/Nursing%20Facility%20Operational%20Characteristics/LTC%20STATS_PVNF_OPERATIONS_2014Q2_FINAL.pdf).
- 12 AARP analysis of 2012 residential care homes, beds counts, and per diem rates. Available at [http://www.ct.gov/dph/lib/dph/facility\\_licensing\\_and\\_investigations/pdf/nursing\\_home\\_book.pdf](http://www.ct.gov/dph/lib/dph/facility_licensing_and_investigations/pdf/nursing_home_book.pdf).
- 13 See the Assisted-Living Service Agency, Home Health Care Agency, and Homemaker/Home Health Care Agency records on the Long-Term Care/Assisted-Living Facilities/Home Health Care/Hospice eLicensing tab at <https://www.elicense.ct.gov/Lookup/GenerateRoster.aspx>.
- 14 As of this writing, the number of Homemaker/Companion agencies that are licensed by the Department of Consumer Protection could not be confirmed.
- 15 Information about the state budget is available at [http://ballotpedia.org/Connecticut\\_state\\_budget](http://ballotpedia.org/Connecticut_state_budget).
- 16 See <http://www.wsj.com/articles/connecticuts-budget-gap-taxation-issues-await-malloy-1420165575>. See also <http://www.courant.com/politics/hc-rescissions-ct-budget-20150123-story.html> and <http://ctmirror.org/2015/02/24/more-cuts-needed-malloy-budget-bursts-spending-cap/>.
- 17 See Governor Malloy’s plan at <http://www.ct.gov/dss/cwp/view.asp?Q=517822&A=4125>.
- 18 Additional information on CHCPE is available at <http://www.ct.gov/agingservices/lib/agingservices/manual/homecareandsupportiveservices/connecticuthomecareprogramforeldersfinal.pdf>.
- 19 Additional information on CHCPDA is available at <http://www.ct.gov/dss/cwp/view.asp?A=2353&Q=390304>.
- 20 For more information about BIP, see <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Long-Term-Services-and-Supports/Balancing/Balancing-Incentive-Program.html>.
- 21 For further information on the No Wrong Door initiative, see the section of this report entitled “Use of Integrated Technology and Other Advances.”
- 22 For additional information about TEFT, see <http://www.medicaid.gov/medicaid-chip-program-information/by-topics/delivery-systems/grant-programs/teft-program.html>.
- 23 Appendix B5 of the 2014 *Scorecard* contains an explanation of when an improvement was deemed to occur. See <http://www.longtermscorecard.org/>. p. 109.
- 24 When change occurs in Medicaid LTSS, eventually it will affect other stakeholders, including payer source.
- 25 See [http://www.ct.gov/opm/lib/opm/budget/2016\\_2017\\_biennial\\_budget/budget/introduction.pdf](http://www.ct.gov/opm/lib/opm/budget/2016_2017_biennial_budget/budget/introduction.pdf). These February 18, 2015, budget remarks by the governor froze enrollment in Category 1 and increased the 7-percent cost share to 15 percent.

- 26 In Connecticut, the annual private pay nursing home cost averages 359 percent of an older adult's annual household income. When the cost of care exceeds median income to such a degree, many people with LTSS needs will deplete their life savings and eventually turn to public aid for assistance.
- 27 See the Connecticut Department of Social Services Medical Assistance Program March 2013 Provider Bulletin for additional information on the Adult Family Living program. Available at [http://www.swcaa.org/wp-content/uploads/2014/01/pb13\\_50AdultFamilyLiving.pdf](http://www.swcaa.org/wp-content/uploads/2014/01/pb13_50AdultFamilyLiving.pdf).
- 28 A 2009 Connecticut Housing Finance Authority document describes the development of one of these sites. See <http://chfa.org/content/CHFA%20Document%20Library/Herbert%20T%20Clark%20Assisted%20Living.pdf>.
- 29 For additional information on the Private Assisted-Living Pilot Program, see <http://www.ct.gov/dss/cwp/view.asp?a=2353&q=391114>.
- 30 Approximately 42 states now have partnership policies. Interview with Connecticut staff, February 11, 2015.
- 31 For more information on the Partnership program, see the annual report available at [http://www.ct.gov/opm/lib/opm/hhs/ltc/annrpt-\\_jan.\\_2015.pdf](http://www.ct.gov/opm/lib/opm/hhs/ltc/annrpt-_jan._2015.pdf).
- 32 Ibid. p. 16.
- 33 LTCI policy data in the 2011 and 2014 *Scorecards* were for the period 2009 and 2011, respectively.
- 34 See Bureau of Labor Statistics, Occupational Employment Statistics, OES data, by year, by state (html) at <http://www.bls.gov/oes/tables.htm>. Home health aide occupation code 31-1011 and personal care aide occupation code 39-9021.
- 35 In 2009, the minimum wage increased to \$8.00. In 2010, the minimum wage increased to \$8.25. These increases could have potentially drawn more workers into the industry in 2010–2012. On January 1, 2014, the minimum wage in Connecticut was raised to \$8.70 and on January 1, 2015, it was further raised to \$9.15. See <http://www.ctdol.state.ct.us/wgwkstnd/wage-hour/history.htm>.
- 36 For more information on unionization of personal care aides in Connecticut, see [http://www.governor.ct.gov/malloy/lib/malloy/EO\\_10\\_Personal\\_Care\\_Attendant\\_Quality\\_Home\\_Care\\_Workforce\\_Council.pdf](http://www.governor.ct.gov/malloy/lib/malloy/EO_10_Personal_Care_Attendant_Quality_Home_Care_Workforce_Council.pdf) and [http://www.ctnewsjunkie.com/archives/entry/malloy\\_keeps\\_promise\\_to\\_unions\\_in\\_signing\\_two\\_executive\\_orders/](http://www.ctnewsjunkie.com/archives/entry/malloy_keeps_promise_to_unions_in_signing_two_executive_orders/).
- 37 For additional information on the employment service process map, see <http://www.ct.gov/connect-ability/lib/connect-ability/research/2011employmentprocessmapreport.pdf>.
- 38 Information on the Connecticut Business Leadership Network is available at <http://ctbln.com/>.
- 39 Additional information on the Connecticut buy-in program is available at <http://www.ct.gov/connect-ability/lib/connect-ability/research/medconnectreport0912.pdf>.
- 40 Research papers and other reports addressing the vocational rehabilitation needs assessment process are available at <http://www.ct.gov/connect-ability/cwp/view.asp?a=4471&q=529696>.
- 41 CMS first approved the use of air-fluidized beds in 1990. See <http://www.cms.gov/medicare-coverage-database/details/nca-decision-memo.aspx?NCAId=4&TAId=2&IsPopUp=y&bc=AAAAAAAAAgAAAA%3D%3D&>.
- 42 CMS issues multiyear scope of work (SOW) requirements to its QIOs. These SOW requirements typically identify pressure sores as a quality improvement priority.
- 43 For more information on the Advancing Excellence program, see <https://www.nhqualitycampaign.org/goalDetail.aspx?g=pu>.
- 44 For current program enrollment information in the Advancing Excellence program, see <http://www.ctculturechange.org/index.php/advancing-excellence/cts-progress/>.
- 45 Additional background information on the unionization of Connecticut nursing homes is available at <http://ctmirror.org/2014/05/06/seiu-1199-wins-fight-for-ct-nursing-home-transparency-law/>.
- 46 For more information on the statewide meeting to address inappropriate use of antipsychotic medication in nursing homes, see <http://c-hit.org/2014/10/01/blumenthal-hosts-discussion-on-use-of-antipsychotic-drugs/>.
- 47 The 2014 three-quarter average measure score is above the national average of 19.2 percent. Information about the use of antipsychotic medication in nursing homes is available at <https://data.medicare.gov/data/nursing-home-compare/Quality%20Measures>. See quality measures—long stay; measure code 419, Percent of Long-Stay Residents Who Received an Antipsychotic Medication; CMS processing date May 1, 2015.
- 48 For example, in 2011, AARP estimated that the economic value of family caregiving was \$450 billion per year. See <http://www.aarp.org/relationships/caregiving/info-07-2011/caregivers-save-us-health-care-system-money.html>.
- 49 Appendix A, Exhibit A15 of the 2014 *Scorecard* includes the component scores across six different measures. “Having a Caregiver Assessment” is the only component that did not receive a score for Connecticut in the 2014 *Scorecard*. See <http://www.longtermscorecard.org>, p. 82.

- 50 Ibid. p. 83.
- 51 The District of Columbia also has a paid sick days law.
- 52 Appendix A, Exhibit A15 of the 2014 *Scorecard* includes the component scores across six different measures. “Having a Caregiver Assessment” is the only component that did not receive a score for Connecticut in the 2014 *Scorecard*. See <http://www.longtermscorecard.org>. p. 82.
- 53 Ibid. p. 83.
- 54 L. Ben-Ishai, R. McHugh, and K. Ujvari. *Access to Unemployment Insurance Benefits for Family Caregivers: An Analysis of State Rules and Practices*. (Washington, DC: AARP Public Policy Institute, April 2015). Available at <http://longtermscorecard.org/publications/access-to-unemployment-insurance-benefits-for-family-caregivers>.
- 55 The District of Columbia also has a law that protects family caregivers from employment discrimination.
- 56 Section 11 of Public Act 12-1 of the June 2012 special session, codified in section 19a-492e of the Connecticut General Statutes. See also [http://www.cga.ct.gov/current/pub/chap\\_368v.htm#sec\\_19a-492e](http://www.cga.ct.gov/current/pub/chap_368v.htm#sec_19a-492e).
- 57 Qualidigm and the Connecticut Hospital Association launched a two-pronged Heart Failure Readmission Initiative in 2010 to reduce preventable hospital readmissions for people with heart failure. The initiative was broadened to include all patients in 2012. Twenty-four hospitals participate in the project. See <http://www.qualidigm.org/index.php/qio-program/care-transitions/>.
- 58 For additional information on the suit filed by the Office of Protection and Advocacy for People with Disabilities and the Bazelon Center for Mental Health Law against Connecticut, see <http://www.bostonglobe.com/metro/2014/05/01/state-advocates-have-deal-mental-health-housing-lawsuit/TdpTYZdzBg4CiC3KAExZ0K/story.html> and <http://www.bazelon.org/LinkClick.aspx?fileticket=nkOemzg1L8o%3D&tabid=179>.
- 59 See the contract with Ascend describing the scope of work. Available at [http://www.ct.gov/dss/lib/dss/09DSS6502YJ\\_ACU\\_orig-A2\\_Ascend\\_Management.pdf](http://www.ct.gov/dss/lib/dss/09DSS6502YJ_ACU_orig-A2_Ascend_Management.pdf).
- 60 The latest year for which data are available is 2011. For data on Medicare beneficiaries by state, see <http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MedicareEnrpts/index.html>. For data on 2011 hospice utilization, see <http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MedicareFeeForSvcPartsAB/MedicareUtilizationforPartA.html>.
- 61 Analysis of the 2011 CMS hospice data was not included in the scope of the 2011 and 2014 *LTSS Scorecards*.
- 62 For an explanation of the toolkits used, see the INTERACT website at <https://interact2.net/>.
- 63 For information on the use of INTERACT in home health agencies, see [http://www.healthcarefornewengland.org/wp-content/uploads/Welcome-to-the-Home-Health-Collaborative-final\\_508.pdf](http://www.healthcarefornewengland.org/wp-content/uploads/Welcome-to-the-Home-Health-Collaborative-final_508.pdf).
- 64 The University of Connecticut, Center on Aging website has extensive information about MFP program statistics including program quality findings. See [http://www.uconn-aging.uhc.edu/money\\_follows\\_the\\_person\\_demonstration\\_evaluation\\_reports.html](http://www.uconn-aging.uhc.edu/money_follows_the_person_demonstration_evaluation_reports.html).
- 65 MFP Quarterly Report: 2014 Q4. Available at <http://www.uconn-aging.uhc.edu/2014%20Q4%20MFP%20report.pdf>.
- 66 For more information on the Access Health CT website, see <https://www.accesshealthct.com/AHCT/LandingPageCTHIX>.
- 67 For more information about the Connecticut Department of Social Services ConneCT website, see <https://connect.ct.gov/access/jsp/access/Home.jsp>.
- 68 For more information about MyPlaceCT, see <http://www.myplacect.org/about-us/welcome>.

---

Insight on the Issues 105, June 2015

© **AARP PUBLIC POLICY INSTITUTE**

601 E Street, NW  
Washington DC 20049

Follow us on Twitter @AARPPolicy  
on facebook.com/AARPolicy  
[www.aarp.org/ppi](http://www.aarp.org/ppi)

For more reports from the Public Policy  
Institute, visit <http://www.aarp.org/ppi/>.



Real Possibilities

**Public Policy  
Institute**