Current state
Connecticut has been implementing strategies to serve more people in home and community-based settings since 1988, when the Long-Term Care Planning Committee was authorized by the legislature. However, the state still has one of the highest per-capita nursing home usages in the country. With the support of almost $73M in new Balanced Incentive Program (BIP) federal funding, Connecticut is looking to move up to 5,200 people from nursing facilities back to the community and to increase the percentage of long-term services and support (LTSS) spending on Home and Community-Based Services (HCBS) from 42 percent to 50 percent of the total by 2015.

Opportunity for Connecticut
Optum™ proposes a solution for Connecticut that supports and augments planned state efforts to rebalance LTSS and HCBS spending. The Optum proposal focuses on early interventions for post-acute transitions of Medicaid members or those individuals who run a high risk of becoming Medicaid eligible in an institutional setting. This approach is supported by national statistics, which indicate that:

- 65 percent of all Medicaid-eligible people who enter a nursing home are still there after six months
- Half of all Medicare admissions remain in the nursing home at six months¹ and
- Nearly two-thirds of long-stay nursing home residents admitted under Medicare end up on Medicaid within a year.

Optum is already successfully managing the medical spend of approximately 2,000 Medicare Advantage Institutional Special Needs Plan (I-SNP) members in 65 Connecticut nursing homes. Optum employs nurse practitioners to provide direct medical care to enrollees so they stay healthy and don’t need to go to the hospital for acute illnesses. The nurse practitioners are available 24/7 and have effectively reduced unnecessary acute care admissions by 50 percent.² We are very selective about the facilities where we offer this program, enabling our program to reinforce high-quality facility care. The facilities benefit by achieving higher quality scores, more referrals and elimination of the three-day hospital stay requirement for Medicare reimbursement.

By leveraging our local clinical resources, care management systems, and nursing facility relationships, Optum can help Connecticut achieve its goals of increasing community living and preventing long-term nursing facility stays. Our proposal focuses on early interventions for post-acute nursing home residents, with the goal of increasing successful transitions to the community.

How this fits into Connecticut’s existing programs

- Targets all nursing facility admissions, regardless of payment source
- Residents that are interested in returning home and have available supports are transitioned before community support network dissolves
- Partners with programs servicing Connecticut’s Home Care Program for Elders (CHCPE) for community-based services
- Residents who remain in the nursing facility do so based on choice and/or medical needs, not circumstance

66% of all long-term Medicare nursing facility admissions are on Medicaid within a year
**Optum proposal for preventing a long-term facility stay**

We share the State’s goal of ensuring that frail seniors and people with disabilities have the proper medical care and functional level supports in the community so that they can remain at home, and don’t return to the hospital or nursing facility after an acute event or short-term stay.

Assisting individuals with post-acute transitions during the critical period early in their nursing home stay is vital to reducing long-term institutionalization; however, many are overlooked by the current system because they are private-pay or Medicare fee for service (FFS). They are not yet Medicaid eligible, and necessary home care services are not paid for by the Medicare program. These individuals are often referred to as “pre-duals” since they are not Medicaid eligible at the time of nursing facility admission but become eligible as they spend down their assets during their long-term stay at the facility.

At Optum, our internal data suggest that when a nursing facility resident has been in the facility for 60 days or more, the likelihood of returning to the community is very low. The failure of residents to leave the nursing facility after day 60 is due to a number of factors, including the loss of community housing and family members coming to accept the idea of a long-term stay. Although Connecticut has a strong and successful Money Follows the Person program that has transitioned many residents after 90 days in the facility, we believe that there needs to be an earlier intervention to prevent more long-term stays. This is particularly true for the Medicare population not yet eligible for Medicaid.

**Optum-proposed program**

Optum proposes identifying sub-acute Medicare residents who have been in the nursing facility for 45–90 days for transition to the community. Working with the nursing facility and using the nursing facility assessment data (Minimum Data Set or MDS), we would target people who could have a successful transition to home-based care. Using our clinical staff to engage, identify and screen residents, we would offer transition services to those individuals who want to go home and have some community support.

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**Preventing long-term stays**

<table>
<thead>
<tr>
<th>30,000</th>
<th>11,000</th>
<th>3,200</th>
<th>644</th>
</tr>
</thead>
<tbody>
<tr>
<td>Admits</td>
<td>Residents remain in nursing facilities 45–90 days</td>
<td>Candidates for transition</td>
<td>Assisted transitions succeed</td>
</tr>
</tbody>
</table>

Identify remaining residents in nursing facilities 45–90 days

Screen for transition to community

Engage transition candidates

Residents screened for successful transition. Characteristics include:

- Elderly admits with limited to no significant cognitive impairment
- Identified and available community/family supports
- Other medical and social factors
- A desire to return home
- Optum will follow the member in the community for 30–60 days
- Of the successful transitions, Optum anticipates half will be Medicare only and fully assisted by the program, and half will be referred to Connecticut’s existing Medicaid support networks

Notes: Percent meeting target criteria and transitioning based on Minnesota’s RTC experience. Optum anticipates numbers qualified and transitioned will ultimately be greater due to earlier screening and increased flexibility in program structure.
Most of these individuals, without the appropriate interventions, would be at risk for long-term stay, and if not already Medicaid eligible would likely become so within the first year. Working together with the individual’s HCBS providers and plan of care, our clinicians can help maintain people at home and out of institutions.

**Proven model**

In 2010, Minnesota implemented its Return to Community initiative to provide support for non-dual Medicare and private-pay beneficiaries who have been in the nursing facility 60–90 days to transition home. The program has successfully transitioned more than 2,000 people who would most likely have become long-term Medicaid residents.3

This program uses state funds to pay for coordinating transitions for people likely to become Medicaid eligible if they stay in the facility and who have the desire and/or support to return to the community. Potential members are identified via MDS data and nursing home referrals. The program is unique because it focuses on private-pay members who would otherwise become Medicaid eligible. Although the state covers the cost of this intervention, any services identified in the care plan are the responsibility of the member. Minnesota has demonstrated that the savings more than cover the program cost. An analysis by The Lewin Group® commissioned by the Administration for Community Living found that if the Return to Community model were implemented nationwide, the ROI would be 2.81 — for each state dollar invested, almost three were saved. This ROI considers the cost of screening potential members, transition of accessed and agreed people, ongoing care planning, and management and delivery of community-based services.

In the “Framework for Value” we compare the Minnesota program to the Connecticut Home Care Program for Elders for another estimate of anticipated savings. In Minnesota, the cost of community-based services is paid by the individual and his or her family; however, where possible Connecticut may prefer to access the existing CHCPE funding. Using the assumption that 25 percent of participants will self-fund, 25 percent will be state funded and 50 percent will require funding equivalent to the CHCPE waiver level, we anticipate monthly service cost at home to be $1,080. The Medicaid saving on nursing facility stay is estimated to be at $56K per year.

In this approach, program costs are developed on a price-per-service model, which includes separate charges for screening of nursing home residents at the 45-day mark, detailed assessments of likely candidates, referrals to the appropriate Medicaid management entity for transition, more intensive transitions of Medicare and program overhead. Using these assumptions, for every 100 Medicare individuals transitioned, the anticipated savings to the state net of the federal match would be $3.9M.4

In order to develop a more detailed analysis of how this program may benefit Connecticut, Optum would

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**Framework for value to Connecticut**

<table>
<thead>
<tr>
<th>Annual facility cost</th>
<th>$69,600</th>
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</thead>
<tbody>
<tr>
<td>Anticipated cost of services at home</td>
<td>$13,000</td>
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<tr>
<td>Annualized savings per transitioned</td>
<td>$56,600</td>
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<tr>
<td>Medicaid savings on 644 transitions</td>
<td>$36,440,000</td>
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<tr>
<td>Est. cost to generate transitions</td>
<td>$4,800,000</td>
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<tr>
<td>Total Savings to Medicaid</td>
<td>$31,700,000</td>
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<tr>
<td>General Revenue Savings to Connecticut</td>
<td>$12,600,000</td>
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<tr>
<td>ROI</td>
<td>2.6x</td>
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</tbody>
</table>

Medicaid cost per CHCPE 2012 Annual Report  
Basis 25% private-pay, 25% state-funded CHCPE, 50% waiver

Assumes 100% of program participants would remain in Nursing facility and spend-down to Medicaid eligibility
Includes fee per resident screened, assessed, transitioned and referred, and program management overhead
Reflects 50% match on Medicaid facility cost and state funding of transition program and ongoing services at 100%

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Note: program estimates based on application of MN RTC to CT facility costs. More detailed data needed to accurately predict local impact.
like to work with the state to obtain the necessary confidentiality agreements to analyze data on the current Medicare and Medicaid population. Access to the Nursing Facility MDS, any state-funded HCBS program data (CHCPE or others), as well as any claims (including pharmacy) information in the proposed program regions of Hartford, Fairfield and New Haven would facilitate this analysis.

We have experience working in a case rate environment as outlined above (per transition or per engaged member per month) and one in which our fees are placed at risk based on successful repatriations and ongoing community maintenance for long-term care delivery. No matter the approach, Optum will work with Connecticut to develop an innovative pricing strategy that fits the state’s business needs and is supported by current funding sources. Potential avenues include reinvestment of state savings achieved through the Balancing Incentive Payment (BIP) and/or Money Follows the Person programs, as Connecticut has indicated that savings from these two initiatives would be reinvested in LTSS.

**Optum experience**

Optum has 30 years of clinical experience delivering direct person-centered care to medically complex individuals. We provide services in 36 states, employing more than 2,400 clinicians. Our experience with the chronic care population has shown that interventions must address medical, behavioral, environmental and social dynamics in an integrated process. Inadequate or irregular care of this high-risk, underserved population leads to significant quality and cost of care issues. Optum has established programs to provide patients and caregivers self-management education, trigger recognition, align treatment goals, and improve home safety, medication management, treatment plan compliance and coordination of care with community providers.

Optum has worked in a number of states, including Massachusetts, New Mexico, Texas, Tennessee, Wisconsin and Hawaii, to help transition people from institutions to community-based care over nursing facility admissions.

One of our longest-running integrated programs is the Massachusetts Senior Care Options (SCO) program. SCO is designed to provide integrated care for beneficiaries regardless of care setting and frailty status. The program is expected to enroll beneficiaries who are community-dwelling and relatively healthy all the way to long-term nursing facility residents.

On average, SCO enrollees were less likely to be long-term nursing facility residents than the total elderly dual-eligible population and more likely to have a history of community-focused care. In the SCO program, there was a 42 percent reduction in nursing facility utilization among participants. Those who did enter nursing facilities were frailer, with more medical needs than those people not enrolled in SCO who admitted to the nursing home. This outcome suggests that the member’s ability to remain in the community for longer periods of time was enhanced by their participation in the SCO program.

Optum looks forward to continued engagement with Connecticut in its efforts to facilitate the transfer of long-term nursing care residents to high quality home-based care and community facilities, which are more cost efficient and sustainable.

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1. 2004 National Nursing Home Survey
2. Dr. Robert Kane et al. University of Minnesota, 2003
3. April 2013 Return to Community Presentation to ADRC
5. MassHealth Senior Care Options Program Evaluation. JEN Associates June, 2008