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Commissioner

TO: The Honorable Paul M. Formica
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The Honorable Toni E. Walker
Co-Chairs, Appropriations Committee

Members, Appropriations Committee

The Honorable Marilyn V. Moore
The Honorable Catherine F. Abercrombie
The Honorable Joe Markley
Co-Chairs, Human Services Committee

Members, Human Services Committee

FROM: Roderick L. Bremby, Commissioner 

DATE: December 19, 2018

RE: Connecticut Home Care Program for Elders
Annual Report for SFY 2017

I am pleased to notify you of the availability of the SFY 2017 Annual Report for the Connecticut Home Care Program for Elders. The report may be accessed on the Department of Social Services web site at www.ct.gov/dss (click on Publications, then Reports, then Annual Reports). The Connecticut Home Care Program exemplifies the state's long-standing commitment to comprehensive community-based care for elders in need of long-term care. By enabling and providing supportive services at home, the state has helped to preserve the dignity and autonomy of older persons and has assisted families struggling to maintain older relatives at home.

In the interest of cost savings, we are not distributing hardcopies of the report but can do so upon request. The report includes comprehensive financial data, including service claims that can take up to a year to complete before they can be compiled and analyzed.

Development of home care options has helped to curb the spiraling costs of institutional care. However, its most important impact has been on the quality of life for Connecticut's older citizens. We thank you for your crucial support of these principles at the General Assembly over the years.

At the close of SFY 2017, over 16,000 Connecticut residents were being served by the Connecticut Home Care Program for Elders.

The program combines federal and state funds to cost-effectively serve older adults according to their needs. Care plans are developed within the limits of 25%, 50% and 100% of the average nursing facility cost. The cost depends upon which Connecticut Home Care Program for Elders functional category corresponds to the individual's needs. Category 1 is currently closed to intake and a waiting list is being maintained. This report describes the criteria for each category served by the program.

This report represents the second year of a five-year renewal for the Home- and Community-Based Services Waiver. The federal Centers for Medicare and Medicaid Services (CMS) has approved the waiver renewal for five years until June 30, 2020. As part of the renewal and approval process, the Department developed a set of performance measures to meet the assurances that states make to CMS when they are operating a waiver.

Highlights of the program include:

DSS continues to work collaboratively with the Department of Community and Economic Development, the Connecticut Housing Finance Authority, the Department of Public Health and the Office of Policy and Management to implement the Assisted Living Demonstration Pilot Project. By offering assisted living services in the demonstration programs, residents are offered a viable choice that will allow them to maintain a degree of continued health, dignity and independence at significantly less cost than a nursing home. Four sites, The Retreat in Hartford, Herbert T. Clark in Glastonbury, Luther Ridge in Middletown and Smithfield Gardens in Seymour, are fully operational.

The Department's Community Options Unit (formerly the Alternate Care Unit), under PA 07-2, Section 29, continues to operate a pilot program implemented in October 2007 -- the Connecticut Home Care Program for Adults with Disabilities. The target population is individuals with degenerative, neurological conditions who are not Medicaid-eligible and who are in need of case management to develop, implement and monitor plans of care. This program was expanded effective July 1, 2014, to 100 slots, an increase from the original 50.

The Community Options unit submitted a renewal application to the Centers for Medicare and Medicaid Services for a Home and Community-Based Services 1915i State Plan Option which was approved for five years and will expire January 31, 2022. The population served under this state plan option is Home Care Program Category 1 clients who are also Medicaid recipients. This allows the state to claim 50% federal match for clients who were previously 100% state-funded. Over 600 persons are served under this state plan option.

As Commissioner of the Department of Social Services, I am proud to be part of the traditional pro-active role Connecticut has taken in developing innovative and effective policies and programs to address the needs of our elders and citizens with disabilities. On behalf of Governor Dannel P. Malloy, I thank you again for your continuing role in moving our state forward in this vital area.

DEPARTMENT OF SOCIAL SERVICES

**HOME AND COMMUNITY-BASED
SERVICES UNIT**



CONNECTICUT HOME CARE PROGRAM FOR ELDERS

ANNUAL REPORT

To the Legislature

SFY 17

July 2016– July 2017

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Preface: A History of the Connecticut Home Care Program

In the mid 1980's the federal government offered states the opportunity to expand home care under special options called Medicaid "home and community-based service waivers". These options were called "waivers" because they allowed states to "waive" certain Medicaid rules including restrictive income limits and prohibitions against coverage for non-medical services. The rationale for creating federal waivers rested in the belief that individuals, who would otherwise be institutionalized at the state's expense, could be diverted from this costly option if services were available to support them in the community. In addition, home health services already covered by Medicaid (nursing, home health aide, physical, speech and occupational therapy and medical transportation) a wide array of home care services were considered necessary to adequately support a frail elder in the community. These services included emergency response systems, respite care, home delivered meals, homemaker, adult day care, chore help, non-medical transportation, companionship, mental health counseling, and care management. The federal waiver option thus allowed states to receive federal matching funds (50% match in Connecticut) for services which previously had been paid primarily with state funds.

In 1985, following a successful demonstration project, the Connecticut General Assembly voted to establish an expanded home care program taking advantage of the new waiver option. This legislation directed the Department of Income Maintenance (DIM) to apply for the federal waiver to maximize federal reimbursement but also required the program to serve individuals who would not qualify for the waiver and whose services would be fully state-funded. The program, then called the Long Term Care Pre-admission Screening and Community-Based Services Program (PAS/CBS) began statewide operation in 1987. It was targeted to very frail elders identified by hospital or nursing facility staff as likely to be admitted to a nursing facility within sixty days.

In 1990, the General Assembly began steps to consolidate home care services for elders. Public Act 92-182 ended admissions for elders in the Adult Services Program operated by the Department of Human Resources and in the state-funded portion of the PAS/CBS program operated by DIM. While existing clients were able to continue receiving services through their respective programs, new applicants in need of state-funded home care services were referred to the Promotion for Independent Living at the Department on Aging. Elders who were eligible for the Medicaid waiver program could still apply to the Department of Income Maintenance.

The second phase of the consolidation came at the end of SFY '92 session. Through Public Act 92-16, the General Assembly merged three major programs: the Preadmission Screening and Community-Based Services, The Promotion of Independent Living and The Elder Services portion of the Adult Services Program and reinstated the state-funded portion of the home care program. The program was then renamed The Connecticut Home Care Program for Elders.

Under the umbrella of the Connecticut Home Care Program for Elders (CHCPE), the program continued to have two components, one fully state-funded: the other receiving matching funds under the federal waiver. The following year, the State reorganized several human services departments resulting in the consolidation of the three original departments under the new Department of Social Services.

Over the past years, new developments in the program increased consumer choices and expanded opportunities for consumers to influence the services that directly affected their lives. In February 1993, the Department began to implement a concept called “self-directed care”, recognizing that many frail older persons were capable of working directly with their providers to assure that services needs were met safely and efficiently.

In SFY '95 the enactment of P.A. 95-160 Subsection 7 eliminated the licensing of Coordination, Assessment and Monitoring Agencies and substituted in their place a new entity call an “Access Agency”. The Department consulted with the Home Care Advisory Committee over the following summer to develop standards for this new agency and issued regulations and Request for Proposals the following November. The Department awarded three Access Agencies contracts to provide assessment and care management services.

The Connecticut Home Care Program for Elders has evolved over the years to better meet the needs of Connecticut’s older citizens. The program uses state-of-the-art approaches for delivering home care services to frail elders who are at risk of institutionalization. The program structure is ever evolving to accommodate changes at the federal and state level.

Several program changes have occurred over the years. Personal care attendant (PCA) services were originally offered in the form of a state-funded pilot program with a limited number of slots and a waiting list. During the ensuing years, PCA services were added as a waiver service. PCA services evolved to include 12 hour shifts and 24 hour live in services. Self-directed PCA services are now covered by Medicaid under Community First Choice under the 1915k state plan option.

Effective 7/1/07, PA 07-185 enacted the Connecticut Home Care Program for Adults with Disabilities (CHCPDA); The CHCPDA Pilot Program was the result of advocacy efforts to develop a program offering a package of services to individuals age 18 – 64 with degenerative neurological conditions and cognitive impairments who need case management as well as other supportive services and who do not meet the financial eligibility criteria for Medicaid. Originally, the program was limited to 50 slots which have been increased to 100 slots.

The Connecticut Home Care Program contracted Ascend Management Innovations to develop a web based client data base, transitioning from paper files to online files. This system has greatly improved efficiency, timeliness of documentation and submission of required forms. In additions, the system features a critical incident reporting system which has tremendously improved the ability to monitor, track, trend and take appropriate actions to address issues of abuse, neglect, exploitation and other issues impacting program participants.

Connecticut Home Care Program staff leads a Quality Assurance Committee, consisting of representatives from the Access Agency and CHCP which has addressed various timely issues, provider quality issues, uniformity of forms, language to improve reporting. See page 12 for more information.

New services have been added during each waiver renewal including care transitions, assistive technology, bill payer, chronic disease self-management, support broker, recovery assistant and

tiered case management. Tiered case management offers different levels of case management intensity based on client needs.

Connecticut Home Care Program staff in conjunction with DXC created a care plan portal in which Access Agency Care Managers enter specific program services with date ranges and specific units of service. Utilization of this system provides greater provider agency accountability.

The Department of Social Services (DSS) mandated that many Home and Community-based services provided by caregivers under the Connecticut Medical Assistance Program (CMAP) utilize Electronic Visit Verification (EVV) as of January 1, 2017. DSS and its MMIS vendor, DXC Technologies, partnered with Sandata Technologies, LLC. to implement this EVV system as well as to provide program orientation & training.

Electronic Visit Verification (EVV) is a telephonic and computer-based system that documents the time caregivers arrive and leave. DSS implemented EVV to ensure that individuals are receiving the services authorized and that the claim submitted for payment contains the correct information. EVV is now federally mandated when Congress passed the 21st Century Cures Act in December of 2016. The Centers for Medicare and Medicaid services have recognized Connecticut as a pioneer in implementing EVV.

The Connecticut Home Care Program continues to evolve and change to respond to needs for new services, increasing emphasis on person-centered goals, provider quality assurance and accountability, new Quality Assurance initiatives and significant improvements in staffing client eligibility services and procedures to improve efficiency.

I. PROGRAM DESCRIPTION AND ORGANIZATION

The Department's Community Options Unit administers the CT Home Care Program for Elders. The mission of the Community Options Unit is to develop a dynamic system that includes a flexible array of cost-effective, community based and institutional long term care alternatives, which are responsive to the needs and preferences of individuals and families with continuing care needs.

This mission supports the Department's broader mission to serve families and individuals who need assistance in maintaining or achieving their full potential for self-direction, self-reliance and independent living. Clinical staff from the Community Options Unit screen individuals when a need for long term care is identified to ensure that the option of home care is considered before institutional care. For a brief history of Connecticut's commitment to home care see Appendix A.

The program is organized under a multi-tiered structure, which enables individuals to receive home care services in levels corresponding to their functional needs and financial eligibility. The first two categories are funded primarily through a State appropriation. Individuals in the third category qualify for reimbursement under the Medicaid waiver program; therefore, costs

for this category are equally distributed between Federal and State funds. Individuals in Category 5, receive services under a 1915i state plan option so service expenditures are federally matched. Category 4 is the state funded pilot program for Adults with Disabilities under the age of 65.

Cost limits for each level of the program are established so that individual care plan expenditures can increase in response to individual needs. In practice, most actual care plan costs are well under the limits for each category. In Category 3, the category serving the neediest group of elders, the average cost of care is less than half of the cost limit.

The following are descriptions of the five program categories. Eligibility limits and other program requirements are described in more detail later in this report. For a brief summary, please refer to the chart on the organization of the program in Appendix B and the revised legislation in Appendix C.

Category 1: This category is targeted to individuals who are at risk of long term hospitalization or nursing facility placement if preventive home care services are not provided. Since these are not individuals who would immediately need nursing facility placement in the absence of the program, individual care plan limits are set at 25% of the weighted average Medicaid cost in a nursing facility. New admissions to this category are currently frozen.

Category 2: This category targets individuals who are frail enough to require nursing facility care, but have resources which would prevent them from qualifying for Medicaid upon admission to a nursing facility. Care plan limits for these individuals cannot exceed 50% of the weighted average Medicaid cost in a nursing facility.

Category 3: This category targets individuals who would otherwise require long term nursing facility care funded by Medicaid. In order to assure cost effectiveness, individual care plan costs cannot exceed 115% of the weighted average Medicaid cost in a nursing facility.

Category 4: This category is the pilot program for persons under 65 with degenerative neurological conditions. The program came out of legislation in 2007 and implementation began October 1, 2007. The financial eligibility and care plan cost limits are the same as Category 2.

Category 5: This category became effective February 1, 2012. Functionally, the participants are the same as Category 1 but since they are Medicaid recipients, their service costs are 50% federally matched.

This program structure was developed in conjunction with Connecticut Home Care Program Advisory Committee, which was established by the Department in 1992. Over the years, the Committee has made many critical recommendations, which have resulted in improvements in access to home care. The advice of the Home Care Advisory Committee continues to provide a valuable perspective for the Department's evolving home care program. A complete listing of current members is included in Appendix D.

Connecticut Home Care Program for Elders at a Glance

\$771	The average monthly client cost on the State Funded portion of the CT Home Care Program.
16,282	The monthly average number of clients on the Medicaid Waiver portion of the CT Home Care.
2,922	The monthly average number of clients on the State Funded portion of the CT Home Care Program.
9,419	The number of individuals screened for the CT Home Care Program who were referred for assessment and became active clients.
20,287	The total number served on the State Funded, Medicaid Waiver 1915c, Adults with Disabilities and 1915i portions of the CT Home Care Program for SFY 2017.
\$360,873,052	The savings generated as a result of the reduced utilization of nursing facility beds due to the CT Home Care Program's Medicaid Waiver.
\$406,670,599	The program expenditures for the Medicaid Waiver and State Funded portion of the CT Home Care Program.

Assisted Living Services Component

Over the past several years, the State of Connecticut has developed alternatives to nursing facility care and assisted living has been a major focus of these efforts. Connecticut offers assisted living in state-funded congregate housing facilities, federally-funded HUD residences and has developed four subsidized assisted living residences in Connecticut communities.

Assisted living is a special combination of housing, supportive services, personalized assistance and health care designed to respond to the individual needs of those who require help with activities of daily living and instrumental activities of daily living. Supportive services are available 24 hours a day to meet scheduled needs in a way that promotes maximum dignity and independence for each resident and involves the resident's family, neighbors, and friends.

Private Assisted Living Pilot

Public Act 02-7 allowed the Department to establish the Private Assisted Living Pilot that became effective January 1, 2003. As of July 1, 2012 the Pilot provides one hundred twenty five (125) clients with the opportunity to remain in their private assisted living facility after they have spent down their assets.

The Pilot grew out of recognition that some elders, after living in a Private Assisted Living Facility for a time, have spent down their assets and thus require help with their living expenses. In order to assist these individuals, the Pilot provides funding for their assisted living services. The Pilot does not pay for room and board; it is expected that such individuals will have family members who are willing and able to assist with some of those expenses. This Pilot is based on the premise that it will be cost effective for the State to provide for such individuals, for in doing so, they will not require admission to a nursing facility.

From July 1, 2016 to June 30, 2017, the Private Assisted Living Pilot served a total of 107 clients at a cost of \$502,209.78. This figure includes both core and assisted living service charges. There was a freeze on new admissions during this fiscal year.

State Funded Congregate and HUD Facilities

Public Act 00-2 allowed the Department of Housing (DOH) to offer assisted living services to residents in State Funded Congregate Housing and Federally Funded HUD Facilities. Through the collaborative effort of DOH, the Department of Public Health (DPH) and the Department of Social Services (DSS), the program became effective February 2001.

Public Act 00-2 also grants Managed Residential Community (MRC) status to approved State Funded Housing and Federally Funded HUD Facilities for the purpose of providing assisted living services and allows the Department of Public Health (DPH) to waive provisions of the assisted living services agency regulations on a case-by-case basis.

The assisted living services are funded through the State Department of Social Services (DSS) or

the State Department of Housing (DOH). The assisted living services are provided by an assisted living services agency (ALSA). The assisted living services agency provides the personal care services, core services and supplemental services based on the care needs of the qualified residents.

Assisted Living Services provide a viable choice to the residents that will enhance and maintain a degree of continued health, dignity and independence at significantly less cost than nursing facility placement.

As of 7/1/16, HUD facilities were no longer state-funded. Going forward, the HUD and Congregate Facilities will be reported together. From July 1, 2016 through June 30, 2017 a total of 204 clients received services in these facilities at a cost of \$1,192,098.57.

Assisted Living Demonstration Project

Over the past several years, the Department of Social Services in collaboration with the Department of Public Health, (DPH) the Department of Housing (DOH) and the Connecticut Housing Finance Authority (CHFA) developed the Assisted Living Demonstration Project which provides 300 subsidized assisted living units in both urban and rural settings.

This unique project combines the development financing through CHFA, the necessary housing component through rental subsidies from DOH, and services through DSS' Connecticut Home Care Program for Elders. Four projects were approved. They are in the cities of: Glastonbury, Hartford, Middletown and Seymour.

From July 1, 2016 to June 30, 2017, 181 clients received services in the DEMO facilities participating in the assisted living pilot at a cost of \$1,804,453.99. This figure includes both core and assisted living service charges.

Care Management and Self-Directed Care

Connecticut was a pioneer in the development of quality standards for case management through the State Licensure for Coordination, Assessment and Monitoring Agencies. Just as Connecticut has been a leader in developing this sophisticated model, the State has also been a leader in challenging the limits of case management, or what is now called "care management."

Many frail elders have complex needs which require ongoing coordination and frequent monitoring of their medical, professional, and social services providers. Most clients in the program continue to benefit from the services of an independent care manager.

As shown in the care continuum (Appendix E) some individuals, whether on their own, with family support, or with the assistance of a provider agency, are fully able to coordinate and monitor their own service providers, that is, to manage their own plan of care. These individuals are considered "self-directed" in the Department's model and receive their services under the self-directed care component of the program.

By the end of June 2017, there were 128 active self-directed care clients representing 1% of the total caseload. The Community Options clinical staff screen those clients who, upon initial assessment into the program, appear to be candidates for self-directed care after an initial six month period of care management services. These clients are reassessed for the self-directed care option at the first six month interval rather than after one full year in the program.

The Community Options staff began logging all self-directed care referrals, their source, and disposition in an effort to spur Access Agency referrals and provide documentation of activity. On a scheduled basis, the Department evaluates all individuals in the program for self-directed care to insure that only those clients who truly need care management are receiving that service.

Quality Enhancement System

The quality enhancement system in place for the CT Home Care Program for Elders is a system that monitors the unique needs and quality of services provided to our clients.

Our Quality Enhancement system has a Quality Assurance team to provide ongoing monitoring of program functions:

- The Quality Assurance Team conducts on-site administrative and chart audits of access agencies, assisted living service agency records, visits provider agencies and clients.
- The Quality Assurance Team reviews Access Agency Reports to identify any trends, issues and questions on the reported information. This team monitors the timeliness of information received and provides any necessary follow-up with the Access Agencies.
- The Quality Assurance Team has fully implemented a critical incident reporting system through a web based application that allows tracking and trending of data both client specific and system wide.

Various QA activities are conducted to monitor provider compliance with CHCPE regulations and policies and to measure client satisfaction with services^[A1]. Currently, the Department is in the final year of testing a new Experience of Care Survey under the Testing Experience and Functional tools federal grant. As of June of 2017, Community Options staff as well as Access Agency Quality Assurance staff were being trained to administer the survey to waiver clients. The goal is to utilize the data from the survey to develop a cross waiver quality improvement strategy.

With the goal of one consistent approach to reward quality and facilitate reporting, the Connecticut Department of Social Services partnered with the University of Connecticut Health Center on Aging. The Consumer Assessment of Healthcare Providers and Systems CAHPS survey was developed to provide the HCBS community with one, universal cross-ability tool to assess and improve HCBS program quality. Its use was initiated July 1st, 2017.

The QA team conducted a review of two Assisted Living facilities this year and chart reviews at each. Additionally, provider compliance was monitored by a record and administrative audit of four Access^[A2] Agencies located in six offices.

- A committee was convened of DSS staff, Access Agency staff and Provider Agency staff to develop Personal Care Attendant PCA training modules with the goal of improving quality of care.
- To meet or exceed performance measures specified in the 1915c and 1915i waiver documents and report finding to CMS.
- The Quality Assurance Committee will continue to review various aspects of program operations and quality of care issues and develop quality improvement strategies. The Committee will continue to identify and work on strategic processes to work on waiver compliance and quality with the goal of ensuring comprehensive, collaborative and integrated oversight and monitoring.

II. COST EFFECTIVENESS OF THE WAIVER

Program Cost and Projected Savings

In order to establish cost-effectiveness under the Federal Standards for Medicaid Waivers, the Department must only demonstrate that the per capita cost for program participants is less than institutional care. In other words, the Federal Standards assume that every client served by the Waiver would otherwise be institutionalized. Therefore, as long as the cost for each individual's care is less than the cost in a nursing facility, the Waiver program is considered cost-effective.

When the Connecticut Home Care Program for Elder's Waiver was established, the Connecticut General Assembly mandated that the program be designed to be not only cost-effective on an individual basis but also cost-neutral overall. Section 17b-342(a) of the Connecticut General Statutes specifically provides that:

"The program shall be structured so that the net cost to the state for long term facility care in combination with the community based services under the program shall not exceed the net cost the state would have incurred without the program".

To meet the General Assembly's higher standard for measuring cost effectiveness under the Waiver, it is critical that the Department's cost analysis recognize that "diverting" a Medicaid recipient to home and community based services does not always mean that the State "saves" the full cost of a nursing facility bed. This is because the bed will still be filled, often by another Medicaid recipient. Approximately 35% of all nursing facility admissions are Medicaid patients.

The Department formulated a cost effectiveness model that computes the total State costs for providing home care services under the Waiver. This is calculated by adding together the actual cost of services (Waiver services plus skilled nursing, and other home health services), and the program's administrative costs provided to persons receiving home care, which would not be incurred if these persons entered a nursing facility. The program is considered cost-effective if the sum of those three costs is less than the estimate of the savings that the State generates as a result of the reduced utilization of nursing facility beds due to the program. In other words:

**SUMMARY OF PROGRAM COSTS AND SAVINGS
WAIVER CLIENTS
SFY 17**

COMMUNITY & HOME CARE SERVICES	AMOUNT
Assessments	2,512
Annual Assessment Cost	\$ \$704,096
Annual Clients Served	15,256
Community First Choice	\$ \$12,923,418
Annual Community Services Cost	\$366,624,393
Annual Home Health Cost	\$ \$32,633,052
Annual Status Reviews	1,088
Annual Status Review Cost	\$ \$111,928
Annual Services Cost	\$ \$412,996,886
ADMINISTRATIVE EXPENSES	
Personnel Services	\$ 1,405,788
Fringe Benefits	\$ 1,171,149
Annual Administrative Cost	\$2,576,938
Adjusted Total Program Costs SFY 17	\$415,573,823
Federal Medicaid Reimbursement (50%)	-\$207,786,911
Total Program Costs After Federal Reimbursement	\$207,786,911
NURSING HOME SAVINGS	
Annual CHCPE Clients Served	15,256
Monthly Nursing Home Cost per Medicaid Client	5,945
Average Annual Cost Per Nursing Home Client	\$71,340
Average Annual Cost Per CHCPE Client	\$24,031
Average Annual Cost Nursing Home Clients	\$1,088,363,040
Average Annual Cost CHCPE Clients	\$366,616,936
Total Annual Difference in Cost	\$721,746,104
Federal Medicaid Reimbursement (50%)	-\$-360,873,052
NET FISCAL IMPACT	
Total Nursing Home Savings After Federal Reimbursement	\$360,873,052

* These totals are for the 1915c Waiver Clients (category 3) clients only.

The analysis of these factors reveals that the program costs are significantly less than nursing facility expenditures. The amount of the difference represents the overall savings realized due to the Waiver home care program.

Since an estimate of the savings attributed to the program must be developed on the basis of assumptions about "what would have happened," no such analysis can be considered to be definitive. However, the Department continues to monitor program expenditures and estimated savings and to update its analysis based upon the best information available.

The State has a moratorium on the construction of nursing facility beds, yet there are vacancies in many facilities. In the face of a growing population of elders, this apparent leveling of nursing home growth is probably the greatest evidence of the success of the CT Home Care Program for Elders in reducing unnecessary institutional expenditures. Many other factors undoubtedly have also influenced this phenomenon.

The Department's formula for estimating the net savings under the Waiver portion of the CT Home Care Program for Elders utilizes an analysis estimating savings by assuming that all Waiver clients would have entered a nursing facility in the absence of the program. Based on the longer length of stay prior to nursing facility admission, the Department has made an additional adjustment in the formula over past years. The Department has not projected savings for any newly enrolled individuals admitted within the fiscal year even though the costs for their services are still counted.

Since new enrollees receive services for an average of six months during the fiscal year of their enrollment, this adjustment has the effect of counting the home care costs but not counting savings for that period. To account for the fact that other Medicaid recipients might fill some of the beds that were left vacant by individuals who enroll in the CT Home Care Program for Elders, the analysis reduces the projected savings by 35% since 35% of nursing home admissions are for individuals on Medicaid. Future CHCPE reports will not include this reduction due to the impact of the Money Follows the Person Program on returning individuals in nursing homes to

**CT Home Care Program For Elders
SFY 2017
Average Monthly Cost per Case Summary**

	MAR	Title XIX			State Funded			1915i			Total		
		Annual	Annual	Monthly Cost /	Annual	Annual	Monthly Cost /	Annual	Annual	Monthly Cost /	Annual	Annual	Monthly Cost /
		Recipients	Expenditures	Service	Recipients	Expenditures	Service	Recipients	Expenditures	Service	Recipients	Expenditures	Service
Screening Services													
Assessments	611	2,512	\$ 704,096	\$ 23.36	4,118	\$ 1,218,174	\$ 24.65	111	\$ 30,315	\$ 22.76	6,741	\$ 1,952,585	\$ 24.14
Reviews	612	1,088	\$ 111,928	\$ 8.57	470	\$ 44,189	\$ 7.83	13	\$ 1,033	\$ 6.62	1,571	\$ 157,150	\$ 8.34
Sub-Total			\$ 816,024			\$ 1,262,363			\$ 31,349			\$ 2,109,736	
Waiver Services													
Case Management	601	15,256	\$ 20,056,232	\$ 109.55	4,326	\$ 4,310,088	\$ 83.03	705	\$ 1,000,184	\$ 118.23	20,287	\$ 25,366,505	\$ 104.20
Adult Day Health	602,841	1,569	\$ 13,189,185	\$ 700.51	325	\$ 2,095,329	\$ 537.26	107	\$ 663,551	\$ 516.78	2,001	\$ 15,948,065	\$ 664.17
Chore	603,842	311	\$ 248,078	\$ 66.47	52	\$ 39,273	\$ 62.94	11	\$ 4,512	\$ 34.18	374	\$ 291,863	\$ 65.03
Companion	604,843	5,847	\$ 39,689,075	\$ 565.66	1,307	\$ 3,830,774	\$ 244.25	446	\$ 2,090,661	\$ 390.63	7,600	\$ 45,610,510	\$ 500.12
Elderly Foster Care	605,84D	949	\$ 23,120,139	\$ 2,030.22	105	\$ 1,356,280	\$ 1,076.41	10	\$ 125,897	\$ 1,049.14	1,064	\$ 24,602,316	\$ 1,926.87
Meals	606,844	4,747	\$ 7,767,329	\$ 136.36	981	\$ 960,320	\$ 81.58	316	\$ 685,011	\$ 180.65	6,044	\$ 9,412,659	\$ 129.78
Homemaker	607,845	7,353	\$ 29,239,647	\$ 331.38	2,092	\$ 5,199,278	\$ 207.11	576	\$ 1,756,893	\$ 254.18	10,021	\$ 36,195,818	\$ 301.00
Mental Health Couns.	608,846	755	\$ 642,615	\$ 70.93	88	\$ 69,578	\$ 65.89	32	\$ 25,163	\$ 65.53	875	\$ 737,355	\$ 70.22
Personal Emerg. Resp.	609,847	9,719	\$ 4,201,107	\$ 36.02	2,610	\$ 835,947	\$ 26.69	408	\$ 182,684	\$ 37.31	12,737	\$ 5,219,739	\$ 34.15
Respite Care	60A,848	180	\$ 793,118	\$ 367.18	64	\$ 127,219	\$ 165.65	0	\$ -	\$ -	244	\$ 920,336	\$ 314.32
Non-Medical Transp.	60B,849	55	\$ 10,777	\$ 16.33	32	\$ 7,499	\$ 19.53	2	\$ 166	\$ 6.93	89	\$ 18,442	\$ 17.27
Assisted Living	60C	280	\$ 4,440,046	\$ 1,321.44	417	\$ 5,163,697	\$ 1,031.91	8	\$ 136,186	\$ 1,418.61	705	\$ 9,739,930	\$ 1,151.29
PCA Agency	60D,84A	6,700	\$ 218,220,144	\$ 2,714.18	1,582	\$ 14,258,425	\$ 751.08	23	\$ 148,971	\$ 539.75	8,305	\$ 232,627,540	\$ 2,334.21
Minor Home Modification	60E,84B	136	\$ 605,957	\$ 371.30	0	\$ -	\$ -	1	\$ 2,849	\$ 237.42	137	\$ 608,806	\$ 370.32
Assistive Technology	60F,84C	328	\$ 309,689	\$ 78.68	24	\$ 20,107	\$ 69.82	2	\$ 1,704	\$ 71.00	354	\$ 331,500	\$ 78.04
PCA Individual	60G	304	\$ 3,904,552	\$ 1,070.33	145	\$ 1,764,072	\$ 1,013.83	0	\$ -	\$ -	449	\$ 5,668,624	\$ 1,052.08
Acc/Assistive Tech	84E	0	\$ -	\$ -	0	\$ -	\$ -	0	\$ -	\$ -	0	\$ -	\$ -
Care Transitions	84F	545	\$ 99,169	\$ 15.16	0	\$ -	\$ -	15	\$ 2,703	\$ 15.02	560	\$ 101,872	\$ 15.16
Bill Payer	84G	254	\$ 87,533	\$ 28.72	32	\$ 8,320	\$ 21.67	9	\$ 1,655	\$ 15.32	295	\$ 97,508	\$ 27.54
Chron Disease Self Mgmt	84H	0	\$ -	\$ -	0	\$ -	\$ -	0	\$ -	\$ -	0	\$ -	\$ -
Support Broker	84I	0	\$ -	\$ -	0	\$ -	\$ -	0	\$ -	\$ -	0	\$ -	\$ -
Recovery Assist Agency	84J	0	\$ -	\$ -	0	\$ -	\$ -	0	\$ -	\$ -	0	\$ -	\$ -
Sub - Total (c)		15,256	\$ 366,624,393	\$ 2,003	4,326	\$ 40,046,206	\$ 771	705	\$ 6,828,791	\$ 807	20,287	\$ 413,499,390	\$ 1,699
Community First Choice (d)		554	\$ 12,923,418	\$ 1,944	0	\$ -	\$ -	0	\$ -	\$ -	554	\$ 12,923,418	\$ 1,944
Home Health Services (e,f)			\$ 32,633,052			\$ 3,450,325			\$ 1,244,543			\$ 37,327,920	
Total - Comm. Svcs.		15,256	\$ 412,996,886	\$ 2,256	4,326	\$ 44,758,894	\$ 862	705	\$ 8,104,683	\$ 958	20,287	\$ 465,860,463	\$ 1,914

(a) All Screening Services, Waiver Services, Community First Choice expenditures and unduplicated recipients are from a Data Warehouse query.

(b) Avg. Monthly Cost per Recipient reflects the Annual Expenditures divided by 12 and by the Total Unduplicated Count of Recipients.

(c) Source of the unduplicated recipients is the figure shown for "Case Management".

(d) Community First Choice costs were estimated using a data Warehouse query since these costs do not appear on the 613T-ACU.

(e) Home Health Expenditures for Title XIX recipients is estimated using the MAR 372 for the CHC Waiver since these costs do not appear on the 613T-ACU.

The reduction in Home Health Expenditures for the Title XIX recipients compared with prior years is due to a change in reporting and not a change in utilization.

(f) Home Health Expenditures for 1915i recipients are estimated using a Data Warehouse query since these costs do not appear on the 613T-ACU

CONNECTICUT HOME CARE PROGRAM OVERVIEW

Financial Eligibility – Medicaid Waiver

In order to qualify financially for the Waiver portion of the program, an elderly person (age 65 or older) must meet the income and asset rules applicable to an institutionalized Medicaid applicant. As specified in the Federal Waiver, this means that the gross income limit is 300% of the SSI payment, or \$2,199. The asset limit for an unmarried applicant is \$1,600, although a number of resources such as a residence, car, burial reserve and \$1,500 face value life insurance policy are exempt. There are special provisions in federal law regarding the treatment of assets for married couples when one spouse is considered “institutionalized” which allows for the protection of assets for the community spouse. As of January 2016, the law allowed a community spouse to protect assets from \$24,180 up to \$117,240 depending upon the couple’s original assets, in addition to the \$1,600 that the “institutionalized” person can keep. If both spouses require Waiver services, each can only have assets of \$1,600 after exemptions.

Financial Eligibility – State Funded

The State Funded portion of the program has no income limit; however, applicants over the income limit may be required to pay applied income based on the amount of income over the limit. The financial eligibility difference between State Funded and Medicaid Waiver is related to asset limits. When the State Funded programs were consolidated in 1992, an asset limit was established to enable individuals with more assets than the Medicaid limit, but not unlimited assets, to qualify for State Funded home care. However, existing clients with assets higher than the new limit were allowed to continue receiving services. The asset limit for an individual in the State Funded portion of the program is 150% of the minimum amount that a community spouse could have under Medicaid; this figure was \$36,270 as of March 2017. A couple on the State Funded portion of the program can have 200% of that amount, or \$48,360 as of March 2017.

Financial Eligibility 1915i

Participants in this category of service are Medicaid recipients whose income is at or below 150% of the federal poverty level.

Targeting the Frail Older Person

A uniform health screen is completed with those financially eligible persons applying to the program. The screen collects information about the person’s ability to perform basic activities of daily living and to carry out more complex tasks like preparing meals and managing medications. The screen also provides a profile of the person’s cognitive status, behavior problems, if any, and informal support system. When the Department’s clinical staff determines need for the program, appropriate clients may be referred to an access agency care manager for an assessment of their service needs. The screen is also used to establish the need for nursing facility care for elders who are seeking direct nursing facility admission.

Assessment, Plan of Care Development, and Care Management

Individuals receiving home care services receive the services of an independent care manager throughout their stay on the program. The care manager is a nurse or social worker who monitors the client's status monthly, reviews the care plan regularly and fully reassesses the client annually. Care management also includes ensuring that services are provided in accordance with the plan of care.

The care manager conducts a full assessment of the individual to determine service needs. Based on the results of the assessment, the care manager develops a written, individualized plan of community based social and medical services. The comprehensive plan of care specifies the type, frequency, duration and cost of all services needed for each client. The care manager is required to use the client's informal support system and pursue other funding sources such as Medicare and third party payors before utilizing program funds. DSS in conjunction with DXC implemented a care plan portal starting 7/1/13. Access Agencies are required to enter clients' care plans and prior authorization in the portal. Provider agencies enroll directly with the Connecticut Medical Assistance Program as service providers and may only provide and bill for the amount and duration of services authorized in the care plan portal. This measure improves quality assurance and ensures that providers may only bill what is authorized.

Application of Cost Limits

Once the plan of care is completed, the care manager must assure that the State's cost for the client's total plan of care, both medical and community based social services, does not exceed the average State cost of nursing facility care. This amount is calculated by deducting the average applied income contribution from the weighted average monthly Medicaid rate for nursing facility beds.

As of January 1, 2017 the limit on the total plan of care for Medicaid waiver clients was \$5,945 and remained the same through the end of SFY 2017. The cost limit on the State Funded portion of the program was \$2,973 based on a percentage of this amount.

Client Fee

Individuals who qualify for services under the special institutional income limit used for the Waiver and the State Funded component have a portion of their income applied to the cost of their care if their income exceeds 200% of the Federal Poverty Level plus the cost of any medical insurance premiums paid and other allowable deductions from the individual's gross income. Any remaining income must be paid toward the cost of care.

During SFY 17, State Funded clients were required to pay a 9% cost share each month based on paid claims data for that month. Allied Community Resources is responsible for collecting both Applied Income as well as cost share from clients. Clients who fail to pay the cost share and/or the Applied Income may be discontinued from the program.

Acceptance of Services

The care manager offers the individual the choice to accept a plan of home and community-based care as an alternative to institutional care. This choice is required by federal law and must be documented in writing. The individual and the care manager sign the plan of care. Individuals who accept a plan of care are expected, to the extent they are able, to take an active part in creating and changing their plan of care as needed. Individuals have the right to refuse the plan of care or any services suggested and be informed of likely consequences of such refusal. In SFY 2017, 4,790 clients accepted plans of care for home and community based services in contrast to 4,601 in the prior year. This represents 53% of the persons referred for assessment.

III. CASELOAD TRENDS: 7/1/16 - 6/30/17

During the twenty eighth year of operations, July 1, 2016 through June 30, 2017, the combined Waiver and State Funded Program caseload increased by 9%.

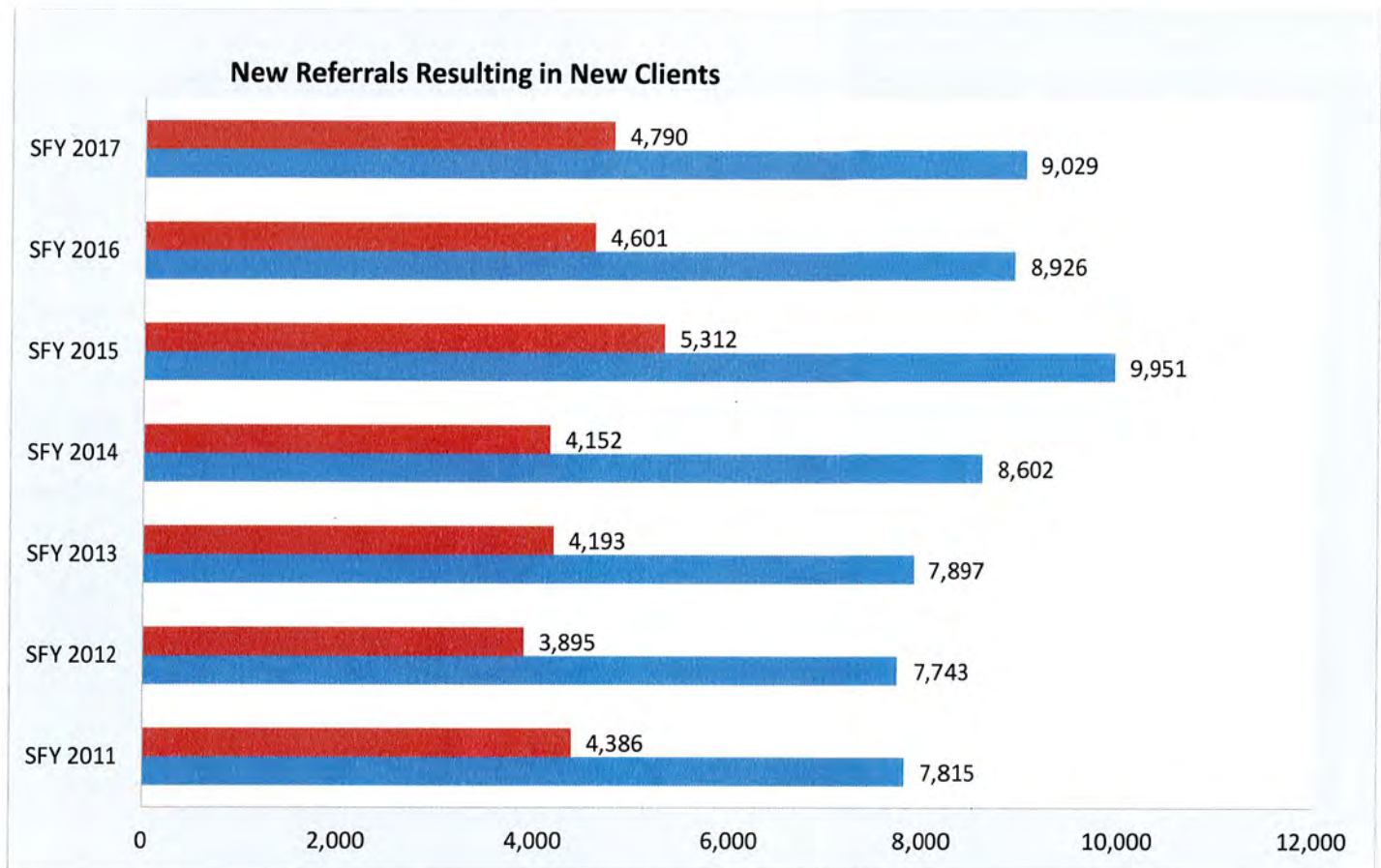
New Program Referrals and Placement Activity

The number of new clients placed on services during SFY 2017 was 4,790. An average of 400 new clients were placed on services each month and an average of 276 discharges occurred, resulting in an average net increase of 126 clients each month.

Throughout SFY17 9,029 individuals were referred for a full assessment of their needs to consider their potential for community placement. This is a slight increase from the previous year.

	New Program Referrals	New Clients
SFY 2011	7,815	4,386
SFY 2012	7,743	3,895
SFY 2013	7,897	4,193
SFY 2014	8,602	4,152
SFY 2015	9,951	5,312
SFY 2016	8,926	4,601
SFY 2017	9,029	4,790

The chart below illustrates the number of new clients that resulted from new program referrals in SFY 11 through SFY 17.

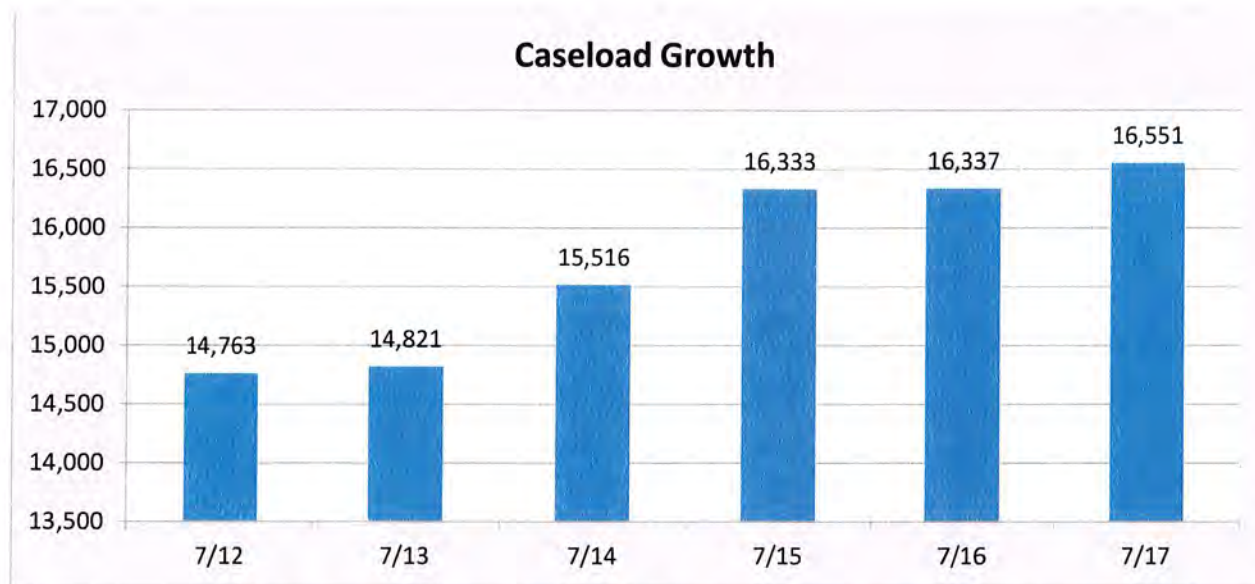


During the past six years, an average of 53% of new referrals resulted in new clients on the CT Home Care Program for Elders. The top three reasons for clients not progressing from referral to the program are:

- Not eligible, either financially or functionally.
- Cost Share. Clients and/or their families do not agree to pay the current rate of cost share for their services.
- Estate Recovery. Clients and/or their families/representatives refuse the program when advised the client’s estate is subject to recovery by the state when the client expires.

Caseload

The following graph illustrates the Connecticut Home Care Program for Elders caseload since July 2011. As of June 30, 2017 there were 16,551 clients. This represents a small increase from the 16,278 active cases at the end of SFY 2016. The caseload size was affected by the freeze on Category 1. The monthly average Connecticut Home Care Program for Elders caseload for SFY 2017 was 16,431.



Caseload by Funding Source

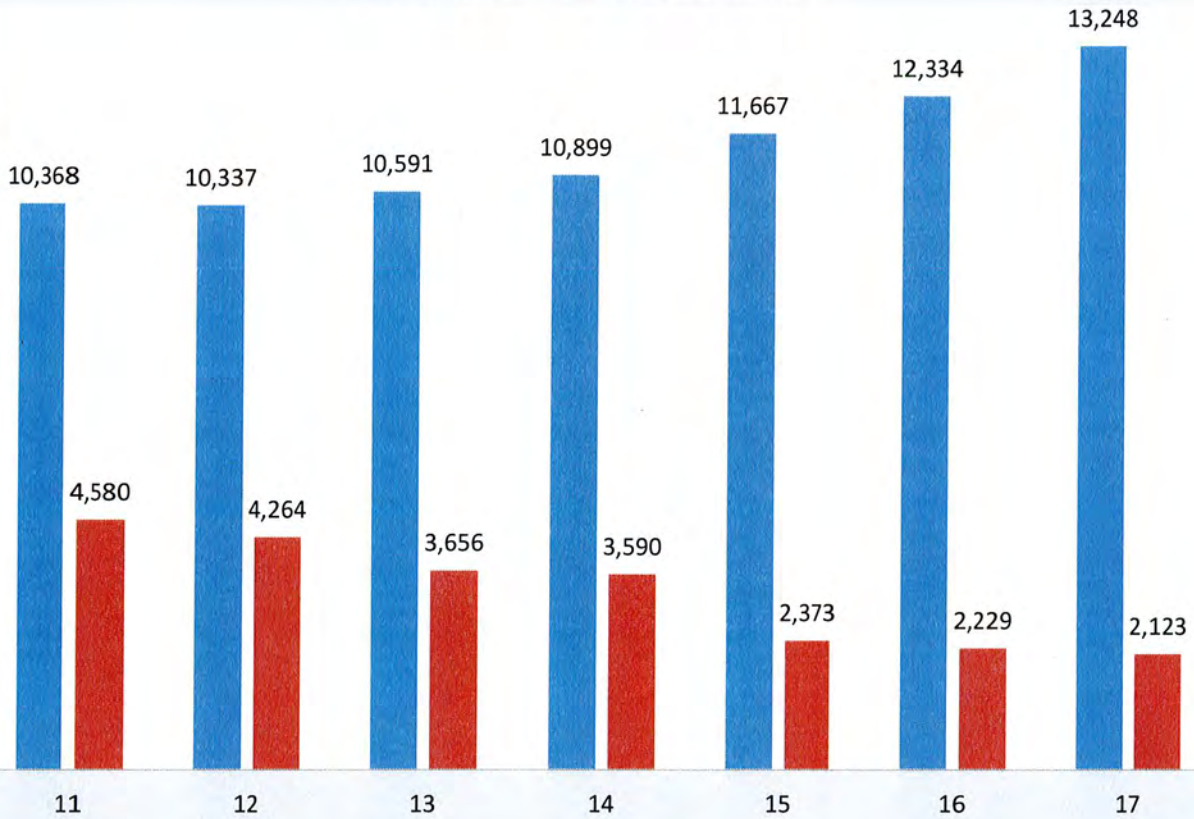
As of July 1, 1989, all State Funded clients were required to apply for Medicaid if their financial information indicated that they would qualify.

The graph below illustrates the volume trends for State Funded and Waiver clients since the beginning of SFY 2010. As of June 30, 2016 approximately 73% of the persons receiving program services have been Waiver clients.

As indicated below, while the number of Waiver clients steadily increases each year, the number of State-Funded clients has steadily decreased since the cost share was implemented.

Caseload Funding by Source

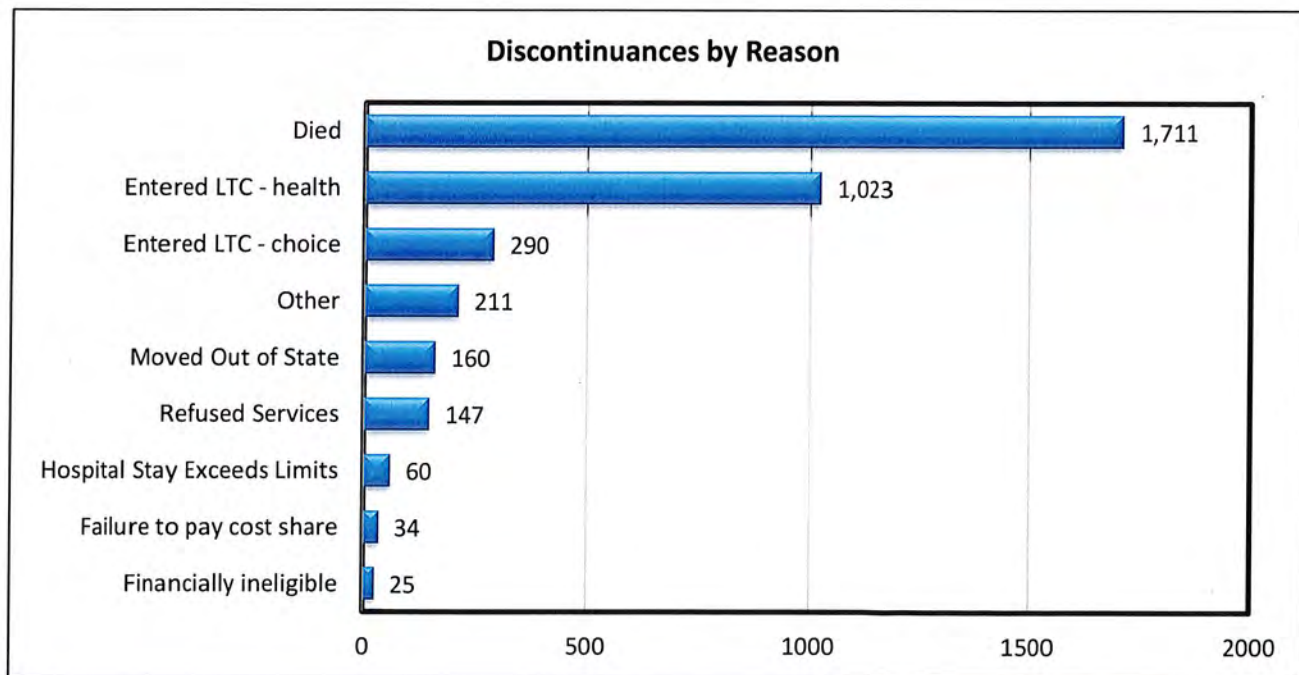
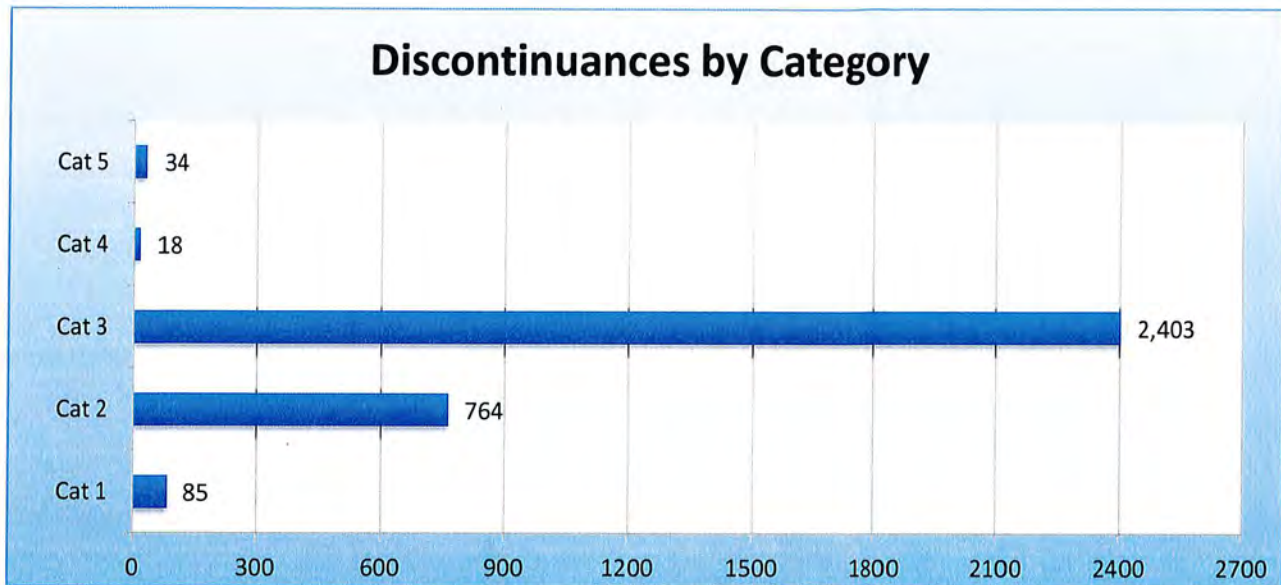
■ Waiver ■ State Funded



IV. PROGRAM ACTIVITY

Admissions and Discharges

The majority of clients discharged from the program are deceased. The primary goal of the program is to allow frail elders to live in their homes rather than a nursing home. Those who do enter a nursing facility do so because they have become too ill to stay at home and/or the cost of their care plan exceeds program limits for being less expensive than nursing home care.



Category 5 clients are Medicaid clients receiving services under the 1915i State Plan which allows 50% federal matching for home and community based services (HCBS). Prior to the approval of 1915i in 2012, all HCBS for these clients were 100% state funded.

VI. TRANSFERS WITHIN THE PROGRAM

Individuals within the program, who experience a change in functional or financial status may qualify for a change in their category of services designation. This change enables them to access increases in the care plan cost limits. Those who qualify for Category 3 gain access to full Medicaid benefits. The change to Category 3 enables the Department to maximize federal financial participation under Medicaid.

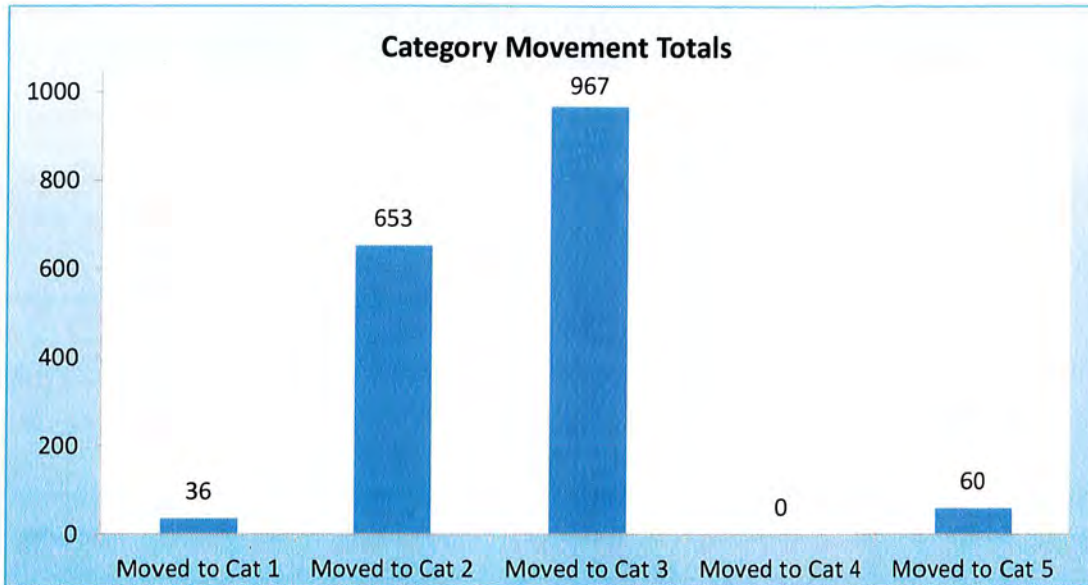
Category 5 clients are Medicaid clients receiving services under the 1915i State Plan which allows 50% federal matching for home and community based services (HCBS). Prior to the approval of 1915i in February 2012, all HCBS for these clients were 100% state funded.

Reasons for clients moving to different categories include:

- Change in functional status
 - Change in financial status
- Clients moving from category 4 are those clients who age into the CT Home Care Program for Elders

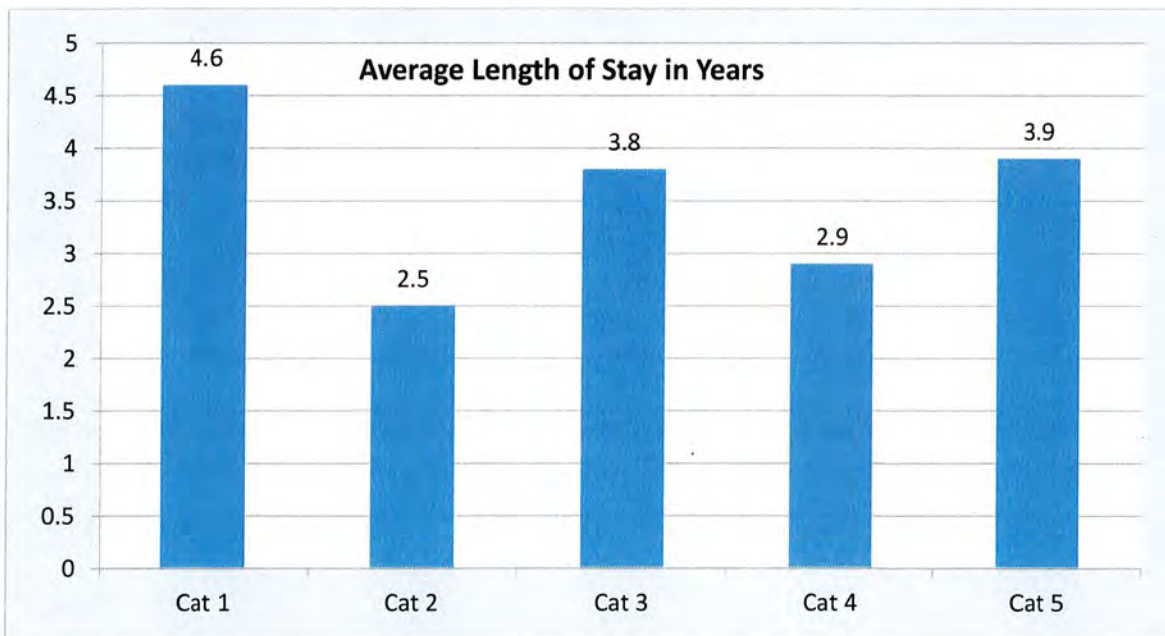
Transfers In From Other Categories

The majority of clients transfer into category 3 due to program goals, CMS target population, increasing functional needs, and when assets have been spent down to the Medicaid level. Clients who transfer into Category 2 include those who have transitioned from category 1 due to increased functional needs and clients who meet functional criteria but have exceeded the Medicaid asset limit. Clients who transfer into category 5 are those who have either become Medicaid eligible or Category 3 clients with fewer functional needs. It is rare for clients to transfer into category 4 except for other waiver clients who meet the diagnostic criteria for degenerative, neurological disease.



VI. LENGTH OF STAY

Categories 1 and 5 are for individuals who are at risk of nursing home placement but do not meet criteria for nursing home level of care. Category 2 individuals are frail enough to require nursing facility care, but are over the Medicaid asset limit. Category 3 individuals meet nursing home level of care. Category 4 is exclusively for adults with neurodegenerative conditions who do not qualify for Medicaid. Since at risk individuals have fewer functional needs and tend to be in better health, the length of stay exceeds the other categories.



II. PROGRAM EXPENDITURES AND COST SAVING PROGRAM ACTIVITIES

Program Expenditures 7/1/16 - 6/30/17

Actual program expenditures in SFY 2017 totaled \$416,917,862 before federal reimbursement. Federal reimbursement cut \$186,726,593 or 56% from the total program costs. The Net State Cost was \$189,726,358.

SFY 2017 Expenditures

	Waiver	State Funded	1915i	Total
Average Monthly Cost/Case	\$2,003	\$862	\$807	\$3,672.00
Total Cost	\$366,616,936	\$40,046,206	\$6,828,791	\$413,491,933
Federal Funds/ Reimbursement	(\$183,308,468)	\$0	(\$3,414,396)	(\$186,722,864)
Net State Cost	\$183,312,197	\$40,046,206	\$3,414,396	\$226,769,069.50

Mandatory Medicaid Applications

As noted above, all State Funded clients served by the Department are required to apply for Medicaid if their financial information indicates that they would qualify. This insures that the State receives the 50% match of federal funds wherever possible and lowers the percentage of clients whose services are purchased with 100% State funds. State Funded clients who appear to be eligible for Medicaid continue to be identified when their income and assets are reviewed during annual reassessments of functional status.

**For information regarding this report, please call:
The Department of Social Services,
Community Options at
1-800-445-5394 or locally at 860-424-4904.**

APPENDIX A

State of Connecticut Regulations, Section 17b-342 - (Formerly Sec. 17-314b). Connecticut Home-Care Program for the Elderly.

(a) The Commissioner of Social Services shall administer the Connecticut home-care program for the elderly state-wide in order to prevent the institutionalization of elderly persons (1) who are recipients of medical assistance, (2) who are eligible for such assistance, (3) who would be eligible for medical assistance if residing in a nursing facility, or (4) who meet the criteria for the state-funded portion of the program under subsection (i) of this section. For purposes of this section, a long-term care facility is a facility which has been federally certified as a skilled nursing facility or intermediate care facility. The commissioner shall make any revisions in the state Medicaid plan required by Title XIX of the Social Security Act prior to implementing the program. The annualized cost of the community-based services provided to such persons under the program shall not exceed sixty per cent of the weighted average cost of care in skilled nursing facilities and intermediate care facilities. The program shall be structured so that the net cost to the state for long-term facility care in combination with the community-based services under the program shall not exceed the net cost the state would have incurred without the program. The commissioner shall investigate the possibility of receiving federal funds for the program and shall apply for any necessary federal waivers. A recipient of services under the program, and the estate and legally liable relatives of the recipient, shall be responsible for reimbursement to the state for such services to the same extent required of a recipient of assistance under the state supplement program, medical assistance program, temporary family assistance program or supplemental nutrition assistance program. Only a United States citizen or a noncitizen who meets the citizenship requirements for eligibility under the Medicaid program shall be eligible for home-care services under this section, except a qualified alien, as defined in Section 431 of Public Law 104-193, admitted into the United States on or after August 22, 1996, or other lawfully residing immigrant alien determined eligible for services under this section prior to July 1, 1997, shall remain eligible for such services. Qualified aliens or other lawfully residing immigrant aliens not determined eligible prior to July 1, 1997, shall be eligible for services under this section subsequent to six months from establishing residency. Notwithstanding the provisions of this subsection, any qualified alien or other lawfully residing immigrant alien or alien who formerly held the status of permanently residing under color of law who is a victim of domestic violence or who has mental retardation shall be eligible for assistance pursuant to this section. Qualified aliens, as defined in Section 431 of Public Law 104-193, or other lawfully residing immigrant aliens or aliens who formerly held the status of permanently residing under color of law shall be eligible for services under this section provided other conditions of eligibility are met.

(b) The commissioner shall solicit bids through a competitive process and shall contract with an access agency, approved by the Office of Policy and Management and the Department of Social Services as meeting the requirements for such agency as defined by regulations adopted pursuant to subsection (e) of this section, that submits proposals which meet or exceed the minimum bid requirements. In addition to such contracts, the commissioner may use department staff to provide screening, coordination, assessment and monitoring functions for the program.

(c) The community-based services covered under the program shall include, but not be limited to, the following services to the extent that they are not available under the state Medicaid plan, occupational therapy, homemaker services, companion services, meals on wheels, adult day care, transportation, mental health counseling, care management, elderly foster care, minor home modifications and assisted living services provided in state-funded congregate housing and in other assisted living pilot or demonstration projects established under state law. Personal care assistance services shall be covered under the program to the extent that (1) such services are not available under the Medicaid state plan and are more cost effective on an individual client basis than existing services covered under such plan, and (2) the provision of such services is approved by the federal government. Recipients of state-funded services and persons who are determined to be functionally eligible for community-based services who have an application for medical assistance pending shall have the cost of home health and community-based services covered by the program, provided they comply with all medical assistance application requirements. Access agencies shall not use department funds to purchase community-based services or home health services from themselves or any related parties.

(d) Physicians, hospitals, long-term care facilities and other licensed health care facilities may disclose, and, as a condition of eligibility for the program, elderly persons, their guardians, and relatives shall disclose, upon request from the Department of Social Services, such financial, social and medical information as may be necessary to enable the department or any agency administering the program on behalf of the department to provide services under the program. Long-term care facilities shall supply the Department of Social Services with the names and addresses of all applicants for admission. Any information provided pursuant to this subsection shall be confidential and shall not be disclosed by the department or administering agency.

(e) The commissioner shall adopt regulations, in accordance with the provisions of chapter 54, to define "access agency", to implement and administer the program, to establish uniform state-wide standards for the program and a uniform assessment tool for use in the screening process and to specify conditions of eligibility.

(f) The commissioner may require long-term care facilities to inform applicants for admission of the program established under this section and to distribute such forms as the commissioner prescribes for the program. Such forms shall be supplied by and be returnable to the department.

(g) The commissioner shall report annually, by June first, to the joint standing committee of the General Assembly having cognizance of matters relating to human services on the program in such detail, depth and scope as said committee requires to evaluate the effect of the program on the state and program participants. Such report shall include information on (1) the number of persons diverted from placement in a long-term care facility as a result of the program, (2) the number of persons screened, (3) the average cost per person in the program, (4) the administration costs, (5) the estimated savings, and (6) a comparison between costs under the different contracts.

(h) An individual who is otherwise eligible for services pursuant to this section shall, as a condition of participation in the program, apply for medical assistance benefits pursuant to

section 17b-260 when requested to do so by the department and shall accept such benefits if determined eligible.

(i) (1) On and after July 1, 1992, the Commissioner of Social Services shall, within available appropriations, administer a state-funded portion of the program for persons (A) who are sixty-five years of age and older; (B) who are inappropriately institutionalized or at risk of inappropriate institutionalization; (C) whose income is less than or equal to the amount allowed under subdivision (3) of subsection (a) of this section; and (D) whose assets, if single, do not exceed the minimum community spouse protected amount pursuant to Section 4022.05 of the department's uniform policy manual or, if married, the couple's assets do not exceed one hundred fifty per cent of said community spouse protected amount and on and after April 1, 2007, whose assets, if single, do not exceed one hundred fifty per cent of the minimum community spouse protected amount pursuant to Section 4022.05 of the department's uniform policy manual or, if married, the couple's assets do not exceed two hundred per cent of said community spouse protected amount.

(2) Except for persons residing in affordable housing under the assisted living demonstration project established pursuant to section 17b-347e, as provided in subdivision (3) of this subsection, any person whose income is at or below two hundred per cent of the federal poverty level and who is ineligible for Medicaid shall contribute seven per cent of the cost of his or her care. Any person whose income exceeds two hundred per cent of the federal poverty level shall contribute seven per cent of the cost of his or her care in addition to the amount of applied income determined in accordance with the methodology established by the Department of Social Services for recipients of medical assistance. Any person who does not contribute to the cost of care in accordance with this subdivision shall be ineligible to receive services under this subsection. Notwithstanding any provision of the general statutes, the department shall not be required to provide an administrative hearing to a person found ineligible for services under this subsection because of a failure to contribute to the cost of care.

(3) Any person who resides in affordable housing under the assisted living demonstration project established pursuant to section 17b-347e and whose income is at or below two hundred per cent of the federal poverty level, shall not be required to contribute to the cost of care. Any person who resides in affordable housing under the assisted living demonstration project established pursuant to section 17b-347e and whose income exceeds two hundred per cent of the federal poverty level, shall contribute to the applied income amount determined in accordance with the methodology established by the Department of Social Services for recipients of medical assistance. Any person whose income exceeds two hundred per cent of the federal poverty level and who does not contribute to the cost of care in accordance with this subdivision shall be ineligible to receive services under this subsection. Notwithstanding any provision of the general statutes, the department shall not be required to provide an administrative hearing to a person found ineligible for services under this subsection because of a failure to contribute to the cost of care.

(4) The annualized cost of services provided to an individual under the state-funded portion of the program shall not exceed fifty per cent of the weighted average cost of care in nursing homes in the state, except an individual who received services costing in excess of such amount under

the Department of Social Services in the fiscal year ending June 30, 1992, may continue to receive such services, provided the annualized cost of such services does not exceed eighty per cent of the weighted average cost of such nursing home care. The commissioner may allow the cost of services provided to an individual to exceed the maximum cost established pursuant to this subdivision in a case of extreme hardship, as determined by the commissioner, provided in no case shall such cost exceed that of the weighted cost of such nursing home care.

(j) The Commissioner of Social Services may implement revised criteria for the operation of the program while in the process of adopting such criteria in regulation form, provided the commissioner prints notice of intention to adopt the regulations in the Connecticut Law Journal within twenty days of implementing the policy. Such criteria shall be valid until the time final regulations are effective.

(k) The commissioner shall notify any access agency or area agency on aging that administers the program when the department sends a redetermination of eligibility form to an individual who is a client of such agency.

(l) In determining eligibility for the program described in this section, the commissioner shall not consider as income Aid and Attendance pension benefits granted to a veteran, as defined in section 27-103, or the surviving spouse of such veteran.

APPENDIX B CATEGORY CHART

**DEPARTMENT OF SOCIAL SERVICES
CONNECTICUT HOME CARE PROGRAM & 1915(i) State Plan Option - FEE FOR SERVICE USE ONLY
Effective 3/1/2017**

rev: 03/17

<u>Category Type</u>	<u>Description</u>	<u>Functional Need</u>	<u>Financial Eligibility</u>	<u>Care Plan Limits</u>	<u>Funding Source</u>	<u>Intake Status</u>
Category 1 CHCPE	Limited home care for moderately frail elders	At risk of hospitalization or short term nursing home placement (1 or 2 critical needs)	Individual Income= No Limit* Assets: Individual = \$36,270.00 Couple= \$48,360.00	<25% NH Cost (\$1466.00 Monthly)	STATE	Two year freeze effec (Wait-list)
Category 2 CHCPE	Intermediate home care for very frail elders with some assets above the Medicaid limits.	In need of short or long term nursing home care (NF LOC)	Individual Income= No Limit* Assets: Individual = \$36,270.00 Couple= \$48,360.00	<50% NH cost (\$2973.00 Monthly)	STATE	OPEN
Category 3 CHCPE	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 (NF LOC)	Individual Income=\$2205.00/Mth Assets: Individual = \$1,600.00 Couple: both as clients = \$1600.00 each one as client = \$24,780.00 (\$1600.00 + \$24,180.00 CSPA)**	100% NH Cost (\$5945.00 Monthly) Social Services 115% NH Cost (\$6837.00 Monthly) 100% Subacute*** (\$13525.00 Monthly) 115% Subacute*** (\$15553.80 Monthly)	MEDICAID WAIVER	OPEN
Category 4 CHCPD	Intermediate home care for individuals under age 65 with a degenerative neurological condition, ineligible for Medicaid	In need of short or long term nursing home care (NF LOC)	Individual Income= No Limit* Assets: Individual = \$36,270.00 Couple= \$48,360.00	<50% NH cost (\$2973.00 Monthly)	STATE	Wait-list limited to 100 slots
Category 5 1915(i)	Same as category 1. Also active on categorically needy Medicaid S01, S02, S03, S04 Must be age 65 or older	At risk of hospitalization or short term nursing home placement (1 or 2 critical needs)	Individual Income - \$1,508.00 Assets: Individual = \$1,600.00		50% Federal Reimbursement	OPEN

- Notes:**
1. Clients in the higher income range are required to contribute to the cost of their care. Applied income starts at \$2010.00
 2. There is no income limit for the State Funded portion. The Medicaid Waiver income limit remains at 300% of SSI which is \$2,205.00
 3. CHCPE Services available in all categories include the full range of home health and community based services.
*1915(i) State Plan Option has limited PCA services to 14 hours weekly and homemaking services are limited to 6 hours weekly.
 4. Care plan limits in all categories are based on the total cost of all state-administered services.
 5. 1915(i) State Plan option covers individuals on Medicaid but who qualify for category 1 services.
CT will claim 50% reimbursement from the federal government for home and community based services not reimbursable under Medicaid.
 6. Some individuals under category 2 may become financially eligible for the Medicaid Waiver.
In these cases, the client must apply for Medicaid and cooperate with the application process.
 - ** 7. Married couples who are over this asset limit for category 3 may be eligible based on the special spousal asset protection rule.
 8. Functional need is a clinical determination by the Department about the applicant's critical need for assistance in the following areas:
Activities of Daily Living (ADL's): Bathing, Dressing, Toileting, Transferring, Eating/Feeding,
Needs factors : 1. Behavioral Need - Requires daily supervision to prevent harm. 2. Medication supports - Requires assistance for administration of physician ordered daily medications. Includes supports beyond set up.
 9. NF LOC is defined as:
 1. Supervision or cueing ≥ 3 ADL's + need factor
 2. Hands-on ≥ 3 ADL's
 3. Hands-on ≥ 2 ADL's + need factor
 4. A cognitive impairment which requires daily supervision to prevent harm
 - *** 10. Subacute LOC is defined as:
 1. Participant requires comprehensive medical monitoring but does not require intensive diagnostic and/or invasive procedures
 2. Participant requires intense medical supervision and therapy such as nursing intervention intermitantly throughout the day and/or the need for ancillary or technological services (such as laboratory, pharmacy, nutrition, diagnostic)
 3. Participant may require services such as brain injury rehabilitation, high intensity stroke or orthopedic programs, ventilator programs, complex wound care or specialized infusion therapy.
11. Care Plan limits are for CHCP fee for service only
12. For contracted Access Agencies use only.

**APPENDIX C
CARE MANAGEMENT CONTINUUM**

		TIERED	CASE	MANAGEMENT
Self-Directed Care	Access Agency Managed	Tier A	Tier B	Tier C
<p>Client or family hires and trains workers independently. Self-directed care assumes that there are situations in which the client/representation can work directly with provider agencies to effectively coordinate and monitor the client's care without the assistance of a care manager. The client chooses from a list of participating providers or hires their own caregiver. The client is the employer responsible for hiring and/or firing employees</p>	<p>Client/family receives services which are arranged, coordinated and monitored by an access agency. Due to cognitive status of client and/or lack of family support, client control is limited and care management by an access agency is intensive.</p>	<p>Consists of:</p> <ul style="list-style-type: none"> • Quarterly contact • Annual Reassessment <p>Client requires three fewer care management interventions in a six month period. If one of those is crisis intervention, the client moves to Tier B.</p>	<p>Consists of:</p> <ul style="list-style-type: none"> • Monthly Monitoring • Six Month Field Visit • Annual Reassessment <p>Client requires four to six care management interventions in a six month period.</p>	<ul style="list-style-type: none"> • Monthly Monitoring • Six Month Field Visit • Annual Reassessment <p>Client requires seven or more care management interventions in a six month period.</p>

i) Tiered Case Management was added 7/1/16 recognizing that all clients do not require the same intensity of care management. Intensity levels are decided clinically by using the four categories of case management below.

ii) The four categories of case management intervention: *Crisis Intervention, Service Brokerage and Advocacy, Risk Management and Client Engagement/Re-engagement.* **Crisis Intervention Efforts** have two principle aims 1) Cushion the stressful event by immediate or emergency emotional or environmental first aid and 2) Strengthen the person in his or her coping through immediate therapeutic clarification and guidance during the crisis period. **Service Brokerage and Advocacy** requires that the Care Manager facilitate continual interaction between various segments of the service delivery system, including activities around finding and keeping providers for clients with difficult service needs, pre and post transitioning from an inpatient setting to the community, hospice and end of life care. **Risk Management** includes the identification of potential and perceived risks to the individual falling into four general categories; health, behavior, personal safety risks, and in-community risks. Managing these risks includes identification and documenting risks, developing written plans for addressing them, negotiating with clients the risks presented keeping client choice central to the process, and monitoring outcomes related to the risk. **Client engagement** refers to the process through which clients become active or involved in their care plans and participation in the program. The engagement process has several conceptualizations where interventions are designed to enhance client 1) receptivity, 2) expectancy 3) investment, 4) working relationship. Care management interventions are weighted according to complexity, severity and number of tasks required.

APPENDIX D

MEMBERS OF THE CONNECTICUT HOME CARE ADVISORY COMMITTEE

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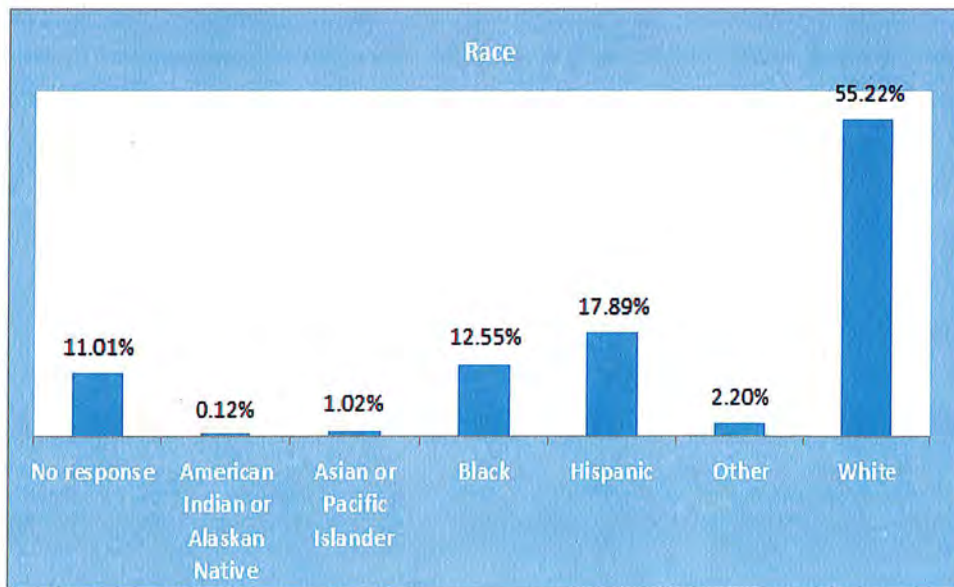
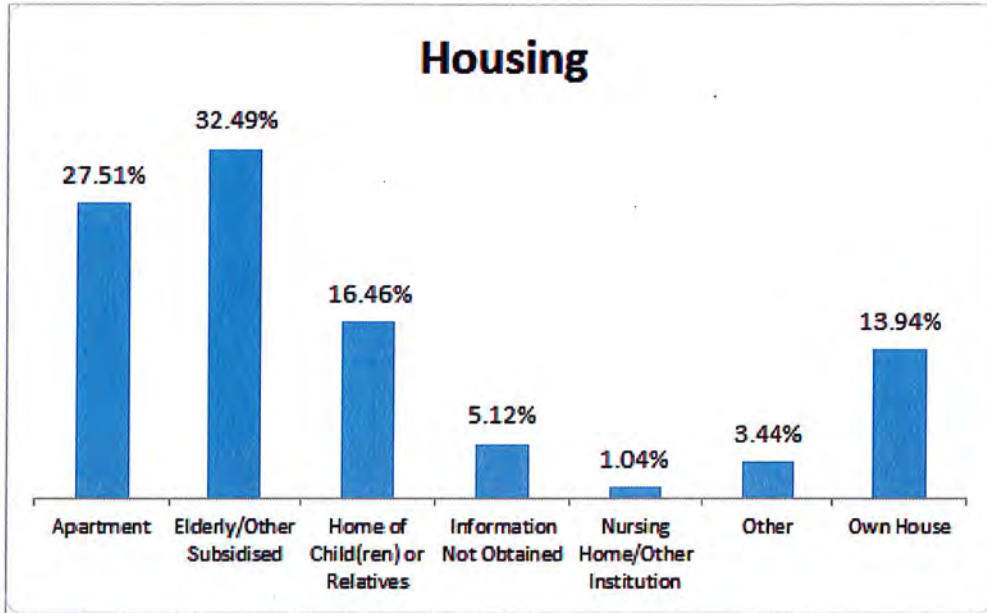
Maria Dexter
State of Connecticut
Department of Social Services
Community Options Unit

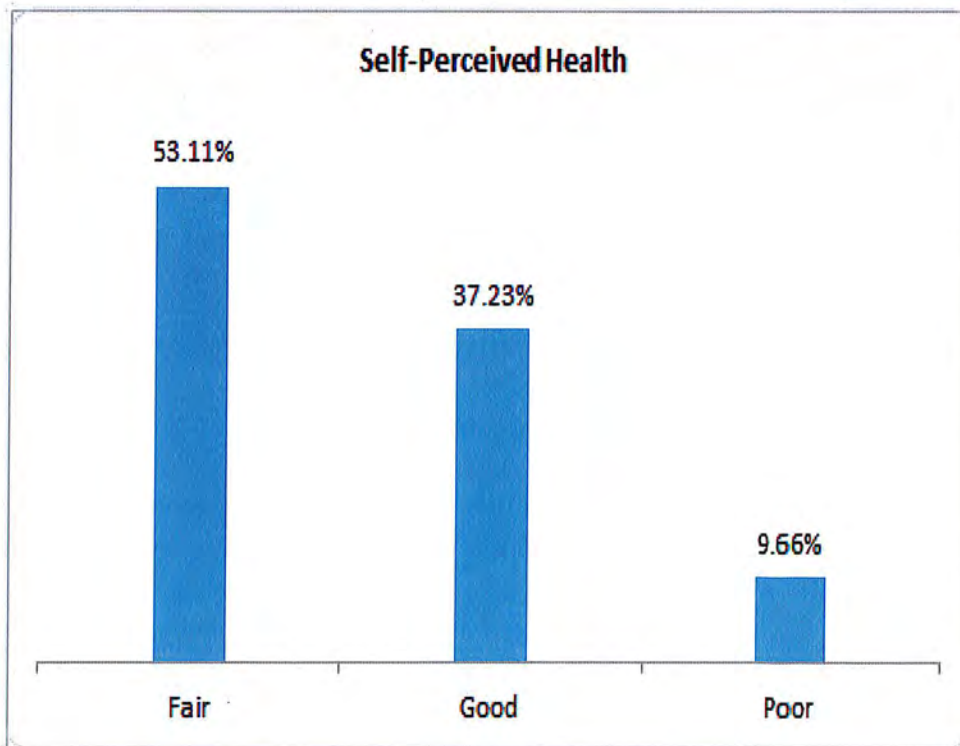
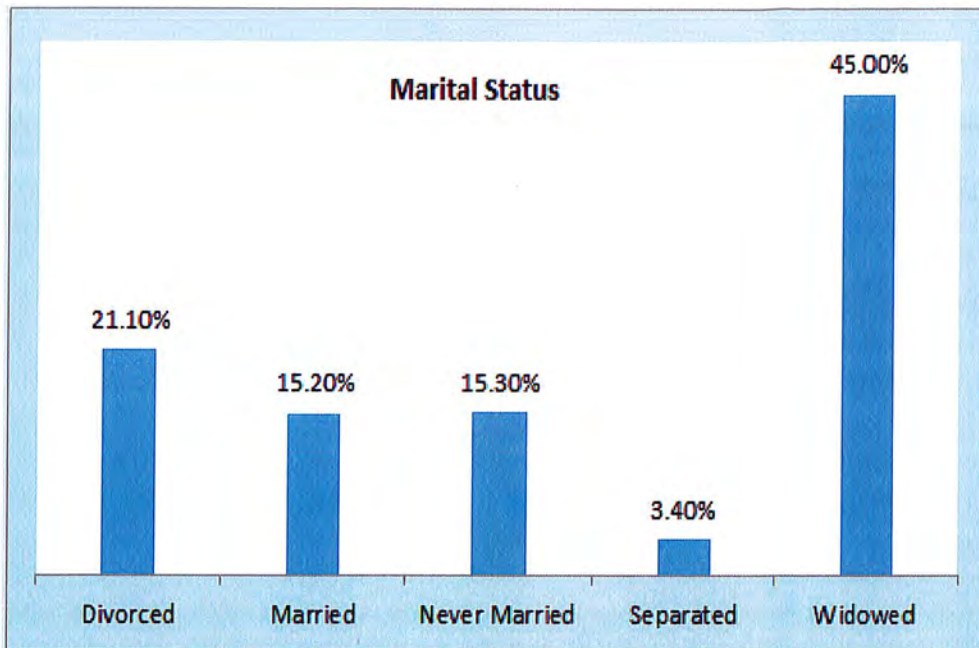
APPENDIX E CHCP CLIENT CHARACTERISTICS FOR SFY 2017

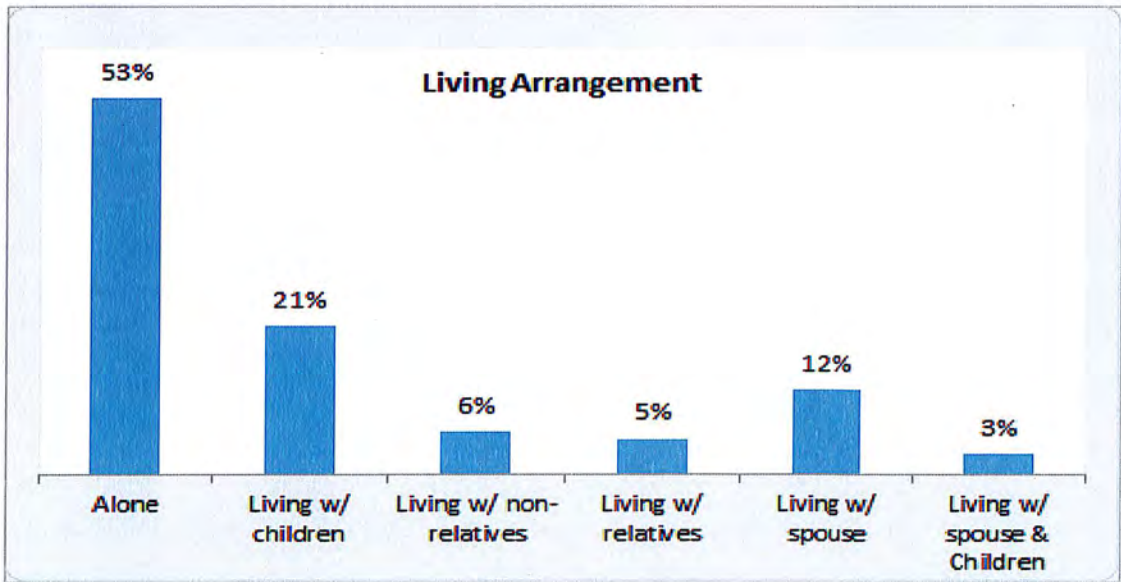
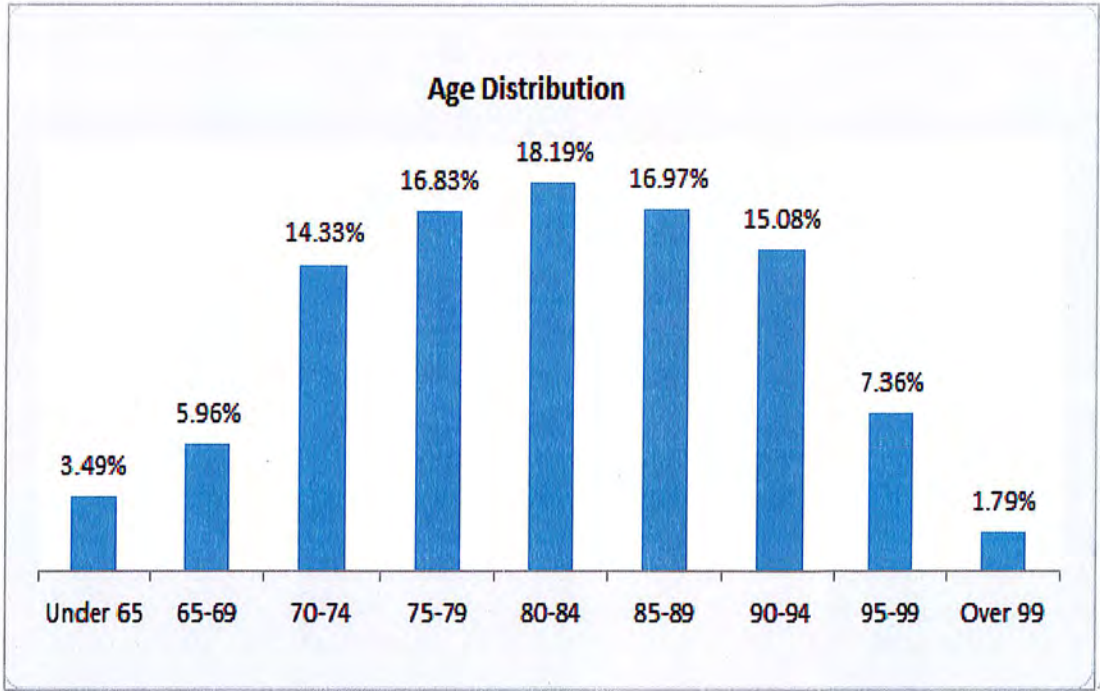
Client Characteristics

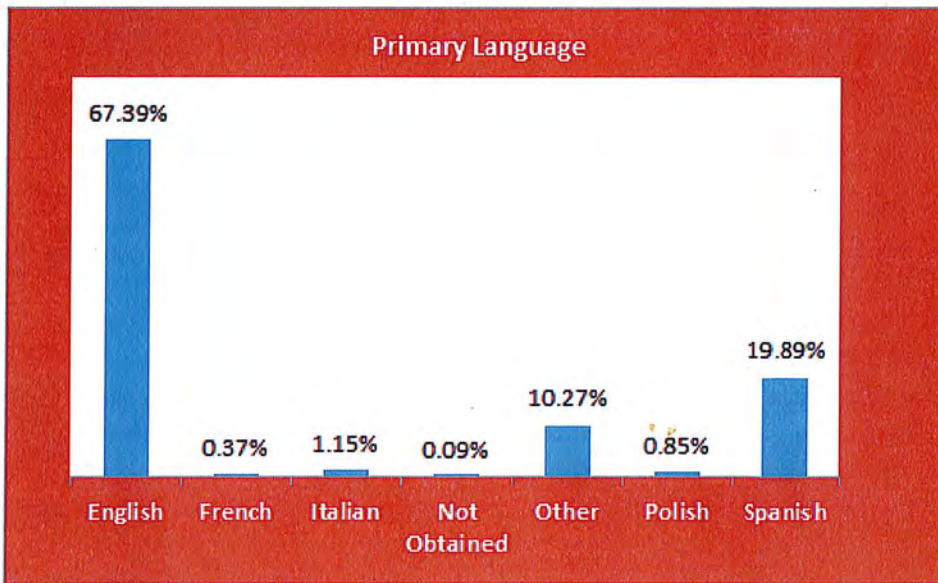
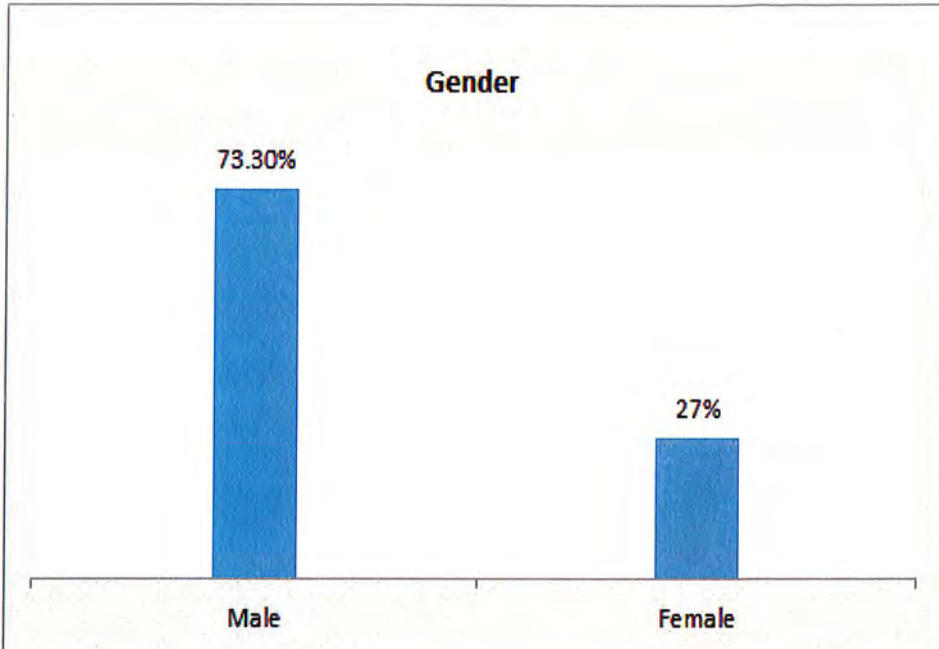
The charts below highlight specific characteristics on CHCPE program participants' information regarding program participant age is found in Appendix E.

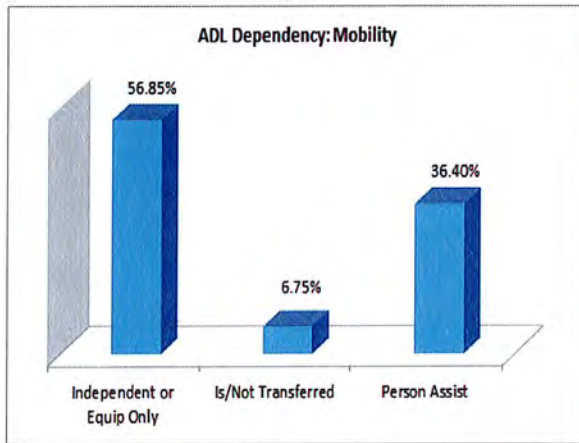
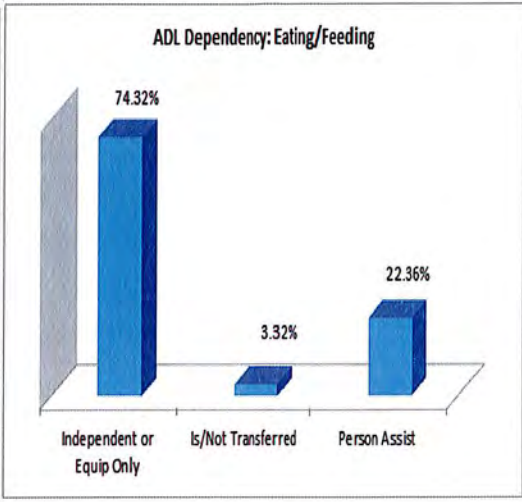
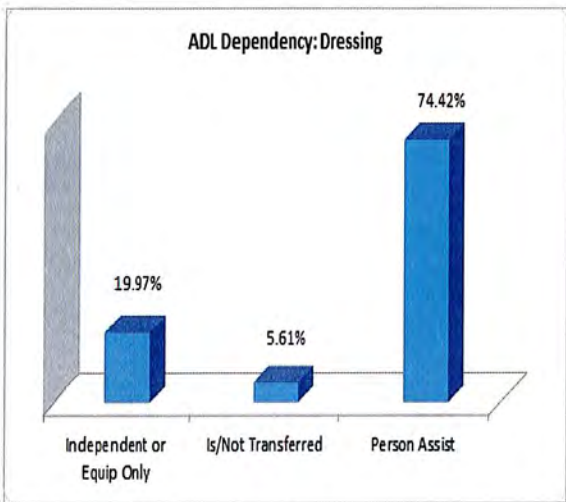
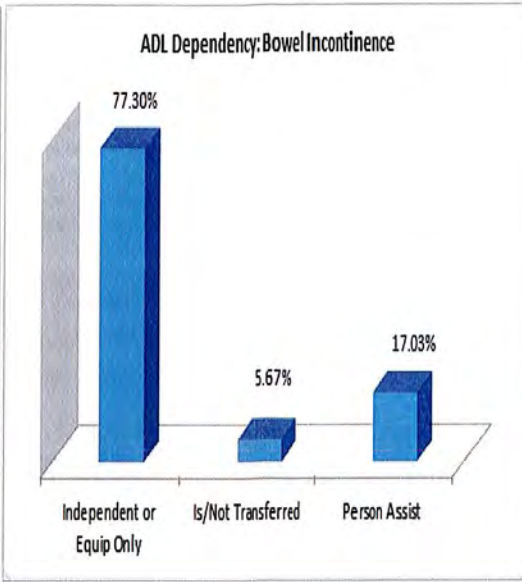
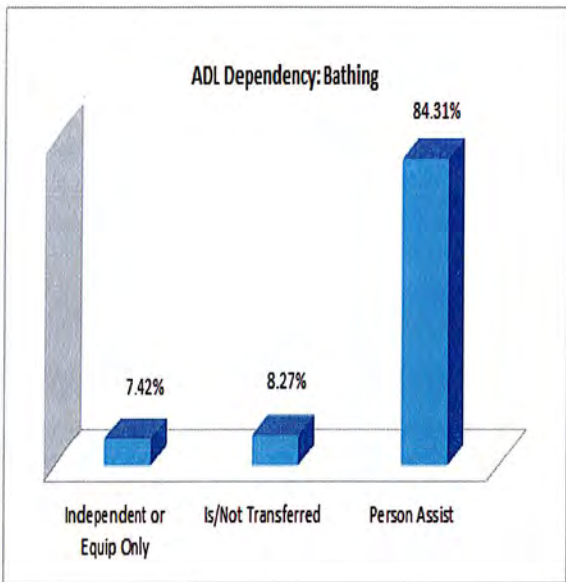
The chart below illustrates the age range of CHCP participants. Thirty-five percent of program participants are between the ages of 75-89. Clients age 70 and under represent 9% and those age 90 and upward represent 23% of all program clients.

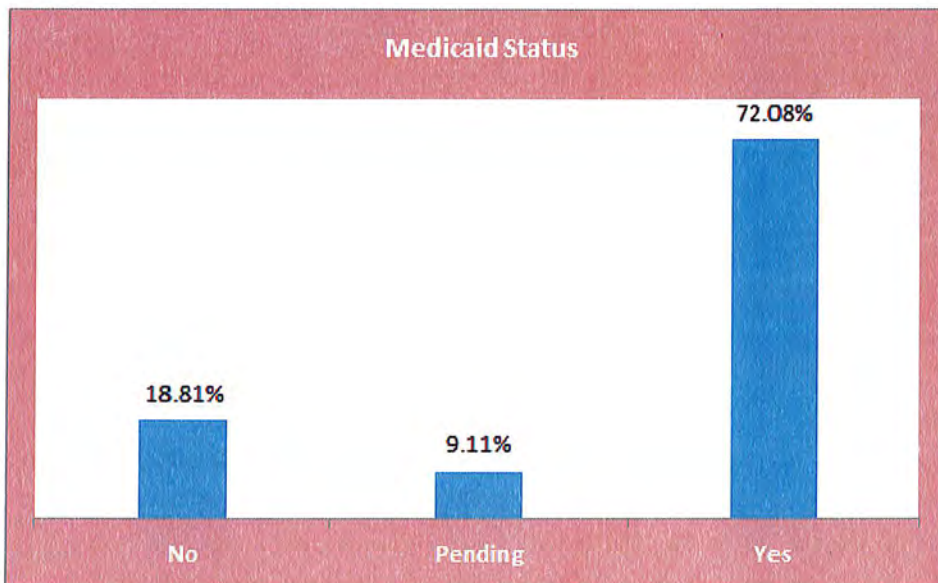
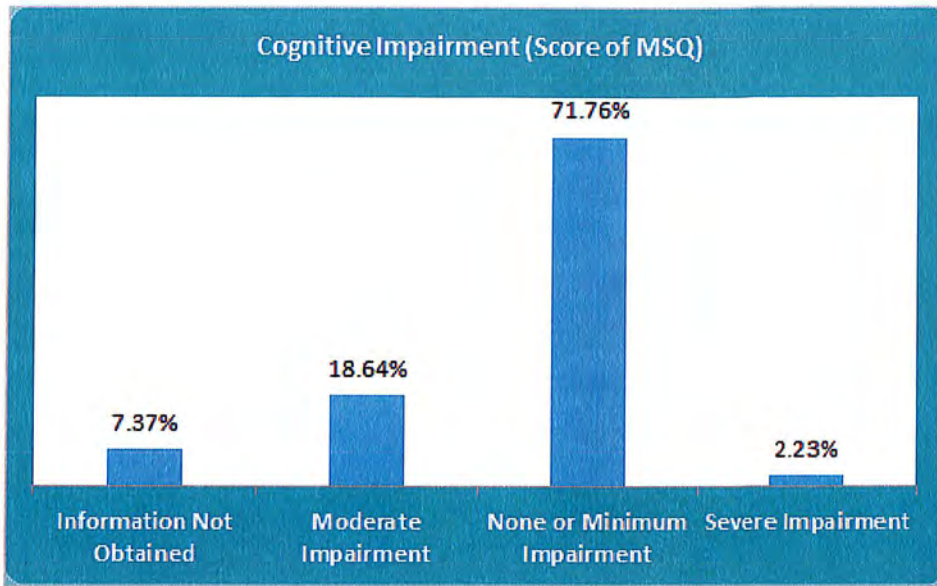






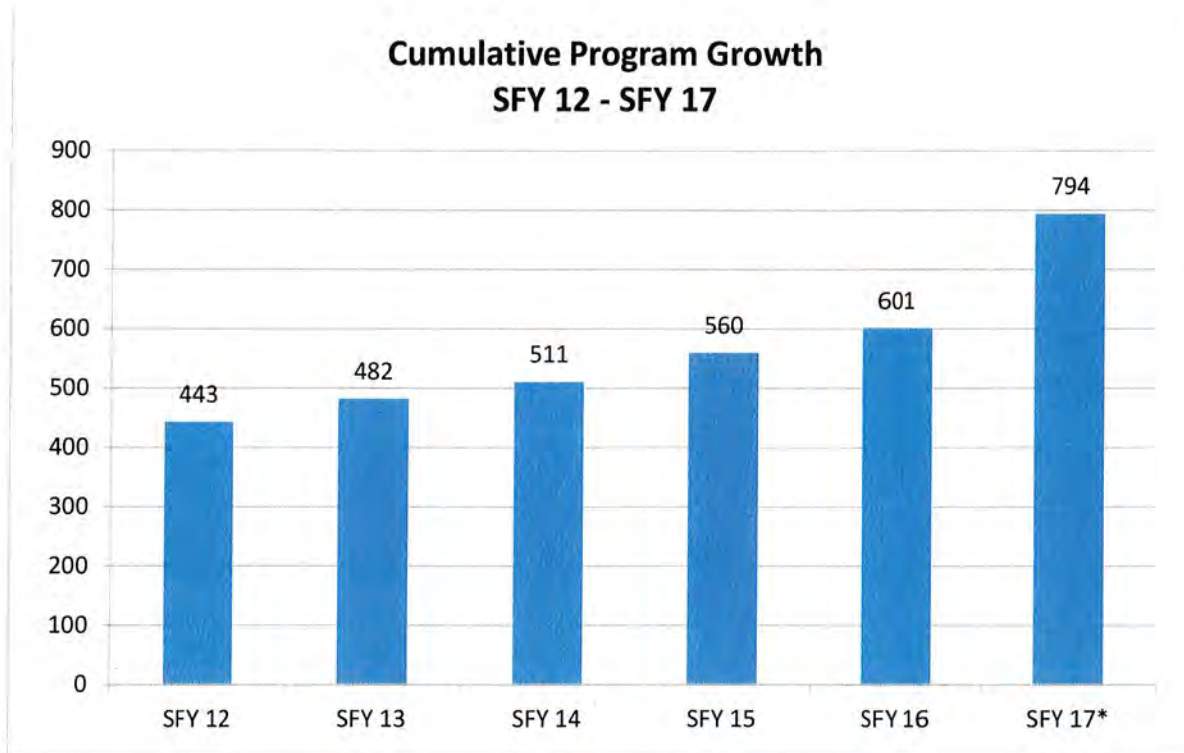






APPENDIX F
STATE-FUNDED CONGREGATES CUMULATIVE CLIENT GROWTH
FROM SFY 01 – SFY 17

The Connecticut Home Care Program for Elders offers Assisted Living Services in State funded congregate housing facilities. This on-site coordination of services that facilitate daily living activities got underway in March 2001. For the purpose of this report, only the last six years of cumulative program growth is displayed.



*Because HUD is no longer state-funded, going forward it will be reported with the congregates.

APPENDIX G HUD FACILITIES

In addition to the State-Funded Congregate sites, there are six HUD facilities participating with the Connecticut Home Care Program for Elders. State funding for HUD facilities ended 8/1/16.

APPENDIX H PRIVATE ASSISTED LIVING PILOT CUMULATIVE GROWTH

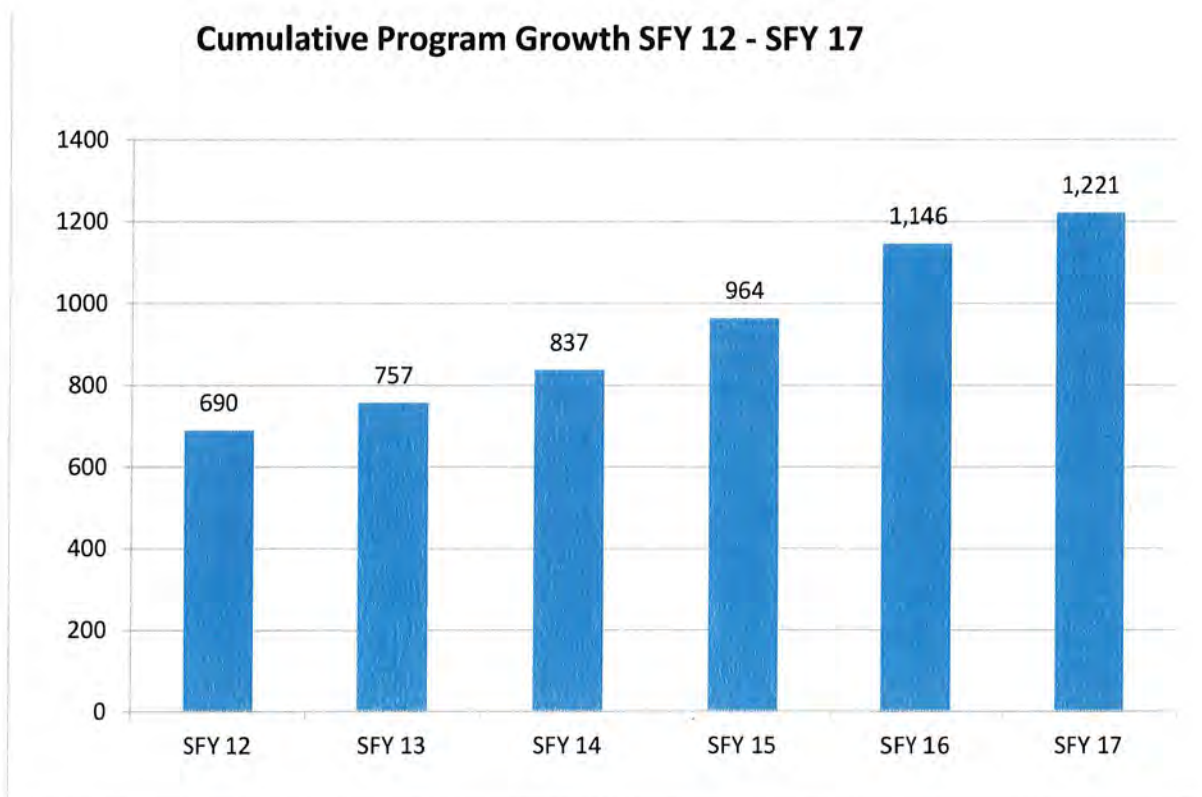
The Private Assisted Living Program was established by the State Legislature effective 7/1/2004. Originally the program was limited to 75 slots and expanded 125 2012. For the purpose of this report, only the last six years of cumulative program growth is displayed.



APPENDIX I

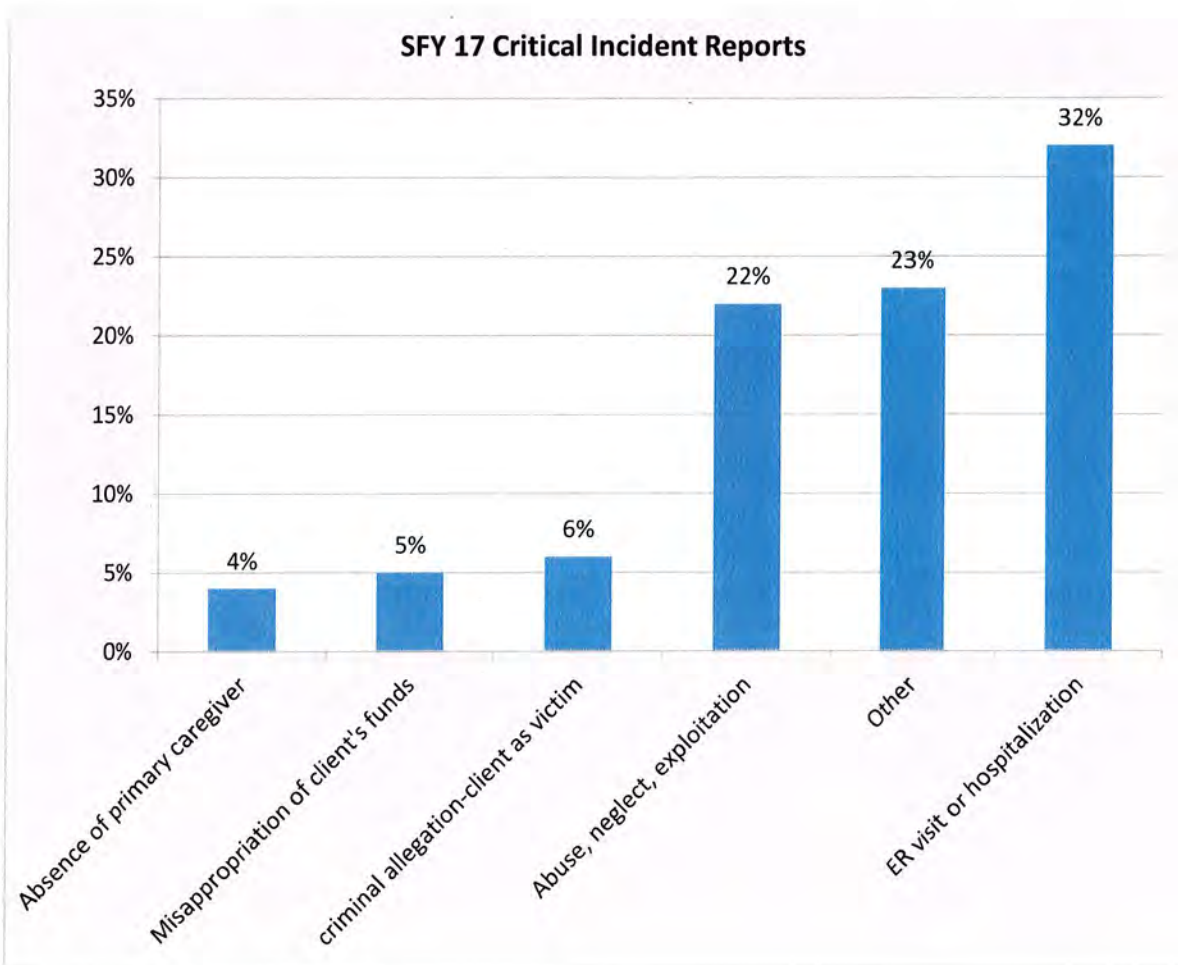
ASSISTED LIVING DEMONSTRATION PROJECT CUMULATIVE GROWTH FROM SFY 10 - SFY 15

¹The Department of Social Services (DSS), in collaboration with the Department of Public Health (DPH), the Department of Economic and Community Development (DECD), the Connecticut Housing Finance Authority (CHFA) and the Office of Policy and Management (OPM) established a demonstration project to provide subsidized assisted living services, as defined in section 19-13-D105 of the regulations of Connecticut state agencies, for persons residing in affordable housing, as defined in section 8-39a. The first units under the demonstration became occupied in September 2004. For the purpose of this report, only the last six years of cumulative program growth is displayed.



APPENDIX J CRITICAL INCIDENT REPORTS SFY 17

One third of critical incidents involve emergency room visits or unexpected hospitalizations, reduced by 20% from the previous fiscal year. Quality Assurance staff review these incidents and provide feedback to the Access Agency regarding methods to prevent further occurrences, if applicable. The majority of the abuse, neglect and exploitation incidents are reported to Protective Services for the Elderly which lies within the Social Work Division of DSS. The Quality Assurance Committee works to strengthen policies and procedures to enable more rapid reporting time and responses, in addition to efforts to reduce the incidents across all categories.



**CT HOME CARE PROGRAM FOR ELDERS
NORTH WESTERN CONNECTICUT REGION
CLIENT SATISFACTION SURVEY REPORT
June 2017**

1. SURVEY ADMINISTRATION AND POPULATION

The Community Options Unit conducted a client satisfaction survey for the Connecticut Home Care Program for Elders (CHCPE) care managed clients, residing in the program's North Western Region. A cover letter and a two page one sided survey were sent to one hundred and one (101) active CHCPE clients. This represents approximately five percent (5%) of the current total client population of 2006 clients, residing in the program's North Western Region.

The surveys were mailed on June 01, 2017. Clients were asked to return the survey by June 30, 2017. Active category one, two, three, four and five clients in the CHCPE program's North Western Region were selected randomly.

2. SURVEY RESULTS

Forty-six percent (46%) of surveyed clients responded to the survey. Seventeen percent (17%) of all surveys mailed were returned undeliverable because of incorrect address or client expiration.

The survey results are presented in six (6) defining categories: (A) respondent identifier; (B) CHCPE alternatives; (C) service satisfaction; (D) service dependability; (E) contact awareness; and (F) service utilization.

A. RESPONDENT IDENTIFIER

Fifty-six percent (56%) of those completing the survey were program clients, thirty-nine percent (39%) were family members, nine percent (9%) were caregivers and the remaining eleven percent (11%) were completed by those identified as "other".

B. CHCPE ALTERNATIVES

One Hundred percent (100%) of survey respondents indicated how they would manage without home care services. Twenty-three (23%) of these respondents reported they would enter a nursing home. Twenty-three percent (23%) said that they would do without home care services and Forty-one percent (41%) reported they would depend on family/friends for help. Zero percent (0%) of those responding said they would rely on some other home care alternative.

C. SERVICE SATISFACTION

Overall, CHCPE clients participating in the survey rated the services they received favorably, reflecting Ninety-five percent (95%) satisfaction and Five percent (5%) dissatisfaction.

D. SERVICE DEPENDABILITY

Ninety-seven percent (97%) of respondents reported that they received services when they were scheduled. Three percent (3%) reported not being able to depend on receiving services as scheduled.

E. CONTACT AWARENESS

Sixty-four (64%) of clients reported they know to contact a care manager if they have a question about their services. Twenty-six percent (26%) contact family and friends regarding services and Ten percent (10%) reported they would contact someone “other”.

F. CHCPE SERVICE UTILIZATION

Service utilization is assumed when a respondent rates a particular service on the survey. Conversely, services not rated by the respondent are considered services the client does not receive. The analysis of service utilization is limited to the number of clients reporting receiving the service, and does not include how often the services are received in a certain amount of time. Care management services are not included in the analysis since all survey participants receive care management services.

The most frequently reported services were Homemaker at Sixty-one percent (61%) and Personal Care Attendant at Sixty-one percent (61%). Fifty percent (50%) of respondents receive Companion Services. Emergency Response System services were reported by Forty-one percent (41%), followed by Thirty-nine percent (39%) receiving Skilled Nursing services and Thirty-three percent (33%) receiving Home Health Aid Services. Chore person at Twenty-six percent (26%), and Thirteen percent (13%) receive Meals on Wheels and Adult Day Center services.

G. SUMMARY AND CONCLUSIONS

The Community Options Unit of the Connecticut Department of Social Services, administered a client satisfaction survey for the CHCPE North Western Region in June 2017. One Hundred and one (101) clients in the CT Home Care Program’s North Western Region were surveyed. Forty-six percent (46%) of surveyed clients responded to the survey. Program clients completed Fifty-one percent (51%) of the returned surveys. Family members were the second most frequent survey responders, accounting for about one third, followed by “others” and caregivers.

Many respondents, clients and family, expressed thanks and appreciation for the services provided and the support received from the staff employed in the North Western region.

PCA Services received a Sixty-eight percent (68%) Excellent rating, Emergency Response System Services at Fifty-three percent (53%), Home Health Aide at Sixty percent (60%) and Skilled Nursing Services at Fifty-six percent (56%) excellent ratings. Homemaker Services received a Fifty-four percent (54%) Excellent rating and Meals on Wheels received a Fifty percent (50%) excellent rating. Chore Person received a Fifty-eight percent (58%) rating and Companion received a Sixty-five percent (65%) rating.

H. EXHIBITS

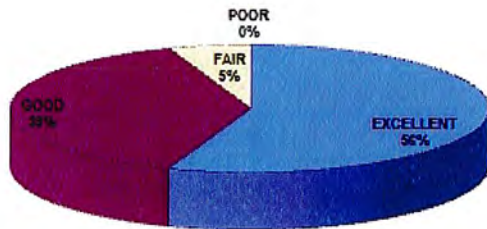
Pie Charts reflecting the following:

- Survey Respondent
- Managing Without Services
- Skilled Nursing Services
- Home Health Aide
- Homemaker
- Companion
- Chore Person
- Meals on Wheels
- Adult Day Centers
- Emergency Response System
- PCA Services

Bar Charts reflecting the following:

- Service Dependability
- Contact Awareness
- Client Satisfaction

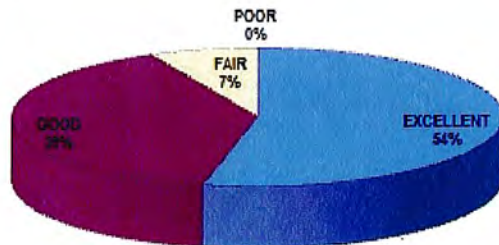
CLIENT SATISFACTION SURVEY
SKILLED NURSING SERVICES



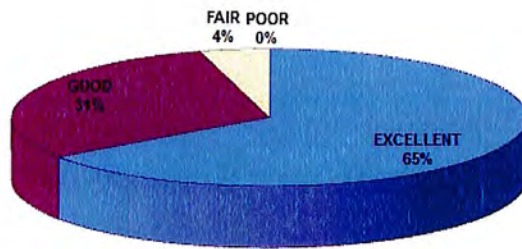
CLIENT SATISFACTION SURVEY
HOME HEALTH AIDE



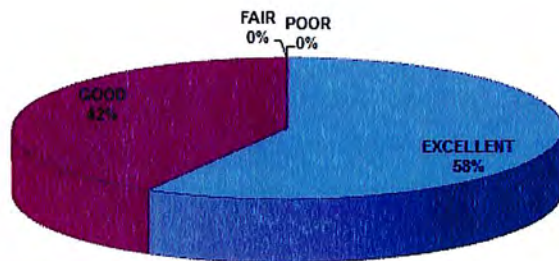
CLIENT SATISFACTION SURVEY
HOMEMAKER



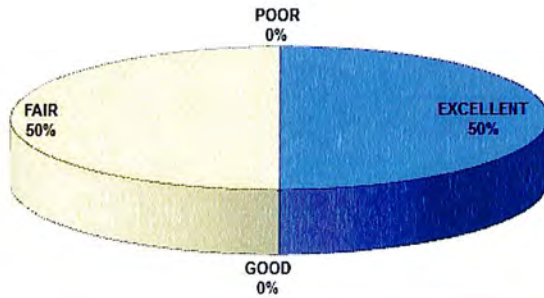
CLIENT SATISFACTION SURVEY
COMPANION



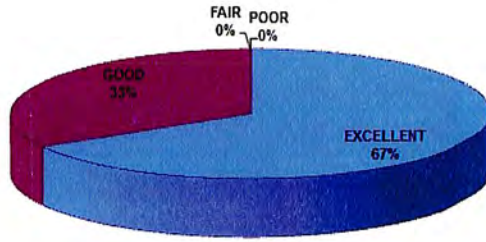
CLIENT SATISFACTION SURVEY
CHORE PERSON



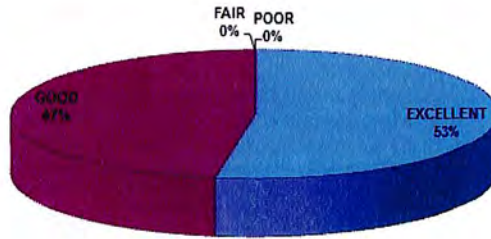
CLIENT SATISFACTION SURVEY
MEALS ON WHEELS



CLIENT SATISFACTION SURVEY
ADULT DAY CARE



CLIENT SATISFACTION SURVEY
EMERGENCY RESPONSE SYSTEM



CLIENT SATISFACTION SURVEY SERVICES UTILIZATION FREQUENCY

