STATE OF CONNECTICUT

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Members, Appropriations Committee

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Co-Chairs, Human Services Committee

Members, Human Services Committee

FROM: Deidre S. Gifford, MD, MPH, Commissioner

DATE: November 5, 2019

RE Connecticut Home Care Program for Elders
Annual Report for SFY 2018

I am pleased to notify you of the availability of the SFY 2018 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 2018, nearly 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 third 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 continues to operate 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 500 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 Ned Lamont, 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 18

July 2017– July 2018

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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. 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. These services included emergency response systems, respite care, home delivered meals, homemaker, adult day care, 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. 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 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 Medicaid waiver. The State reorganized several human services departments resulting in the consolidation of the three original departments under the new Department of Social Services.

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 to develop standards for this new agency and issued regulations and Request for Proposals. The most recent Request for Proposal in 2013 resulted in four agencies being awarded contracts to provide care management services under the CT. Home Care Program.

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. Agency based PCA services are now a waiver service. PCA services evolved to include 12 hour shifts and 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.

The Connecticut Home Care Program contracted Ascend Management Innovations to develop a web-based client database, transitioning from paper files to online files. This system improved efficiency, timeliness of documentation and submission of required forms. 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 Quality Assurance staff convene a Quality Assurance Committee, consisting of representatives from the Access Agencies, the Fiscal Intermediary and CHCP which has addressed various timely issues, provider quality issues and methods to improve reporting. See page 12 for more information.

New services have been added during waiver renewals 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. The waiver is due to be renewed on July 1, 2020.

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 federally mandated by 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.

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 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 financial eligibility and care plan cost limits are the same as Category 2.

Category 5: This category targets individuals who are functionally equivalent to Category 1 who are Medicaid recipients so 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

$934	The average monthly client cost on the State Funded portion of the CT Home Care Program.
12,808	The monthly average number of clients on the Medicaid Waiver portion of the CT Home Care.
2,773	The monthly average number of clients on the State Funded portion of the CT Home Care Program.
8,802	The number of individuals screened for the CT Home Care Program who were referred for assessment and became active clients.
19,189	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 2018.
$441,400,754	The program expenditures for the Medicaid Waiver and State Funded portion of the CT Home Care Program.

Assisted Living Services Component

Over the past ten to fifteen 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 congregate housing facilities, federally-funded HUD residences and 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.

Assisted Living is offered in several settings under the Home Care Program. Public Act 02-7 allowed the Department to establish the Private Assisted Living Pilot that became effective January 1, 2003. The Pilot offers one hundred twenty five (125) clients the opportunity to remain in their private assisted living facility after they have spent down their assets. From July 1, 2017 to June 30, 2018, the Private Assisted Living Pilot served a total of 117 clients at a cost of $1,443,352.30. This figure includes both core and assisted living service charges.

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.

From July 1, 2017 through June 30, 2018 a total of 243 clients received services in these facilities at a cost of $2,641,622.5

Over the past ten to fifteen 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.

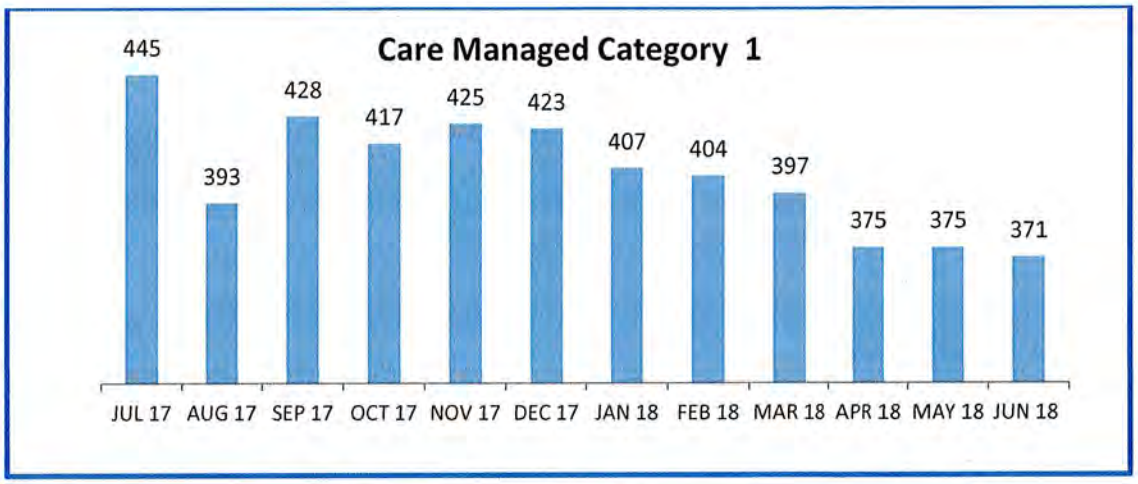
From July 1, 2017 to June 30, 2018, 266 clients received services in the DEMO facilities participating in the assisted living pilot at a cost of $4,270,350.71. This figure includes both core and assisted living service charges.

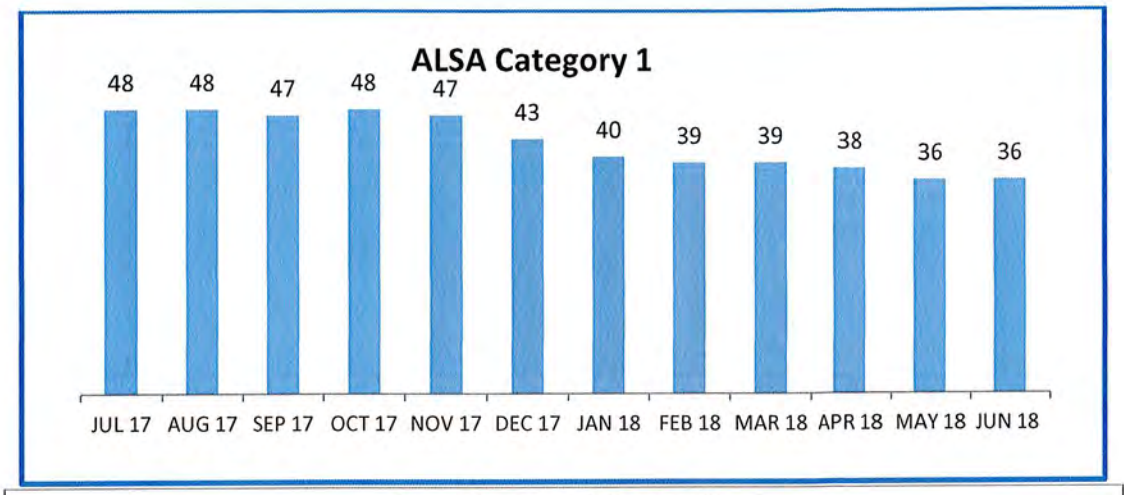
Care Management

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. Clients in the program continue to benefit from the services of an independent care manager.

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.

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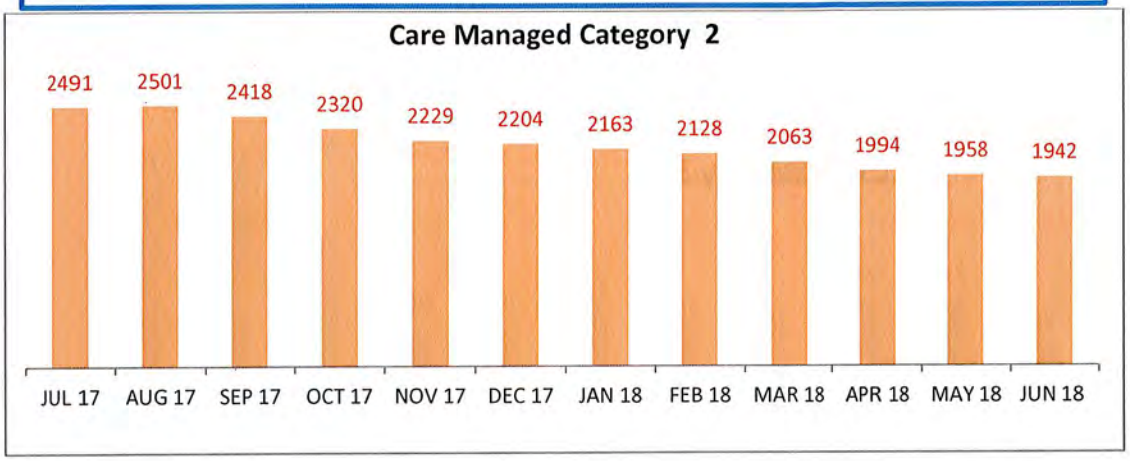
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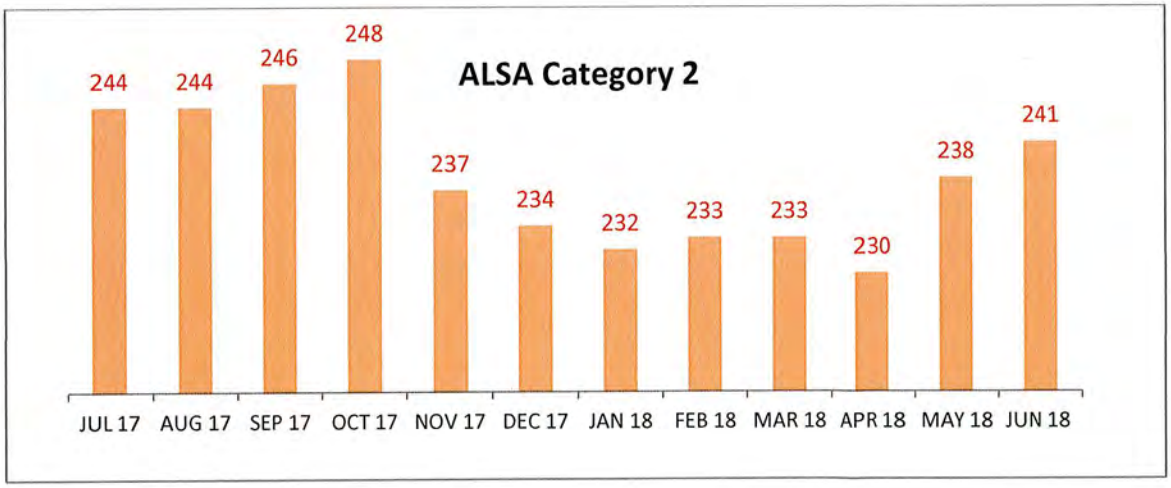
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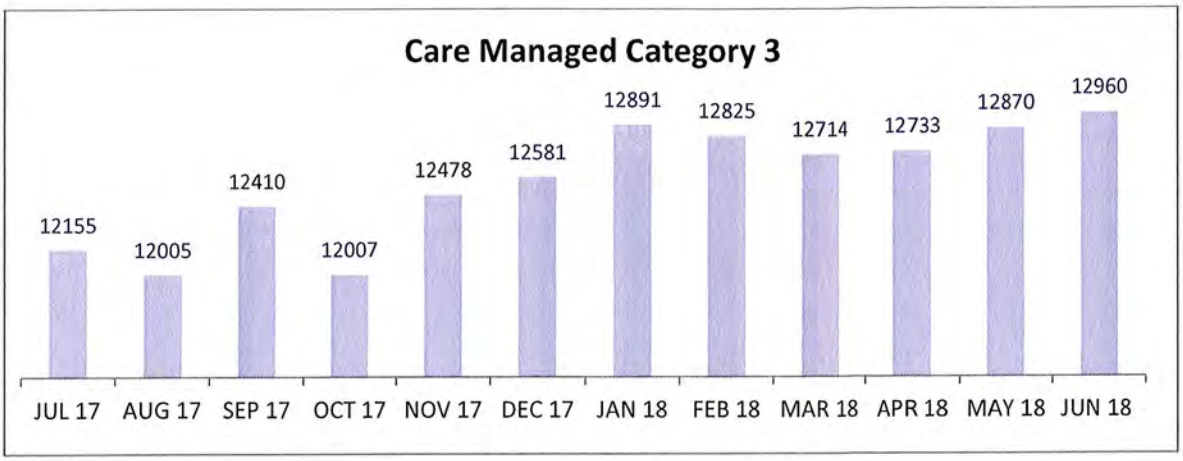
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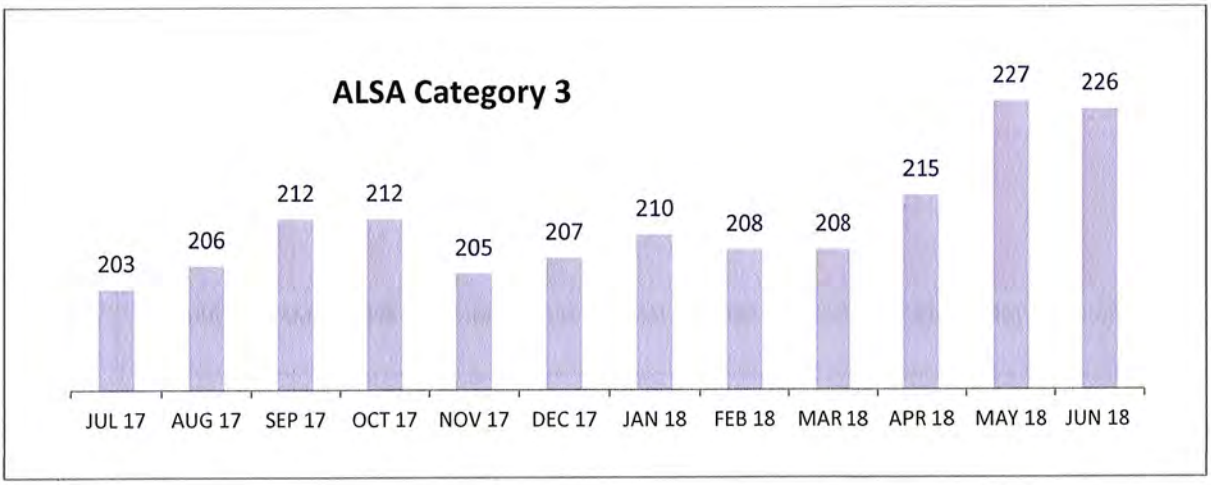
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Quality Improvement

The goal of quality improvement is to monitor the unique needs and quality of services provided to our clients.

The Quality Assurance Team:

- Conducts on-site administrative and chart audits of access agencies, assisted living service agency records, provider agencies and residential care homes to ensure CMS performance measures are met.
- 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.
- Reviews and investigates critical incidents 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. The Department has launched the utilization of a new Experience of Care Survey under the Testing Experience and Functional tools federal grant. 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 reviews of four Assisted Living facilities this year and chart reviews at each. Additionally, provider compliance was monitored by a record and administrative audit of four Access Agencies located in six offices.

Goals for New Fiscal Year

- A committee consisting of DSS staff, Access Agency staff and Provider Agency staff developed Personal Care Attendant (PCA) Training with certification test designed to improve quality of care. This training is now mandated for all agency-based PCAs.
- 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.
- Develop a cross waiver quality improvement strategy utilizing data sources from the Universal Assessment and the HCBS CAHPS Experience of Care survey

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 18

COMMUNITY & HOME CARE SERVICES	AMOUNT
Assessments	2,374
Annual Assessment Cost	$665,762
Annual Clients Served	15,259
Community First Choice	$18,531,654
Annual Community Services Cost	$395,361,133
Annual Home Health Cost	$26,702,913
Annual Status Reviews	1,292
Annual Status Review Cost	$139,292
Annual Services Cost	$441,400,754
ADMINISTRATIVE EXPENSES	
Personnel Services	$1,323,839
Fringe Benefits	$1,138,369
Annual Administrative Cost	$2,462,208
Adjusted Total Program Costs SFY 17	$443,862,962
Federal Medicaid Reimbursement (50%)	$(221,812,276)
Total Program Costs After Federal Reimbursement	$221,812,276
NURSING HOME SAVINGS	
Annual CHCPE Clients Served	15,259
Monthly Nursing Home Cost per Medicaid Client	$6,778
Average Annual Cost Per Nursing Home Client	$81,336
Average Annual Cost Per CHCPE Client	$29,088
Average Annual Cost Nursing Home Clients	$1,241,106,024
Average Annual Cost CHCPE Clients	$443,853,792
Total Annual Difference in Cost	$797,252,232
Federal Medicaid Reimbursement (50%)	-$(398,626,116)
NET FISCAL IMPACT	
Total Nursing Home Savings After Federal Reimbursement	$398,626,116

* 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.

CT Home Care Program For Elders
SFY 2018
Average Monthly Cost per Case Summary

		Title XIX			State Funded			1915i			Total		
	MAR COS	Annual Recipients	Annual Expenditures	Monthly Cost / Service	Annual Recipients	Annual Expenditures	Monthly Cost / Service	Annual Recipients	Annual Expenditures	Monthly Cost / Service	Annual Recipients	Annual Expenditures	Monthly Cost / Service
Screening Services													
Assessments	611	2,374	$ 665,762	$ 23	2,753	$ 772,222	$ 23	51	$ 13,705	$ 22	5,178	$ 1,451,689	$ 23
Reviews	612	1,292	$ 139,292	$ 9	515	$ 57,948	$ 9	19	$ 1,977	$ 9	1,826	$ 199,217	$ 9
Sub-Total			**$ 805,055**			**$ 830,170**			**$ 15,681**			**$ 1,650,905**	
Waiver Services													
Case Management	601	15,259	$ 20,210,739	$ 110	3,306	$ 3,786,167	$ 95	624	$ 883,817	$ 118	19,189	$ 24,880,723	$ 108
Adult Day Health	602,841	1,425	$ 12,129,257	$ 709	259	$ 1,726,745	$ 556	91	$ 612,702	$ 561	1,775	$ 14,468,704	$ 679
Chore	603,842	186	$ 214,849	$ 96	37	$ 36,420	$ 82	8	$ 13,080	$ 136	231	$ 264,349	$ 95
Companion	604,843	4,855	$ 34,825,358	$ 598	892	$ 3,216,701	$ 301	405	$ 1,754,103	$ 361	6,152	$ 39,796,163	$ 539
Elderly Foster Care	605,84D	1,354	$ 32,065,569	$ 1,974	125	$ 1,979,328	$ 1,320	8	$ 149,522	$ 1,558	1,487	$ 34,194,419	$ 1,916
Meals	606,844	4,464	$ 6,998,640	$ 131	716	$ 769,647	$ 90	276	$ 548,799	$ 166	5,456	$ 8,317,086	$ 127
Homemaker	607,845	6,202	$ 24,050,778	$ 323	1,519	$ 4,017,242	$ 220	504	$ 1,377,103	$ 228	8,225	$ 29,445,124	$ 298
Mental Health Couns.	608,846	740	$ 559,792	$ 63	80	$ 50,658	$ 53	31	$ 18,350	$ 49	851	$ 628,800	$ 62
Personal Emerg. Resp.	609,847	10,026	$ 4,100,360	$ 34	2,153	$ 742,851	$ 29	364	$ 154,422	$ 35	12,543	$ 4,997,633	$ 33
Respite Care	60A,848	282	$ 1,316,113	$ 389	32	$ 81,413	$ 212	1	$ 5,939	$ 495	315	$ 1,403,464	$ 371
Non-Medical Transp.	60B,849	27	$ 3,080	$ 10	22	$ 6,153	$ 23	3	$ 226	$ 6	52	$ 9,460	$ 15
Assisted Living	60C	258	$ 3,877,929	$ 1,253	372	$ 4,392,561	$ 984	8	$ 108,192	$ 1,127	638	$ 8,378,682	$ 1,094
PCA Agency	60D,84A	7,632	$ 252,976,000	$ 2,762	1,404	$ 14,865,601	$ 882	45	$ 452,249	$ 837	9,081	$ 268,293,850	$ 2,462
Minor Home Modification	60E,84B	93	$ 430,534	$ 386	2	$ 11,080	$ 462	1	$ 2,750	$ 229	96	$ 444,364	$ 386
Assistive Technology	60F,84C	319	$ 284,287	$ 74	19	$ 16,072	$ 70	3	$ 2,567	$ 71	341	$ 302,926	$ 74
PCA Individual	60G	200	$ 1,155,178	$ 481	100	$ 1,333,564	$ 1,111	0	$ -	$ -	300	$ 2,488,742	$ 691
Acc/Assistive Tech	84E	0	$ -	$ -	0	$ -	$ -	0	$ -	$ -	0	$ -	$ -
Care Transitions	84F	446	$ 77,827	$ 15	0	$ -	$ -	14	$ 2,134	$ 13	460	$ 79,961	$ 14
Bill Payer	84G	238	$ 84,843	$ 30	37	$ 9,730	$ 22	4	$ 750	$ 16	279	$ 95,323	$ 28
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)		**15,259**	**$395,361,133**	**$ 2,159**	**3,306**	**$ 37,041,934**	**$ 934**	**624**	**$ 6,086,707**	**$ 813**	**19,189**	**$438,489,774**	**$ 1,904**
Community First Choice (d)		**671**	**$ 18,531,654**	**$ 2,301**	**0**	**$ -**	**$ -**	**0**	**$ -**		**671**	**$ 18,531,654**	**$ 2,301**
Home Health Services (e,f)			**$ 26,702,913**			**$ 2,554,058**			**$ 1,070,880**			**$ 30,327,851**	
Total - Comm. Svcs.		**15,259**	**$441,400,754**	**$ 2,411**	**3,306**	**$ 40,426,162**	**$ 1,019**	**624**	**$ 7,173,268**	**$ 958**	**19,189**	**$489,000,184**	**$ 2,124**

(a) The source of all Screening Services, Waiver Services, Community First Choice expenditures and unduplicated recipients is 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 undpulicated recipients is the figure shown for "Case Management".

(d) Community First Choice costs by waiver participation are estimated using a data Warehouse query.

(e) Home Health Expenditures for waiver and 1915i recipients are estimated using a Data Warehouse query.

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 $26,320 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 $37,080 as of March 2018. A couple on the State Funded portion of the program can have 200% of that amount, or $49,440 as of March 2018.

Financial Eligibility 1915i

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

Community First Choice

The Affordable Care Act added section 1915(k) to the Social Security Act allowing states the option of providing home and community-based personal care attendant services and supports through their State Plans.2 Section 1915(k), also known as the Community First Choice (CFC) benefit is designed to provide long-term services and supports (LTSS) to individuals in their homes or communities rather than in institutional settings. These benefits are consistent with and support the Centers for Medicare & Medicaid Services' (CMS') goal of rebalancing Medicaid LTSS spending; encouraging a person-centered, long-term support system; and giving enrollees the opportunity to decide where they live and to increase control over services received.

Since the implementation of Community First Choice, individual hire PCAs are no longer paid through the Connecticut Home Care Program for Elders Waiver, but rather through Medicaid fee-for-service. Agency-based PCAs continue to be covered under the Waiver.

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. Access Agency care managers use a care plan portal to enter clients' care plans and prior authorizations. 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 March, 2018 the limit on the total plan of care for Medicaid waiver clients was $6,205. The cost limit on the State Funded portion of the program was $3,102 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 18, 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 person-centered 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 2018, 4,790 clients accepted plans of care for home and community based services. This represents 53% of the persons referred for assessment.

III. CASELOAD TRENDS: 7/1/17 - 6/30/18

During the twenty eighth year of operations, July 1, 2017 through June 30, 2018, the combined Waiver and State Funded Program caseload increased by 9%.

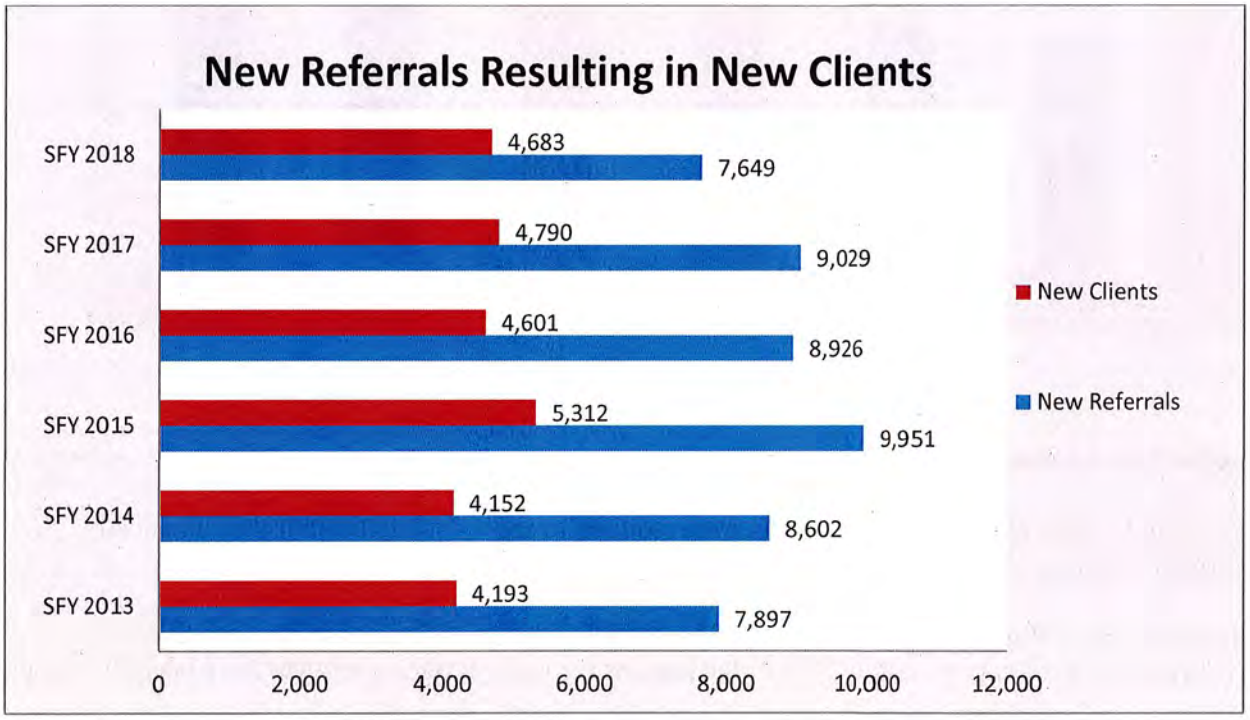
New Program Referrals and Placement Activity

The number of new clients placed on services during SFY 2018 was 4,683. 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 SFY18 7,649 individuals were referred for a full assessment of their needs to consider their potential for community placement. This is a decrease from the previous year. Reasons for the decrease may be improved screening procedures for applicants who do not qualify and the implementation of Community First Choice, a federal initiative and a State Plan service offered to active Medicaid members as part of the Affordable Care Act. This program allows individuals to receive supports and services in their home. These services can include—but are not limited to—help preparing meals and doing household chores, and assistance with activities of daily living (bathing, dressing, transferring, etc.).

	New Program Referrals	New Clients
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
SFY 2018	7,649	4,683

The chart below illustrates the number of new clients that resulted from new program referrals in SFY 11 through SFY 18.

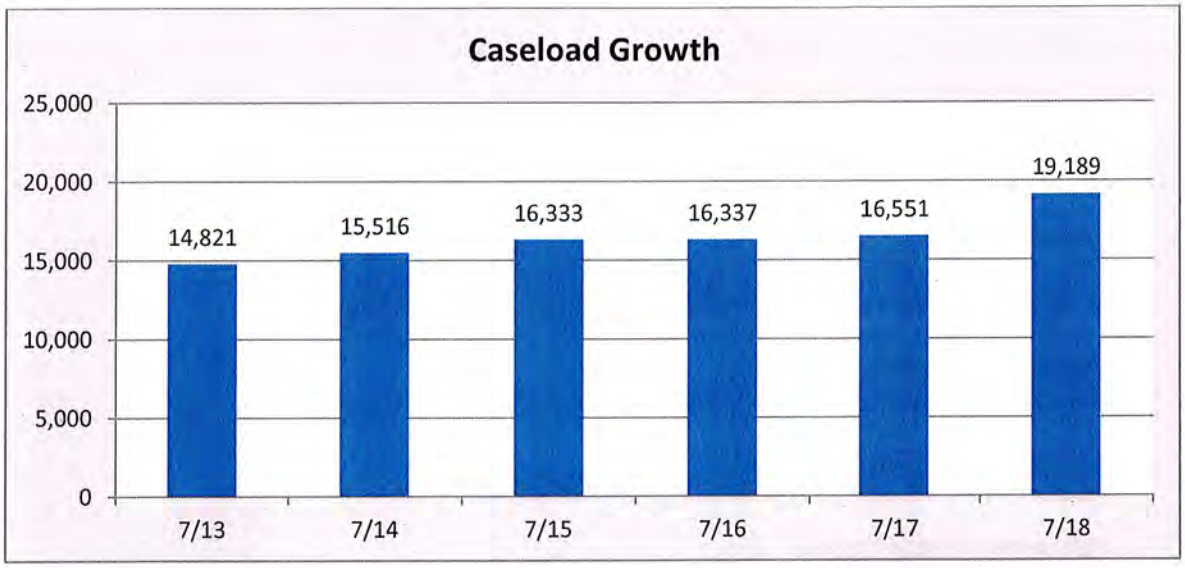


During the past six years, an average of 61% of new referrals resulted in new clients on the CT Home Care Program for Elders. The top three reasons for clients not progressing from referral to the program are:

- 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 2013. Caseload consists of any client who was an active participant at any time during the year. As of June 30, 2018 there was a total of 19,189 **unduplicated** clients. This increase is due to state-funded clients moving off of the waiting list due to admissions being frozen from the previous year. The monthly average Connecticut Home Care Program for Elders caseload for SFY 2018 was 12,808.

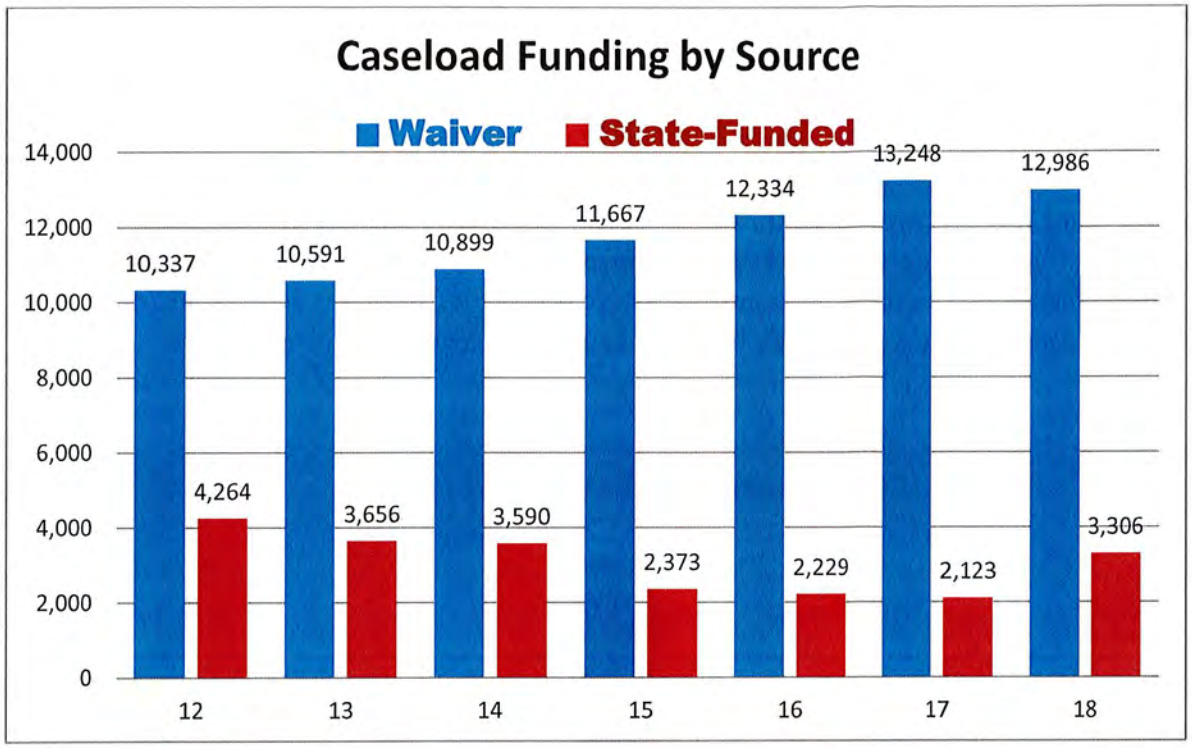


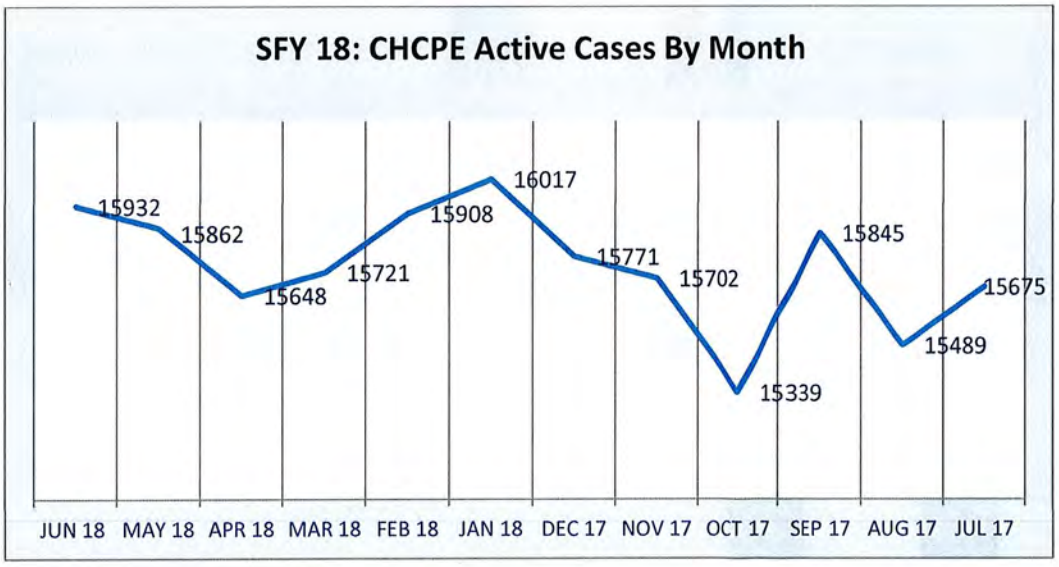
Caseload by Funding Source

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 SFY 2013. As of June 30, 2018 approximately 70% 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.

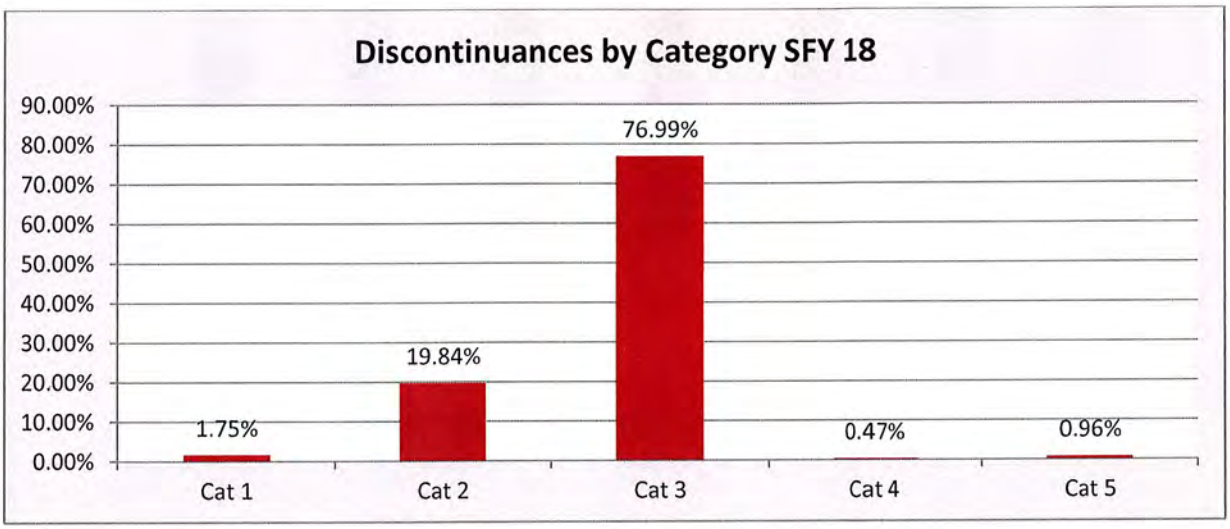

Caseload Funding by Source
Waiver
State-Funded
14,000
12,000
10,000
8,000
6,000
4,000
2,000
0
10,337
4,264
10,591
3,656
10,899
3,590
11,667
2,373
12,334
2,229
13,248
2,123
12,986
3,306
12
13
14
15
16
17
18

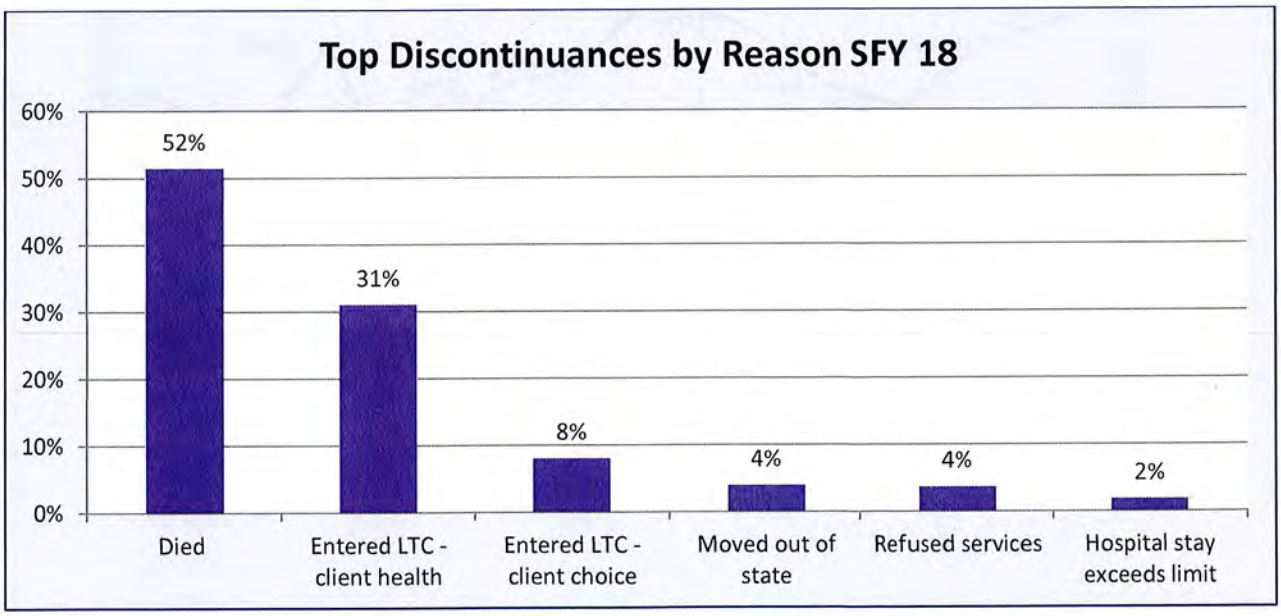

SFY 18: CHCPE Active Cases By Month
15932
15862
15648
15721
15908
16017
15771
15702
15339
15845
15489
15675
JUN 18
MAY 18
APR 18
MAR 18
FEB 18
JAN 18
DEC 17
NOV 17
OCT 17
SEP 17
AUG 17
JUL 17

IV. PROGRAM ACTIVITY

Admissions and Discharges

The majority of discontinuances are category 3 clients who expired. Category 3 clients must meet nursing home level of care and are the target population for the CT Home Care Program. Category 2, state-funded, clients are also required to meet nursing home level of care Those who enter a nursing facility do so primarily 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 1 and Category 5 clients are considered at risk for nursing home admission but do not meet the criteria for nursing home level of care. Category 5 client 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. Category 3 is the Medicaid Waiver. Category 4 is a pilot program for those diagnosed with a neurodegenerative condition.

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.

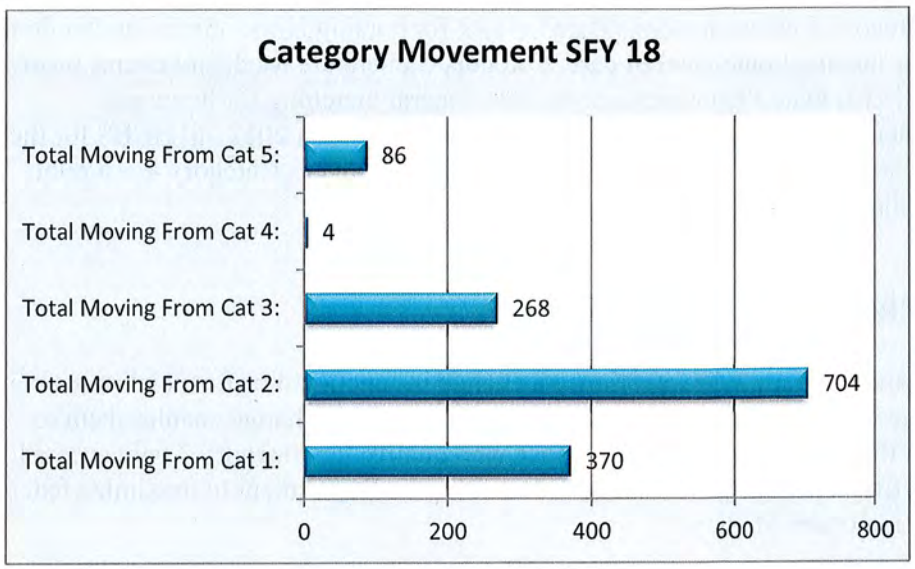
Category 5 clients are Medicaid clients receiving services under the 1915i State Plan which allows 50% federal matching for home and community based services (HCBS). Prior to the approval of 1915i in February 2012, all HCBS for these clients were 100% state funded.

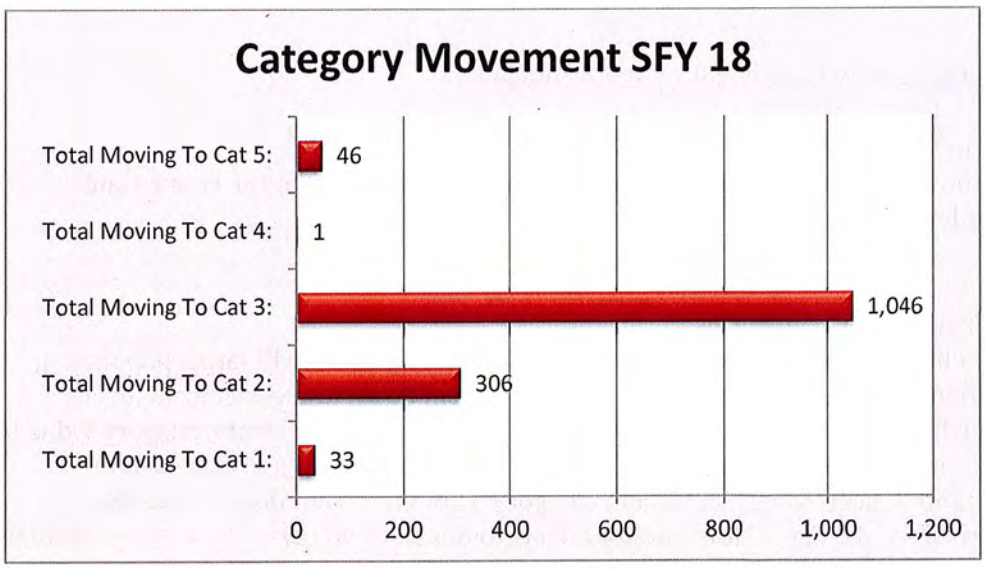
Reasons for clients moving **to** different categories include:

- 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

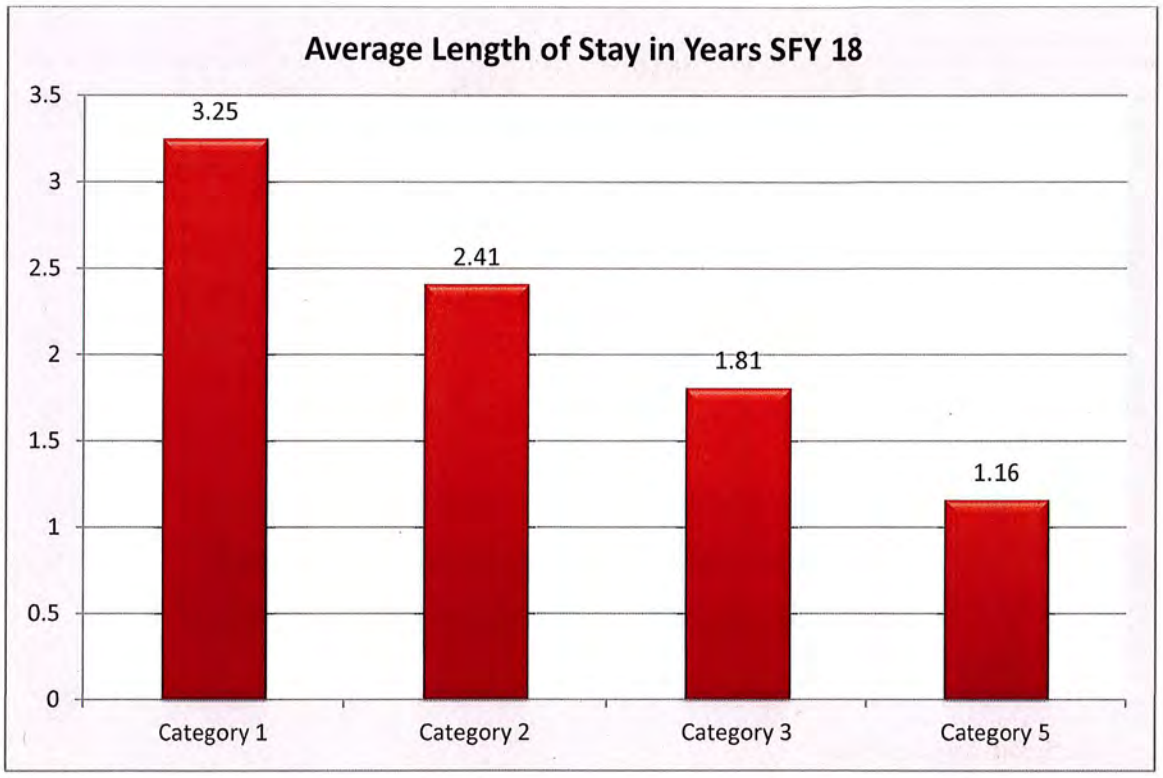
The majority of clients transfer into category 3 due to program goals, CMS target population, increasing functional needs, and when assets have been spent down to the Medicaid level. Clients who transfer into Category 2 include those who have transitioned from category 1 due to increased functional needs and clients who meet functional criteria but have exceeded the Medicaid asset limit. Clients who transfer into category 5 are those who do not meet the functional criteria for Category 3. It is rare for clients to transfer into category 4 except for other waiver clients who meet the diagnostic criteria for degenerative, neurological disease.


Category Movement SFY 18
Total Moving From Cat 5:
86
Total Moving From Cat 4:
4
Total Moving From Cat 3:
268
Total Moving From Cat 2:
704
Total Moving From Cat 1:
370
0
200
400
600
800


Category Movement SFY 18
Total Moving To Cat 5:
46
Total Moving To Cat 4:
1
Total Moving To Cat 3:
1,046
Total Moving To Cat 2:
306
Total Moving To Cat 1:
33
0
200
400
600
800
1,000
1,200

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.



II. PROGRAM EXPENDITURES AND COST SAVING PROGRAM ACTIVITIES

Program Expenditures 7/1/17 - 6/30/18

Actual program expenditures in SFY 2018 totaled $438,489,774 before federal reimbursement. Federal reimbursement cut $186,726,593 or 54% from the total program costs. The Net State Cost was $237,765,855.

SFY 2018 Expenditures

	Waiver	State Funded	1915i	Total
Average Monthly Cost/Case	$2,159	$934	$813	$3,906
Total Cost	$395,361,133	$37,041,934	$6,086,707	$438,489,774
Federal Funds/ Reimbursement	($197,680,567)	$0	($3043354)	($200,723,921)
Net State Cost	**$197,680,567**	**$37,041,934**	**$3,043,354**	**$237,765,855**

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.

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 SFY 2018

DEPARTMENT OF SOCIAL SERVICES

CONNECTICUT HOME CARE PROGRAM & 1915(i) State Plan Option - FEE FOR SERVICE USE ONLY

rev: 03/18 ***Effective 3/1/2018***

Category Type	Description	Functional Need	Financial Eligibility	Care Plan Limits	Funding Source	Intake Status
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 = $37,080.00 Couple= $49,440.00**	<25% NH Cost **($1474.00 Monthly)**	STATE	Intake frozen **(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 = $37,080.00 Couple= $49,440.00**	<50% NH cost **($2947.00 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=$2250.00/Mth Assets: Individual $1,600.00 Couple: both as clients = $1600.00 each one as client = $26,320.00 ($1600.00 + $24,720.00 CSPA)****	100% NH Cost **($5894.00 Monthly) Social Services** 115% NH Cost **($6778.00 Monthly)** 100% Subacute*** **($12968.00.00 Monthly)** 115% Subacute*** **($14913.20 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 = $37,080.00 Couple= $49,440.00**	<50% NH cost **($2947.00 Monthly)**	STATE	**Wait-list** limited to 100 slots
Category 5 1915(i)	**Same as category 1.. active on categorica 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 - $1,518.00 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 $2024.00
* 2. There is no income limit for the State Funded portion. The Medicaid Waiver income limit remains at 300% of SSI which is $2,250.00
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. Medcation supports - Requires assistance for administrati
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 interventionintermittenly 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 intensitystroke 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**
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	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.	Consists of: • Quarterly contact • Annual Reassessment 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.	Consists of: • Monthly Monitoring • Six Month Field Visit • Annual Reassessment Client requires four to six care management interventions in a six month period.	• Monthly Monitoring • Six Month Field Visit • Annual Reassessment Client requires seven or more care management interventions in a six month period.

i) Tiered Case Management was added 7/1/17 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

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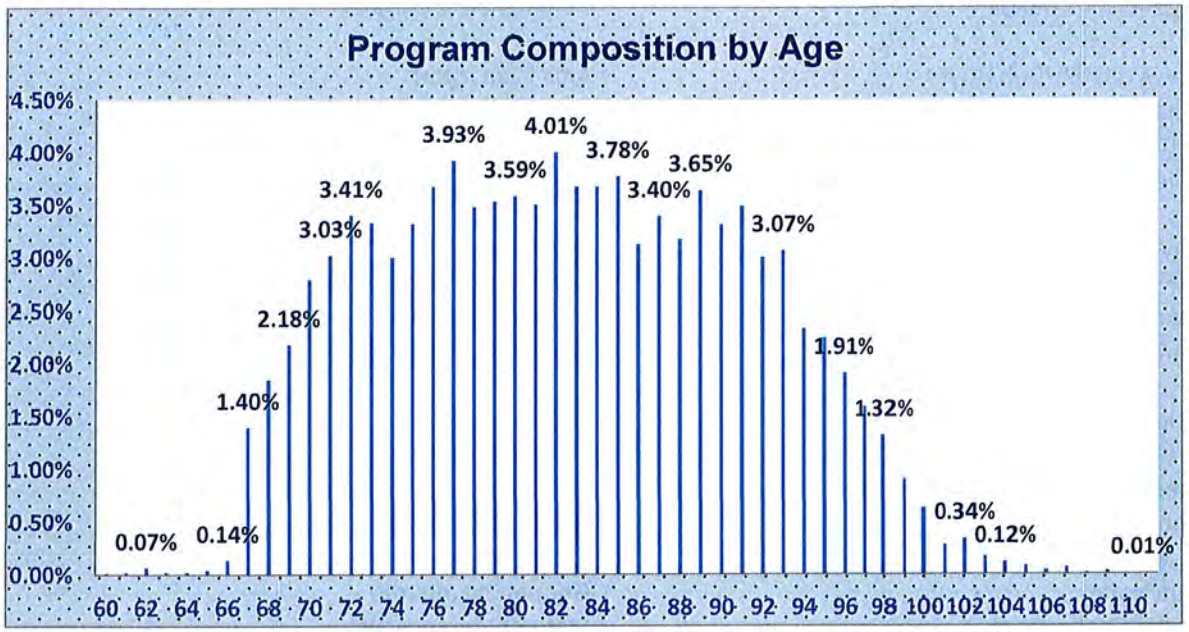
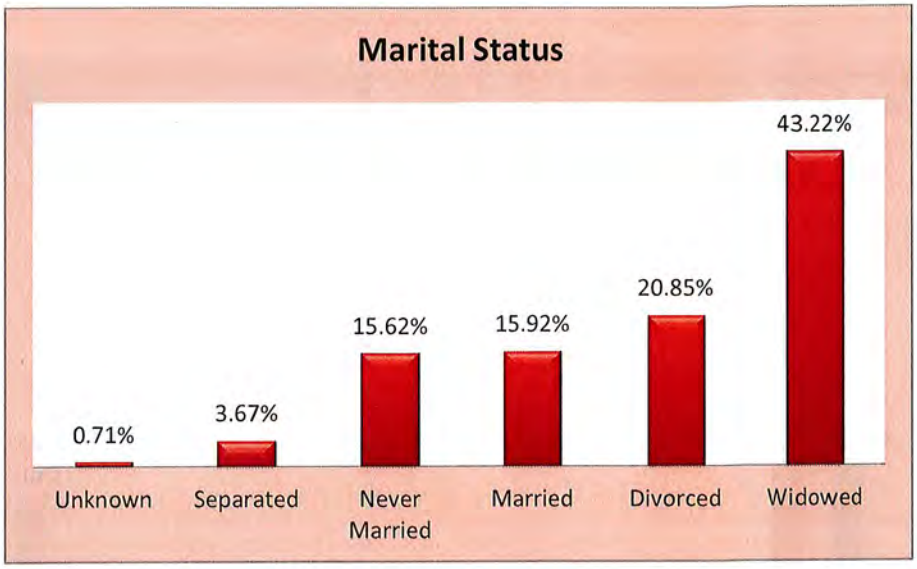
APPENDIX E
CHCP CLIENT CHARACTERISTICS FOR SFY 2018

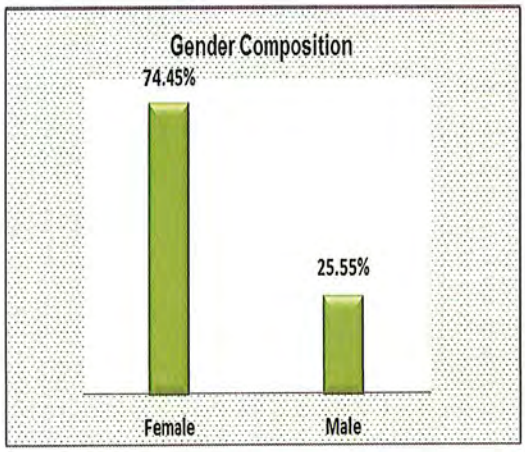
Client Characteristics

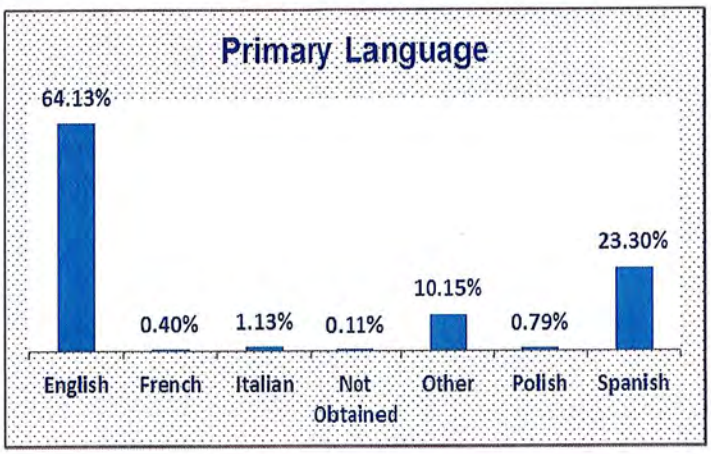
The charts below highlight specific characteristics on CHCPE program participants' information regarding program participant age is found in Appendix E.

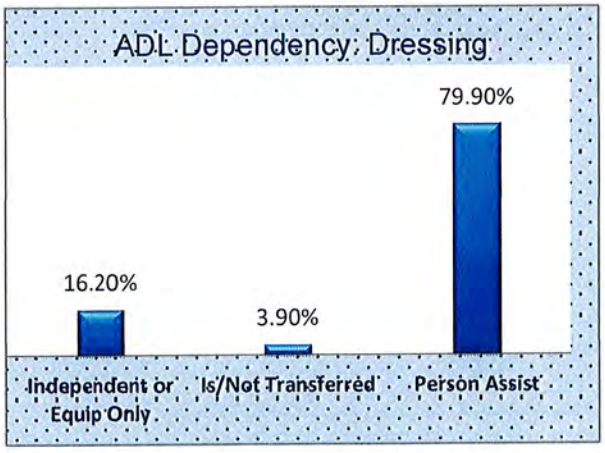
The chart below illustrates the age range of CHCP participants. Thirty-five percent of program participants are between the ages of 75-89. Clients age 70 and under represent 9% and those age 90 and upward represent 23% of all program clients.

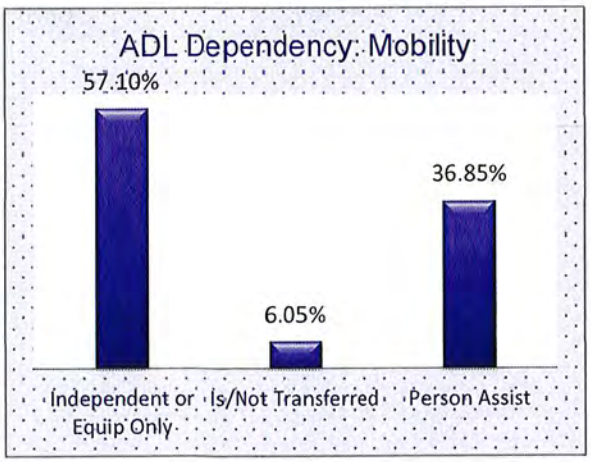


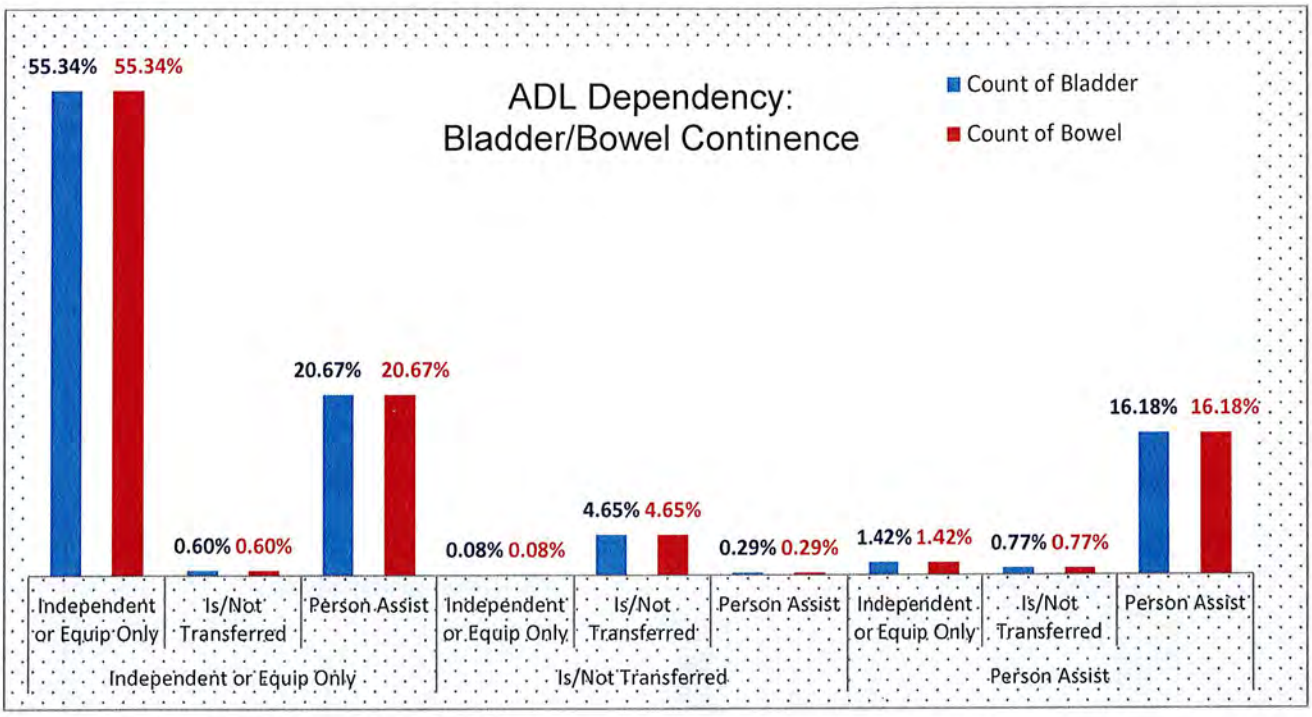

Marital Status
0.71%
3.67%
15.62%
15.92%
20.85%
43.22%
Unknown
Separated
Never Married
Married
Divorced
Widowed

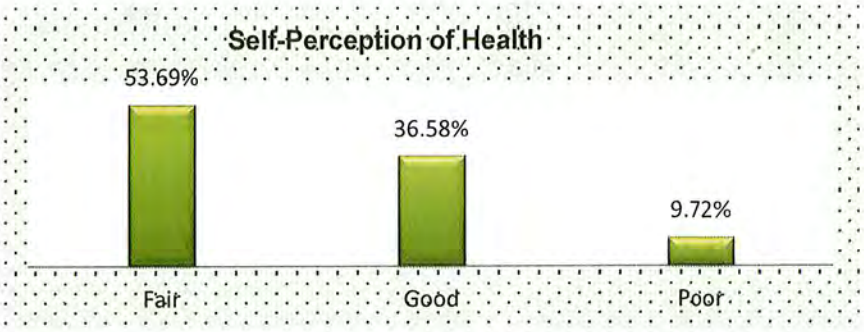

Gender Composition
74.45%
25.55%
Female
Male


Primary Language
64.13%
0.40%
1.13%
0.11%
10.15%
0.79%
23.30%
English
French
Italian
Not Obtained
Other
Polish
Spanish


ADL Dependency: Dressing
16.20%
3.90%
79.90%
Independent or Equip Only
Is/Not Transferred
Person Assist

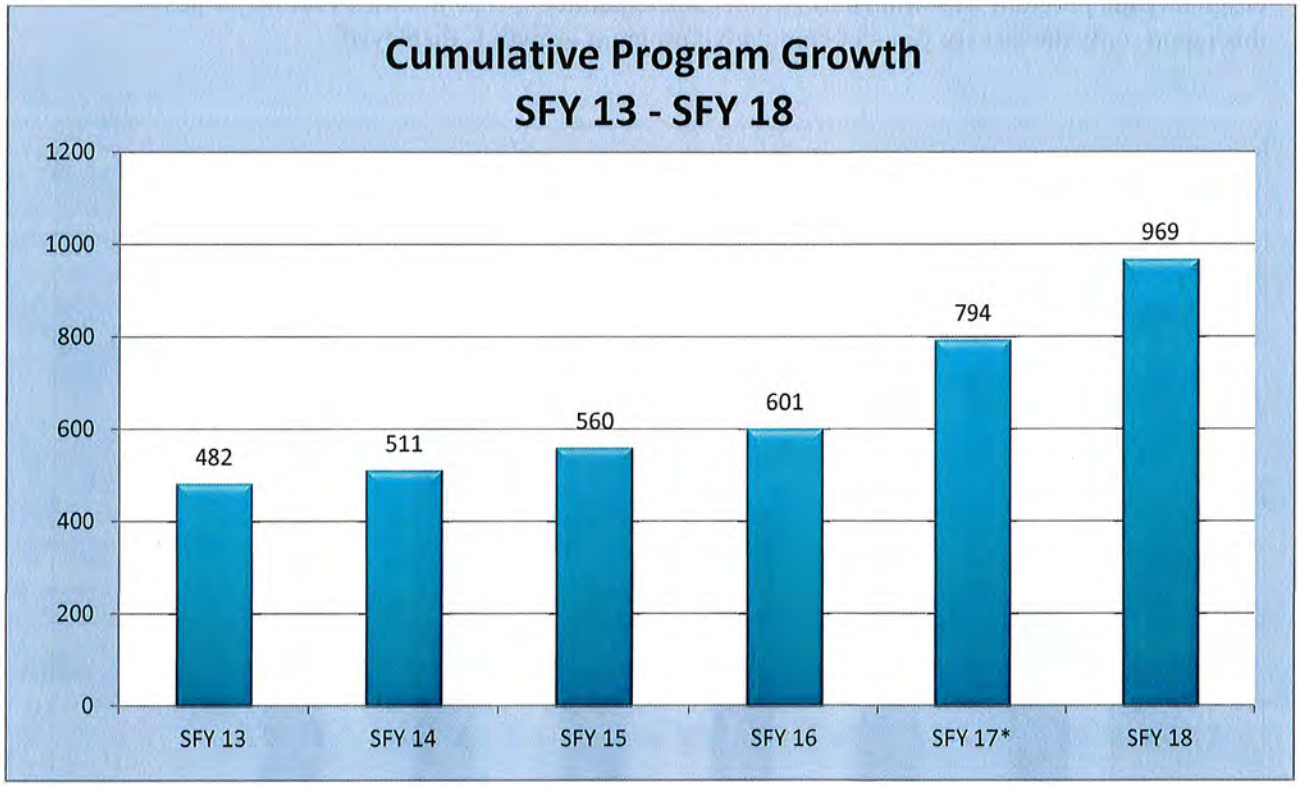

ADL Dependency: Mobility
57.10%
6.05%
36.85%
Independent or Equip Only
Is/Not Transferred
Person Assist


ADL Dependency:
Bladder/Bowel Continence
Count of Bladder
Count of Bowel
55.34% 55.34%
0.60% 0.60%
20.67% 20.67%
0.08% 0.08%
4.65% 4.65%
0.29% 0.29%
1.42% 1.42%
0.77% 0.77%
16.18% 16.18%
Independent or Equip Only
Is/Not Transferred
Person Assist
Independent or Equip Only
Is/Not Transferred
Person Assist
Independent or Equip Only
Is/Not Transferred
Person Assist


Self-Perception of Health
53.69%
36.58%
9.72%
Fair
Good
Poor

APPENDIX F
STATE-FUNDED HUD AND CONGREGATES CUMULATIVE CLIENT GROWTH FROM SFY 01 – SFY 18

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, it will be reported together with the congregates.

APPENDIX G
HUD FACILITIES

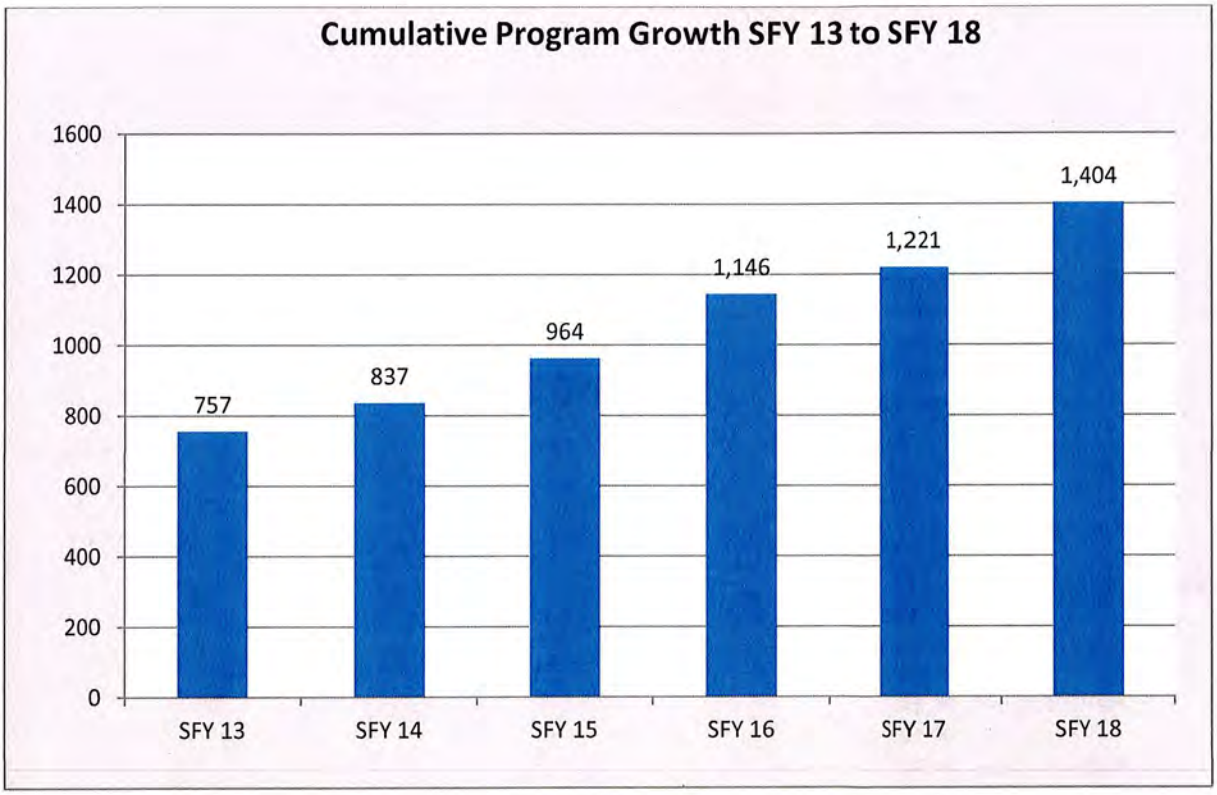
In addition to the State-Funded Congregate sites, there are six HUD facilities participating with the Connecticut Home Care Program for Elders. State funding for HUD facilities ended 8/1/16.

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 to 125 in 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 13 – SFY 18

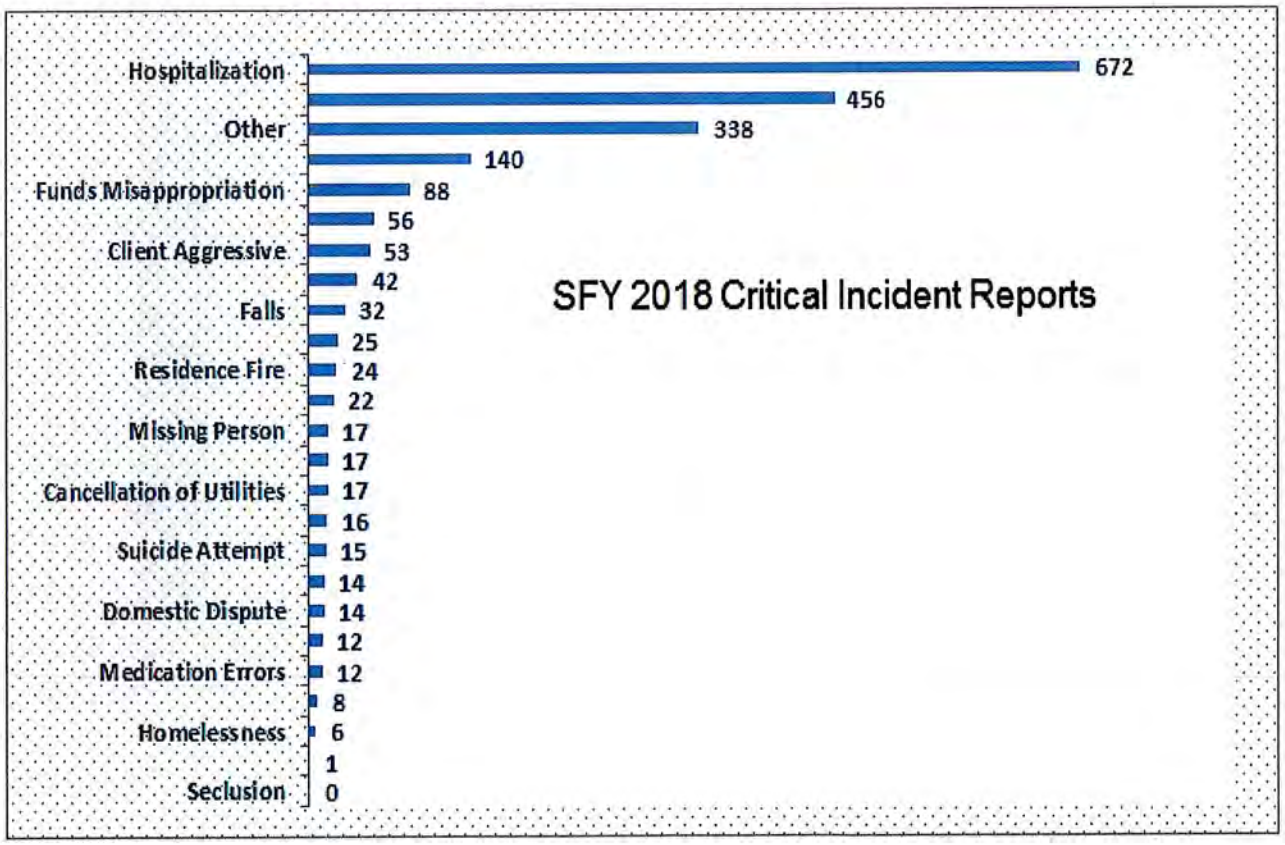
[1]The Department of Social Services (DSS), in collaboration with the Department of Public Health (DPH), the Department of Economic and Community Development (DECD), the Connecticut Housing Finance Authority (CHFA) and the Office of Policy and Management (OPM) established a demonstration project to provide 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 18

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.

Adequate training of Personal Care Assistants (PCA) was identified as an issue contributing to the frequency of critical incidents. Community Options Quality Assurance staff and subject matter experts from community agencies produced the PCA Training Modules and Certification Test. The training is now a requirement for all agencies who employ PCAs. The training is available on the Community Options webpage.



APPENDIX K
Consumer Assessment of Health Provider Systems Home and Community-Based Services (HCBS CAHPS) Survey

Connecticut has seen a growth in use of Medicaid funded home and community-based services (HCBS) along with increasing use of Access Agencies contracted for case management. Historically each agency has used its own survey to provide the quality assurance data required by Centers for Medicare and Medicaid Services (CMS) and Connecticut. This lack of a standardized, universal instrument has made it challenging to compare and report results across Medicaid programs and case management (CM) providers.

To provide the HCBS community with one universal, cross-disability tool to assess and improve HCBS program quality, Truven Health Analytics created the Experience of Care (EoC) survey. The EoC survey received approval from the national Consumer Assessment of Health Provider Systems consortium (CAHPS) and was endorsed by the National Quality Forum as a standardized, cross-disability tool to measure quality within HBCS.

SFY 18 was the first year the survey was utilized. For global ratings, respondents were asked to rate the help they get from each type of staff based on a scale from 0 to 10, or using a worded scale from poor to excellent or definitely no, probably no, probably yes, or definitely yes.

Results from the CHCPE survey: