Balancing the System:

Working Toward Real Choice for Long-Term Services and Supports in Connecticut

A Report to the General Assembly
January 2019

APPENDICES

A. Authorizing Statute for the Long-Term Care Planning Committee and the Long-Term Care Advisory Council

B. Long-Term Care Planning Committee Membership

C. Long-Term Care Advisory Council Membership

D. Sources of Public Comment

E. Long-Term Services and Supports Planning History

F. Status Report: 2016 Long-Term Care Plan for Connecticut (June 2018)

G. State Long-Term Services and Supports Programs and Expenditures – SFY 2017-2018

APPENDIX A.

Authorizing Statute for the Long-Term Care Planning Committee and the Long-Term Care Advisory Council

CONNECTICUT GENERAL STATUTES
TITLE 17B. SOCIAL SERVICES
CHAPTER 319Y. LONG-TERM CARE

§ 17b-337. Long-term elderly care planning committee. Long-term care plan.

(a) There shall be established a Long-Term Care Planning Committee for the purpose of exchanging information on long-term care issues, coordinating policy development and establishing a long-term care plan for all persons in need of long-term care. Such policy and plan shall provide that individuals with long-term care needs have the option to choose and receive long-term care and support in the least restrictive, appropriate setting. Such plan shall integrate the three components of a long-term care system including home and community-based services, supportive housing arrangements and nursing facilities. Such plan shall include: (1) A vision and mission statement for a long-term care system; (2) the current number of persons receiving services; (3) the current number of persons receiving long-term care supports and services in the community and the number receiving such supports and services in institutions; (4) demographic data concerning such persons by service type; (5) the current aggregate cost of such system of services; (6) forecasts of future demand for services; (7) the type of services available and the amount of funds necessary to meet the demand; (8) projected costs for programs associated with such system; (9) strategies to promote the partnership for long-term care program; (10) resources necessary to accomplish goals for the future; (11) funding sources available; and (12) the number and types of providers needed to deliver services. The plan shall address how changes in one component of such long-term care system impact other components of such system.

(b) The Long-Term Care Planning Committee shall, within available appropriations, study issues relative to long-term care including, but not limited to, the case-mix system of Medicaid reimbursement, community-based service options, access to long-term care and geriatric psychiatric services. The committee shall evaluate issues relative to long-term care in light of the United States Supreme Court decision, Olmstead v. L.C., 119 S. Ct. 2176 (1999), requiring states to place persons with disabilities in community settings rather than in institutions when such placement is appropriate, the transfer to a less restrictive setting is not opposed by such persons and such placement can be reasonably accommodated. The committee, within available appropriations, shall evaluate available data on the average net actual Medicaid expenditures for nursing homes, in comparison

to average net actual Medicaid expenditures for home and community-based services waiver participants who require a nursing home level of care, including the number of individuals served, to assist in short-term and long-term Medicaid expenditure forecasting.

(c) The Long-Term Care Planning Committee shall consist of: (1) The chairpersons and ranking members of the joint standing committees of the General Assembly having cognizance of matters relating to human services, public health, elderly services and long-term care; (2) the Commissioner of Social Services, or the commissioner's designee; (3) one member of the Office of Policy and Management appointed by the Secretary of the Office of Policy and Management; (4) one member from the Department of Public Health appointed by the Commissioner of Public Health; (5) one member from the Department of Housing appointed by the Commissioner of Housing; (6) one member from the Department of Developmental Services appointed by the Commissioner of Developmental Services; (7) one member from the Department of Mental Health and Addiction Services appointed by the Commissioner of Mental Health and Addiction Services; (8) one member from the Department of Transportation appointed by the Commissioner of Transportation; (9) one member from the Department of Children and Families appointed by the Commissioner of Children and Families; and (10) one member from the Health Systems Planning Unit of the Office of Health Strategy appointed by the executive director of the Office of Health Strategy; and (11) one member from the Department of Rehabilitation Services appointed by the Commissioner of Rehabilitation Services. The committee shall convene no later than ninety days after June 4, 1998. Any vacancy shall be filled by the appointing authority. The chairperson shall be elected from among the members of the committee. The committee shall seek the advice and participation of any person, organization or state or federal agency it deems necessary to carry out the provisions of this section.

(d) Not later than January 1, 2018, and annually thereafter, the Long-Term Care Planning Committee shall submit a report to the joint standing committees of the General Assembly having cognizance of matters relating to aging and human services on the number of persons receiving (1) long-term care supports and services in the community; and (2) long-term care supports and services in institutions.

(e) Not later than January 1, 1999, and every three years thereafter, the Long-Term Care Planning Committee shall submit a long-term care plan pursuant to subsection (a) of this section to the joint standing committees of the General Assembly having cognizance of matters relating to human services, public health, elderly services and long-term care, in accordance with the provisions of section 11-4a, and such plan shall serve as a guide for the actions of state agencies in developing and modifying programs that serve persons in need of long-term care.

(f) Any state agency, when developing or modifying any program that, in whole or in part, provides assistance or support to persons with long-term care needs, shall, to

the maximum extent feasible, include provisions that support care-giving provided by family members and other informal caregivers and promote consumer-directed care.

§ 17b-338. Long-Term Care Advisory Council. Membership. Duties

(a) There is established a Long-Term Care Advisory Council which shall consist of the following: (1) The executive director of the Commission on Women, Children and Seniors, or the executive director's designee; (2) the State Nursing Home Ombudsman, or the ombudsman's designee; (3) the president of the Coalition of Presidents of Resident Councils, or the president's designee; (4) the executive director of the Legal Assistance Resource Center of Connecticut, or the executive director's designee; (5) the state president of AARP, or the president's designee; (6) one representative of a bargaining unit for health care employees, appointed by the president of the bargaining unit; (7) the president of LeadingAge Connecticut, Inc., or the president's designee; (8) the president of the Connecticut Association of Health Care Facilities, or the president's designee; (9) the president of the Connecticut Association of Residential Care Homes, or the president's designee; (10) the president of the Connecticut Hospital Association or the president's designee; (11) the executive director of the Connecticut Assisted Living Association or the executive director's designee; (12) the executive director of the Connecticut Association for Homecare or the executive director's designee; (13) the president of Connecticut Community Care, Inc. or the president's designee; (14) one member of the Connecticut Association of Area Agencies on Aging appointed by the agency; (15) the president of the Connecticut chapter of the Connecticut Alzheimer's Association; (16) one member of the Connecticut Association of Adult Day Centers appointed by the association; (17) the president of the Connecticut Chapter of the American College of Health Care Administrators, or the president's designee; (18) the president of the Connecticut Council for Persons with Disabilities, or the president's designee; (19) the president of the Connecticut Association of Community Action Agencies, or the president's designee; (20) a personal care attendant appointed by the speaker of the House of Representatives; (21) the president of the Family Support Council, or the president's designee; (22) a person who, in a home setting, cares for a person with a disability and is appointed by the president pro tempore of the Senate; (23) three persons with a disability appointed one each by the majority leader of the House of Representatives, the majority leader of the Senate and the minority leader of the House of Representatives; (24) a legislator who is a member of the Long-Term Care Planning Committee; (25) one member who is a nonunion home health aide appointed by the minority leader of the Senate; and (26) the executive director of the nonprofit entity designated by the Governor in accordance with section 46a-10b to serve as the Connecticut protection and advocacy system or the executive director's designee.

(b) The council shall advise and make recommendations to the Long-Term Care Planning Committee established under section 17b-337.

(c) The Long-Term Care Advisory Council shall seek recommendations from persons with disabilities or persons receiving long-term care services who reflect the socio-economic diversity of the state.

APPENDIX B.

Long Term Care Planning Committee Members (November 2018)

Legislators

Senator Douglas McCrory, Co-Chair, Aging Committee
Representative Joseph C. Serra, Co-Chair, Aging Committee
Senator Kevin C. Kelly, Co-Chair, Aging Committee
Representative Gary Byron, Ranking Member, Aging Committee
Senator Theresa B. Gerratana, Co-Chair, Public Health Committee
Representative Jonathan Steinberg, Co-Chair, Public Health Committee
Senator Heather Bond Somers, Co-Chair, Public Health Committee
Representative Whit Betts, Ranking Member, Public Health Committee
Senator Marilyn Moore, Co-Chair, Human Services Committee
Representative Catherine F. Abercrombie, Co-Chair, Human Services Committee
Senator Joe Markley, Co-Chair, Human Services Committee
Representative Jay M. Case, Ranking Member, Human Services Committee

State Agencies Representatives

David Guttchen, Office of Policy and Management (Chair of Planning Committee)
Jennifer Avenia, Department of Children and Families
Kathy Bruni, Department of Social Services
Margy Gerundo-Murkette, Department of Rehabilitation Services
Kelley Kendall, Department of Developmental Services
Erin Leavitt-Smith, Department of Mental Health and Addiction Services
Donna Ortelle, Department of Public Health
Amy Porter, Department of Rehabilitation Services
Jessica Rival, Office of Health Strategy
Lisa Rivers, Department of Transportation
Michael Santoro, Department of Housing
Laura Watson, Department of Housing

Staff

Melissa Morton, Office of Policy and Management

APPENDIX C.

Long-Term Care Advisory Council Member Organizations

CT Commission on Women, Children and Seniors
CT Association of Residential Care Homes
Personal Care Attendant
CT Association of Area Agencies on Aging
CT Council for Persons with Disabilities
CT Association of Health Care Facilities
CT Assisted Living Association
CT Association of Adult Day Care
Bargaining Unit for Heath Care Employees/
1199 AFL-CIO
CT Family Support Council
Consumer
AARP – CT
CT Association of Home Care, Inc.
LTC Ombudsman's Office
Legal Assistance Resource Center
CT Community Care, Inc.
CT Hospital Association
CRT/CT Assoc. of Community Action Agencies
CT Alzheimer's Association
LeadingAge CT
Family Caregiver
CT Coalition of Presidents of Resident Councils
American College of Health Care Administrators
Consumer
Consumer
Nonunion Home Health Aide

Friends of the Advisory Council
Representative Jonathan Steinberg

APPENDIX D.

Sources of Public Comment

With the assistance of the Long-Term Care Advisory Council, a draft of the Plan recommendations was distributed widely in August 2018 to diverse organizations and individuals throughout Connecticut with an interest in long-term services and supports. A draft of the full Plan and appendices was distributed for comment in December 2018. In total, public comments were received from 4 organizations.

Organizations

- Long-Term Care Advisory Council:
  - CT Alzheimer's Association: Christy Kovel
  - CT Association of Health Care Facilities: Matthew Barrett
  - CT Association for Healthcare at Home: Deborah R. Hoyt, President and CEO
  - Leading Age CT: Margaret Morelli

APPENDIX E.

A. Long-Term Care Planning Committee History

Establishment of the Long-Term Care Planning Committee

The Long-Term Care Planning Committee (Planning Committee), created in 1998 under Pubic Act 98-239, was established for the purpose of exchanging information on long-term services and supports issues, coordinating policy development and establishing a long-term care plan. The Planning Committee is comprised of representatives from ten State agencies and the Chairs and Ranking Members of the General Assembly's Aging, Human Services, and Public Health Committees. (See Appendix A for the authorizing statute and Appendix B for a listing of Planning Committee members.)

The Planning Committee grew out of the recommendations of a December 1996 report issued by the Legislative Program Review and Investigations Committee. The study concluded that the State's structure for planning, funding and overseeing long-term services and supports needed reinforcement and coordination. The Legislative Program Review and Investigations Committee recommended the creation of an interagency committee to "exchange information on long-term care issues, ensure coordinated policy development, and establish a long-term care plan."

In addition to the Long-Term Care Planning Committee, Public Act 98-239 also established the Long-Term Care Advisory Council (Advisory Council) to advise and make recommendations to the Planning Committee. The Advisory Council members include a balance of consumers, providers and advocates representing a wide range of interests. (See Appendix C for a listing of Advisory Council members.)

Originally, the Planning Committee was required to establish a long-term care plan for the elderly that integrates the three components of a long-term services and supports system including home and community based services, supportive housing arrangements and nursing facilities. Subsequently, Public Act 01-119 broadened the Planning Committee's purview by requiring a plan for all persons in need of long-term care.

Long-Term Care Planning Committee Products

Preliminary Long-Term Care Plan – 1999

As noted above, the Planning Committee was created by statute in 1998 and held its initial meeting in August 1998. The Planning Committee's authorizing statute required the Planning Committee to produce its first Long-Term Care Plan by January 1999. Due to the short timeframe, the Planning Committee produced a Preliminary Long-Term Care Plan that provided a description of Connecticut's long-term services and supports

system in order to develop a baseline for future Plans. In addition, the Preliminary Plan was focused on long-term services and supports for elderly persons in keeping with the original statutory charge for the Planning Committee (this requirement was later changed, through Public Act 01-119, to require the Long-Term Care Plan to address all individuals who need long-term care, regardless of age or disability). The Planning Committee then began the work to develop a comprehensive Long-Term Care Plan due to the General Assembly by January 2001 (the original statute required a Long-Term Care Plan every two years – this requirement was later changed, through Public Act 01-119, to mandate a Plan be developed every three years).

Home Care Report – 2000

In 1999, the General Assembly enacted Public Act 99-279 that required the Planning Committee to develop, by February 2000, a plan that ensures the availability of home care services for elderly persons under the Connecticut Home Care Program for Elders (CHCPE) who would otherwise qualify for the program except their income exceeds the program's established income limits. The impetus for this legislation was the fact that the CHCPE had a strict income eligibility requirement that resulted in individuals with as little as one dollar above the income level being ineligible for home care services. This contrasted with the income requirements for nursing home coverage through Medicaid that allows individuals with incomes that are not sufficient to pay for their care to be eligible while contributing most of their income towards their care.

To meet this requirement, the Planning Committee produced a report titled "Home Care for Older Adults - A Plan for Increasing Eligibility Under the Connecticut Home Care Program for Elders." that was delivered to the General Assembly in February 2000. The report concluded that the only mechanism to assure the availability of home care services under the CHCPE was to revise the income eligibility cap to mirror the income requirements utilized for nursing home care eligibility, thus allowing individuals to buy into the CHCPE.

During the 2000 legislative session, the General Assembly approved legislation that revised the income requirements for both the State-funded and Medicaid components of the CHCPE to allow individuals with incomes in excess of the income eligibility cap to become eligible for the CHCPE by buying into the program. The expanded income level was implemented for the State-funded portion of the CHCPE in October 2000. However, to implement a similar revision for the Medicaid portion of the CHCPE, federal approval was needed. The Department of Social Services (DSS) submitted a revision to their CHCPE Medicaid waiver in 2001, but the DSS proposal was not approved by the federal government.

Long-Term Care Plan - 2001

After the completion of its Preliminary Long-Term Care Plan in 1999, the next Plan from the Planning Committee was due by January 2001. Beginning in early 1999, the

Planning Committee undertook an ambitious effort to solicit public input regarding what was needed for a comprehensive Long-Term Care Plan.

In March 1999, the Planning Committee, in conjunction with the Advisory Council, held a public hearing at the Legislative Office Building where over 50 individuals provided testimony regarding Connecticut's long-term services and supports system. The Planning Committee then embarked on a series of meetings with a variety of groups and organizations involved with the long-term care system. Most of the groups were members of the Advisory Council. All told, Planning Committee and Advisory Council members held 24 forums throughout 1999 and 2000. In addition, the Planning Committee and Advisory Council held five public hearings throughout the state in 2000 to garner additional feedback and input for the Long-Term Care Plan.

The input gathered through the forums and public hearings helped develop the framework for the Planning Committee's Long-Term Care Plan that was submitted to the General Assembly in January 2001.

Long-Term Care Plan – 2004

The Long-Term Care Planning Committee's third plan was issued in January 2004 in accordance with Public Act 01-119 which required the Planning Committee to issue its long-term care plan every three years instead of every two. The Advisory Council worked in partnership with the Planning Committee in four essential areas: providing data, identifying areas of need, developing priorities and recommendations, and obtaining public input.

2004 Long-Term Care Plan Status Reports

Following the release of the 2004 Long-Term Care Plan, a status update was issued annually in June of 2004, 2005 and 2006. The first section of the Status Report described progress implementing the recommendations made in the 2004 Long-Term Care Plan by State Agencies or the legislature, along with any new funds appropriated. The second section documented the implementation of the action steps issued in Connecticut's Olmstead Plan, entitled "Choices are for Everyone", developed by the Department of Social Services in collaboration with the Long-Term Care Planning Committee and the Community Options Task Force.

Long-Term Care Website

In 2002, the General Assembly passed Public Act 02-7 (May 9 Special Session) that required the Office of Policy and Management (OPM), within existing budgetary resources and in consultation with the Select Committee on Aging, the Commission on Aging and the Long-Term Care Advisory Council, to develop a consumer-oriented website that provides comprehensive information on long-term care options that are available in Connecticut.

In September 2006, the Connecticut Long-Term Care Services and Supports website was completed and released to the public. The website provides information to all individuals in need of long-term care services and supports, regardless of age or disability.

Policy Statement Formalized into Law

Public Act 05-14 codified in law a broad philosophical statement to guide future policy and budget decisions. As a result of this legislation, the policy and planning work done through the Long-Term Care Planning Committee is required to "provide that individuals with long-term care needs have the option to choose and receive long-term care and support in the least restrictive, appropriate setting." This statement positions Connecticut to make the necessary changes to the laws and regulations that govern the State's long-term care system to make real choices for consumers a reality.

Long-Term Care Needs Assessment

In 2006 and 2007, a needs assessment on long-term care services and supports in Connecticut was conducted by the University of Connecticut Health Center's Center on Aging. The General Assembly's Commission on Aging, in consultation with the Long-Term Care Advisory Council and the Long-Term Care Planning Committee, contracted with the Center on Aging to conduct a comprehensive needs assessment of the unmet long-term care needs in the state and projections of the future demand for these services. This Needs Assessment was mandated by Public Act 06-188, Section 38, and funded with a $200,000 appropriation from the Connecticut General Fund and an additional $80,000 from the Connecticut Long-Term Care Ombudsman Program. Findings from the Needs Assessment informed both the 2007 and the 2010 Long-Term Care Plans, and the many of the recommendations made in the Needs Assessment have been included in the 2010 Plan. (See the Needs Assessment reports at http://www.uconn-aging.uchc.edu/res_edu/assessment.html)

Long-Term Care Plan – 2007

The Long-Term Care Planning Committee's fourth plan was issued in January 2007.

2007 Long-Term Care Plan Status Reports

Following the release of the 2007 Long-Term Care Plan, a status update was issued in June of 2007 and 2008 and in October of 2009.

Long-Term Care Plan – 2010

The Long-Term Care Planning Committee's fifth plan was issued in January 2010.

2010 Long-Term Care Plan Status Reports

Following the release of the 2010 Long-Term Care Plan, a status update was issued in June of 2010, 2011 and 2012.

Long-Term Care Plan – 2013
The Long-Term Care Planning Committee's sixth plan was issued in January 2013.

2013 Long-Term Care Plan Status Reports
Following the release of the 2013 Long-Term Care Plan, a status update was issued in June of 2013, 2014 and 2015.

Long-Term Care Plan – 2016
The Long-Term Care Planning Committee's seventh plan was issued in January 2016.

2016 Long-Term Care Plan Status Reports
Following the release of the 2016 Long-Term Care Plan, a status update was issued in June of 2017 and 2018.

B. Olmstead Planning Efforts

On June 22, 1999, the United States Supreme Court decided the *Olmstead v. L.C*. case, holding that unjustified isolation, caused by unjustified placement or retention of persons with disabilities in institutions, should be regarded as discrimination based on disability, in violation of the Americans with Disabilities Act (ADA).

Federal regulation requires public entities to make "reasonable modifications" to their policies, practices, or procedures in order to avoid discrimination on the basis of disability, unless the modifications would "fundamentally alter" the nature of the service or program. As part of the Olmstead decision, four Justices stated that one of the ways the reasonable modification standard could be met is if the State had a comprehensive, effectively working plan of placing qualified persons with disabilities in less restrictive settings.

In 2000, the Department of Social Services began developing an Olmstead Plan and the Long-Term Care Planning Committee provided oversight and leadership for the process. In order to assure that individuals with disabilities and family members of persons with disabilities were active participants in the development of the Olmstead Plan, a Community Options Task Force was created to take the lead in the development of the Plan. The men and women of this advisory group, made up of adults of all ages with various disabilities, family members of persons with disabilities, and representatives from the elder community, worked hard on Connecticut's Community Options Plan, entitled "Choices are for Everyone," for two years.

On March 25, 2002, the "Choices are for Everyone" Plan was completed as a collaboration between the Department of Social Services, the Long-Term Care Planning Committee and the Community Options Take Force.

A number of activities in Connecticut support the goals outlined in the "Choices are for Everyone" Plan, some of which are highlighted below.

"Choices are for Everyone" Plan -- Action Steps Update

"Choices are for Everyone" included a series of Action Steps. The Long-Term Care Planning Committee committed to the implementation of these Action Steps. Progress was reported in the annual Status Reports for the 2004 and 2007 Long-Term Care Plans.

Systems Change Grants

Since 2002, the goals of this Plan have been advanced through the work accomplished with the funding of seven *Systems Change for Community Living* grants awarded to Connecticut by the Centers for Medicare and Medicaid Services (CMS) as part of the federal New Freedom Initiative. These grants were designed to assist states in their efforts to remove barriers to equality for individuals living with disabilities or long-term illnesses, enabling them to live in the most integrated setting suited to their needs, exercise meaningful choices about their living arrangements and exercise more control over the providers of the services they receive.

- Nursing Facility Transition Grant: 2001-2004
- Real Choice Systems Change Grant: 2002- 2005
- Community-integrated Personal Assistance Services and Supports (C-PASS) Grant: 2003-2006
- Independence Plus Waiver Initiative: 2003-2006
- Quality Assurance and Improvement in Home and Community-Based Services: 2003-2006
- Mental Health Transformation Grant: October 2005 – September 2010
- Medicaid Infrastructure Grant: October 2005 – September 2010

Connecticut Behavioral Health Partnership

Operation of the Connecticut Behavioral Health Partnership program began on January 1, 2006, serving children and families enrolled in the state HUSKY A and B programs and DCF involved children with special behavioral health needs. DCF and DSS have formed the Behavioral Health Partnership to oversee an integrated public behavioral health service system for children and families. The primary goal is to provide enhanced access to and coordination of a more complete and effective system of community-based behavioral health services and supports and to improve member outcomes. Secondary goals include better management of state resources and increased federal financial participation in the funding of behavioral health services.

Money Follows the Person Rebalancing Demonstration

The Money Follows the Person (MFP) Rebalancing Demonstration began operation in December 2008. The objective of the MFP Rebalancing Demonstration is to rebalance long-term services and supports from institutional care to home-based services. The program serves individuals across the age span with physical disabilities, mental illness and intellectual disabilities. Connecticut has established five rebalancing benchmarks under MFP that are aligned with the goals of the Long-Term Services and Supports Plan:

1. Transition 5,200 people from institutions to the community.
2. Increase dollars to home and community-based services.
3. Increase hospital discharges to the community rather than to institutions.
4. Increase the probability of returning to the community during the six months following nursing home admission.
5. Increase the percentage of LTSS participants living in the community compared to the institution.

In April 2015, DSS submitted a five-year MFP Sustainability Plan to the Centers for Medicare and Medicaid Services (CMS) outlining the state's strategy to continue program efforts through 2020. Over the next five years, MFP will continue the provision of (1) addiction services and supports; (2) informal caregiver supports; (3) peer supports; and (4) Transitional Recovery Assistance services and implement new rebalancing strategies focusing on community collaboration, social determinant interventions and collaboration with no-wrong door initiatives. DSS will administer the transitional program until 2018 when the last nursing home transition will be made as part of the MFP demonstration. CMS awarded DSS $236 million dollars through 2020 to implement the sustainability plan.

State Balancing Incentive Payments Program (BIP)

Connecticut received $72.8 million in 2012, and an additional $4.2 million in July 2015, to implement the BIP program. Key aspects of the BIP include development and implementation of (1) a pre-screen and a common comprehensive assessment for all persons entering the LTSS system; (2) conflict-free case management across the system; (3) a "no-wrong door" system for access to LTSS through a web-based platform branded "My Place CT." My Place CT aims to coordinate seamlessly with both ConneCT and the health insurance exchange; and (4) new LTSS aimed to address gaps that prevent people from moving to or remaining in the community**.**

Community First Choice (CFC)

On July 1, 2015, DSS launched a new Medicaid State Plan service pursuant to 1915(k) of the Social Security Act. This new option, made possible by the Affordable Care Act, will enable Medicaid beneficiaries who require nursing facility or other institutional level of care to self-direct community-based services utilizing individual budgets, with the support of a fiscal intermediary. Services include transitional supports when moving from institutions to the community as well as services that increase independence or substitute for human assistance such as, personal care assistants, support and planning coaches, nurse coaches, home delivered meals, environmental accessibility modifications, Personal Emergency Response System, and assistive technology. As a parallel component to CFC implementation, all Medicaid Waivers offering self-directed services, including Personal Care Attendant and Acquired Brain Injury, were revised to remove personal care attendant services. Effective July 1, 2015, self-directed services

for individuals on the affected Waivers are provided as a Medicaid State Plan service through CFC.

APPENDIX F.

LONG-TERM SERVICES AND SUPPORTS PLANNING EFFORTS

Status Report:

2016 Long-Term Care Plan for Connecticut

June 2018

Status Report

2016 LONG-TERM SERVICES AND SUPPORTS PLAN FOR CONNECTICUT

Connecticut Long-Term Care Planning Committee

June 2018

Status Report – June 2018
2016 LONG-TERM SERVICES AND SUPPORTS PLAN FOR CONNECTICUT

Introduction

This Status Report is the second annual update on the status of the 2016 Long-Term Care Plan recommendations. It provides information on actions of the State agencies to address the Plan recommendations as well as on relevant legislation passed by the General Assembly and signed by the Governor.

Acronyms Used in this Status Report

AAA - Area Agency on Aging
ADA – Americans with Disabilities Act
ADRC – Aging and Disability Resource Centers
CMS – Center for Medicare and Medicaid Services
CT – Connecticut
CFC- Community First Choice
CHCPE - Connecticut Home Care Program for Elders
DDS – Department of Developmental Services
DMHAS – Department of Mental Health and Addiction Services
DPH – Department of Public Health
DOH – Department of Housing
DORS – Department of Rehabilitation Services
DOT – Connecticut Department of Transportation
DSS – Department of Social Services
HUD - Department of Housing and Urban Development (HUD), Department of Economic and Community Development
LTC - Long-Term Care
LTSS – Long-Term Services and Supports
MFP – Money Follows the Person
OPM – Office of Policy and Management
PASRR - Pre-Admission Screening Resident Review
PCA – Personal Care Assistant
SUA – State Unit on Aging (formerly the State Department on Aging, now under the Department of Rehabilitation Services)
SFY – State Fiscal Year
VA – Veteran's Administration
VD-HCBS – Veteran Directed Home and Community-Based Services program

Status Report – June 2018
2016 LONG-TERM SERVICES AND SUPPORTS PLAN FOR CONNECTICUT

RECOMMENDATIONS	ADMINISTRATIVE AND OTHER ACTIONS	LEGISLATIVE ACTIONS AND NEW FUNDING
(i) GOAL 1. Balancing the ratio of home and community-based and institutional care		
Develop a system that provides for more choice and opportunities for community integration as alternatives to all institutional settings, and increases the proportion of individuals receiving Medicaid long-term home and community-based care from 60 percent in 2015 to 75 percent by 2025, requiring approximately a 1.5 percent increase in the proportion of individuals receiving Medicaid long-term services and supports in the community every year.		**P.A. 17-123 (sH.B. 7020) - An Act Requiring The Implementation Of The Recommendations Of The Program Review And Investigations Committee Concerning Long-Term Care.** This bill makes various changes in the collection and reporting of long-term care data. Effective Date: October 1, 2017
	DSS developed an Informed Choice process for individuals residing in nursing homes and other institutional settings to increase access to information regarding services and supports offered under Medicaid.	
	Community First Choice (CFC), a new Medicaid state plan service (1915(k)), began in July, 2015, thereby allowing people at nursing home level of care to self-direct their services, including care plan development, management of an individualized budget and employment authority. CFC was redesigned during the period to ensure compliance with federal	

RECOMMENDATIONS	ADMINISTRATIVE AND OTHER ACTIONS	LEGISLATIVE ACTIONS AND NEW FUNDING
	guidelines.	
	Update, enhancement of and integration of My Place CT giving individuals online access to information about LTSS Options	
	Develop local community based networks for access to LTSS information: Care Through Community initiative. During the period, the group continued to meet monthly to develop the community partner concept. 30 partners were established. SUA worked with DSS to develop an MOU with local community- based networks. SUA offered CHOICES certification to partners pursuing Medicaid certification when it becomes available.	
	DOH continues to work with DSS on the implementation of Money Follows the Person through the commitment and provision of State Rental Assistance to eligible individuals.	
	DOH, in conjunction with DSS, DDS and DMHAS, is implementing the federal Section 811 Project-Based Rental Assistance (PRA) program. $4.14 million has been awarded for the first five years of the program.	
	As nursing homes are closing, DSS is actively involved in providing residents assistance with community housing for those residents that are eligible for MFP	

RECOMMENDATIONS	ADMINISTRATIVE AND OTHER ACTIONS	LEGISLATIVE ACTIONS AND NEW FUNDING
	assistance. DPH continues oversight of the nursing homes' discharge planning process and approval of the facility closure plan in accordance with regulations to ensure there is a safe plan for closure.	
	In 2017, SUA piloted a Benefits Enrollment Center in 3 prison settings to ensure older adults and persons with disabilities were getting connected to medical and other financial programs upon release.	
	DDS is in the process of implementing the national Charting the LifeCourse planning practices to assist families to develop and use a broad foundation of supports and services that includes community-based supports and eligibility-based services such as MFP, CFC, and all LTSS options.	
(b) <u>GOAL 2. Balancing the ratio of public and private resources</u>		
Increase the proportion of costs for long-term services and supports covered by private insurance and other dedicated sources of private funds to 25 percent by 2025. Such an increase in private insurance and other sources of private funding would reduce the burden both on Medicaid and on individuals' out-of-pocket expenses. Nationally, private insurance (long-term care and other health insurance) represented 11.9 percent of spending for long-term services and supports in 2012.	Continued implementation of the CT Partnership for Long-Term Care program. It's estimated the Partnership has saved over $35 million in Medicaid funds.	

RECOMMENDATIONS	ADMINISTRATIVE AND OTHER ACTIONS	LEGISLATIVE ACTIONS AND NEW FUNDING
LONG TERM RECOMMENDATIONS		
Provide true individual choice and self-direction to all users of long-term services and supports.	Implementation of Community First Choice state plan (1915 (k)) service to allow individuals to develop their own care plan and self-direct their own staff.	
	DDS continues to promote choice and self-direction in all its services. Beginning in SFY 17, DDS implemented person centered counseling training for all case managers. This online and in-person course was provided by a grant obtained by the CT Department on Aging (now the DORS State Unit on Aging). Over 200 employees have since completed the course. In addition, DDS has presented training in Charting the Life Course planning tools and resources as well as developed a group of LifeCourse Ambassadors to promote its use in schools and other community and DDS settings.	
	SUA was selected to pilot a national personal centered counseling (PCC), No Wrong Door (NWD) curriculum for the federal Administration for Community Living (ACL). As of May 2017, 75 people were registered for this curriculum & 8 individuals are being trained to become PCC trainers for the in-person component.	

RECOMMENDATIONS	ADMINISTRATIVE AND OTHER ACTIONS	LEGISLATIVE ACTIONS AND NEW FUNDING
	FY 2017, 479 were registered for the curriculum. 303 individuals completed all of the requirements, 91 completed half and the others either didn't complete the lessons or are in the beginning phases.	
Promote efforts to enhance quality of life in various long-term services and supports settings.	Continued efforts under the Testing Experience and Functional Assessment Tools (TEFT) grant to study the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey and to move forward with this as a quality measure.	**P.A. 16-8 (S.B. 280) - An Act Concerning The Long-Term Care Ombudsman's Notice To Nursing Home Residents.** This bill adds an informational letter on patients' rights and available services to the written notice that long-term care facilities must provide to patients and other parties when planning to terminate a service or substantially decrease bed capacity. Under the bill, the informational letter must be jointly issued by the Office of Long-Term Care Ombudsman and the Department on Aging. Effective Date: July 1, 2016
	DPH is working with the Centers for Medicare and Medicaid Services (CMS) on changes to the regulation and survey process. The federal requirements for participation as Long Term Care (LTC) facilities were first published in the Federal Register on February 2, 1989.These regulations have been revised and added to since that time, principally as a result of legislation or a need to address a specific issue. However, they have not been	**P.A. 16-209 (S.B. 266) - An Act Concerning Nursing Home Resident Admissions Agreements.** This bill requires a nursing home to include in any resident admission agreement notice of the: (1) duties, responsibilities, and liabilities of the person who signs the agreement (i.e., "responsible party") and (2) circumstances in which (a) the responsible party will be held legally

RECOMMENDATIONS	ADMINISTRATIVE AND OTHER ACTIONS	LEGISLATIVE ACTIONS AND NEW FUNDING
	comprehensively reviewed and updated since 1991, despite substantial changes in service delivery within this setting. Since the current requirements were developed, significant innovations in resident care and quality assessment practices have emerged. In addition, the population of nursing facilities has changed, becoming more diverse and clinically complex. The regulations and survey process will be changed in three phases which began in November 2016 and will continue to November 2019.	liable and (b) his or her personal assets may be pursued for payment to the nursing home. It also specifies the required font size and mandates that the notice be initialed by the responsible party. Failure by a nursing home to provide notice and obtain the initials of a responsible party will deem the resident admission agreement unenforceable with regard to the responsible party. Effective Date: July 1, 2016
	DPH is working with CMS in the third year of a three year pilot project to improve assessment of infection control and prevention regulations in Long Term Care (LTC) facilities, hospitals, and during transitions of care. The surveys use a draft surveyor Infection Control Worksheets (ICSW) based on the new Long Term Care regulation as well as a revised hospital surveyor ICWS. Hospital surveys will be paired with surveys of LTC facilities, in order to provide an opportunity to assess infection prevention during transitions of care. CMS and the CDC are collaborating on the development of a training course in infection prevention and control for long-	**Special Session P.A. 16-3 (as amended by Senate Amendment A (S.B. 502)) – An Act Concerning Revenue And Other Items To Implement The Budget For The Biennium Ending June 30, 2017 Section 178.** Requires the Commission on Women, Children and Seniors to study the need for emergency power generators at Connecticut's elderly public housing sites. It defines “elderly public housing” as any building where at least 50% of the units are rented to individuals ages 62 and older under any state affordable housing program. The Commission submitted a final report to the Aging, Housing and Public Safety Committees by January 1, 2017. Effective Date: July 1, 2016

RECOMMENDATIONS	ADMINISTRATIVE AND OTHER ACTIONS	LEGISLATIVE ACTIONS AND NEW FUNDING
	term care nursing home staff. This course will be free of charge and available on-line and on-demand Spring 2019. Completion of this course will provide specialized training in infection prevention and control.	
	DPH is working with the National Partnership to Improve Dementia Care in Nursing Homes. CMS is partnering with federal and state agencies, nursing homes, other providers, advocacy groups and caregivers to improve comprehensive dementia care. CMS plans to monitor the reduction of antipsychotics, as well as the possible consequences, review the cases of residents whose antipsychotics are withdrawn to make sure they don't suffer an unnecessary decline and add the antipsychotic measure to the calculations that CMS makes for each nursing home's rating on the agency's Five Star Quality Rating System.	**Special Act 16-5 (sSB 88) - An Act Establishing A Task Force To Study The Zoning Of Temporary Health Care Structures.** Establishes a task force to study the zoning of temporary health care structures and to develop a model zoning ordinance for temporary health care structures. Such study shall include, but not be limited to, an examination of regulations, ordinances and legislation pertaining to temporary health care structures in other states. Effective upon passage June, 2016.
	DMHAS and DSS continues to develop and improve alternative therapy groups in Chelsea Place and Touchpoints of Manchester as part of a Class Action Lawsuit. DMHAS engaged Toivo, an arm of Advocacy Unlimited, to provide monthly groups using yoga, Chi Gong, singing bowls and other alternative healing modalities to assist in engaging residents.	**P.A. 17-34 (S.B. 762) - An Act Clarifying The Role Of The Office Of The Long-Term Care Ombudsman In The Mandated Reporting Of Abuse Of Elderly Persons And Deleting Obsolete Statutory Provisions.** This bill clarifies that representatives of the Office of the Long-Term Care Ombudsman are not mandated reporters of elder abuse. In

RECOMMENDATIONS	ADMINISTRATIVE AND OTHER ACTIONS	LEGISLATIVE ACTIONS AND NEW FUNDING
		doing so, the bill conforms to state law and new federal regulations. Effective upon passage, June 6, 2017.
	DMHAS held various trainings for diversion nurses and Mental Health Waiver staff on advances in diabetes medications.	
	DMHAS' Nursing Home Diversion and Transition Program has collaborated with the Connecticut Association of Residential Care Homes to assist RCHs in managing people with psychiatric disabilities so that they remain in the community and avoid institutionalization.	**S.A. 17-14 - An Act Concerning The Patient Bill Of Rights For Long-Term Care Residents.** This bill requires the Commissioners of DPH and DSS to study whether the statutorily defined patient bill of rights adequately protects patient rights related to room transfers within the same facility. The Commissioners must submit a report to the General Assembly committees of cognizance on aging and public health by January 1, 2018. Effective Upon passage (July 7, 2017)
	DDS participated in the development of the CAHPS survey and will be piloting across the DDS waivers.	
Ensure the availability of a wide array of support services for those living in the community.	DSS continues to support the CFC state plan service to allow individuals to develop their own care plan and self-direct their own staff. Update, enhancement of and integration of My Place CT giving individuals access to information about LTSS Options.	

RECOMMENDATIONS	ADMINISTRATIVE AND OTHER ACTIONS	LEGISLATIVE ACTIONS AND NEW FUNDING
	DSS also continued to expand local community based networks for access to LTSS information: Care Through Community. SUA continued to be on the leadership committee working on this initiative.	
	During FY17, DDS continued to provide training entitled "Healthy Relationships" twice a year in each region.	
	DDS added assistive technology, shared living, and peer supports as services offered through the waiver.	
	DORS-BESB's Adult's Services program provides rehabilitation and adaptive technology services in the home to hundreds of older adults who are blind.	
	In March 2017, CMS granted renewal of the Mental Health Waiver for another 5 years, effective April 1, 2017. Included in the renewal was approval to add a chore service for participants. This includes light household cleaning activities as well as heavy cleaning including remediation of bed bugs and hazardous waste. The chore service has been a useful addition to the array of waiver services and has been used to assist clients in remaining independent in their own homes.	
Ensure quality of long-term services and supports in the context	Continue implementation of CFC state plan	

RECOMMENDATIONS	ADMINISTRATIVE AND OTHER ACTIONS	LEGISLATIVE ACTIONS AND NEW FUNDING
of a flexible and person-centered service delivery system that acknowledges the dignity of risk.	service to allow individuals to develop their own care plan and self-direct their own staff.	
	The Mental Health Waiver program for individuals with serious mental illness encompasses the recovery orientation adopted by DMHAS, but also signals new directions in the community treatment of people with serious psychiatric disabilities. Each person enrolled in the Mental Health Waiver program participates in a Person-centered planning process leading to the development of an individualized Recovery Plan. The Mental Health Waiver allows individuals choice among credentialed providers and also a self-directed Recovery Assistant option. The waiver enables participants to remain in the community in the most integrated setting possible and allows people to "age in place."	
	DMHAS successfully implemented the Senior Outreach and Engagement Program, in January 2018, after a Request for Proposals process was completed. One agency in each of the 5 DMHAS regions was selected allowing for outreach services to be statewide. The program provides assessment and case management services to at risk older adults (55 and older) by utilizing proactive approaches to identify, engage and refer seniors for various	

RECOMMENDATIONS	ADMINISTRATIVE AND OTHER ACTIONS	LEGISLATIVE ACTIONS AND NEW FUNDING
	individually tailored community treatment options. Services include education, support, counseling (including in-home counseling) referrals to senior service networks and referrals for treatment. The program complements existing DMHAS programs that focus on diverting older adults from long term care and developing home and community based services to assist older adults with "aging in place."	
	The SUA continued to work with the VA and the 5 AAAs to administer the self-directed VD-HCBS program.	
	Beginning in SFY 17, DDS implemented person-centered counseling training for all case managers. In addition, DDS has presented training in Charting the Life Course planning tools and resources as well as developed a group of Ambassadors to promote its use in schools and other community and DDS settings.	
Provide individuals, caregivers and persons on nursing home waitlists options counseling and decision support to encourage advanced person-centered planning for long-term services and supports to prevent institutionalization and to extend the availability of private funds for care.		**P.A. 17-124 (sH.B. 7032) - An Act Regarding The Office Of The State Treasurer's Recommended Revisions To The Achieving A Better Life Experience Program.** This bill makes revisions to the Achieving a Better Life Experience (ABLE) account program including, removing the requirement that designated beneficiaries of federally qualified ABLE

RECOMMENDATIONS	ADMINISTRATIVE AND OTHER ACTIONS	LEGISLATIVE ACTIONS AND NEW FUNDING
		accounts be residents of CT or a state without an ABLE account program that contracts with CT to provide ABLE accounts to that state's residents. As under current law, the bill requires a beneficiary to be eligible (i.e., meet the disability requirements) and an owner of a qualified ABLE account. Effective Date: October 1, 2017 except for the changes regarding designated beneficiaries and certain minor and technical changes, which take effect upon passage.
Achieve greater integration and uniformity of administration of State long-term services and supports serving both older adults and people with disabilities and their families, and emphasize policies related to function as opposed to age or diagnosis.	Continue implementation of CFC state plan service to allow individuals to develop their own care plan and self-direct their own staff.	
	Implementation across all Waivers and HCBS Packages of a Universal Assessment Tool, and for CFC a Universal Self-Directed Tool	
	Waivers were consolidated under DSS Community Options Unit including the transition of the Autism waivers from DDS to DSS on 7/1/16; The universal assessment was redesigned and re-launched in August, 2017. After demonstrating effectiveness in implementation, the assessment and	

RECOMMENDATIONS	ADMINISTRATIVE AND OTHER ACTIONS	LEGISLATIVE ACTIONS AND NEW FUNDING
	universal allocation methodology was scheduled to roll out to all waivers beginning in June 2018	
	DDS has aligned all three DDS waivers across quality and performance measures to improve overall quality of service.	
Encourage communities to take an active role in planning and supporting long-term services and supports for their residents.	Continued Rightsizing grants for facilities to partner with their local communities and develop alternative business models.	
	SUA and DSS are collaborating with community agencies who are willing to: 1) disseminate My Place CT materials; 2) assist individuals with using My Place CT; and 3) offer additional training for individuals who are pursuing Medicaid certification.	
	In FY'16 DDS conducted 17 presentations in the community on Life Course tools and the concept of planning throughout a person's life and preparing for transition times.	
	In FY' 2017 DORS partnered with DDS to offer a joint program to help integrate Life Course materials with PCC course materials.	
	In FY'17, DDS conducted 12 presentations in the community on Life Course tools and the concept of planning throughout a person's life and preparing for transition times.	

RECOMMENDATIONS	ADMINISTRATIVE AND OTHER ACTIONS	LEGISLATIVE ACTIONS AND NEW FUNDING
Address the long-term services and supports education and information needs of the Connecticut public, including specialized educational efforts to specific groups, such as baby boomers and employers.	DSS continued development of MyPlaceCT as a "one-stop-shop" for information on LTSS in Connecticut.	
	DSS is developing local community based networks for access to LTSS information: Care Through Community initiative.	
	In SFY 2016, the CT Partnership for LTC (OPM and SUA in conjunction with the Area Agencies on Aging (AAAs) held five public forums for 234 attendees on Partnership LTC insurance and the importance of planning ahead for future LTC needs. Additionally, in SFY 2016, the Partnership disseminated 86 information packets and provided telephonic counseling and assistance to over 100 consumers. In 2017 the CT Partnership for LTC (OPM and SUA) held five public forums for 225 attendees on Partnership LTC Insurance and the importance of planning ahead for future needs. Also, the CT Partnership held over 65 additional presentations, reaching over 1,000 individuals. Additionally, in 2017 the Partnership disseminated 64 information packets and provided telephonic counseling and assistance to	

RECOMMENDATIONS	ADMINISTRATIVE AND OTHER ACTIONS	LEGISLATIVE ACTIONS AND NEW FUNDING
	over 100 consumers. In 2018 the CT Partnership for LTC (OPM and SUA) held five public forums for over 280 attendees on Partnership LTC Insurance and the importance of planning ahead for future needs. Also, the CT Partnership held over 35 additional presentations, reaching over 600 individuals.	
	The CHOICES program continued to offer the New to Medicare Training throughout the state. This presentation includes information on various Medicare related topics such as the limited Medicare coverage for LTSS.	
	The Connect-Ability Distance Learning Initiative offers free online training modules on a variety of topics, such as Personal Care Attendant, Independent Living skills, Assistive Technology, Service Dogs and more.	
	The Mental Health Waiver's Administrative Service Organization – Advanced Behavioral Health – continues to provide regularly scheduled trainings for certified Recovery Assistants who can also be dually-trained to provide Recovery Assistant services for the Acquired Brain Injury II Waiver overseen by DSS. Recovery Assistant service was initially developed for	

RECOMMENDATIONS	ADMINISTRATIVE AND OTHER ACTIONS	LEGISLATIVE ACTIONS AND NEW FUNDING
	the Mental Health Waiver as a combination of companion, homemaker, PCA and respite services with a focus on teaching independent living skills.	
	DMHAS has expanded information on the agency web site regarding older adult services and contacts for the treatment of substance use disorders in older adults.	
	DMHAS developed and implemented a training: Older Adults and Mental Health, for their learning management system. This allows DMHAS and DMHAS funded staff to access the training electronically. The training was shared with DSS and is on their internal training system. The Older Adult Work Group is looking to modify the training for My Place CT so community-based waiver staff can access the training.	
Address the anticipated long-term services and supports workforce shortage.	DSS Is continuing efforts to partner with DOL to advance Workforce Development, including the development of an online job search and hire platform for PCAs.	
Provide support to informal caregivers.	DSS development of an Informal Caregiver's Supports pilot that includes additional hands-on training post-discharge to increase confidence of informal caregivers through education and reinforcement.	**P.A. 16-59 - An Act Expanding Utilization Of Patient-Designated Caregivers.** This bill extends to nursing homes existing requirements for hospitals regarding the designation of patient caregivers at the time of a patient's discharge.

RECOMMENDATIONS	ADMINISTRATIVE AND OTHER ACTIONS	LEGISLATIVE ACTIONS AND NEW FUNDING
	DSS is integrating the above with Informal Care Giver Supports resources under Caregiver Communities on My Place CT. DSS established partnership with SIM to host focus groups with the aim of creating a statewide technical assistance center.	
	Support groups and other training and information-sharing venues for persons caring for older adults as well as grandchildren are in place across the state through the National Family Caregiver Support Program (NFCSP).	
	DDS continues to fund the CT Family Support Network to provide networking and training activities to families and unpaid caregivers who have a loved one with a disability across the lifespan.	
Preserve and expand affordable and accessible housing for older adults and individuals with disabilities, including assisted living, residential care homes, and other supportive housing and emergency housing options for older adults.	DSS continues to work with DOH to secure 811 housing for eligible individuals.	**S.A. 17-19 (H.B. 6603) - An Act Concerning A Study Of Certain Tenants Of State-Funded Public Housing Projects.** This bill requires the Commissioner of DOH, in consultation with DMHAS, SDA, DDS and Disability Rights CT, Inc. (DRCT), to, within available appropriations, conduct a study of the state-funded housing projects that provide services to elderly tenants and younger tenants with disabilities and specifies the minimum data points that must be part of the study. Additionally,

RECOMMENDATIONS	ADMINISTRATIVE AND OTHER ACTIONS	LEGISLATIVE ACTIONS AND NEW FUNDING
		as part of the study, the Commissioner of DOH, in consultation with DMHAS, SDA, DDS and DRCT, shall convene meetings of stakeholders to obtain information about each state-funded housing project as designated in this bill. Effective Upon Passage.
	DSS is investigating options to utilize RCH model of service delivery as part of the continuum of LTSS while maximizing Medicaid reimbursement	
	DMHAS continues to expand supportive housing options across all populations that receive DMHAS services, including those that are homeless. Specifically, DMHAS manages over 1,200 units of Shelter Plus Care, a HUD rental subsidy program for homeless individuals with a mental health or substance abuse disorder.	
	DMHAS works with housing authorities across the state to ensure that DMHAS clients are able to access Section 8 vouchers.	
	DMHAS housing coordinators work with DSS and DOH on obtaining RAP certificates to house people transitioning to the community on the Mental Health and ABI waivers.	
	DMHAS maintains a housing and living subsidy program for DMHAS clients on the Mental Health and ABI waiver who would	

RECOMMENDATIONS	ADMINISTRATIVE AND OTHER ACTIONS	LEGISLATIVE ACTIONS AND NEW FUNDING
	otherwise not be able to afford housing. This enables clients to access community settings and avoid longer institutional stays.	
	DOH and the Connecticut Housing Finance Authority (CHFA) continue to prioritize permanent supportive housing development in many of their capital programs.	
	DOH, OPM, DSS, DPH and CHFA continue to implement a variety of assisted living programs.	
	DOH was awarded $6 million under the National Housing Trust Fund, and has prioritized the use of these funds to produce deep income targeted supportive housing.	
	DMHAS' Nursing Home Diversion and Transition Program has collaborated with the Connecticut Association of Residential Care Homes to assist RCH's in managing people with psychiatric disabilities so that they remain in the community and avoid institutionalization.	
	DDS has added Shared Living option to its waiver services, and efforts to increase the use of Community Companion Homes are ongoing. DDS also supports families to participate in Creative Housing family training activities and roommate matching activities.	

RECOMMENDATIONS	ADMINISTRATIVE AND OTHER ACTIONS	LEGISLATIVE ACTIONS AND NEW FUNDING
Encourage and enable the provider community to transform and develop services and supports that will help to achieve the goals of this Plan.	Continued DSS Rightsizing grants for facilities to partner with community organizations and develop alternative business models.	**Special Session P.A. 16-3 (as amended by Senate Amendment A (S.B. 502)) – An Act Concerning Revenue And Other Items To Implement The Budget For The Biennium Ending June 30, 2017 Section 129.** Establishes a 63 member Commission on Women, Children and Seniors and consolidates and replaces the following three Commissions (1) The Permanent Commission on the Status of women; (2) the Commission on Children; and (3) the Commission on Aging. Effective Date: July 1, 2016.
	DSS is streamlining provider billing and capturing of time worked through implementation of an electronic visit verification system.	
	SUA offered, free of charge, the national PCC NWD curriculum to communities across the state through an ACL grant. SUA, through an ACL grant, funded an Asset Mapping of Older Adult Behavioral Health services in CT that was released in March 2016. The Older Adult Behavioral Health Workgroup has begun to develop a strategic plan based on these recommendations. In FY 2017 DORS partnered with DDS to offer a joint program to help integrate Life Course materials with SUA PCC course materials.	

RECOMMENDATIONS	ADMINISTRATIVE AND OTHER ACTIONS	LEGISLATIVE ACTIONS AND NEW FUNDING
	DORS Issued contracts to 3 provider agencies and 4 individual contractors to provide services to 49 individuals with deaf-blindness to reduce isolation and increase access to their communities.	
Expand and improve employment opportunities and vocational rehabilitation for persons with disabilities and older adults.	My Place CT – integration of resources from CTAbility.	
	SUA's Senior Community Service Employment Program (Title V) has encouraged program participants to train for healthcare employment opportunities, including Certified Nurse's Aide Training. ADRC, CHOICES and SUA connected SSD recipients to DORS & Benefits Counselors to encourage an exploration of employment options. MIPPA ADRC and ADRC counselors screened for MedConnect eligibility and encouraged persons on SSDI to explore employment through connection to BRS staff	
	DORS established Memoranda of Understanding with the 5 Regional Workforce Development Boards to coordinate employer outreach and access to training programs for clients with disabilities.	
Support state and local efforts to improve and expand accessible, affordable, and inclusive transportation that	DOT owns the local bus systems in various cities, operating them under the CTtransit	

RECOMMENDATIONS	ADMINISTRATIVE AND OTHER ACTIONS	LEGISLATIVE ACTIONS AND NEW FUNDING
accommodates the needs of residents, family and direct care worker companions.	brand name, and enters into transit operating assistance contracts with local transit districts in non-CTtransit service areas. DOT also contracts directly for federally-mandated complementary ADA paratransit services or subsidizes ADA operations. In addition, transit services provided by community organizations state-wide include specialized transportation via bus or mini-bus for seniors and people with disabilities as fixed-route or demand response (dial-a-ride) service. Community transportation operators include municipalities and/or senior centers and nonprofit organizations. DOT supports many of these community transportation operators with state or federally-funded grants (Municipal Grant Program, Section 5310). DOT also funds innovative initiatives throughout the state such as accessible taxi voucher programs, which allow an ADA-eligible rider a 50% discount on a ride in an accessible taxi and the Mobility Ombudsmen program, which oversees 5 regional mobility managers who connect people with disabilities, seniors and veterans with accessible, reliable	

RECOMMENDATIONS	ADMINISTRATIVE AND OTHER ACTIONS	LEGISLATIVE ACTIONS AND NEW FUNDING
	transportation.	
Improve quality of life and reduce utilization of long-term services and supports and health care services by focusing on health promotion and disease prevention.	DSS is working towards integration of health promotion resources through My Assessment and utilization of personal health records.	
	Inclusion of objectives and strategies for the promotion of prevention and wellness programs in the draft CT State Plan on Aging (2018-2020)	
	Behavioral Health Homes (BHH) were implemented in a targeted manner. Local Mental Health Authorities provide Health Promotion Services to eligible enrollees. Health promotion activities encourage and support healthy living concepts to motivate individuals to adopt healthy behaviors and promote self-management of their health and wellness. BHH has worked closely with the Nursing Home Diversion and Transition Program as well as the Mental Health Waiver to enroll clients in the care management portion of BHH to assist in overall client care.	
Address emergency preparedness/disaster planning for older adults and persons with disabilities.	Waivers utilize an emergency classification system identifying persons at risk given a range of emergencies.	**P.A. 17-62 (S.B. 772) An Act Requiring Emergency Generators In Certain Housing For The Elderly.** This bill requires each privately owned, multifamily housing project in a municipality with a population of at least

RECOMMENDATIONS	ADMINISTRATIVE AND OTHER ACTIONS	LEGISLATIVE ACTIONS AND NEW FUNDING
		130,000 but less than 135,000, to install and maintain at least one emergency power generator. Effective Date: October 1, 2017
	DORS has an extensive section of the agency website dedicated to emergency preparedness, providing information in English and Spanish (http://www.ct.gov/besb/cwp/view.asp?a=2848&Q=556260&PM=1).	
	DPH is enforcing the new CMS regulations regarding emergency preparedness for the certified facilities within DPH jurisdiction. The new regulations address the facility requirements of risk assessment and emergency planning, policies and procedures, communication plan, and training and testing.	
SHORT TERM RECOMMENDATIONS		
(i) Programs and Services		
▪ Adequately support and increase the number of and funding for slots of all the existing Medicaid home and community-based services waivers to meet the needs of all eligible applicants.	MFP continues to reserve capacity for individuals completing 365 days with the demonstration and migrate to the waiver.	
▪ Ensure access to all levels of the State-funded Connecticut		

RECOMMENDATIONS	ADMINISTRATIVE AND OTHER ACTIONS	LEGISLATIVE ACTIONS AND NEW FUNDING
Home Care Program for Elders.		
▪ In the State-funded tiers of the Connecticut Home Care Program for Elders, eliminate the required co-payment.		
▪ Support the continued implementation of the 1915(k) state plan option, Community First Choice.	Continued development of CFC for staff within the agency, sister agencies, as well as outside partners and recipients.	
	Ongoing meetings of the CFC Development Council to inform program development and implementation. The Council is comprised of members from SUA, DSS, OPM and various advocacy organizations and consumer representatives. The council makes regular reports to the Long Term Services and Supports Rebalancing Committee (formerly the MFP Steering Committee).	
▪ Identify skills needed for residents of institutions who desire to transition back to the community and provide appropriate skill training and resources.	DSS continued to use the MFP Transition Challenges and Action Plan documents to support discharge to the community.	
	The Connect-Ability Distance Learning Initiative continued to offer free online training modules on a variety of topics such as Personal Care Attendant, Independent Living Skills, Assistive Technology, Service Dogs and more.	
	The Mental Health Waiver for individuals with Serious Mental Illness encompasses	

RECOMMENDATIONS	ADMINISTRATIVE AND OTHER ACTIONS	LEGISLATIVE ACTIONS AND NEW FUNDING
	the recovery orientation adopted by DMHAS and emphasizes the following skill-building services: • Intensive psychiatric rehabilitation provided in the participant's home and in other community settings; • Attention to both psychiatric and physical needs; • Emphasis on wellness and recovery; • Person-centered planning leading to development of an individualized recovery plan; and Use of peer supports provided by people trained and certified in rehabilitative care, who know form first-hand experience about recovery from mental illness.	
	DDS continues to use the MFP process to transition individuals from state institutions, nursing homes and hospitals back to the community.	
▪ Expand funding for State-funded respite services, such as the Statewide Respite Program, the state-funded tiers of the Connecticut Home Care Program for Elders and the Department of Developmental Services in-home and out-of-home respite services in order to provide support to informal caregivers.	The National Family Caregiver Support Program administered through the statewide Area Agencies on Aging, and funded by the Older Americans Act, provides caregiver training, information and assistance, counseling and specific funding for respite care and crucial healthcare items not covered under other sources for the care recipient to ease the burden of the caregiver.	

RECOMMENDATIONS	ADMINISTRATIVE AND OTHER ACTIONS	LEGISLATIVE ACTIONS AND NEW FUNDING
▪ Support family caregivers with training, respite care, mental health services and counseling, financial assistance, workplace flexibility and opportunities for workplace benefits.	DSS developed an Informal Caregiver's Supports pilot that includes additional hands-on training post-discharge to increase confidence of Informal Caregivers through education and reinforcement.	
	DSS developed local community based networks for access to LTSS information: Care Through Community initiative.	
	DMHAS and DSS are working on revising an existing training on older adults and mental health for caregivers to access on My Place CT.	
▪ Measure the effectiveness of the new Adult Family Living model to determine future resource allocation, policy and programmatic enhancements and potential growth.	DSS continues to expand this service under the various waivers.	
▪ Address isolation of all older adults and individuals with disabilities living in the community. Cultivate an atmosphere in communities of diversity and inclusiveness Also, address the impact of isolation on quality of life, abuse, neglect and exploitation.	DMHAS implemented the Senior Outreach and Engagement Program that targets at risk older adults, 55 years and older. Staff are working with local community organizations to increase awareness of older adult mental health and substance use issues and ways to utilize the program for people in their communities.	
▪ Strengthen the No Wrong Door system and connection between State and local services by exploring reimbursement options for assistance through the CHOICES	SUA initiated discussion between Connecticut Tech Act Project to partner on further development of the state's No	

RECOMMENDATIONS	ADMINISTRATIVE AND OTHER ACTIONS	LEGISLATIVE ACTIONS AND NEW FUNDING
network, developing ongoing person-centered and options counseling training to senior centers, municipal government offices, resident service coordinators and other community agencies.	Wrong Door. This is planned for 2018 under SUA. PCC NWD training was offered free of charge. CHOICES certification training was offered free of charge to partners in the NWD system with SUA and DSS.	
▪ Identify and remove barriers, such as insurance/entitlement reimbursements and licensing requirements that prevent or limit access to long-term services and supports.		**P.A. 16-12 (S.B. No. 107) – An Act Concerning The Treatment Of The Cash Value Of Life Insurance Policies When Evaluating Medicaid Eligibility.** This bill removes a requirement that an institutionalized individual must use the proceeds from his or her life insurance policy valued at less than ten thousand dollars toward the cost of his or her care in order to qualify such individual for Medicaid. Effective upon passage
		P.A. 16-63 (sH.B. 5521) – An Act Concerning Short-Term Care Insurance. This bill establishes "short-term care insurance" as a new type of insurance providing certain health benefits for 300 or fewer days.
		P.A. 16-176 (S.B. 392) - An Act Concerning The Adoption Of The Special Needs Trust Fairness Act In Connecticut Upon Passage In Congress. This bill allows for Connecticut to comply with the federal Special Needs Trust Fairness Act of 2015 upon its passage by

RECOMMENDATIONS	ADMINISTRATIVE AND OTHER ACTIONS	LEGISLATIVE ACTIONS AND NEW FUNDING
		Congress. The technical changes will allow nonelderly individuals with disabilities to establish a special needs trust on their own behalf and allow such trust to be excluded from asset limits when determining eligibility for the Medicaid program.
		P.A. 16-20 (S.B. 189) - An Act Concerning Irrevocable Funeral Service Contracts. Increases the maximum allowable amount of an irrevocable services contract from $5,400 to $8,000 *Effective July 1, 2016*
▪ Promote coordination and service integration between physical and behavioral health providers and support the utilization of evidence based practices for providing care across the lifespan.	During FY'17, DDS had conducted over 17 presentations in the community and with providers on Life Course tools and the concept of planning throughout a person's life and preparing for transition times. DDS also conducted Behavior Intervention training to Emergency Mobile Psychiatric Services personnel.	
	Several bureaus within DORS utilized Life Course tools and the concept of planning throughout a person's life and preparing for transition times.	
	DMHAS has Behavioral Health Homes, an innovative, integrated healthcare service delivery model that is recovery-oriented, person and family centered and promises better patient experience and better	

RECOMMENDATIONS	ADMINISTRATIVE AND OTHER ACTIONS	LEGISLATIVE ACTIONS AND NEW FUNDING
	outcomes than those achieved in traditional services. The Behavioral Health Home service delivery model is an option for providing a cost-effective, longitudinal "home" to facilitate access to an inter-disciplinary array of behavioral health care, medical care, and community-based social services and supports for both adults and children with chronic conditions.	
▪ Develop a pilot project focused on improving person-centered care across settings when an individual is transferred from one care setting to another.	DSS continued effort to develop the standardization and transferability of health care and LTSS information through initiatives such as, implementation of a universal assessment, Functional Assessment Standardized Items testing (FASI), utilization of the Consumer Assessment of Healthcare Providers System (CAHPS), and utilization of Personal Health Records (PHR).	
	DSS initiated a care transitions service under the Elder Waiver.	
	DDS MFP participants took part in the Quality of Life survey overseen by UCONN.	
▪ Address the education and training of direct care workers to include skills and competencies related to the physical, cultural, cognitive and behavioral health care needs of consumers of long-term services and supports.	During FY '17 DDS continued to provide training on the Signs and Symptoms of Dementia to direct care staff in their Community Living Arrangements and other state run residential facilities.	
	SUA, through an ACL grant, funded an	

RECOMMENDATIONS	ADMINISTRATIVE AND OTHER ACTIONS	LEGISLATIVE ACTIONS AND NEW FUNDING
	Asset Mapping of Older Adult Behavioral Health services in CT that was released in March 2016. The Older Adult Behavioral Health workgroup began its work to develop a strategic plan based on these recommendations.	
	DMHAS and DSS are working on revising an existing training on older adults and mental health for direct care staff to access on My Place CT.	
▪ Adequately support Protective Services for the Elderly, the Office of Protection and Advocacy, the Office of the Chief State's Attorney, and other relevant agencies to identify, investigate and prosecute cases of abuse, neglect and exploitation. Support the development of multi-disciplinary teams to enhance response to abuse.	During FY'17 legislation was completed that transitioned the investigation role from the Office of Protection and Advocacy to the newly created DDS Division of Investigation.	**P.A. 16-6 (S.B. 161)** - **An Act Concerning Notification Of Penalties For Abuse And Neglect Of Nursing Home Residents.** To provide notification of the civil, criminal and administrative penalties for abuse and neglect of nursing home residents by requiring the Commissioner of Public Health to add to the front page of any application of licensure for acquisition of a nursing a statement regarding the civil and criminal penalties for abuse/neglect by a facility employee.
	The Coalition for Elder Justice in CT has been working on some initiatives to address these concerns in a collaborative fashion. The Coordinating Council of the Coalition consists of 26 members from various state agencies and other public/private organizations with involvement in elder abuse issues. The	**P.A. 16-66 (sHB 5537) An Act Concerning Various Revisions To The Public Health Statutes.** This bill abolishes the state Office of Protection and Advocacy and creates a non-profit protection and advocacy system designated by the Governor. Effective upon passage June, 2016 with formal closure of the state

RECOMMENDATIONS	ADMINISTRATIVE AND OTHER ACTIONS	LEGISLATIVE ACTIONS AND NEW FUNDING
	Coalition is chaired by the SUA Attorney & LTC Ombudsman. The Coalition conducted an annual conference / symposium to support increased awareness and movement toward multi-disciplinary teams. Area Agencies on Aging continued to receive limited funding through the SUA of OAA Title VII Elder Abuse Funding to support outreach in the individual regions, conferences and conduct of multi-disciplinary teams.	OPA and transition to the non-profit entity occurring by July 1, 2017.
▪ Support a robust local long-term services and supports system to address community needs through strategic collaborations among and between other municipal departments and divisions such as parks and recreation, public health and transportation services and community leaders. Explore opportunities for regional collaboration.	DSS continued development of No Wrong Door Care through a community campaign to allow local entities/people to become certified as a credible source of information on local, state, and federal resources for their community. SUA continued to work with DSS on this initiative.	
▪ Provide advocacy and financial support for increased use of assistive technology to meet the needs of individuals within their homes and avoid or defer the need for institutionalization.	CFC supports the needs of individuals by offering Assistive Technology as a service.	
	DORS oversees low interest loans made available through Connecticut Tech Act Project for purchase of assistive technologies devices and services. Assistive Technology (AT) demonstration centers	

RECOMMENDATIONS	ADMINISTRATIVE AND OTHER ACTIONS	LEGISLATIVE ACTIONS AND NEW FUNDING
	along with recycling and reuse of AT are also available.	
▪ Provide nutritional counseling and elimination of food insecurity.	SDA provided nutrition counseling and congregate and home delivered meals through the Elderly Nutrition Program to older adults over 60 years and eligible persons with disabilities. In 2017, 20,584 consumers received 1,876,157 meals (congregate and home delivered). In 2017, 13,250 units of nutrition education and 2, 015 units of nutrition counseling were delivered.	
(ii) Infrastructure		
▪ Coordinate efforts among various entities impacting No Wrong Door development and monitor progress on the state's No Wrong Door endeavors.	DSS initiated a work group to develop NWD strategy and reengaged UCONN to monitor progress.	
	SUA piloted a NWD Governance Tool for ACL in partnership with DSS. This tool is a checklist for the governing body of the NWD system of access to LTSS. The tool looks at state agency collaboration, roles and responsibilities, stakeholder inclusion, Management Information Systems, Continuous Quality Improvement and staffing.	
▪ Continue the Balancing Incentive Program (BIP), to create infrastructure investments of a consumer friendly statewide No Wrong Door system, a conflict free case management,	DSS continued development on MyPlaceCT and Care Through Community partners to streamline access to information for	

RECOMMENDATIONS	ADMINISTRATIVE AND OTHER ACTIONS	LEGISLATIVE ACTIONS AND NEW FUNDING
and a uniform assessment tool.	individuals. In addition, continued efforts with MyPlaceCT and DOL to connect employees with employers.	
▪ With a focus upon hospital admission and discharge, use best efforts to divert individuals to an appropriate care setting of their choice.		
▪ Address the historical fragmentation of the Medicaid home and community-based waivers, which are associated with specific age and diagnostic eligibility criteria.	DSS launched CFC, a State Plan Entitlement that allows access to in-home care to individuals on Medicaid that meet Institutional Level of Care. Unlike the waivers, CFC does not have criteria related to age or specific diseases/diagnoses.	
	DMHAS participated in a statewide initiative to revise the Universal Assessment, a tool used with all home and community based waivers. DMHAS and DSS jointly funded 6 MFP positions to assess people with mental health disorders that may be eligible for the mental health waiver, and instituted the use of the Universal Assessment to match procedures of all other waivers.	
	DMHAS is working with DSS on the hiring of an eligibility specialist that would be dedicated to entitlement issues and redeterminations for Mental Health Waiver participants.	
▪ Provide timely eligibility decisions regarding eligibility in all	DSS developed a 'Fast-Track' pilot for LTSS	

RECOMMENDATIONS	ADMINISTRATIVE AND OTHER ACTIONS	LEGISLATIVE ACTIONS AND NEW FUNDING
government sponsored long-term services and supports programs. Consider development and use of a presumptive eligibility model.	HCBS Medicaid applications. The one and a half year pilot demonstrated limited success.	
	Since July of 2016, paper forms have been scanned into a digital format and stored in a secured electronic eligibility database accessible to specified DDS and DSS staff, thereby, reducing the need to file and store paper records. Missing documents are quickly identified in this electronic format reducing eligibility decision wait time. Data exists in an electronic format making analysis of compiled data more immediate, resulting in faster trend identification.	
	DMHAS overhauled the referral process to expedite assessments of clients. This has resulted in shorter time periods between referrals and face to face assessment.	
▪ Promote more widespread adoption of telehealth and other assistive technologies to improve access to care, coordination, quality and outcomes for residents, while reducing health costs.	DDS has conducted 10 presentations in FY'16 about the many aspects of Assistive Technology that can be helpful with healthcare and other needs.	
	DSS continues to make Assistive technology available under waiver programs as well as Community First Choice	
▪ Ensure the Aging and Disability Resource Center initiative under the CHOICES program continues to offer information, referral, assistance and LTSS options counseling services	Public Act No. 15-19 became effective July 1, 2015 that placed the Aging and Disability Resource Center Program under the State	

RECOMMENDATIONS	ADMINISTRATIVE AND OTHER ACTIONS	LEGISLATIVE ACTIONS AND NEW FUNDING
statewide and is integrated within the state's No Wrong Door system.	Department on Aging. The program is administered as part of the SUA's CHOICES program. ADRCs were able to use Title IIIB funds to continue ADRC services.	
▪ Achieve greater integration of employment of persons with disabilities into the Money Follows the Person Rebalancing Initiative and home and community-based services.		
▪ Support improved coordination, communication and guidance among the medical care, behavioral health and long-term services and supports systems.	MFP continued to transition individuals that benefit from the comprehensive services provided through Behavioral Health Homes.	
	DDS has sponsored several Community of Practice workgroups with participants from State, private and community providers, and family members. In FY'17 these groups provided presentations to DSS autism groups, DORS staff and the IDD Workgroup.	
○ Ensure that current and future initiatives affecting the long-term services and supports system are well coordinated and complementary.	DMHAS continues to participate in the MFP Steering Committee as well as the Long Term Care Planning Committee and the ABI Advisory Council.	
○ Support the development of electronic health records by providers of long-term services and supports and exchange of electronic health records	DSS continued efforts on the TEFT grant which includes four components; (1) Experience of Care Survey; (2) CARE Assessment Tool;	

RECOMMENDATIONS	ADMINISTRATIVE AND OTHER ACTIONS	LEGISLATIVE ACTIONS AND NEW FUNDING
among providers across the Connecticut health care system to streamline care transitions, coordinate care delivery and improve quality and outcomes.	(3) Personal Health Records; and (4) Standards & Interoperability Framework for e-LTSS.	
	The Mental Health Waiver and its Administrative Service Organization, Advanced Behavioral Health, implemented an electronic record system that integrates with the DSS Personal Health Records. DSS also granted access to the MFP data base for all Mental Health Waiver staff as well as DMHAS diversion nurses.	
○ Support a learning collaborative approach to bring together providers across disciplines and perspectives, and to learn from older adults and individuals with disabilities.	Providers that primarily work with older adults met with providers that primarily work with individuals with disabilities during the in-person component of the PCC NWD curriculum for a shared understanding and learning.	
	CHOICES held 5 New Counselor Training Sessions (1 per AAA region) in SFY '17. CHOICES partners at Senior Resources and the Center for Medicare Advocacy, Inc. (CMA) also offered an additional CHOICES New Counselor Training, which was funded through NWD. CHOICES Regional Coordinators, AAA CHOICES staff, and CMA staff conducted each training. Nearly 80 individuals participated in the 6 trainings, which included volunteers (representatives of the Medicare population- older adults &	

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	individuals with disabilities) and in-kind professionals (aging & disability professionals). Sessions include a half day orientation & 5 full training days. CHOICES Update Trainings included a CHOICES & SMP Conference. CHOICES Regional Coordinators held their annual CHOICES Open Enrollment training. CHOICES also conducted webinars with Access Health CT and the Veterans Administration's Suicide Prevention program. CHOICES counselors conducted more than 33,600 individual counseling sessions with Medicare beneficiaries and their caregivers/families. Nearly 12,000 Medicare Part D, Medicare Advantage, and Medigap plan comparisons were provided. More than 3,000 beneficiaries received assistance with enrolling into Medicare Part D or Medicare Advantage plans. Counselors also conducted 16,000 eligibility screenings for Extra Help/Low Income Subsidy, Medicare Savings Program and Medicaid benefits. More than 7,800 beneficiaries were provided Extra Help/Low Income Subsidy, Medicare Savings Program, and Medicaid application assistance.	

RECOMMENDATIONS	ADMINISTRATIVE AND OTHER ACTIONS	LEGISLATIVE ACTIONS AND NEW FUNDING
	CHOICES participated in more than 550 outreach events, which included 335 CHOICES presentations with an audience of more than 14,000; staffing 80 booths or exhibits at health and senior fairs or other special events with more than 6,200 people stopping to talk with CHOICES representatives; and conducting more than 100 enrollment events which helped nearly 2,000 attendees with eligibility screenings, plan comparisons, and enrollments into Medicare Part D and Medicare Advantage plans.	
	DMHAS Older Adult Services co-chairs a workgroup with SUA, comprised of public and private entities. The committee successfully completed an asset mapping of delivery system's strengths and needs and integrating SBIRT (Screening, Brief Intervention, and Referral to Treatment). A roll out of the findings was held at the Capitol in March 2016. The committee continues to work on implementation of recommendations and successfully completed a training on older adults and mental health for posting on the DMHAS and DSS electronic training sites. Additionally, in FY 2017 The Older Adult	

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	Behavioral Health Committee continued to meet to develop curriculum to educate providers on older adult behavioral health issues.	
	Beginning in SFY 17, DDS case management staff began person-centered counseling training provided by the CT Department on Aging (now SUA, DORS). DDS staff were able to participate in this training with members of other agencies providing services to older adults.	
▪ Develop or enhance mobility management programs to help consumers learn how to access and navigate transportation options.	Orientation and Mobility Staff from DORS continued to provide travel training to individuals who are blind. The DORS website includes an extensive transportation resources guide. (http://www.ct.gov/besb/cwp/view.asp?a=2848&q=331472).	
	DDS continues to collaborate with the Kennedy Center helping individuals to access transportation training in their communities.	
	DOT currently funds and oversees the Mobility Ombudsmen program, in which 5 regional mobility managers connect people with disabilities, seniors and veterans state-wide with accessible, reliable transportation. A key goal of the program is to identify gaps and barriers to public transportation that prevent individuals	

RECOMMENDATIONS	ADMINISTRATIVE AND OTHER ACTIONS	LEGISLATIVE ACTIONS AND NEW FUNDING
	from using existing services.	
	The Kennedy Center, Inc. provides travel training via a nationally acclaimed program that teaches people with disabilities and seniors how to properly and safely use the local bus and rail system on a one-to-one basis throughout the state of Connecticut.	
▪ Identify funding streams to sustain coordinate, grow and make more convenient both fixed route and demand-responsive transportation options (including providing door-to-door service), and provide technical assistance to support regionalization.	DSS has entered into a contract with a new non-emergency medical transportation provider, Veyo.	
	DOT administers the Section 5310 program, a Federal grant program that provides funding to municipalities, nonprofit organizations and transit agencies for eligible capital and operating expenses that enhance mobility for seniors and individuals with disabilities. An application cycle and competitive selection process occurs every state fiscal year, with a focus on coordination.	
	DOT administers the Municipal Grant Program that provides State funding to municipalities that operate demand-response services.	
(iii) Financing		

RECOMMENDATIONS	ADMINISTRATIVE AND OTHER ACTIONS	LEGISLATIVE ACTIONS AND NEW FUNDING
▪ Achieve adequate and sustainable provider reimbursement levels that support the cost of long-term services and supports and quality requirements for all segments of the long-term services and supports continuum in order to ensure capacity to meet the evolving needs and demographics of Connecticut residents.	Medicaid HCBS Waiver rates have increased by 1% since 2007.	
▪ Provide greater flexibility in the budgeting and use of Medicaid funds for long-term services and supports.	CFC offers people individualized budgets by choosing from an array of services to meet the person's needs and goals in the community.	
▪ Capture and reinvest cost savings across the long-term services and supports continuum.		
○ Reinvest savings resulting from Money Follows the Person, the Balancing Incentive Program and other emerging Medicaid long-term services and supports programs to enhance the availability and capacity of home and community based services.		
▪ Explore reforming the Medicaid rate setting system to reflect quality, reimbursement related to the actual costs of care, the acuity level of the consumers and uncompensated		

RECOMMENDATIONS	ADMINISTRATIVE AND OTHER ACTIONS	LEGISLATIVE ACTIONS AND NEW FUNDING
care for all LTSS providers across the continuum consistent with long-term services and supports rebalancing, rightsizing and a range of home and community-based service initiatives.		
▪ Explore various methods to increase the private sector's greater involvement as a payer of long-term services and supports.		
○ Explore the development of tax incentives for the purchase of private long-term care insurance, including tax incentives for employer-based coverage.		
▪ Work with the Federal government to preserve and reauthorize the Older Americans Act and preserve Social Security Act provisions for Supplemental Security Income, Social Security and Social Security Disability benefits funding, which are currently at risk.		On 4/19/16 Congress passed Public Law 114-144, to reauthorize the Federal Older American Act.
(iv) Quality		
▪ Enable a collaborative, flexible and efficient regulatory		

RECOMMENDATIONS	ADMINISTRATIVE AND OTHER ACTIONS	LEGISLATIVE ACTIONS AND NEW FUNDING
environment that is adaptive and receptive to individual provider's forward thinking ideas and planning. Such an environment would encourage providers of the long-term services and supports continuum to adjust, modernize and diversify their models of care to address current and future consumer needs and expectations, which in turn should lead to higher quality care.		
▪ The Departments of Public Health and Social Services should work together to ensure consistency among their respective regulations and oversight activities.	DSS developed a joint initiative on Person-Centered Planning that would better coordinate care planning for individuals.	
▪ Review licensing certification requirements and Probate Court protocols (currently there is no licensing for conservators or guardians) for training of community-based formal caregivers, conservators and guardians to assure that the specialized needs of the individual are met and provide training where there are gaps.	The Probate Administration is leading an Action Team in the development of conservator and guardian on-line training. Action Team members include representative of legal services, the Elder Law section of the CT Bar and other private attorneys, Probate Court Administration, AARP and others involved in conservator/guardianship issues in the state. Ongoing to 2018. In FFY 2017 the Action Team worked together to develop web based training for both consumers and professionals. It is anticipated to go live in FFY 2018. Discussion continued concerning formalization of any type of certification.	

RECOMMENDATIONS	ADMINISTRATIVE AND OTHER ACTIONS	LEGISLATIVE ACTIONS AND NEW FUNDING
▪ Expand the scope of the Long-Term Care Ombudsman program to provide Ombudsman support to consumers receiving long-term services and supports regardless of setting in order to align the program with Medicaid LTSS rebalancing efforts. Additional appropriations to the Long-Term Care Ombudsman program would be necessary to expand beyond their current jurisdiction.		
▪ Support an integrated approach to CT's response to abuse, neglect and exploitation.	The Coalition for Elder Justice in Connecticut continues to explore further integration and initiatives to prevent and protect older individuals from abuse, neglect and exploitation. Ongoing through 2018	
▪ Establish "learning collaboratives" where health care professionals come together on a regular basis for education and discussion on evidenced-based and emerging best practices in LTSS across the lifespan, in areas of both physical and behavioral health.		
(v) Housing		
▪ Support programs that divert or transition individuals from nursing facilities or other institutions to community housing options, such as CT811.	DOH continues to administer a CT811 Project-Based Rental Assistance program, which works with three populations; (1) the Coordinated access network of homeless individuals with disabilities documented as living in shelters to remove them from homelessness and potentially	

RECOMMENDATIONS	ADMINISTRATIVE AND OTHER ACTIONS	LEGISLATIVE ACTIONS AND NEW FUNDING
	divert them from institutions, (2) the DDS Autism Spectrum waiver for individuals that are living in different settings to give them access to housing in order to prevent potential institutionalization, (3) and the MFP population to move consumers from institutionalized settings into the community.	
	DOH, in conjunction with DSS, DDS and DMHAS, is implementing the federal Section 811 PRA program. $4.14 million has been awarded for the first five years of the program.	
	The Office of the Ombudsman continues to support informed choice and transitions to community living for institutionalized individuals through Ombudsman activities and participation the Money Follows the Person Steering Committee.	
	The DMHAS Nursing Home Diversion and Transition Program has expanded their role in helping people “age in place” The nurses have developed expertise in medication assisted therapy, diabetes management, level of care assessments and hoarding issues. Nurses are available to consult across the state on a wide variety of education issues as stated above. They work closely with the Mental Health Waiver and MFP staff to assist clients in living in the most integrated setting	

RECOMMENDATIONS	ADMINISTRATIVE AND OTHER ACTIONS	LEGISLATIVE ACTIONS AND NEW FUNDING
	possible to meet their psychiatric and medical needs. They are also providing telephonic consultation to MHW staff regarding medical issues.	
	DOH, OPM, DSS, DPH, and CHFA continue to implement a variety of assisted living programs.	
▪ Develop new housing alternatives for persons with serious and persistent mental illness who do not need nursing facility level of care.	DOH, in conjunction with DDS, is implementing the I-DASH initiative, to develop mixed population affordable housing, specifically targeting the development of units for persons with intellectual difficulties. Approximately $20 million is available for this initiative. DOH has funded two projects so far totaling approximately $13.5 million.	
▪ Adopt policies that encourage incorporation of accessible housing features into new construction so that new housing can support its residents throughout the lifespan.	CT811 developments and DOH are learning what accessibility means to us given the information from the project. The data model will use the Mercer data.	
Continue and expand State investment in the development of housing that is affordable and accessible for older adults and persons with disabilities.	DOH continues to require 10% of all units developed with state financing to be handicapped accessible/adaptable.	
	DOH and DMHAS are engaged in a variety of interagency collaborative initiatives associated with the provision of permanent	

RECOMMENDATIONS	ADMINISTRATIVE AND OTHER ACTIONS	LEGISLATIVE ACTIONS AND NEW FUNDING
	supporting housing, including those through the Interagency Committee on Supportive Housing. These include: the Social Innovation Fund Housing Program which houses homeless individuals that are high users; programs to address individuals cycling through the shelter and criminal justice systems; and supportive housing for individuals discharging from an inpatient psychiatric settings.	
▪ Encourage the growth and development of community-based service models that bring long- term services and supports to housing residents. Work with the federal government to secure at-risk housing subsidy, preservation, and development funds.	MFP continues to transitions individuals with housing plus supports via two methods: (1) RAP-tenant based and (2) 811- voucher-based.	
	DDS partnered with DOH and DSS to implement the IDSH (Intellectual Disabilities Autism Spectrum Disorder Housing) program which works with owners of existing, or developers of proposed, housing to offer new affordable housing opportunities to individuals with support needs. DOH and DDS are also exploring a HUD 811 program that awards housing subsidy vouchers to eligible applicants.	

RECOMMENDATIONS	ADMINISTRATIVE AND OTHER ACTIONS	LEGISLATIVE ACTIONS AND NEW FUNDING
(vi) Workforce		
Develop a comprehensive and safe direct care workforce-consumer on-line matching system.	DSS continued efforts with DOL to connect home care professions to individuals seeking assistance. Access continues to be streamlined through MyPlaceCT as a jumping point to connect to DOL.	
Promote model re-training programs that allow the existing pool of institutionally-based paid direct care workers to be trained to provide services and supports in the community.		
Promote workforce training that addresses physical and mental health needs across the lifespan.	A Wellness and Safety Committee was implemented for DORS employees. SUA participated in planning the Aging Matters conference with DDS and the aging network for individuals working with persons with developmental disabilities.	
Promote flexibility in workplace employment policies and practices to accommodate the circumstances of unpaid family caregivers.		

APPENDIX G.

State Long-Term Services and Supports Programs and Expenditures

SFY 2017 – 2018

I. **Overview of State Agencies Providing Long-Term Services and Supports**

II. **State Long-Term Services and Supports Programs in Connecticut – SFY 2018**

III. **State Long-Term Services and Supports Program Expenditures in Connecticut – SFY 2018**

I. Overview of State Agencies Providing Long-Term Services and Supports

Department of Social Services (DSS): DSS provides a broad range of services to people who are elderly or have disabilities, families and individuals who need assistance in maintaining or achieving their full potential for self-direction, self-reliance, and independent living. It administers over 90 programs. By statute, it is the State agency responsible for administering a number of programs under federal legislation, including the Social Security Act (which includes Medicaid) and the Food Stamp Act. DSS administers the Connecticut Home Care Program for Elders (CHCPE), a portion of which is State-funded, the Connecticut Home Care Program for Adults with Disabilities that is also state-funded, and other programs such as the Personal Care Assistance (PCA) Waiver Program, the Acquired Brain Injury (ABI) Waiver Programs, the Katie Beckett Model Waiver Program, the Lifespan Autism Waiver, Money follows the Person, the Department of Developmental Services Home and Community Based Waiver Programs, the Department of Mental Health and Addiction Services Medicaid Waiver program, and the Connecticut AIDS Drug Assistance Program. DSS also received approval from the Centers for Medicare and Medicaid (CMS) for a 1915(i) State Plan Home and Community-Based Services option for individuals age 65 and older who are at risk of nursing home placement but not yet nursing facility level of care. In addition, DSS was recently approved by CMS to add the Community First Choice state plan option of home and community-based services to its array of options for community -based long-term services and supports.

Department of Developmental Services (DDS): DDS provides case management, residential habilitation, individualized supports, campus settings, day habilitation, prevocational services, supported employment, respite care, and family support to approximately 17,038 persons with intellectual disabilities and their families. As of June 2018, 65.9 percent of those people eligible to receive services from DDS were living in their own or their family home, 26.1 percent lived in public or private community living arrangements or received 24-hour continuous residential supports in the community, 2.2 percent lived in community companion homes, 2 percent lived in campus settings and 2 percent were in skilled nursing facilities.

Department of Mental Health and Addictions Services (DMHAS): DMHAS serves as both the state's State Mental Health Authority (SMHA) and Single State Agency for addiction services (SSA). It is an independent state agency having statutory responsibility to promote and administer an integrated system of comprehensive behavioral health preventive, treatment, and rehabilitative services. The DMHAS mission is "to improve the quality of life of the people of Connecticut by providing an integrated network of comprehensive, effective, and efficient mental health and addiction services that foster self-sufficiency, dignity, and respect." Its primary purpose is to assist persons with mental health and/or substance use disorders to recover and sustain their health through delivery of high quality services that are person-centered, promote hope, attend to trauma, improve overall health, and are anchored to a recovery-oriented system of care that is culturally competent and rooted in evidence-based practices.

To this end, DMHAS operates, funds, and coordinates inpatient and community-based behavioral health services for adults (18 and older) with serious substance use and/or mental health conditions as well as provides programs for individuals with special needs (e.g., AIDS/HIV, gambling, substance abusing pregnant women, etc.) and defined target populations (e.g., young adults, including those transitioning out of the DCF system, and those involved with the criminal justice system) including persons with serious mental illness residing in nursing homes, military personnel and their families, and persons who are homeless. DMHAS is responsible for the state's behavioral health general funds and SAMHSA block grant allocations, and manages the clinical aspects of the Medicaid Behavioral Health Services Partnership for adults. DMHAS directly operates two inpatient hospitals and contracts with community hospitals and one private psychiatric hospital for inpatient and ambulatory care. Department-operated inpatient hospitals provide psychiatric care and medically managed detoxification and residential rehabilitation services. DMHAS administers the mental health service system through a network of 13 Local Mental Health Authorities (LMHAs) statewide, six state-operated and seven non-profit, along with over 90 affiliated nonprofit community-based organizations. LMHAs are the sub-state administrative and direct care component for the delivery and coordination of mental health services across the state. They develop, maintain, and manage a comprehensive system of mental health treatment, rehabilitative services, and recovery support for designated local service.

Department of Housing (DOH): The Department of Housing strengthens and revitalizes communities by promoting inclusive affordable housing opportunities. The Department seeks to eliminate homelessness and to catalyze the creation and preservation of quality, affordable housing to meet the needs of all individuals and families statewide to ensure that Connecticut continues to be a great place to live and work.

DOH works in concert with municipal leaders, public agencies, community groups, local housing authorities, and other housing developers in the planning and development of affordable homeownership and rental housing units, the preservation of existing multi-family housing developments, community revitalization and financial and other support for our most vulnerable residents through our funding and technical support programs. As the State's lead agency for all matters relating to housing, DOH provides leadership for all aspects of policy and planning relating to the development, redevelopment, preservation, maintenance and improvement of housing serving very low, low, and moderate income individuals and families. DOH is also responsible for overseeing compliance with applicable statutes, regulations and financial assistance agreements for funded activities through long-term program compliance monitoring.

Department of Transportation (CTDOT): CTDOT provides subsidies to bus and paratransit systems throughout the state. Local bus systems in Hartford, New Haven, Stamford, Waterbury, New Britain, Meriden and Wallingford are owned by CTDOT and operated under the CT*transit* brand name and account for about 80% of the annual statewide bus ridership. In non-CT*transit* service areas, local transit districts assume operation of bus services and enter into transit operating assistance contracts with CTDOT to obtain funding from the State. The fixed-route bus system provides

discounted (half-fare) rides to seniors and people with disabilities. If an individual has a disability that precludes him or her from using the fixed-route service, he or she can apply for ADA paratransit eligibility. Paratransit is a shared ride, advanced reservation, origin-to-destination service for persons with disabilities who are unable to use the public bus service because of their disability, and is mandated by the Americans with Disabilities Act of 1990. ADA paratransit services are available to origins and destinations within ¾ mile of the local bus route and are operated during the same days and hours as the fixed-route service. In addition, CTDOT administers the Section 5310 grant program and the State Matching Grant program. Section 5310 is a Federal grant program intended to improve mobility for seniors and individuals with disabilities by removing barriers to transportation service and expanding mobility options. It is open to private nonprofit organizations, local governmental authorities and operators of public transportation for qualifying projects and funds both capital and operating expenses. The State Matching Grant program, also known as the Municipal Grant Program (MGP), allows municipalities to apply for a pre-set amount of operating funding (determined by formula) on an annual basis. The funding allows municipalities to provide new or expanded transportation services to seniors and people with disabilities and requires a local match.

The Department of Public Health (DPH): The mission of DPH is to protect and improve the health and safety of the people of Connecticut. DPH is the state's leader in public health policy and advocacy. The Department is a partner to local health departments for which it provides advocacy, training and certification, technical assistance, consultation, and specialty services such as risk assessment that are not available on the local level. Additionally, DPH establishes health priorities and evaluates the effectiveness of health initiatives. The agency also has regulatory functions which focus on the quality of services provided by licensed professionals, health care institutions, laboratories, ambulances, and environmental health entities. Resources are also dedicated to epidemiology, vital statistics, health education, and surveillance.

Department of Children and Families (DCF)**:** DCF provides a variety of community-based and institutional services for children and adolescents with disabilities and their parents. The department's mandates include Prevention, Child Protection, Juvenile Justice Services and Behavioral Health. Services are provided through contracted providers as well as State operated facilities. DCF is part of the Behavioral Health Partnership, along with DSS and DMHAS, with the goal to provide access to a more complete, coordinated, and effective system of community-based behavioral health services and support.

Office of Health Strategy (OHA): The Office of Health Strategy (OHS) was created in 2017 and established in 2018 by a strong bipartisan effort of the CT General Assembly to forward high-quality, affordable, and accessible healthcare for all residents. The legislation re-organized existing state resources into one body, redeploying people and programs more efficiently, and centralizing health policymaking to advance the healthcare reform initiatives that will drive down healthcare costs; close Connecticut's deeply entrenched racial, economic, and gender health disparities, and undertake

technology-driven modernization efforts throughout the system. OHS has a multitude of statutory and regulatory responsibilities including Health Systems Planning and the Certificate of Need program, the development of the state's Health Information Exchange, administering the All Payer Claims Database and Consumer Information Website, and initiatives to improve drug pricing transparency. The work of OHS is funded, in part, by tens of millions of dollars in federal grants that are secured through a competitive process, positioning Connecticut as a leader in healthcare policy reform.

In many national surveys, Connecticut is a top ten state for healthcare. In 2018, U.S. News Best States ranked Connecticut fourth highest for healthcare. This is a promising statistic, but Connecticut is also among the states with the highest cost and high cost growth in the country. OHS collaborates with a variety of experts, consumers, and provider stakeholder groups to examine and address the barriers in Connecticut's health system - cost, access, and outcomes. A healthy population creates value for employers, is necessary for a strong economy, and is key to a high quality of life.

Department of Rehabilitation Services (DORS): DORS receives both federal and state dollars to provide a broad array of services, equipment and supports to individuals with disabilities and older adults that promote independent living, community participation, self-advocacy and employment. DORS implements these services and supports through a variety of programs. The Bureau of Rehabilitation Services (BRS) administers the Title I Vocational Rehabilitation and Title VI Supported Employment (SE) programs of the Rehabilitation Act of 1973, as amended. BRS services are provided to adults who have a mental or physical impairment that is an impediment to employment. Supports are individualized to each job seeker and may include services such as personal assistance for evaluation and training purposes. The Driver Training Program for Persons with Disabilities provides driver instruction for qualified permanent Connecticut residents who require specialized equipment to operate a motor vehicle. The BRS' Independent Living program provides comprehensive independent living services, through contracts with Connecticut's five community-based independent living centers. The Workers' Rehabilitation Program assists injured workers in a return to gainful employment in the most timely and cost effective manner possible while taking into account the needs of the individual. Deaf and Hard of Hearing Services (formerly the Commission on the Deaf and Hearing Impaired) works to advocate, strengthen and implement state policies affecting individuals who are deaf or hard of hearing. Services and supports include counseling services and assistance to persons who are deaf and hard of hearing and their families. The Bureau of Disability Determination Services is charged with deciding eligibility for the Social Security Disability Insurance (SSDI) and Supplemental Security Insurance (SSI) programs. These programs provide cash benefits to individuals who are unable to maintain employment due to the severity of their disabilities. The Bureau of Education and Services for the Blind (BESB) offers a comprehensive array of services to improve the independent living skills of adults and children who are legally blind or visually impaired. Services are customized to each consumer's specific situation and include vocational counseling, technology training, and teaching to improve activities of daily living, training in use of devices for safe travel, provision of low vision evaluations and aides, and self-advocacy training. Rehabilitation professionals are available to come

to the homes, schools and places of employment of consumers, delivering specialized independent living, educational and vocational training. In addition, the agency Business Enterprises Program offers a unique opportunity for people who are blind to become entrepreneurs. The Bureau on Aging, consisting of the State Unit on Aging (SUA) and the Long Term Care Ombudsman Program (LTCOP), ensures that Connecticut's older adults have access to the supportive services necessary to live with dignity, security, and independence. The bureau is responsible for planning, developing, and administering a comprehensive and integrated service delivery system for older persons in Connecticut. The State Unit on Aging administers Older Americans Act programs for supportive services, in-home services, and congregate and home-delivered meals. It also administers programs that provide senior community employment, health insurance counseling, and respite care for caregivers. The Long-Term Care Ombudsman Program provides individual advocacy to residents of skilled nursing facilities, residential care homes and assisted living facilities. The State Ombudsman also advocates for systemic changes in policy and legislation in order to protect the health, safety, welfare and rights of individuals who reside in those settings. The LTCOP and SUA works closely with the aging network partners to provide these services. Partners include Connecticut's five area agencies on aging, municipal agents for the elderly, senior centers, and many others who provide services to older adults.

Department of Veterans' Affairs (DVA) – DVA provides health care, residential and rehabilitative services for veterans honorably discharged from the Armed Forces. An Adult Care Facility, operated by DVA, is licensed by the state DPH as a Chronic Disease Hospital and provides general medical care, Alzheimer's and related dementia care, end of life care, palliative care, long term care, rehabilitation, respite care, mental health and psychological counseling. The Residential Facility is certified by the Federal Department of Veterans Affairs. Veterans receive substance abuse treatment, social work services, educational and vocational rehabilitation, job skills development, self-enhancement workshops, employment assistance and transitional living opportunities.

II. State Long-Term Services and Supports Programs in Connecticut – SFY 2018

State Agency	Long-Term Services and Supports Program	Services	Settings	Eligibility	Demographics July 1, 2017 – June 30, 2018
DSS	Connecticut Home Care Program (CHCP)	Adult day health care Adult Family Living Assisted living services Assistive Technology Care Transitions Chronic Disease Self Management Programs Care management Chore services Companion services Home health aide services Home delivered meals Homemaker services Hospice services Independent Support Broker MH counseling Minor home modifications Nursing services Nutritional services PCA services Personal emergency response system Physical, speech, respiratory & occupational therapy Respite care Transportation	Personal residences Adult day care centers Congregate housing Elderly housing Residential care homes Managed Residential Communities (Assisted Living) Alzheimer's units within Assisted Living Communities	Age 65 and over. Must have at least one critical need (bathing, dressing, toileting, transferring, eating/ feeding, meal preparation, medication administration). Medicaid Waiver income limit = $2250/ month. Medicaid asset limit = Indiv $1,600/ couple $3,200. Medicaid 1915(i) income limit = 150% of FPL, $1,518/month. Medicaid asset limit = indiv. $1,600. State funded income limit = no limit. State funded asset limit = Indiv $37,080/ couple $49,440 (one or both receiving services)	Total Participants Total – 16,623 Waiver – 13,527 State – 2,574 1915i- 522 Age 65-84: 60.6 85+: 39.4 Gender male: 26.0 female: 74.0 Race/Ethnicity –N/A

State Agency	Long-Term Services and Supports Program	Services	Settings	Eligibility	Demographics July 1, 2017 – June 30, 2018
DSS	CT Home care Program for adults with Disabilities (CHCPD)	Adult day health care Adult Family Living Assisted living services Assistive Technology Care Transitions Chronic Disease Self Management Programs Care management Chore services Companion services Home health aide services Home delivered meals Homemaker services Hospice services Independent Support Broker MH counseling Minor home modifications Nursing services Nutritional services PCA services Personal emergency response system Physical, speech, respiratory & occupational therapy Respite care Transportation	Personal residences Adult day care centers Congregate housing Elderly housing Residential care homes Assisted living Alzheimer's facilities with private assisted living	Ages 18-64 Must be diagnosed with a degenerative neurological condition Must need assistance with at least 3 critical needs Must not be Medicaid active or eligible Financial eligibility is the same as the state funded portion of the CT Home care Program for elders	<u>Total Participants</u> 85 <u>Age</u> Under 50: 11 50-64: 74 65+: <u>Gender</u> M: 29 F: 56 <u>Race/Ethnicity</u> N/A

State Agency	Long-Term Services and Supports Program	Services	Settings	Eligibility	Demographics July 1, 2017 – June 30, 2018
DSS	Personal Care Assistance Waiver	Care Management Independent Support Broker Adult Family Living	Personal residences	Age 18-64. Chronic severe and permanent disabilities. Would otherwise require nursing facility care. Capable of self-direction. Medicaid income limit = 300% of SSI . Income in excess of 200% FPL applied to care.	Total Participants 920 Age Under 50: 329 Over 50: 591 Gender Male: 432 Female: 488 Race/Ethnicity N/A
DSS	Home and Community Supports Waiver for Persons with Autism	Clinical Behavioral Support Service Community Mentor Individual Goods and Services Personal Emergency Response System Social Skills Group Specialized Driving Assessment Live In Companion Respite Assistive Technology	Personal Residences	Functional Eligibility: Self-care, Understanding and use of language, Learning Mobility Self-direction, or Capacity for independent living. The functional impairments must have been diagnosed before age 22 and be expected to continue indefinitely.	Total Participants 94 Age Not reported Gender Female: 19 Male: 74 Transgender: 1 Race/Ethnicity N/A

State Agency	Long-Term Services and Supports Program	Services	Settings	Eligibility	Demographics July 1, 2017 – June 30, 2018
DSS	Acquired Brain Injury Waivers (ABI + ABI II)	Case-management Chore Cognitive behavioral program Community living supports Companion Day Habilitation Durable medical equipment Family training Homemaker services Home delivered meals Independent living skill training Information and referral Personal care assistance Personal emergency response system Pre-vocational services Respite care Substance abuse Supported employment Transportation Vehicle modification Transitional living	Personal care residence Group residence	Age 18-64. Brain injury that is not a result of a developmental disability or degenerative condition. Dysfunction is not primarily the result of a mental illness. Would otherwise be institutionalized. Medicaid income limit = Less than 200% FPL. Medicaid asset limit = Individual $1,600	Total Participants 573 Age 18-49: 256 50+: 317 Gender Male: 395 Female: 178 Race/Ethnicity N/A

State Agency	Long-Term Services and Supports Program	Services	Settings	Eligibility	Demographics July 1, 2017 – June 30, 2018
DSS	Katie Beckett Model Waiver	Case management & Medicaid State Plan services	Personal Residences	Birth to 22 years old (those who are over age 22 as of 12/31/11 have the option to remain on the waiver) Would otherwise require care in a nursing home ICF/ID or chronic disease hospital. Medicaid income limit = $1,692. 300% of SSI? Medicaid asset limit = $1,000. $1,600? Income of parent or spouse not counted.	Total Participants 307 Age N/A Gender N/A Race/Ethnicity N/A
DSS	Community First Choice	Personal care assistance Worker's Compensation Home delivered meals Support and Planning coach Health Coach-nurse/PT/OT/ST Assistive technology Environmental modifications Transitional services	Personal Residences	At Institutional Level of care: 1. Supervision or cueing ≥ 3 ADLs + need factor 2. Hands-on ≥ 3 ADLs 3. Hands-on ≥ 2 ADLs +need factor 4. A cognitive impairment which requires daily supervision to prevent harm Living in a community	Total Participants 763 Age N/A Gender N/A Race/Ethnicity N/A

State Agency	Long-Term Services and Supports Program	Services	Settings	Eligibility	Demographics July 1, 2017 – June 30, 2018
				setting Choosing to self-direct and manage an individual budget Active on Husky Medicaid	
DSS	Money Follows the Person	Transition Services Housing Services Peer Support Services Addiction & Substance Abuse Services and Supports Informal Caregiver's Support	Personal Residences	Title 19 Active (pays the last day) Institutionalized at least 90 consecutive days Approved Plan of Care Returning to Qualified housing Approved Transition plan	Total Participants 510 (as of 09/27/18) Age N/A Gender N/A Race/Ethnicity N/A
DDS	Home and Community-Based Services Waivers	Personal support Individualized home support Adult companion services Group day services Individualized day services	Personal residences Community living arrangement Community companion home Community day program	Individuals over the age of three. Person with intellectual disability needing ICF/ID level of care.	Total Participants As of June 2018 Comprehensive Waiver 5,232 Individual and Family

State Agency	Long-Term Services and Supports Program	Services	Settings	Eligibility	Demographics July 1, 2017 – June 30, 2018
		Respite care Residential habilitation Supported employment services Environmental accessibility adaptations Personal emergency response system (PERS) Transportation Parenting Support Senior Supports Vehicle modifications Specialized medical equipment and supplies IFS family training Behavioral support Healthcare coordination Assistive Technology Peer Support Shared Living Training and Counseling for Unpaid Caregivers	site Community employment	Medicaid program: Income less than 300% of SSI and assets less than $1600.	Support Waiver 3,671 Employment and Supports Waiver 1,206 <u>Age</u> N/A <u>Gender</u> N/A <u>Race/Ethnicity</u> N/A
DDS	Intermediate Care Facility for persons with Intellectual Disability(ICF/ID)	Residential habilitation Day habilitation Prevocational services Supported employment services	ICF/ID	No age limit. Person with intellectual disability needing ICF/ID level of care. Medicaid program: Income less than 300% of SSI and assets less than $1600.	<u>Total Participants in DDS operated ICF/IDs</u> 349 <u>Age</u> 0-18: 0 19-54: 103 55-64: 102 65+: 144

State Agency	Long-Term Services and Supports Program	Services	Settings	Eligibility	Demographics July 1, 2017 – June 30, 2018
					Total Participants in privately operated ICF/IDs 358 Age 0-18: 0 19-54: 187 55-64: 86 65+: 85 Gender N/A Race/Ethnicity N/A
DMHAS	Mental Health Standard Case management-	Info & Referral Transportation Case management	Personal Residences RCH NF Shelters Supportive housing sites Clubhouses	Adults age 18 and over. Primary diagnosis of a psychiatric disorder; Requires assistance in obtaining and coordinating treatment, rehabilitation, and social services without which the individual would likely require a more intensive level of care.	Total Participants 1,844 Age 18-20 76 21-25 186 26-34 263 35-44 274 45-54 339 55-64 488 65+ 214 Unknown 4 Gender Female 840

State Agency	Long-Term Services and Supports Program	Services	Settings	Eligibility	Demographics July 1, 2017 – June 30, 2018
				No private insurance to pay for comparable services.	Male 998 Trans* 2 Unknown 4 <u>Race</u> Am Indian 6 Asian 60 Black 495 Multi-race 13 Hawaiian 3 Other 251 Unknown 39 White 977 <u>Ethnicity</u> Hispanic 365 Non-Hispanic 1,388 Unknown 91
DMHAS	Community Support Program	Mental health and substance use rehabilitation services and supports necessary to assist an individual in achieving and maintaining the highest degree of independent functioning. The service utilizes a team approach to provide intensive, rehabilitative community support, crisis intervention, individual, and group psycho-education and skill	Personal residences Community settings	Adults age 18 and over with severe and persistent psychiatric disorders or co-occurring severe and persistent psychiatric and substance use disorders.	<u>Total Participants 5,873</u> <u>Age</u> 18-20 42 21-25 225 26-34 895 35-44 930 45-54 1,503 55-64 1,680 65+ 597 Unknown 1 <u>Gender</u> Female 2,846 Male 3,023

State Agency	Long-Term Services and Supports Program	Services	Settings	Eligibility	Demographics July 1, 2017 – June 30, 2018
		building for activities of daily living, peer support and self-management.			Trans* 1 Unknown 3 <u>Race</u> Am Indian 43 Asian 63 Black 1,135 Hawaiian 13 Other 585 Multi-race 26 Unknown 122 White 3,886 <u>Ethnicity</u> Hispanic 925 Non-Hispanic 4,728 Unknown 220
DMHAS	Mental Health Assertive Community Treatment (ACT)	A set of clinical, medical & psychosocial services, provided on a one-to-one basis, essential to maintaining an individual's ability to function in community settings. Services available 24/7.	Personal residences Community settings	Adults age 18 and over. Primary diagnosis of a psychiatric disorder; Would otherwise require more intensive and restrictive services. No private insurance to pay for comparable services.	<u>Total Participants</u> 1,445 <u>Age</u> 18-20 183 21-25 479 26-34 260 35-44 155 45-54 147 55-64 187 65+ 34 <u>Gender</u> Female 567 Male 878 <u>Race</u> Am Indian 9

State Agency	Long-Term Services and Supports Program	Services	Settings	Eligibility	Demographics July 1, 2017 – June 30, 2018
					Asian 21 Black 371 Multi-race 17 Hawaiian 2 Other 177 Unknown 30 White 818 <u>Ethnicity</u> Hispanic 277 Non-Hispanic 1,094 Unknown 74
DMHAS	Mental Health Intensive Outpatient Services	Individual, group or family psychotherapy; Psycho-educational groups; Classes on ADLs; Recovery oriented services.	Non-residential services provided in a general hospital, private free-standing psychiatric hospital, psychiatric out-patient clinic for adults, or a State-operated facility.	Adults age 18 and over. Primary diagnosis of a psychiatric disorder; Behavior does not pose an imminent risk of harm to self and other; Living environment can assure a reasonable degree of safety; Symptomology/ behavior warrants an increase in frequency and/ or intensity of clinical contact in an effort to stabilize the individual. No private insurance to pay for comparable	<u>Total Participants</u> 350 <u>Age</u> 18-20 12 21-25 62 26-34 84 35-44 69 45-54 77 55-64 41 65+ 5 <u>Gender</u> Female 179 Male 171 <u>Race/</u> Am Indian 5 Asian 5 Black 19 Multi-race 1 Other 10

State Agency	Long-Term Services and Supports Program	Services	Settings	Eligibility	Demographics July 1, 2017 – June 30, 2018
				services.	Unknown 12 White 298 <u>Ethnicity</u> Hispanic 19 Non-Hispanic 321 Unknown 10
DMHAS	Mental Health Outpatient Clinical Services	Individual, group or family counseling; Education to client and family; Support with connecting to/referral to natural community supports; Assistance with obtaining/ maintaining employment.	Non-residential services provided in a general hospital, private free-standing psychiatric hospital, a State-operated facility, a facility licensed by DPH to offer "outpatient treatment," or by a private independent psychiatrist or psychologist or private group practice.	Adults age 18 and over. Primary diagnosis of a psychiatric disorder. No private insurance to pay for comparable services.	<u>Total Participants</u> 34,389 <u>Age</u> 18-20 981 21-25 2,655 26-34 5,948 35-44 5,916 45-54 7,652 55- 64 7,690 65+ 3,393 Unknown 154 <u>Gender</u> Female 18,553 Male 15,814 Trans* 6 Unknown 16 <u>Race</u> Am Indian 208 Asian 412 Black 5,010 Hawaiian 94 Multi-race 101 Other 5,041

State Agency	Long-Term Services and Supports Program	Services	Settings	Eligibility	Demographics July 1, 2017 – June 30, 2018
					Unknown 954 White 22,569 <u>Ethnicity</u> Hispanic 7,194 Non-Hispanic 25,962 Unknown 1,233
DMHAS	Methadone Maintenance				<u>Total Participants</u> 13,535 <u>Age</u> 18-20 38 21-25 557 26-34 3,714 35-44 3,511 45-54 3,079 55-64 2,173 65+ 462 Unknown 1 <u>Gender</u> Female 5,083 Male 8,444 Unknown 8 <u>Race</u> Am Indian 37 Asian 29 Black 1,025 Hawaiian 19 Multi-race 37 Other 2,327 White 9,867 Unknown 194

State Agency	Long-Term Services and Supports Program	Services	Settings	Eligibility	Demographics July 1, 2017 – June 30, 2018
					Ethnicity Hispanic 3,015 Non-Hispanic 10,053 Unknown 467
DMHAS	Mental Health Residential - Group Home	Rehabilitative support focusing on areas of self-care and independent living skills.	Group home	Adults age 18 and over. Primary diagnosis of a psychiatric disorder; Significant skill deficits in the area of self-care and independent living as a result of the psychiatric disability. No private insurance to pay for comparable services.	Total Participants 260 Age 18-20 1 21-25 14 26-34 68 35-44 52 45-54 49 55-64 58 65+ 17 Unknown 1 Gender Female 80 Male 180 Race Am Indian 2 Asian 5 Black 55 Multi-race 1 Other 34 White 159 Unknown 4 Ethnicity

State Agency	Long-Term Services and Supports Program	Services	Settings	Eligibility	Demographics July 1, 2017 – June 30, 2018
					Hispanic 37 Non-Hispanic 214 Unknown 9
DMHAS	Mental Health Residential - Supervised Apartments	Supportive counseling directed at solving day to day problems with community living; Psycho-education groups; Assistance with employment; Rehabilitative support.	Supervised housing	Adults age 18 and over. Primary diagnosis of a psychiatric disorder; Significant skill deficits in the area of independent living as a result of severe and persistent mental illness. No private insurance to pay for comparable services.	Total Participants 838 Age 18-20 65 21-25 167 26-34 143 35-44 134 45-54 150 55-64 150 65+ 28 Unknown 1 Gender Female 295 Male 541 Trans* 2 Race Am Indian 5 Asian 8 Black 201 Multi-race 9 Other 80 Unknown 15 White 520 Ethnicity Hispanic 130 Non-Hispanic 666 Unknown 42

State Agency	Long-Term Services and Supports Program	Services	Settings	Eligibility	Demographics July 1, 2017 – June 30, 2018
DMHAS	Social Rehabilitation	Independent living and community reintegration skill development.	Community setting	Adults age 18 and over. Primary diagnosis of a psychiatric disorder; Moderate impairment in vocational, educational and/or social functioning; Needs assistance with at least 2 ADLs. No private insurance to pay for comparable services.	Total Participants 6,110 Age 18-20 63 21-25 343 26-34 835 35-44 890 45-54 1,609 55-64 1,790 65+ 556 Unknown 24 Gender Female 2,550 Male 3,554 Trans* 1 Unknown 5 Race Am Indian 29 Asian 51 Black 1,628 Hawaiian 13 Multi-race 28 Other 633 Unknown 117 White 3,611 Ethnicity Hispanic 981 Non-Hispanic 4,905 Unknown 224

State Agency	Long-Term Services and Supports Program	Services	Settings	Eligibility	Demographics July 1, 2017 – June 30, 2018
DMHAS	Crisis Stabilization Beds (respite)	Short-term residential services to help stabilize a rapidly deteriorating behavioral health condition and avert hospitalization.	A facility of not more than 15 beds staffed 24/7.	Adults age 18 and over. Primary diagnosis of a psychiatric disorder; Increased exacerbation of symptoms within the past 24 hours; Does not present as an imminent safety risk to self or others consistent with criteria for inpatient psychiatric care. No private insurance to pay for comparable services.	Total Participants 915 Age 18-20 25 21-25 87 26-34 214 35-44 195 45-54 229 55-64 149 65+ 16 Gender Female 337 Male 576 Trans* 1 Unknown 1 Race Am Indian 5 Asian 6 Black 224 Hawaiian 2 Multi-race 5 Other 87 Unknown 22 White 564 Ethnicity Hispanic 132 Non-Hispanic 748 Unknown 35

State Agency	Long-Term Services and Supports Program	Services	Settings	Eligibility	Demographics July 1, 2017 – June 30, 2018
DMHAS	Mobile Crisis Services	Psychiatric evaluation; Psychiatric stabilization; Brief clinical treatment; Medication evaluation; Hospital pre-screening.	Personal residences Congregate housing Elderly housing Residential care homes Nursing facilities Shelters On the streets	Adults age 18 and over. Primary diagnosis of a psychiatric disorder; Presentation of symptoms/ behaviors that place the individual at risk to self or others. No private insurance to pay for comparable services.	Total Participants 5,782 Age 18-20 284 21-25 584 26-34 1,083 35-44 957 45-54 1,075 55-64 960 65+ 654 Unknown 185 Gender Female 2,752 Male 3,019 Trans* 9 Unknown 2 Race Am Indian 18 Asian 58 Black 1,050 Hawaiian 6 Multi-race 44 Other 746 Unknown 572 White 3,288 Ethnicity Hispanic 1,009 Non-Hispanic 4,090 Unknown 683

State Agency	Long-Term Services and Supports Program	Services	Settings	Eligibility	Demographics July 1, 2017 – June 30, 2018
DMHAS	Long-Term Psychiatric Hospitalization	Medication evaluation; Individual/ group counseling; Specialized treatment services.	Psychiatric hospital	Adults age 18 and over. Primary diagnosis of a psychiatric disorder; Chronic risk of being a danger to self or to others or chronic grave disability as a result of the psychiatric disorder. No private insurance to pay for comparable services.	Total Participants 1,034 Age 18-20 25 21-25 99 26-34 233 35-44 178 45-54 203 55-64 202 65+ 94 Gender Female 303 Male 731 Race Am Indian 6 Asian 15 Black 296 Multi-race 10 Other 90 Unknown 46 White 571 Ethnicity Hispanic 152 Non-Hispanic 800 Unknown 82

State Agency	Long-Term Services and Supports Program	Services	Settings	Eligibility	Demographics July 1, 2017 – June 30, 2018
DMHAS	Substance Abuse Residential - Long-Term Care	Clinical/ therapeutic services Individual/ group counseling Psychosocial programming Relapse Prevention Employment skill development	Structured recovery environment	Adults age 18 and over with significant problems with behavior and functioning in major life activities due to substance abuse.	Total Participants 178 Age 21-25 5 26-34 47 35-44 48 45-54 45 55-64 31 65+ 2 Gender Female 40 Male 138 Race Asian 2 Black 8 Other 12 White 151 Unknown 5 Ethnicity Hispanic 17 Non-Hispanic 150 Unknown 11

State Agency	Long-Term Services and Supports Program	Services	Settings	Eligibility	Demographics July 1, 2017 – June 30, 2018
DOH	Congregate Operating Subsidy Program	Assisted living services Care management Chore services Companion services Health insurance counseling Info & referral Nutritional services PCA services Recreation services Transportation	Congregate housing	Age 62 and over and frail. One ADL minimum. Annual income cannot exceed the "Low Income" for the area adjusted for family size as defined by HUD.	Total Participants 1,052 residents Age 65+: 1,031 Gender N/A Race/Ethnicity N/A
DOH	Elderly Rental Registry and Counseling	Funds provided to hire a Resident Service Coordinator to assist residents of State-funded elderly facilities.	Elderly Housing	N/A	Total Participants 4,740 units in 59 communities Age N/A Gender N/A Race/Ethnicity N/A
DOH	Elderly Rental Assistance Program	Financial Assistance to make rents affordable to low/ moderate income elderly.	Personal residences	Age 62 and over or disabled. Certified disabled by Social Security Board or other federal board or agency as being totally disabled.	Total Participants 2,145 units Age 0-64: 315 65+: 967 Gender

State Agency	Long-Term Services and Supports Program	Services	Settings	Eligibility	Demographics July 1, 2017 – June 30, 2018
				Annual income cannot exceed the "Low Income" for the area adjusted for family size as defined by HUD.	N/A <u>Race/Ethnicity</u> N/A
DOH	811 PRA	Federal Financial Assistance to make rents affordable to extremely low income (ELI) non-elderly disabled.	Personal residences	Extremely Low Income (ELI) under the age of 62 and disabled.	<u>Total Participants</u> 12 <u>Gender</u> N/A <u>Race/Ethnicity</u> N/A
DORS	Independent Living (IL) Program	Provides comprehensive independent living services, including peer support, information and referral, advocacy, facilitated transition of youth to post-secondary life and independent living skills training.	Community-based, cross-disability, nonresidential, private nonprofit agencies	No eligibility requirements.	Total Participants 153 Age 0-5: 0 5-19: 0 20-24: 17 25-59:136 60 up: 0 Gender Female: 68 Male: 85 Race Am Ind/Alask: 0

State Agency	Long-Term Services and Supports Program	Services	Settings	Eligibility	Demographics July 1, 2017 – June 30, 2018
					Asian: 4 AA: 31 Hawaiian/PI: 0 White: 70 Hisp/Lat: 48 2 or more: 0 Unknown: 0 Disability Cognitive:0 Mental/Emot:0 Physical: 3 Hearing: 0 Vision: 80 Multiple: 68 Other: 0
DORS	Independent Living- Older Individuals who are Blind (OIB)	Provides comprehensive independent living services, including adaptive aids and devices, and training in their use, to enable individuals who are blind to maintain independence in their residences and communities.	Services are provided directly by DORS staff in the residences and communities of the individual, and through third party low vision practitioners at their medical practices.	Age 55 or older and legally blind or significantly visually impaired.	Total Participants 758 Age 55-59:65 60 up: 693 Gender Female: 520 Male: 238 Race Am Ind/Alask: 0 Asian: 6 AA: 83 Hawaiian/PI: 1 White: 607

State Agency	Long-Term Services and Supports Program	Services	Settings	Eligibility	Demographics July 1, 2017 – June 30, 2018
					Hisp/Lat: 50 2 or more: 8 Unknown: 3 Disability Totally Blind: 24 Legally Blind:697 Severe Visual Impairment:37
DORS	CHOICES	State Health Insurance assistance Program (SHIP), including Medicare Improvements for Patients & Provider Act services (MIPPA) Health insurance counseling Outreach Training Information & referral	Area Agencies on Aging CHOICES Volunteer Host Organization Locations-sites where CHOICES Team members provide counseling and outreach assistance Senior Centers Libraries Personal residences Elderly housing Assisted living Hospice facilities Nursing facilities Area Agencies on Aging	Medicare-eligible beneficiaries, and their caregivers, Providers and individuals interested in serving as program volunteers Assistance for beneficiaries with low income or residing in rural communities Age 60 and over. Under 60 if Medicare eligible.	CHOICES New Volunteer Training Number of Sessions=6 Participants=75 Beneficiary Contacts One-on-one Counseling=30,304 individuals 64 and younger = >5,000 65 and older =>23,000 Age not reported = <1,000 Income below 150% FPL >12,000 Examples of

State Agency	Long-Term Services and Supports Program	Services	Settings	Eligibility	Demographics July 1, 2017 – June 30, 2018
					assistance provided: Medicare Part D, Medicare Advantage, & Medicare Supplement Plan comparisons and Enrollments =>15,000 Medicare Savings Program, Extra Help/Low Income Subsidy, & Medicaid Application Assistance= >9,000 Outreach (presentations, enrollment events, & staff at booths/exhibits) = >500 events >22,000 attendees Total Participants Individual Clients - 32,575 Number Receiving Application Assistance: 6,419

State Agency	Long-Term Services and Supports Program	Services	Settings	Eligibility	Demographics July 1, 2017 – June 30, 2018
					Age 65 and over=26,744 64 and under=5,831 Gender F=21,932 M=10,625 Not available=18 Race/Ethnicity Percentage White, non-Hispanic = 81.4% Black, African American= 8.4% Hispanic, Latino or Spanish= 7.4% Other= 2.8% Total Outreach Events: 541 Beneficiaries Reached at Interactive Presentations or Enrollment Events= 8,598
DORS	SMP – Senior Medicare Patrol	Information & referral Train the trainer	Congregate housing Elderly housing Assisted living Senior centers	N/A	Total Participants Presentations – 143

State Agency	Long-Term Services and Supports Program	Services	Settings	Eligibility	Demographics July 1, 2017 – June 30, 2018
					Beneficiaries who attended presentations 3,683 Community outreach events – 189 One-on-one individual interactions - 599
DORS	CT Partnership for Long-Term Care - Information & Education Program	Information & referral One-on-one counseling Regional public forums	Personal residences Libraries Schools Senior Centers Variety of public venues	Age 18-89	Total Participants Calls for information - 223 Individuals counseled - 119 Attended public forums 293 Age 44-66 attended forums Gender N/A Race/Ethnicity N/A
DORS	Statewide Respite Care Program (for persons with	Adult day care Care management	Personal residences Adult day care centers	No age requirement.	Total Participants 653

State Agency	Long-Term Services and Supports Program	Services	Settings	Eligibility	Demographics July 1, 2017 – June 30, 2018
	Alzheimer's or related dementia)	Chore services Companion services Counseling Home health aide services Home delivered meals Homemaker services Information & referral Nursing services Personal emergency response system Short-term respite care Information and referral Support groups Cognitive training Self-directed care Transportation	Congregate housing Elderly housing Residential care homes Assisted living for short-term respite Hospice facilities Nursing facilities	Alzheimer's or a related dementia. $44,725 income $ 118,905 assets Co-pay of 20% of cost of service required (may be waived upon financial hardship)	<u>Age</u> N/A <u>Gender</u> N/A <u>Race/Ethnicity</u> N/A
DORS	Supportive Services and Health and Wellness: Older Americans Act Title lllB and Title lllD	Adult day care Care management Chore services Companion services Home health aide services Homemaker services Hospice services Information & referral Mental health counseling Nursing services PCA services Personal emergency response system Recreation services Respite care Transportation Medication monitoring Evidence-Based Health	Area Agencies on Aging Personal residences Adult day care centers Congregate housing Elderly housing	Age 60 and over.	<u>Total Participants</u> 11,548 <u>Age</u> N/A <u>Gender</u> N/A <u>Race/Ethnicity</u> N/A

State Agency	Long-Term Services and Supports Program	Services	Settings	Eligibility	Demographics July 1, 2017 – June 30, 2018
		Promotion Programs			
DORS	Elderly Nutrition Program: Older Americans Act Title lllC and State Nutrition	Nutritionally balanced meals served through congregate meal sites and home delivery. Other nutrition services such as education and counseling provided as appropriate.	Congregate meals: senior community cafes, congregate housing, restaurants, schools, churches Home delivered meals: residential homes	Age 60 and over and their spouses/ caregivers	<u>Total Participants</u> Congregate meals: 645,726 meals served to 14,652 participants Home delivered meals: 1,228,844 meals served to 5,932 participants 2,015 units of Nutritional counseling were provided to 1,864 unduplicated persons *Nutrition Education = 13,250 Units *Federal reporting does not require the count of people for this service, only units. Totals reflect units for FFY 2017.
DORS	CT's National Family Caregiver Support Program: Older Americans Act Title lllE	Adult day care Assistive devices/ Supplemental services Care management Chore services Home health aide services	Personal residences Adult day care centers Elderly housing Nursing facilities (for short term respite only)	Care recipient must be age 60 and over. Two or more ADL limitations.	<u>Total Participants</u> Respite – 282 Supplemental services – 595

State Agency	Long-Term Services and Supports Program	Services	Settings	Eligibility	Demographics July 1, 2017 – June 30, 2018
		Homemaker services Information & referral Personal emergency response system Transportation Grandparents support Support groups Cognitive training Self-directed care		Children 18 yrs of age or younger for grandparent support.	One-on-one assistance – 14,528 Counseling, support groups, training – 641 Total caregivers caring for older adults = 1,181 Total grandparents and kinship caregivers caring for children and persons 18-59 with disabilities = 179 <u>Age</u> Caregivers: N/A <u>Gender: N/A</u> <u>Race/Ethnicity</u> N/A
DORS	Congregate Housing Services	Adult day care Care management Chore services Companion services Home health aide services Information & referral Nutritional services Personal care attendant services Personal emergency response system	Congregate housing	Age 60 and over. Frail adults with temporary or permanent disabilities.	<u>Total Participants</u> 278 <u>Age</u> 62+ = 266 18-61= 12 <u>Gender</u> Female = 231 Male = 47 <u>Race/Ethnicity</u> White (non-Hisp) =

State Agency	Long-Term Services and Supports Program	Services	Settings	Eligibility	Demographics July 1, 2017 – June 30, 2018
		Transportation Medication monitoring Foot care			273 Hisp = 5 Black (non-Hisp) = 0 Amer. Indian/Alaskan Native= 0 Asian/Pac. Islander = 0
DORS	Senior Community Service Employment Program	Employment & training	Community (AAA, Community Action Agencies, municipalities, community-based orgs.)	Age 55 and over. Income not exceeding 125% of the federal poverty level.	<u>Total Participants</u> 103 <u>Age</u> 55-64: 72 65-74: 27 75+: 44 <u>Gender</u> male: 40 female: 63 <u>Race/Ethnicity</u> W = 43 AA = 50 Hisp = 6 Asian = 0 Am Ind = 3
DORS	Medicare Legal and Education Assistance Project	Health insurance counseling Information & referral Legal representation for Medicare appeals	Not setting specific	Medicare eligible by virtue of age or disability.	<u>Total Participants</u> 9,532 direct client assistance <u>Age</u> N/A <u>Gender</u> N/A

State Agency	Long-Term Services and Supports Program	Services	Settings	Eligibility	Demographics July 1, 2017 – June 30, 2018
					<u>Race/Ethnicity</u> N/A
	(NO LONGER BEING ADMINISTERED)				
DORS	Evidenced-Based Health Program	Chronic Disease Self-Management Education Program (CDSME), Statewide Fall Prevention Program Tai Ji Quan, Moving for Better Balance (TJQMBB)	Agencies on Aging VNA's, hospitals Community centers, Senior Centers Health departments Municipal agencies		<u>Total Participants</u> 659 CDSME course completers **1,342** - Attended fall prevention Clinics **686** – Attend Tai Chi Moving for Better Balance & Tai Chi for Arthritis Programs **105** – Received Postural Blood Pressure screenings **Total = 2,133**
DORS	No Wrong Door (Aging & Disability Resource Centers) with funding from ACL Grants	Assessment Assistance Advocacy Care Transitions Case Consultation Decision Support Follow-Up Information Options Counseling Benefits	Agencies on Aging Centers for Independent Living Some hospitals Personal residences Other public places By phone	Any person across the lifespan who is a person with a disability, older adult caregiver or planning ahead for future long term care needs. Available statewide	<u>Total Participants</u> 1,125 (FY 2017) 414 unique individuals were enrolled in the Person Centered Counseling No Wrong Door training (PCC NWD) in 2017 243 DDS Case

State Agency	Long-Term Services and Supports Program	Services	Settings	Eligibility	Demographics July 1, 2017 – June 30, 2018
		Employment Long Term Support; Referral Short Term Support			Managers and Supervisors completed all of the requirements of the PCC NWD curriculum. 400 individuals received a joint training with DDS and DORS to help participants connect LifeCourse materials with PCC NWD materials.
DORS	Prevention of Elder Abuse, Neglect and Exploitation	Strengthen and carry out programs or activities by raising awareness to prevent, detect, intervene, investigate and respond to elder abuse, neglect and exploitation. -support of multi-disciplinary teams directed at advocacy to curtail elder abuse - financial exploitation education and training - Coalition for Elder Justice in Connecticut	Agencies on Aging State agencies Law Enforcement Aging, legal, victims, and disability networks Medical and educational organizations For-profit and non-profit, public and private organizations	Age 60+ and persons with disabilities	

State Agency	Long-Term Services and Supports Program	Services	Settings	Eligibility	Demographics July 1, 2017 – June 30, 2018
DOT	Local Bus Services	Transportation	Community	Open to the public, inclusive of seniors and people with a qualifying disability.	Total Participants 42,135,226 passenger trips) Age N/A Gender N/A Race/Ethnicity N/A
DOT	ADA Paratransit Services	Transportation	Community (within 3/4 mile of local public bus routes)	All ages Any person with a disability who is unable, due to physical or mental impairment, and without the assistance of another individual, to board, ride or disembark from any public local bus. Also for those with a specific impairment-related condition that prevents them from traveling to or from a bus stop.	Total Participants 1,157,630 passenger trips (SFY 2018) Age N/A Gender N/A Race/Ethnicity N/A

State Agency	Long-Term Services and Supports Program	Services	Settings	Eligibility	Demographics July 1, 2017 – June 30, 2018
DOT	State Matching Grant Program	Demand Responsive Transportation to Seniors and People with Disabilities	Municipality applies for funds and provides matching funds	Seniors and people with disabilities of all ages.	Total Participants 80+ recipients, inclusive of municipalities that pool funding together for regional coordinated Dial-a-Ride service via local transit districts. Age N/A Gender N/A Race/Ethnicity N/A
DOT	Section 5310 Federal Grant Program	Transportation related services that go beyond traditional public transportation services and the Americans with Disabilities Act (ADA) complementary paratransit services.	Services must be derived from a locally-coordinated public transit human services transportation plan.	Seniors and people with disabilities of all ages	Total Participants 100+ recipients that provide service statewide. Age N/A Gender N/A Race/Ethnicity N/A

State Agency	Long-Term Services and Supports Program	Services	Settings	Eligibility	Demographics July 1, 2017 – June 30, 2018
DPH	Facility Licensing and Investigations Section (FLIS)	Regulatory jurisdiction for state licensing programs. Conducts surveys/ investigations of health care entities that participate in Medicare and Medicaid.	Nursing Homes Residential Care Homes Hospitals Outpatient Clinics Dialysis Units Ambulatory Surgical Facilities Substance Abuse and Mental Health Facilities Home Health Agencies Assisted Living Services Agencies Homemaker Home Health Agencies	Institutions identified under CGS 19a-490. Medicare and Medicaid entitlement enrollment is a voluntary participation program open to various types of providers.	N/A
DVA	Veterans' Health Care Services	Licensed Chronic Disease Hospital provides continuous professional comprehensive healthcare services including: General medical care Alzheimer's/dementia care End of life care Palliative care Long term care Rehabilitation Respite care Mental health and Psychological counseling	John L. Levitow Healthcare Center (onsite)	Veterans as defined by CGS 27-103 who served honorably, are residents of Connecticut, and have a chronic disease/illness.	<u>Average Monthly Census</u> 111 <u>Age</u> N/A <u>Gender</u> 1 Female, 110 Male <u>Race/Ethnicity</u> N/A

State Agency	Long-Term Services and Supports Program	Services	Settings	Eligibility	Demographics July 1, 2017 – June 30, 2018
DVA	Residential and Rehabilitative Services	Provides domiciliary level of care to facilitate rehabilitation and return to independent living including: Residential services General medical care Substance abuse treatment Social work services Educational support Employment skill development	Residential domicile (onsite)	Veterans as defined by CGS 27-103 who served honorably and are residents of Connecticut	Average Monthly Census 130 Age N/A Gender 3 Female, 127 Male Race/Ethnicity N/A

III. State Long-Term Services and Supports Program Expenditures in Connecticut – SFY 2018

State Agency	Long-Term Care Program	Total Expenditures SFY 2018	State Expenditures	Medicaid Expenditures	OAA Title III Expenditures	Other Federal Expenditures	Other Expenditures
DSS	Connecticut Home Care Program (CHCPE)	$470,440,577	$40,416,290 (includes CHCPD expenditures)	$430,024,287			
DSS	Connecticut Home Care Program for Adults with Disabilities (CHCPD)	$1,734,517	$1,734,517 (Included in CHCPE expenditures)	NA			
DSS	Personal Care Assistance Waiver	$2,170,243	NA	$2,170,243			
DSS	Acquired Brain Injury Waiver (ABI)	$47,052,042	NA	$47,052,042			
DSS	ABI II	$18,559,695	NA	$18,559,695			
DSS	Katie Beckett Model Waiver	$75,796	NA	$75,796			

State Agency	Long-Term Care Program	Total Expenditures SFY 2018	State Expenditures	Medicaid Expenditures	OAA Title III Expenditures	Other Federal Expenditures	Other Expenditures
DSS	Autism Waiver	$1,541,620	NA	$1,541,620			
DSS	Community First Choice	$80,917,516		$80,917,516			
DSS	Money Follows the Person	$35,311,014		$35,311,014			
DDS	Home and Community Based Services Waivers	$881,960,000		$881,960,000			
DDS	Intermediate Care Facility for Persons with Mental Retardation (ICF/MR)	$122,660,000		$122,660,000 Does not include private ICF/IDs which are funded by DSS			
DMHAS[1]	Case Management	$41,312,523	$37,885,565	$139,378	$0	$1,098,990	$2,188,590

[1] All DMHAS data is for FY 2017, the most current full year of expenditure data available at the time of this report.

State Agency	Long-Term Care Program	Total Expenditures SFY 2018	State Expenditures	Medicaid Expenditures	OAA Title III Expenditures	Other Federal Expenditures	Other Expenditures
DMHAS	Assertive Community Treatment	$20,964,502	$20,540,341	$185,974	$0	$0	$238,187
DMHAS	Home and Community Based Services Waivers	$13,159,269	$0	$13,159,269	$0	$0	$0
DMHAS	MH Intensive Outpatient	$1,280,790	$255,472	$0	$0	$158,192	$867,126
DMHAS	MH Outpatient Therapy	$103,608,911	$70,077,495	$9,125,025	$0	$815,806	$23,590,585
DMHAS	MH Residential Group Home	$27,870,512 (previous report was overstated by $4,646,372)	$18,255,485 (previous report was overstated by $5,589,058)	$6,384,611 (previous report was understated by $942,686)	$0	$0	$3,230,416
DMHAS	MH Supervised Housing	$59,919,745	$56,418,467	$115	$0	$71,139	$3,430,024

State Agency	Long-Term Care Program	Total Expenditures SFY 2018	State Expenditures	Medicaid Expenditures	OAA Title III Expenditures	Other Federal Expenditures	Other Expenditures
DMHAS	MH Supported Housing	$44,449,588	$24,977,866	$ 0	$0	$18,272,735	$1,198,987
DMHAS	MH Psychosocial Rehabilitation	$20,756,710	$17,944,303	$0	$0	$1,752,805	$1,059,602
DMHAS	Crisis Stabilization	$10,688,288	$9,395,779	$0	$0	$996,944	$295,565
DMHAS	Mobile Crisis Services	$13,826,952	$11,296,514	$18,424	$0	$1,587,268	$924,746
DMHAS	Long Term Psychiatric Hospitalization	$145,114,423	$145,078,112	$0	$0	$0	$36,311
DMHAS	Substance Abuse Residential Long Term Care	$1,332,476 (previous report was overstated by $842,960)	$938,297		$0	$138,571	$255,608 (previous report was overstated by $842,960)

State Agency	Long-Term Care Program	Total Expenditures SFY 2018	State Expenditures	Medicaid Expenditures	OAA Title III Expenditures	Other Federal Expenditures	Other Expenditures
DMHAS	Substance Abuse Residential Long Term Treatment	$22,736,924 (previous report was overstated by $6,759,033)	$16,753,577	$0	$0	$3,948,705	$2,334,642 (previous report was overstated by $6,759,033)
DMHAS	Substance Abuse Residential Transitional / Halfway House	$2,866,927 (previous report was overstated by $1,965,560)	$2,448,898	$0	$0	$315,689	$102,340 (previous report was overstated by $1,965,560)
DOH	Congregate Operating Subsidy Program	$7,189,480	$7,189,480				
DOH	Elderly Rental Registry and Counseling	$1,012,902	$1,012,902				
DOH	Elderly Rental Assistance Program	$1,942,268	$1,942,268				
DOH	811 PRA	$252,509	$0			$252,509	

State Agency	Long-Term Care Program	Total Expenditures SFY 2018	State Expenditures	Medicaid Expenditures	OAA Title III Expenditures	Other Federal Expenditures	Other Expenditures
DORS	Independent Living (IL) Program	$562,901	$338,507			$224,394	
DORS	Independent Living – Older Individuals who are Blind (OIB)	$451,592	$44,847			$406,745	
DORS	CHOICES	$1,005,374	$419,910			$585,461	
DORS	SMP – Senior Medicare Patrol	$0				$0	
DORS	CT Partnership for LTC - Information & Education Program	$750				$750	
DORS	Statewide Respite Care Program (for persons with Alzheimer's or related dementia)	$1,806,138	$1,806,138				
DORS	Supportive Services	$4,877,680	$90,997		$4,786,683		

State Agency	Long-Term Care Program	Total Expenditures SFY 2018	State Expenditures	Medicaid Expenditures	OAA Title III Expenditures	Other Federal Expenditures	Other Expenditures
	and Administration						
DORS	Health and Wellness (Title IIID)	$289,907	$4,789		$285,118		
DORS	Elderly Nutrition Program (Title lllC and NSIP)	$12,905,193	$2,652,163		$10,253,030		
DORS	CT's National Family Caregiver Support Program (Title lllE)	$2,179,018			$2,179,018		
DORS	Congregate Housing Services	$527,853	$134,230			$393,623	
DORS	Senior Community Service Employment Program	$990,304				$990,304	
DORS	Medicare Legal and Education Assistance Project	$275,444	$275,444				
DORS	Elderly Health Promotion	$123,357	$123,357				

State Agency	Long-Term Care Program	Total Expenditures SFY 2018	State Expenditures	Medicaid Expenditures	OAA Title III Expenditures	Other Federal Expenditures	Other Expenditures
DORS	Evidenced Based Health Program: Fall Prevention	$376,023					$376,023
DORS	No Wrong Door: Aging & Disability Resource Centers	$201,707				$201,707	
DORS	Prevention of Elder Abuse, Neglect and Exploitation	$61,541			$61,541		
DOT	Local Bus Services	$221,528,491 Data projections for SFY 2018 (rounded)	$173,856,810 Data projections for SFY 2018			$1,671,246 Data projections for SFY 2018	$1,662,409 (Local) $214,122 (Other) $44,123,905 (Passenger Revenue) Data projections for SFY 2018
DOT	ADA Paratransit Services	$42,227,325 Data projections for SFY 2018 (rounded)	$38,329,166 Data projections for SFY 2018				$1,205,343 (Local) $2,692,817 (Passenger Revenue) Data projections for SFY 2018
DOT	State Matching Grant Program	$8,305,516 Data for SFY 2018	$4,152,758 Data for SFY 2018				$4,152,758 (Local) Data for SFY 2018

State Agency	Long-Term Care Program	Total Expenditures SFY 2018	State Expenditures	Medicaid Expenditures	OAA Title III Expenditures	Other Federal Expenditures	Other Expenditures
DOT	Section 5301 Program	$4,637,642 Data projections for FFY 2017 Award Cycle (most recent)	$526,450 Data projections for FFY 2017 Award Cycle (most recent)			$3,181,318 Data projections for FFY 2017 Award Cycle (most recent)	$929,874 Data projections for FFY 2017 Award Cycle (most recent)
DVA	Veterans' Health Care Services	$12,683,021	$11,394,160				$501,733
DVA	Residential and Rehabilitative Services	$1,918,186	$958,560				