

DEPARTMENT OF SOCIAL SERVICES
HOME AND COMMUNITY-BASED
SERVICES



CONNECTICUT HOME CARE PROGRAM FOR
ELDERS
ANNUAL REPORT TO THE LEGISLATURE
SFY 2019
July 1, 2018– June 30, 2019

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Preface: A History of the Connecticut Home Care Program

In the mid 1980's the federal government offered states the opportunity to expand home care under Medicaid "home and community-based service waivers". Waivers allow states to "waive" certain Medicaid rules. The rationale rested in the belief that individuals, who would otherwise be institutionalized at the state's expense, could be diverted from this costly option if services were available to support them in the community. The federal waiver option thus allowed states to receive federal matching funds (50% match) in Connecticut) for services which previously had been paid primarily with state funds.

In 1985, the Connecticut General Assembly voted to establish an expanded home care program taking advantage of the new waiver option. The program, then called the Long-Term Care Pre-admission Screening and Community-Based Services Program (PAS/CBS) began statewide operation in 1987. It was targeted to frail elders identified by hospital or nursing facility staff as likely to be admitted to a nursing facility within sixty days.

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

In SFY '95 P.A. 95-160 Subsection 7 eliminated the licensing of Coordination, Assessment and Monitoring Agencies and substituted in their place a new entity calls an "Access Agency". The Department consulted with the Home Care Advisory Committee to develop standards for this new agency and issued regulations and Request for Proposals. The most recent Request for Proposal in 2013 resulted in four agencies being awarded contracts to provide care management services under the CT. Home Care Program. Contracts for the provision of care management services continue with the four contractors through June 30, 2022.

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

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

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



The Connecticut Home Care Program contracted Ascend Management Innovations to develop a web-based participant database. This system improved efficiency, timeliness of documentation and submission of required forms. The system features a critical incident reporting system which has tremendously improved the ability to monitor, track, trend and take appropriate actions to address issues of abuse, neglect, exploitation and other issues impacting program participants.

Connecticut Home Care Program Quality Assurance staff convene a Quality Assurance Committee, consisting of representatives from the Access Agencies, the Fiscal Intermediary and CHCP which has addressed various timely issues, provider quality issues and methods to improve reporting. See page 12 for more information.

New services have been added during waiver renewals including care transitions, assistive technology, bill payer, chronic disease self-management, support broker, recovery assistant and tiered case management. Tiered case management offers different levels of case management intensity based on participant needs. The waiver was renewed effective July 1, 2020.

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

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

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

Additional progress with the implementation of the CARES Act requirements for Electronic Visit Verification include:

- A consumer/employee portal, under development, will allow consumers to view, correct and approve visit data and allow employees to view and correct visits.
- A fiscal management portal allows the fiscal intermediary (FI) to view and correct visit data for use in payroll processing.
- A business intelligence reporting tool will enable robust analytics.
- A caregiver speaker verification ensures the correct employee is providing services



- Capacity for consumer to verify visit at point of care

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

I. PROGRAM DESCRIPTION AND ORGANIZATION

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

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

The program is organized under a multi-tiered structure, which enables individuals to receive home care services in levels corresponding to their functional needs and financial eligibility. The first two categories are funded primarily through a State appropriation. Individuals in the third category qualify for reimbursement under the Medicaid waiver program; therefore, costs for this category are equally distributed between Federal and State funds. Category 5 participants receive services under a 1915i state plan option, so service expenditures are federally matched. Category 4 is the state funded pilot program for Adults with Disabilities under the age of 65.

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

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

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



Category 3: This category targets individuals who would otherwise require long term nursing facility care funded by Medicaid. In order to assure cost effectiveness, individual care plan costs cannot exceed 125% of the weighted average Medicaid cost in a nursing facility.

Category 4: This category is the pilot program for persons under 65 with degenerative neurological conditions. The financial eligibility and care plan cost limits are the same as Category 2.

Category 5: This category targets individuals who are functionally equivalent to Category 1. Participants must be active Medicaid recipients and their service costs are 50% federally matched.

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

Connecticut Home Care Program for Elders at a Glance

\$934	The average monthly participant cost on the State Funded portion of the CT Home Care Program.
13,146	The monthly average number of participants on the Medicaid Waiver portion of the CT Home Care.
2,358	The monthly average number of participants on the State Funded portion of the CT Home Care Program.
9,119	The number of individuals screened for the CT Home Care Program who were referred for assessment and became active participants.
18,577	The total number served on the State Funded, Medicaid Waiver 1915c, Adults with Disabilities and 1915i portions of the CT Home Care Program for SFY 2019.
\$448,009,616	The program expenditures for the Medicaid Waiver and State Funded portion of the CT Home Care Program.



Assisted Living Services Component

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

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

Assisted Living is offered in several settings under the Home Care Program. Public Act 02-7 allowed the Department to establish the Private Assisted Living Pilot that became effective January 1, 2003. The Pilot offers one hundred twenty-**five** (125) participants the opportunity to remain in their private assisted living facility after they have spent down their assets. From July 1, 2018 to June 30, 2019, the Private Assisted Living Pilot served a total of 101 participants at a cost of \$1,558,154. This figure includes both core and assisted living service charges. During SFY 2019, there was a total of 45 discontinuances due to death or entering a nursing home.

Public Act 00-2 also grants Managed Residential Community (MRC) status to approved State Funded Housing and Federally Funded HUD Facilities for the purpose of providing assisted living services and allows the Department of Public Health (DPH) to waive provisions of the assisted living services agency regulations on a case-by-case basis. Since State funding ended for HUD facilities, they are now combined with Congregate sites.

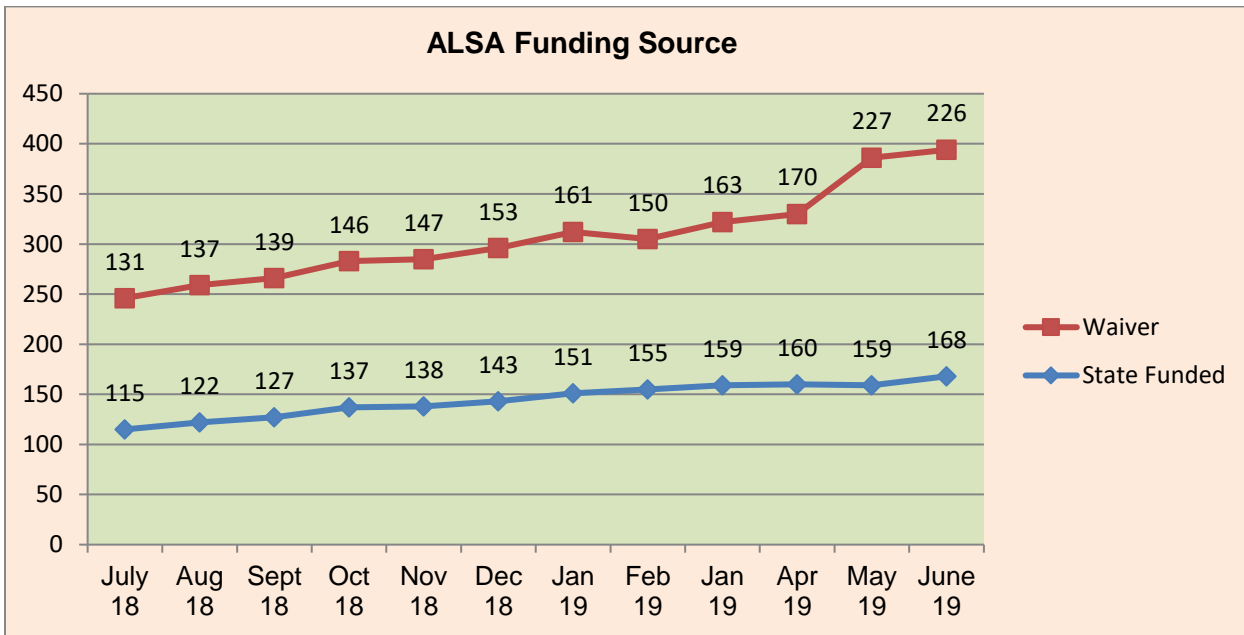
From July 1, 2018 through June 30, 2019 a total of 216 participants received services in these facilities at a cost of \$2,667,207

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

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

From July 1, 2018 to June 30, 2019, 288 participants received services in the demonstration project facilities participating in the assisted living pilot at a cost of \$4,331,739.46. This figure includes both core and assisted living service charges.



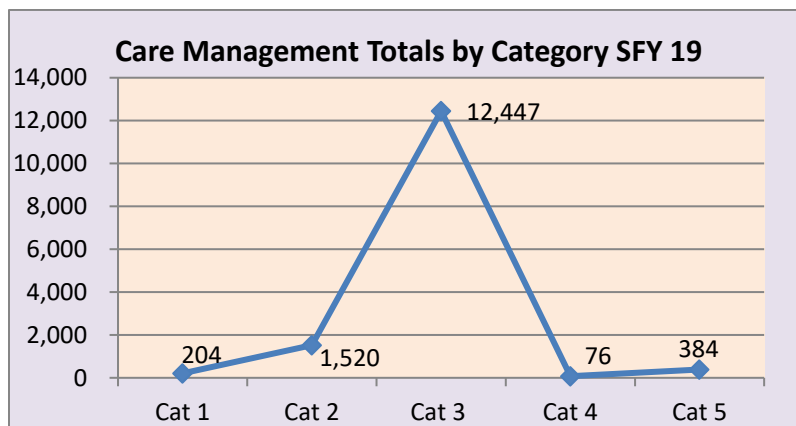


This chart indicates that there has been a gradual increase in the number of participants on the Medicaid Waiver, while the number of participants on the state-funded has not fluctuated significantly during this time period. The variables impacting numbers on the Waiver and State-Funded program are the level of need, spend down of assets and cost share payments.

Care Management

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

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



The chart above illustrates the care management levels of care and caseload mix. Each level of need is assigned a tier based on amount of time required to address these needs. (See Appendix C for descriptions.) Some applicants decline services due to the cost share. Cost share is based on 9% of paid claims during the month. Some applicants decline to accept services due to the cost share. Care plans are limited by category and cost caps. (See Appendix B.)

Quality Improvement

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

The Quality Assurance Team:

- Conducts on-site administrative and chart audits of access agencies, assisted living service agency records, provider agencies and residential care homes to ensure CMS performance measures are met.
- Reviews Access Agency Reports to identify any trends, issues and questions on the reported information. This team monitors the timeliness of information received and provides any necessary follow-up with the Access Agencies.
- Reviews and investigates critical incidents through a web-based application that allows tracking and trending of data both participant specific and system wide.

Various QA activities are conducted to monitor provider compliance with CHCPE regulations and policies and to measure participant satisfaction with services. The Department has launched the utilization of a new Experience of Care Survey under the Testing Experience and Functional tools federal grant. The goal is to utilize the data from the survey to develop a cross waiver quality improvement strategy.

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

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

Goals for State Fiscal Year 2020

- Monitor agency compliance with requiring PCAs to complete the training curriculum that was developed collaboratively with the provider community.
- To meet or exceed performance measures specified in the 1915c and 1915i waiver documents and report finding to CMS.
- The Quality Assurance Committee will review various aspects of program operations and quality of care issues and develop quality improvement strategies.
- The Quality Assurance Committee will identify and work on strategic processes to



improve waiver compliance and quality, towards the goal of ensuring comprehensive, collaborative and integrated oversight and monitoring.

- Development and implementation of a cross waiver quality improvement strategy utilizing data sources from the Universal Assessment and the HCBS CAHPS Experience of Care survey.

II. COST EFFECTIVENESS OF THE WAIVER

Program Cost and Projected Savings

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

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

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

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

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

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The SFY 2019 summary of CHCPE Program Costs and Savings are as follows:

**SUMMARY OF PROGRAM COSTS AND SAVINGS
WAIVER PARTICIPANTS
SFY 2019**

COMMUNITY & HOME CARE SERVICES	AMOUNT
Assessments	2,429
Annual Assessment Cost	\$719,079
Annual Participants Served	18,577
Community First Choice	\$24,164,789
Annual Community Services Cost	\$448,009,616
Annual Home Health Cost	\$26,906,753
Annual Status Reviews	1411
Annual Status Review Cost	\$146,922
Annual Services Cost	\$448,009,616
ADMINISTRATIVE EXPENSES	
Personnel Services	\$3,364,186
Fringe Benefits	\$3,204,261
Annual Administrative Cost	\$3,284,224



Adjusted Total Program Costs SFY 2019	\$457,862,287
Federal Medicaid Reimbursement (50%)	\$228,931,144
Total Program Costs After Federal Reimbursement	\$228,931,144
NURSING HOME SAVINGS	
Annual CHCPE Participants Served	18,577
Monthly Nursing Home Cost per Medicaid Participant	\$6,778
Average Annual Cost Per Nursing Home Participant	\$98,437,298
Average Annual Cost Per CHCPE Participant	25,437,371
Average Annual Cost Nursing Home Participants	\$1,181,247,575
Average Annual Cost CHCPE Participants	\$443,853,792
Total Annual Difference in Cost	\$737,393,783
Federal Medicaid Reimbursement (50%)	\$228,931,144
NET FISCAL IMPACT	
Total Nursing Home Savings After Federal Reimbursement	\$508,462,639

* These totals are for the 1915c Waiver Participants (category 3) participants only.

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



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

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

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

III. CONNECTICUT HOME CARE PROGRAM OVERVIEW

Financial Eligibility – Medicaid Waiver

In order to qualify financially for the Waiver portion of the program, an elderly person (age 65 or older) must meet the income and asset rules applicable to an institutionalized Medicaid applicant. As specified in the Federal Waiver, this means that the gross income limit is 300% of the SSI payment, or \$2,313. The asset limit for an unmarried applicant is \$1,600, although a number of resources such as a residence, car, burial reserve and \$1,500 face value life insurance policy are exempt. There are special provisions in federal law regarding the treatment of assets for married couples when one spouse is considered “institutionalized” which allows for the protection of assets for the community spouse. As of January 2019, the law allowed a community spouse to protect assets from \$26,844 up to \$117,240 depending upon the couple’s original assets, in addition to the \$1,600 that the “institutionalized” person can keep. If both spouses require waiver services, each can only have assets of \$1,600 after exemptions.

Financial Eligibility – State Funded

The State Funded portion of the program has no income limit; however, applicants over the income limit may be required to pay applied income based on the amount of income over the limit. The financial eligibility difference between State Funded and Medicaid Waiver is related to asset limits. When the State Funded programs were consolidated in 1992, an asset limit was established to enable individuals with more assets than the Medicaid limit, but not unlimited assets, to qualify for State Funded home care. However, existing participants with assets higher than the new limit were allowed to continue receiving services. The asset limit for an individual in the State Funded portion of the program is 150% of the minimum amount that a community spouse could have under Medicaid; this figure was \$37,926 as of March 2019. A couple on the State Funded portion of the program can have 200% of that amount, or \$50,568 as of March 2019.

Financial Eligibility 1915i

Home and Community-Based Services Waivers (HCBS) Medicaid waivers and Long-Term Services and Supports demonstration waivers generally allow higher income limits than do state Medicaid plans. This varies by state. Participants in this category of service are Medicaid recipients whose income is at or below 150% of the federal poverty level. The income limit is \$1,562, \$18,744 annualized, for Category 5 participants while the income limit for participants on the Medicaid Waiver is 300% of the poverty level, \$3,124, \$37,488 annualized.

Community First Choice

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



enrollees the opportunity to decide where they live and to increase control over services received.

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

Mandatory Medicaid Applications

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

Targeting the Frail Older Person

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

Assessment, Plan of Care Development, and Care Management

Contracted Access Agencies serving different regions of the State provide care management to program participants receiving home care services. Care managers are required to be nurses, social workers or those with a related degree and have two years experience. The care manager conducts an assessment of needs, offers services and a list of providers, connects participants with services, monitors the participant's status, reviews the care plan regularly and fully reassesses the participant's level of need annually. Care management includes ensuring that services are provided in accordance with the plan of care.

The Access Agency care manager conducts a full assessment of the individual to determine service needs. Based on the results of the assessment, the care manager develops a written, individualized plan of community based social and medical services. The comprehensive plan of care specifies the type, frequency, duration and cost of all services needed for each participant. The care manager is required to use the participant's informal support system and pursue other funding sources such as Medicare and third-party payors before utilizing program funds. Care managers use a care plan portal to enter participants' care plans and prior authorizations. This measure improves quality assurance and ensures that service providers can only bill what is authorized.

Application of Cost Limits

Once the plan of care is completed, the care manager must ensure that the State's cost for the participant's total plan of care including both medical and community based social services, does



not exceed the average State cost of nursing facility care. The average State cost of nursing facility care is calculated by deducting the average applied income contribution from the weighted average monthly Medicaid rate for nursing facility care.

As of March 2019, the maximum amount for a total plan of care for Medicaid waiver participants was \$6,205. The maximum cost limit on the State Funded portion of the CHCPE was \$3,102, 50% of the maximum cost of a nursing home bed.

Participant Fee

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

During SFY 2019, State Funded participants were required to pay a 9% cost share each month based on the participants' paid claims data for that month. Allied Community Resources, the fiscal intermediary, is responsible for collecting the applied income and/or cost share from participants. Participants who fail to pay the cost share and/or the applied income may be discontinued from the program.

Acceptance of Services

The care manager offers the individual the choice to accept a person-centered plan of home and community-based care as an alternative to institutional care. This choice is required by federal law and must be documented in writing. The individual and the care manager sign the plan of care. Individuals who accept a plan of care are expected, to the extent they are able, to take an active part in creating and changing their plan of care as needed. Individuals have the right to refuse the plan of care or any services suggested and be informed of likely consequences of such refusal. In SFY 2019, 4,256 participants accepted plans of care for home and community-based services. This represents 45% of the persons referred for assessment.

IV. CASELOAD TRENDS: 7/1/18 - 6/30/19

New Program Referrals and Placement Activity

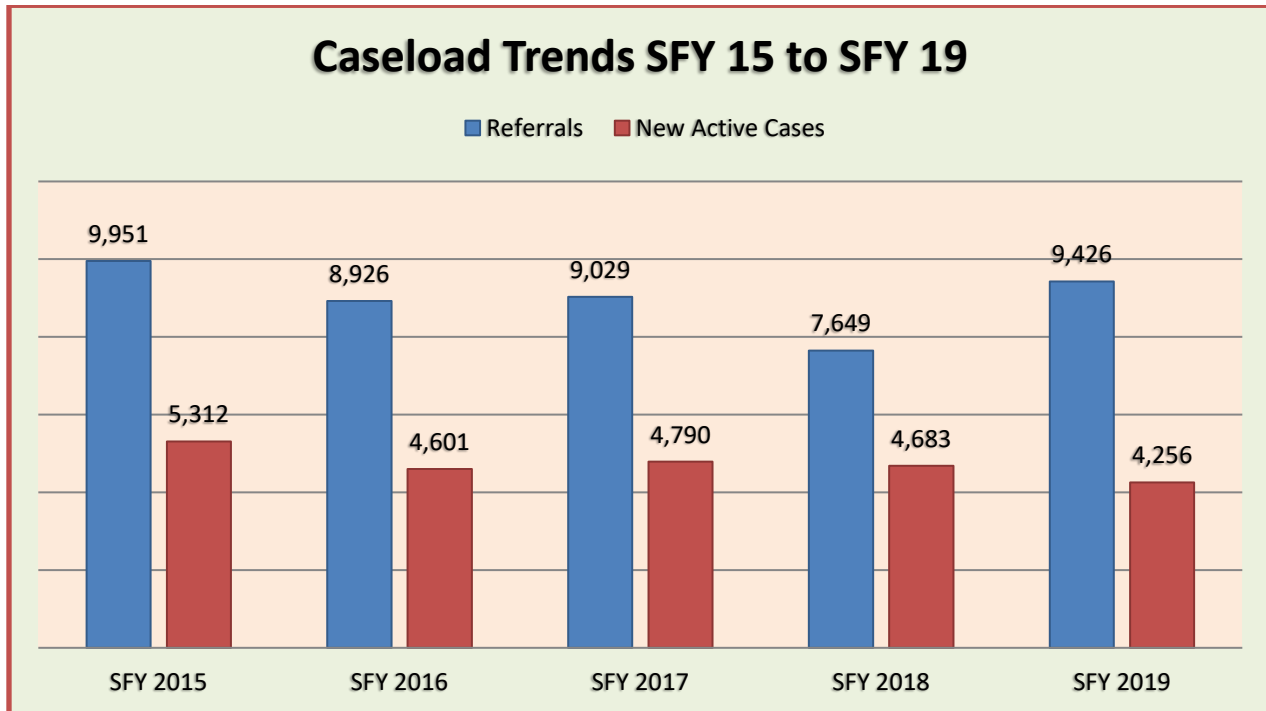
During SFY 2019, 4,256 new participants received services through CHCPE. An average of 400 new participants were placed on services each month and an average of 276 discharges occurred, resulting in an average net increase of 126 participants each month.

Throughout SFY 2019, 9,426 individuals were referred to an Access Agency care manager for a full assessment of their needs to consider their potential for community placement.



	New Program Referrals	Participants
SFY 2015	9,951	5,312
SFY 2016	8,926	4,601
SFY 2017	9,029	4,790
SFY 2018	7,649	4,683
SFY 2019	9,426	4,256

This chart illustrates the number of new participants that resulted from new program referrals from SFY 2015 through SFY 2019.

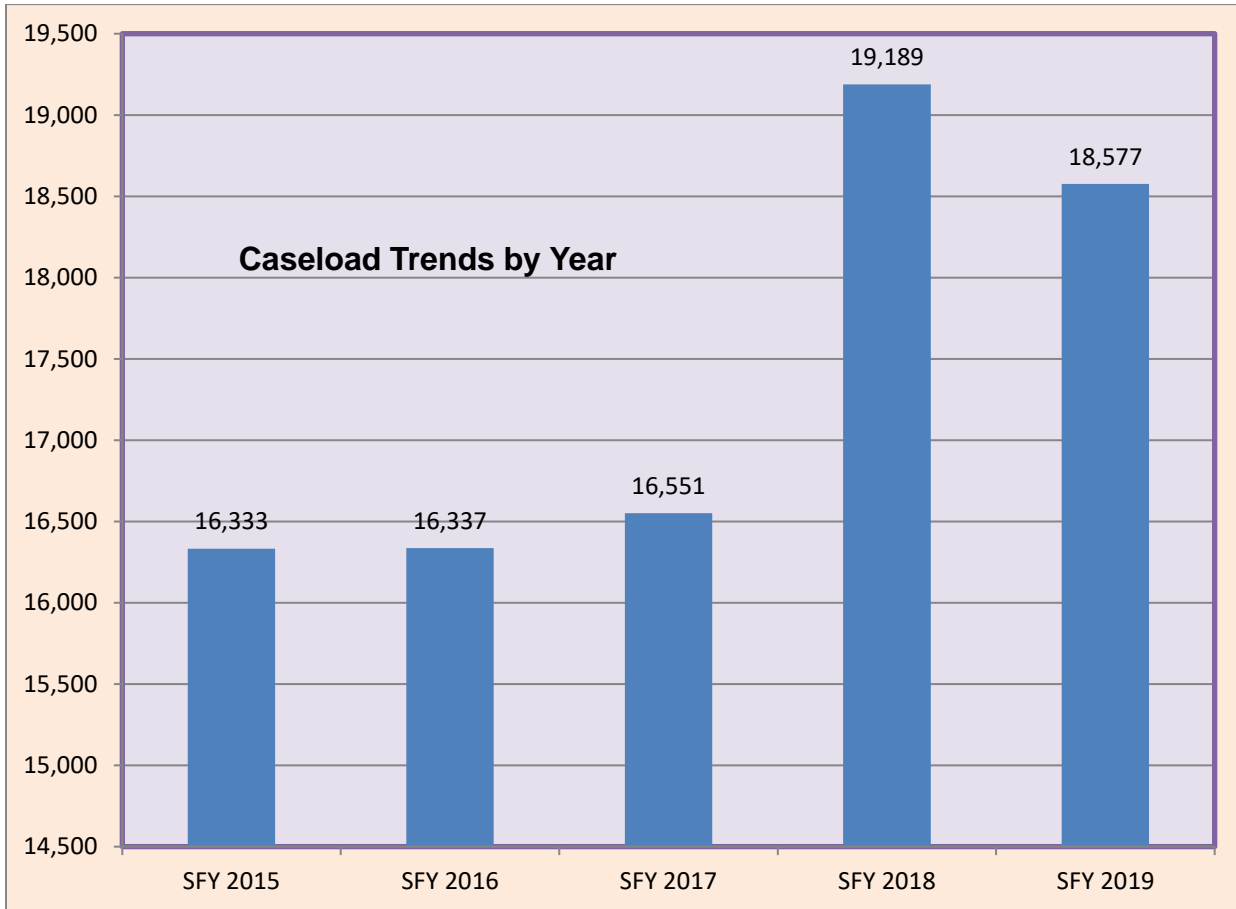


During the past six years, an average of 51% of new referrals resulted in new participants to the CHCPE. The top three reasons for participants not progressing from referral to the program are:

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

Caseload

The following graph illustrates the CHCPE caseload since July 2015. Caseload consists of any participant who was an active participant on the CHCPE at any time during the year. As of June 30, 2019, there was a total of 18,577 unduplicated participants. As Category 2 participants spend down their assets, most transfer to Category 3.



Caseload by Funding Source

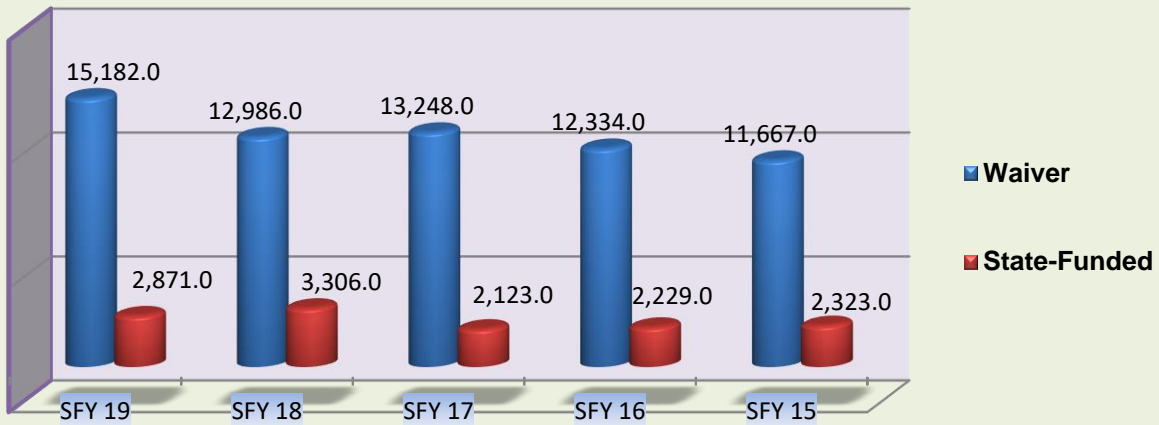
As of July 1, 1989, all State Funded CHCPE participants were required to apply for Medicaid if their financial information indicated that they would qualify.

The graph below illustrates the volume trends for State Funded and Waiver participants since SFY 2015. As of June 30, 2019, approximately 70% of the persons receiving CHCPE services are waiver participants.

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

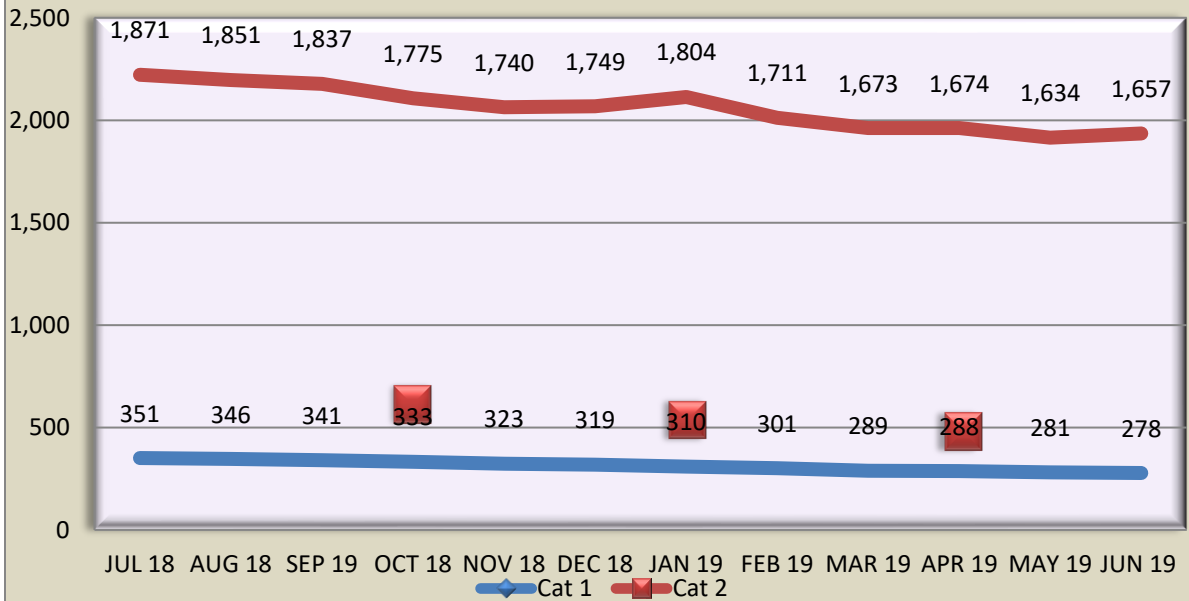


Caseload Mix: Waiver and State-Funded SFY 15 to SFY 19



Month by Month State-Funded Caseload Mix

Cat 1 (-73) Cat 2 (-214)



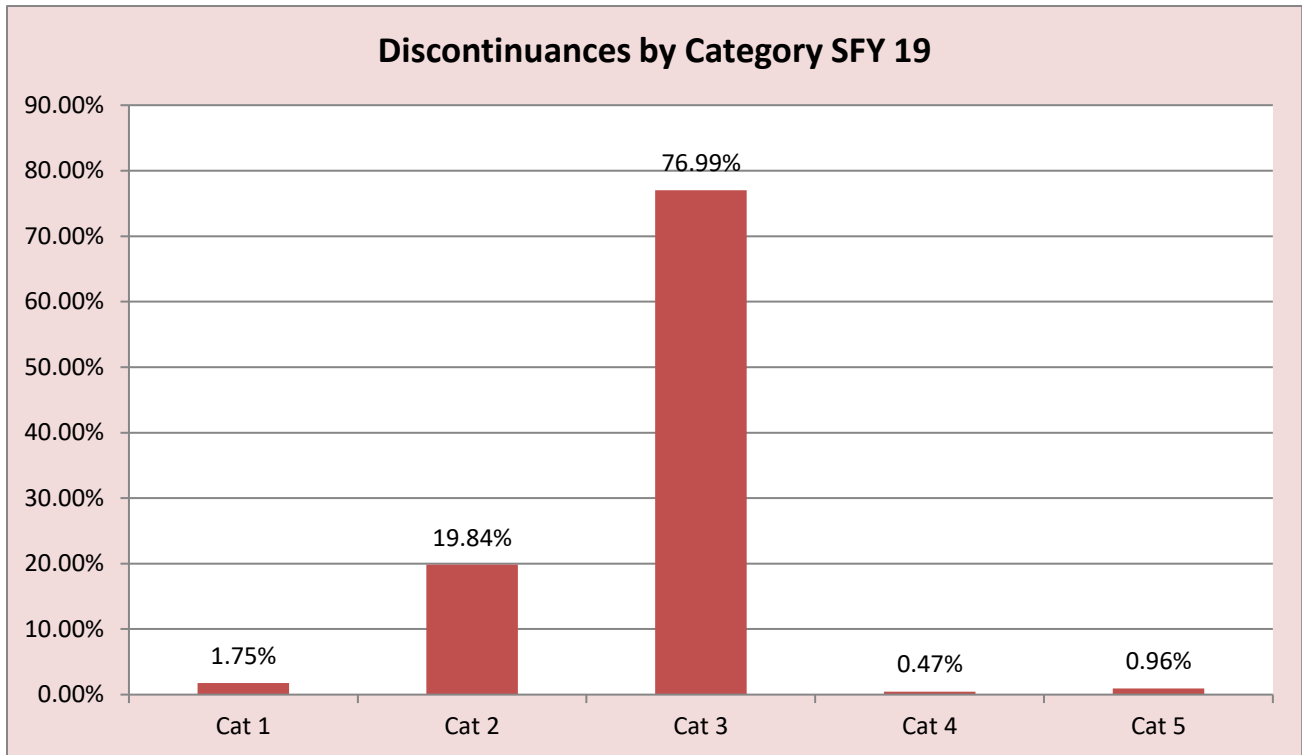
The State Legislature placed a freeze on new referrals to CHCPE Category 1 as of August 1, 2016. Only active participants can change to Category 1. The number of active cases continues to go down as participants are discontinued from the program. Persons who have been referred to CHCPE Category 1 are kept in a waiting status should their functional and/or financial situation change. The only transfers into Category 1 are active Category 5 participants with assets above the limit or active Category 2 participants with fewer functional needs. The cost share applied income amount and/or estate recovery factor into the applicant’s decision to accept services.

V. PROGRAM ACTIVITY

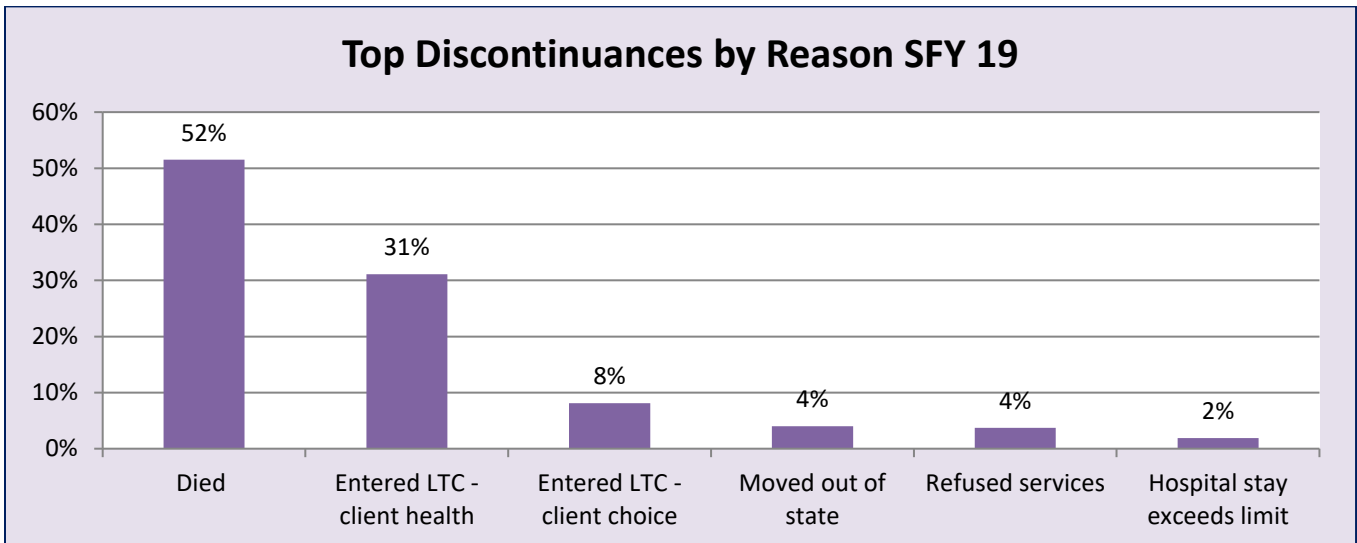
Admissions and Discharges

Most discontinuances are category 3 participants who expire. Category 3 participants must meet nursing home level of care and are the target population for the CT Home Care Program.

Category 2, state-funded, participants are also required to meet nursing home level of care. Those who enter a nursing facility do so primarily because they have become too ill to stay at home and/or the cost of their care plan exceeds program limits for being less expensive than nursing home care.



Category 1 and Category 5 participants are considered at risk for nursing home admission but do not meet the criteria for nursing home level of care. Category 5 participants are Medicaid participants receiving services under the 1915i State Plan which allows 50% federal matching for home and community-based services (HCBS). Prior to the approval of 1915i in 2012, all HCBS for these participants were 100% state funded. Category 3 is the Medicaid Waiver. Category 4 is a pilot program for those diagnosed with a neurodegenerative condition.



VI. TRANSFERS WITHIN THE PROGRAM

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

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

Reasons for participants moving to different categories include:

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

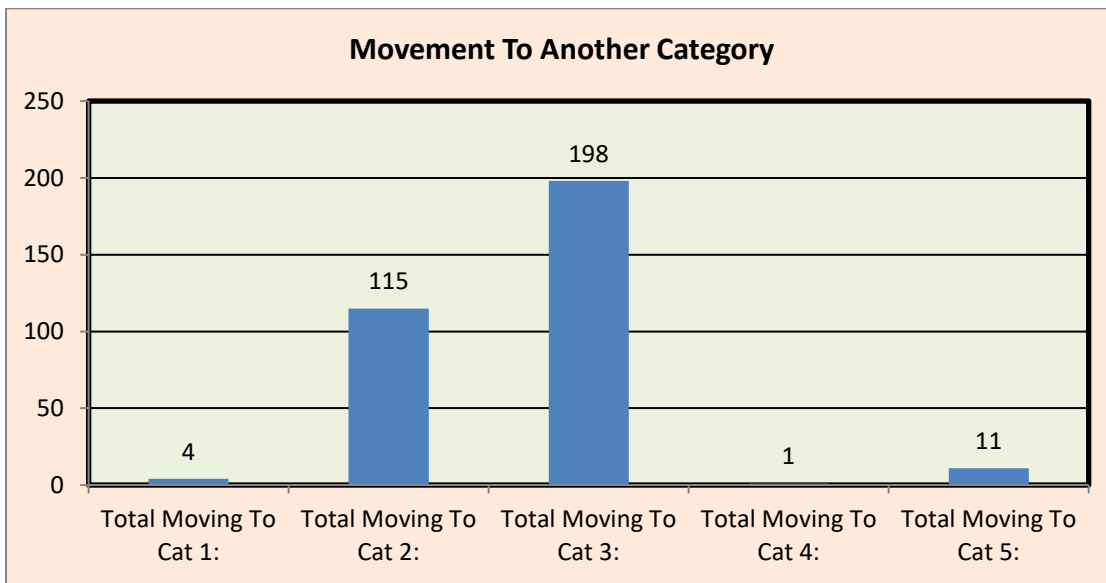
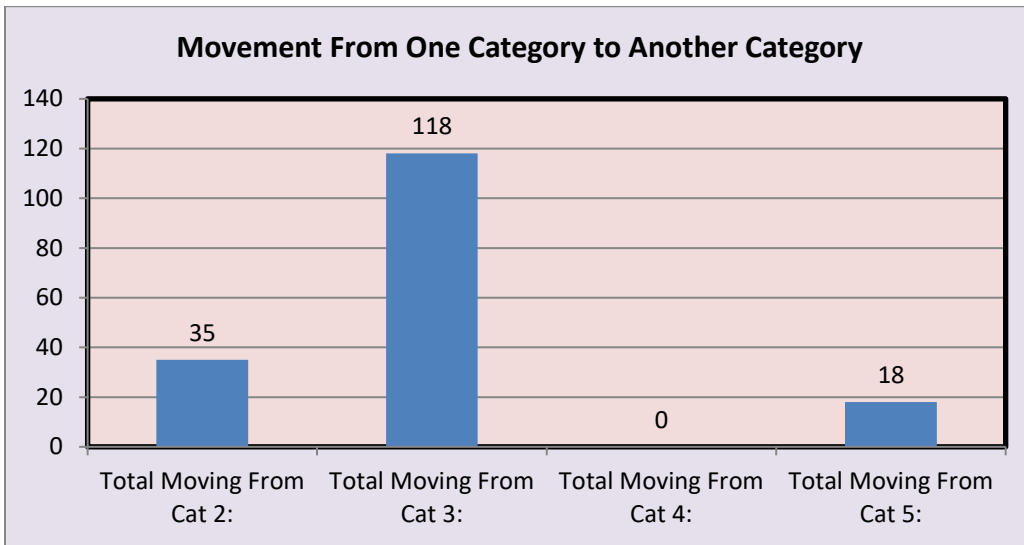
Transfers Between Categories

Most participants transfer into category 3 due to increased functional needs, and when assets have been spent down to the Medicaid level.

Participants who transfer into Category 2 include those who have transitioned from category 1 due to increased functional needs and participants who meet functional criteria but have exceeded the Medicaid asset limit.

Participants who transfer into category 5 are those who do not meet the functional criteria for Category 3. It is rare for participants to transfer into category 4 except for other waiver participants who meet the diagnostic criteria for degenerative, neurological disease.

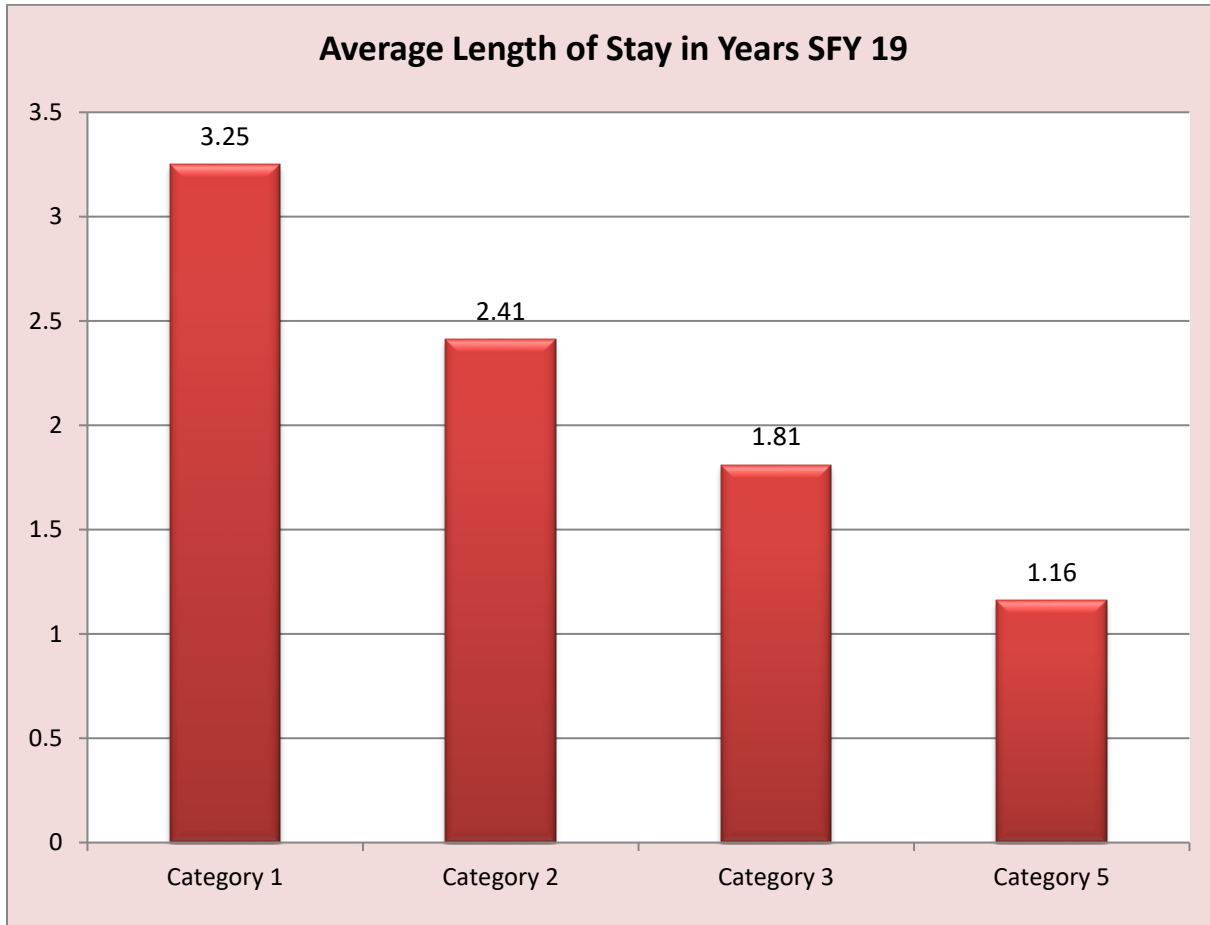




The greatest number of participants transition to category 3 due to increased functional needs and spending down excess assets.

VII. LENGTH OF STAY

Categories 1 and 5 are for individuals who are at risk of nursing home placement but do not meet criteria for nursing home level of care. Category 2 individuals are frail enough to require nursing facility care but are over the Medicaid asset limit. Category 3 individuals meet nursing home level of care.



Factors that affect length of stay include level of need and financial eligibility. Category 1 participants are considered “at risk” of institutionalization. While category 2 is considered nursing home level of care, the cost cap for category 2 is much lower than category 3. Participants with the greatest level of need tend to have more health conditions or disabilities which affect the length of stay. Category 5 participants transitioning to category 2 or 3 at the time of discontinuance is a factor in the lower length of stay.

VIII. PROGRAM EXPENDITURES AND COST SAVING PROGRAM ACTIVITIES
Program Expenditures 7/1/18 - 6/30/19

Actual program expenditures in SFY 2019 totaled \$448,009,616 before federal reimbursement. Federal reimbursement cut \$250,329,049 or 54% from the total program costs. The Net State Cost was \$288,625,385.

SFY 2019 Expenditures

	Waiver	State Funded	1915i	Total
Average Monthly Cost/Case		\$934	\$813	\$1,747.00
Total Cost	\$448,009,616	\$35,350,464	\$5,766,085	\$489,126,165.00
Federal Funds/ Reimbursement	(\$250,329,049)	\$0	(\$2,945,872)	(\$253,274,921)
Net State Cost	\$250,329,049.00	\$35,350,464	\$2,945,872	\$288,625,385.00

This chart provides a snapshot of the costs and savings resulting from receipt of home and community-based services. The cost of a nursing home bed is \$6,205 per month. Each participant staying out of a nursing facility for one year saves the State \$74,460. The total annual cost of participant care plans needs to be lower than the cost of a nursing home bed to demonstrate the cost neutrality of the Waiver. The Waiver continues to demonstrate that is more cost effective, as well as person-centered, to provide waiver services to keep individuals at home who would otherwise have been placed in a nursing facility.



**CONNECTICUT HOME CARE PROGRAM FOR ELDERS
PROGRAM COSTS**

Program Expenses	Waiver	State Funded	1915i	Total
Assessments / Status Reviews	\$ 823,607	\$ 1,146,277	\$ 10,011	\$ 1,979,895
Home and Community Based Services	\$ 410,246,146	\$ 31,997,384	\$ 5,766,085	\$ 448,009,616
Community First Choice	\$ 24,164,789	\$ -	\$ -	\$ 24,164,789
Home Health	\$ 24,316,154	\$ 1,714,169	\$ 876,430	\$ 26,906,753
Total Expenses	\$ 459,550,697	\$ 34,857,831	\$ 6,652,525	\$ 501,061,053
Administrative Services	Waiver	State Funded	1915i	Total
Salaries	1,379,316.37	252,313.97	50,462.81	\$1,682,093
Fringe Benefits	1,313,747.07	240,319.61	48,063.93	\$1,602,131
Annual Administrative Costs	\$2,693,063	\$492,634	\$98,527	\$3,284,224
Net Costs	Waiver	State Funded	1915i	Total
Total Cost	\$ 462,243,760	\$ 35,350,464	\$ 6,751,052	\$ 504,345,276
Federal Reimbursement for Administrative Expenses	\$ (1,346,532)	\$ -	\$ (49,263)	\$ (1,395,795)
Federal Reimbursement for Program Expenses	\$ (231,225,236)	\$ -	\$ (3,326,263)	\$ (234,551,498)
Net State Costs	\$ 229,671,993	\$ 35,350,464	\$ 3,375,526	\$ 268,397,983
Waiver and 1915i expenditures estimated at 50% federal financial participation. Community First Choice Costs estimated at 56% federal financial participation.				

This chart's line items provide more detail about the expenses and savings resulting from reduced nursing home admissions.



APPENDIX A

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

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

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



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

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

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

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

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

(h) An individual who is otherwise eligible for services pursuant to this section shall, as a condition of participation in the program, apply for medical assistance benefits pursuant to section 17b-260 when requested to do so by the department and shall accept such benefits if determined eligible.



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

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

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

(4) The annualized cost of services provided to an individual under the state-funded portion of the program shall not exceed fifty per cent of the weighted average cost of care in nursing homes in the state, except an individual who received services costing in excess of such amount under the Department of Social Services in the fiscal year ending June 30, 1992, may continue to receive such services, provided the annualized cost of such services does not exceed eighty per cent of the weighted average cost of such nursing home care. The commissioner may allow the cost of services provided to an individual to exceed the maximum cost established pursuant to



this subdivision in a case of extreme hardship, as determined by the commissioner, provided in no case shall such cost exceed that of the weighted cost of such nursing home care.

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

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

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



APPENDIX B CATEGORY CHART SFY 2019

DEPARTMENT OF SOCIAL SERVICES

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

rev:

03/19

Effective 3/1/2019

<u>Category</u>	<u>Description</u>	<u>Functional</u>	<u>Financial</u>	<u>Care Plan</u>	<u>Funding</u>	<u>Intake</u>
<u>Type</u>		<u>Need</u>	<u>Eligibility</u>	<u>Limits</u>	<u>Source</u>	<u>Status</u>
Category			Individual Income= No	<25% NH		Intake
1	Limited home	At risk of	Limit*	Cost	STATE	frozen
CHCPE	care for	hospitalization	Assets:	(\$1551.00 Monthly)		effective
	moderately frail	or short term	Individual =			07/01/2015
	elders	nursing home	Couple= \$50,568.00			(Wait-list)
		placement				
		(1 or 2 critical needs)				
Category			Individual Income= No	<50% NH		
2	Intermediate home	In need of	Limit*	cost	STATE	OPEN
CHCPE	care for very	short or long	Assets:	(\$3102.00 Monthly)		
	frail elders	term nursing	Individual =			
	with some assets	home care	Couple= \$50,568.00			
	above the Medicaid	(NF LOC)				
	limits.					
Category		In need of	Individual	100% NH	MEDICAID	
3	Extensive home	long	Income=\$2313.00/Mth	Cost	WAIVER	OPEN
CHCPE	care for very	term nursing	Assets:	(\$6205.00 Monthly)		
	frail elders	home care	Individual = \$1600.00	\$1,600.00	Social	
	who would other-	(NF LOC)	Couple:		Services	
	wise be in a		both as participants =	125% NH		
			\$1600.00 each	Cost		
	nursing home on		one as participant =			
			\$26,884.00	(\$7756.00 Monthly)		



				(\$1600.00 +			
	Medicaid.			\$25,284.00 CSPA)**			
					100% Subacute***		
					(\$13308.00.00 Monthly)		
					125% Subacute***		
					(\$16635.00 Monthly)		
Category			Individual Income= No		<50% NH		
4	<i>Intermediate home</i>	<i>In need of</i>	<i>Limit*</i>		<i>cost</i>	STATE	OPEN
							<i>limited</i>
							<i>to 100</i>
CHCPD	<i>care for individuals</i>	<i>short or long</i>	Assets:		(\$3102.00 Monthly)		slots
			Individual =				
	<i>under age 65 with</i>	<i>term nursing</i>	\$37,926.00				
	<i>a degenerative</i>	<i>home care</i>	Couple= \$50,568.00				
	<i>neurological condition.</i>	<i>(NF LOC)</i>					
	<i>ineligible for Medicaid</i>						
Category	Same as category		Individual Income -		50% Federal		
5	1.Also	<i>At risk of</i>	\$1,562.00		Reimbursement		OPEN
1915(i)	active on categorically	<i>hospitalization</i>	Assets:				
	needy Medicaid	<i>or short term</i>	Individual =	\$1,600.00			
	S01, S02, S03, S04	<i>nursing home</i>					
	Must be age 65 or	<i>placement</i>					
	older	<i>(1 or 2 critical needs)</i>					

- Notes:**
1. Participants in the higher income range are required to contribute to the cost of their care. Applied income starts at \$2082.00
 - * 2. There is no income limit for the State Funded portion. The Medicaid Waiver income limit remains at 300% of SSI which is \$2,313.00
 3. CHCPE Services available in all categories include the full range of home health and community-based services.
 - *1915(i) State Plan Option has limited PCA services to 14 hours weekly and homemaking services are limited to 6 hours weekly.
 4. Care plan limits in all categories are based on the total cost of all state-administered services.
 5. 1915(i) State Plan option covers individuals on Medicaid but who qualify for category 1 services.
 - CT will claim 50% reimbursement from the federal government for home and community-based services not reimbursable under Medicaid.
 6. Some individuals under category 2 may become financially eligible for the Medicaid Waiver.
 - In these cases, the participant must apply for Medicaid and cooperate with the application process.
 - ** 7. Married couples who are over this asset limit for category 3 may be eligible based on the special spousal asset protection rule.
 8. Functional need is a clinical determination by the Department about the applicant's critical need for assistance in the following areas:
 - Activities of Daily Living (ADL's) :Bathing, Dressing, Toileting, Transferring, Eating/Feeding,
 - Needs factors : 1. Behavioral Need - Requires daily supervision to prevent harm. 2. Medication supports - Requires assistance for administration of physician ordered daily medications. Includes supports beyond set up.



9. *NF LOC is defined as;*

1. *Supervision or cueing \geq 3 ADL's + need factor*
2. *Hands-on \geq 3 ADL's*
3. *Hands-on \geq 2 ADL's + need factor*
4. *A cognitive impairment which requires daily supervision to prevent harm*

10. *Subacute LOC is defined as;*

1. *Participant requires comprehensive medical monitoring but does not require intensive diagnostic and/or invasive procedures*
 2. *Participant requires intense medical supervision and therapy such as nursing intervention intermittently throughout the day and/or the need for ancillary or technological services (such as laboratory, pharmacy, nutrition, diagnostic)*
 3. *Participant may require services such as brain injury rehabilitation, high intensity stroke or orthopedic programs, ventilator programs, complex wound care or specialized infusion therapy.*
11. *Care Plan limits are for CHCP fee for service only*
12. *For contracted Access Agencies use only.*

**APPENDIX C
CARE MANAGEMENT CONTINUUM**

TIERED CASE MANAGEMENT

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

i) Tiered Case Management was added 7/1/17 recognizing that all participants do not require the same intensity of care management. Intensity levels are decided clinically by using the four categories of case management below.

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



APPENDIX D

MEMBERS OF THE CONNECTICUT HOME CARE ADVISORY COMMITTEE

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Community Options Unit

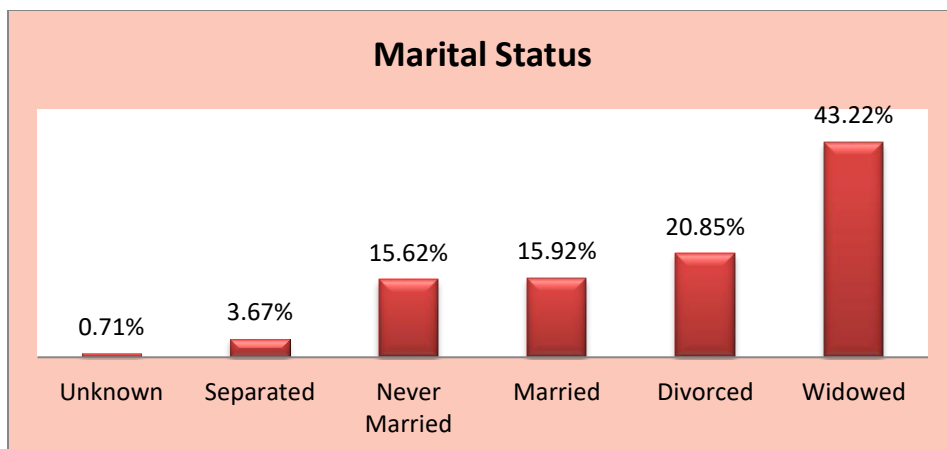
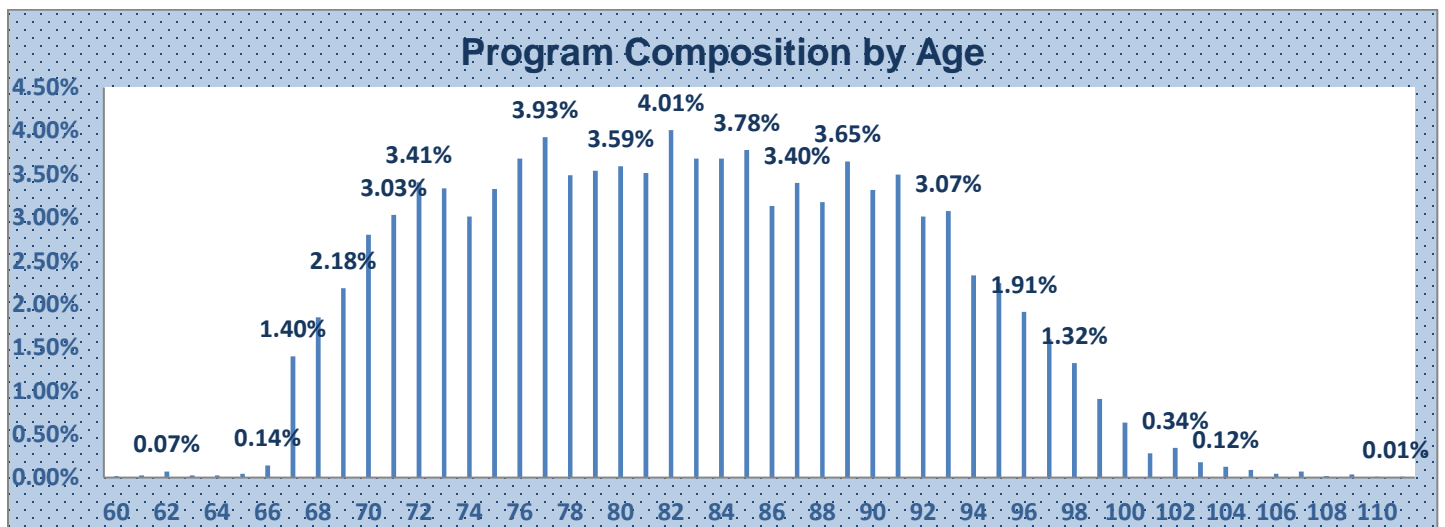


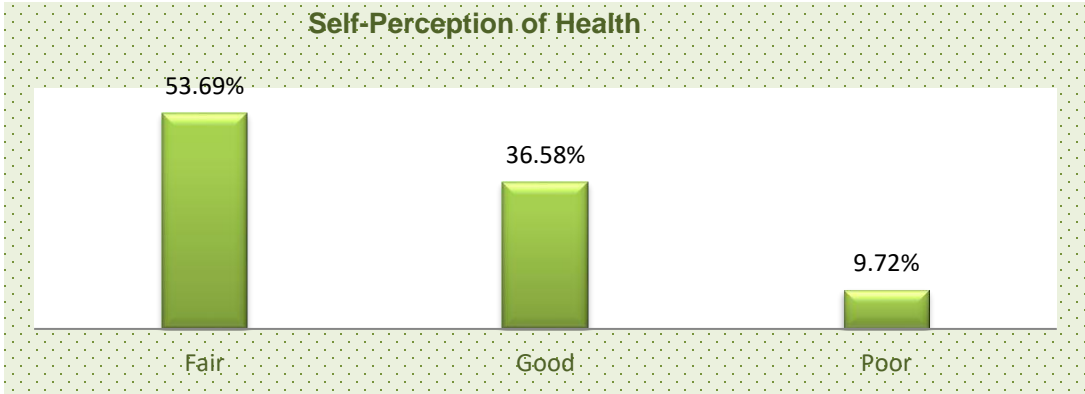
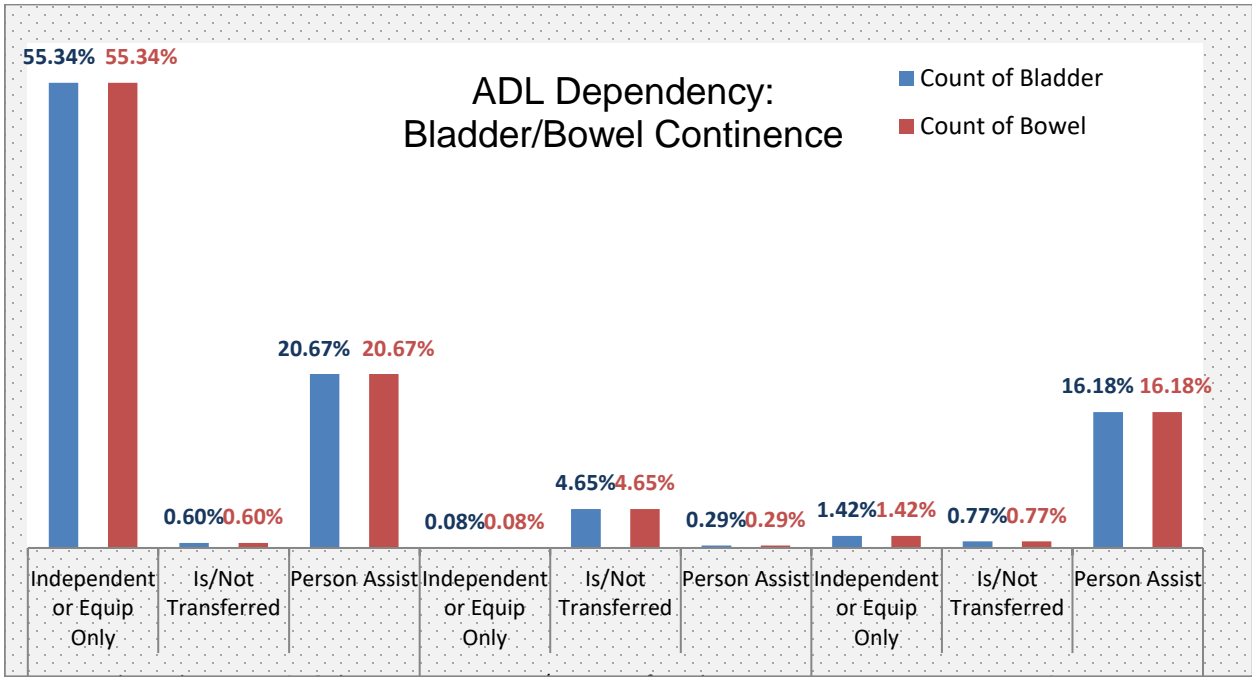
APPENDIX E CHCPE PARTICIPANT CHARACTERISTICS FOR SFY 2019

Participant Characteristics

The charts below highlight specific characteristics on CHCPE program participants derived from the results of the Consumer Assessment of Health Provider Systems Home and Community-Based Services (HCBS CAHPS).

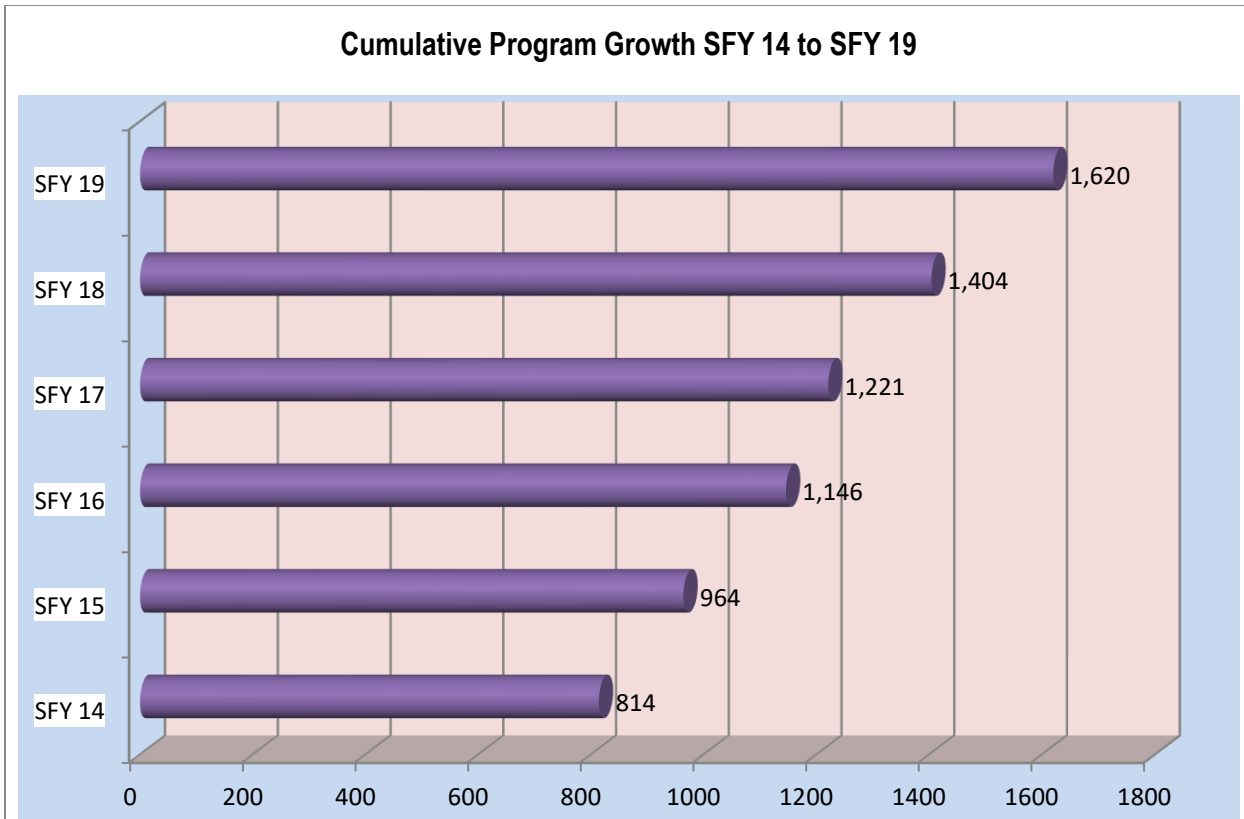
The chart below illustrates the age range of CHCP participants. Thirty-five percent of program participants are between the ages of 75-89. Participants age 70 and under represent 9% and those age 90 and upward represent 23% of all program participants.





APPENDIX F STATE-FUNDED HUD AND CONGREGATES CUMULATIVE PARTICIPANT GROWTH FROM SFY 2014 – SFY 2019

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

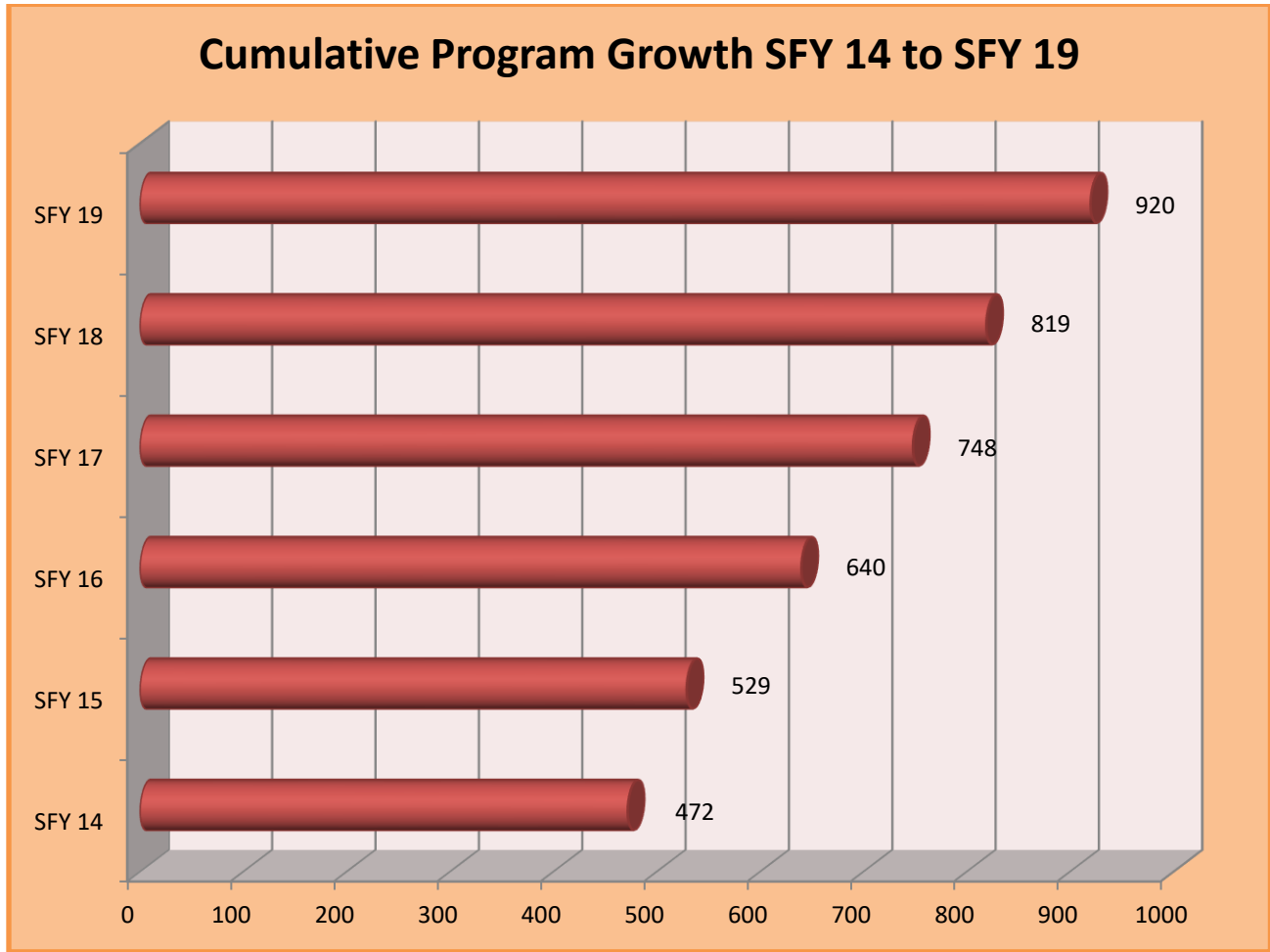


Because HUD is no longer state-funded, it is reported together with the congregates.

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

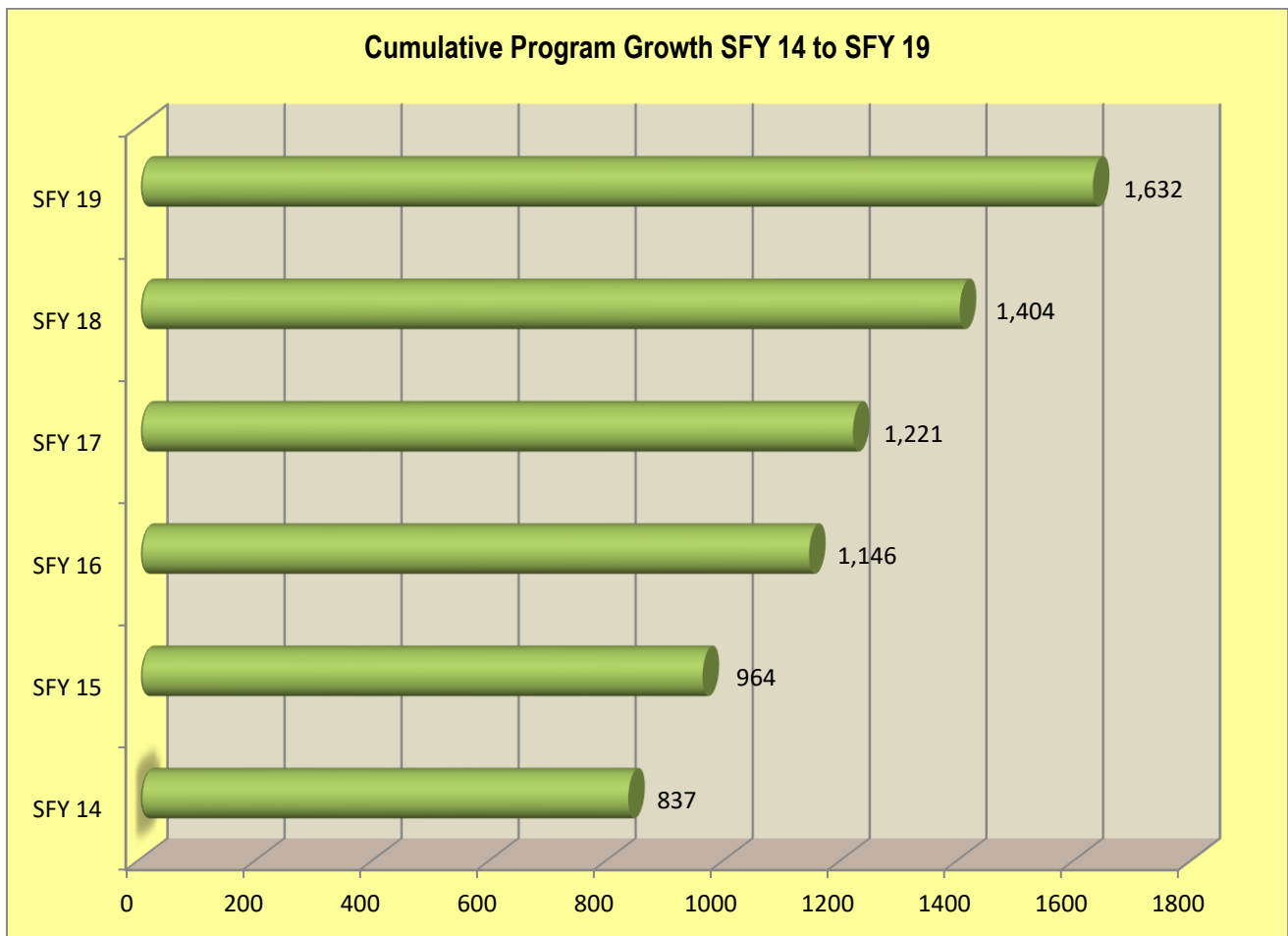
APPENDIX G PRIVATE ASSISTED LIVING PILOT CUMULATIVE GROWTH

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



APPENDIX H ASSISTED LIVING DEMONSTRATION PROJECT CUMULATIVE GROWTH FROM SFY 2013 – SFY 2019

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



APPENDIX I

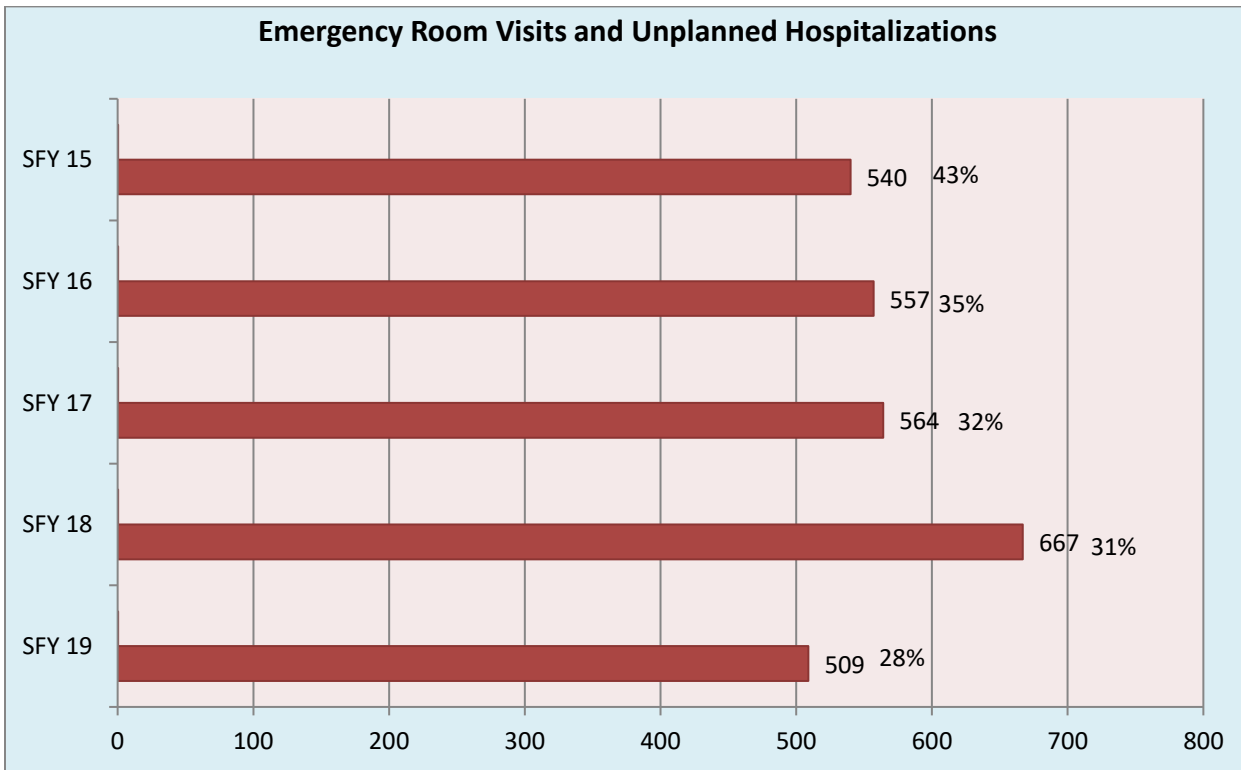
CRITICAL INCIDENT REPORTS SFY 2019

Critical Incidents are reported by Access Agencies using the Ascend online system. There are several types of critical incidents. Community Options Quality Assurance staff review these incidents and provide feedback to the Access Agency regarding methods to prevent further occurrences, if applicable. Many of the abuse, neglect and exploitation incidents are reported to Protective Services for the Elderly which lies within the Social Work Division of DSS. The Quality Assurance Committee works to strengthen policies and procedures to enable more rapid reporting time and responses, in addition to efforts to reduce the incidents across all categories. Quality Assurance staff have transitioned into playing a more active role in investigations. Staff's expertise and knowledge have increased over the years. The policies and procedures have been modified and improved as situations result in devising new and different strategies and methods. The overarching goal is prevention and reduction of critical incidents due to a concerted effort by DSS QA staff and the Access Agencies. QA staff contact providers who have not followed policies and procedures, may request documentation or take further actions.

Emergency Room Visits and Unplanned Hospitalizations

One third of critical incidents involve emergency room visits or unexpected hospitalizations. Having identified this, Quality Assurance staff used new strategies to reduce this number. One of the interventions was attention to follow up care afterward by suggesting services such as skilled nursing. Since the previous year, emergency room visits and unplanned hospitalizations were reduced by 20% from the previous fiscal year.

Community Options Quality Assurance staff increased scrutiny of critical incidents has gradually decreased the number of unplanned hospitalizations and Emergency Room. Visits to the ER are evaluated according to severity and urgency of visit. Elders may press the Emergency Response System button for an ambulance when a visit to the Primary Care Physician or Skilled Nursing Visits might have alleviated the need for frequent hospital visits. As is happening currently, elders on the program generally have one or more health conditions and/or care needs which may legitimately require an Emergency Room visit or unplanned hospitalization.



The above chart indicates that efforts to prevent and reduce emergency room visits and unplanned hospitalizations have slowly reduced the incident rate.

Personal Care Assistant Training

Adequate training of Personal Care Assistants (PCA) was identified as an issue contributing to the frequency of critical incidents. Community Options Quality Assurance staff and subject matter experts from community provider agencies produced the PCA Training Modules and Certification Test. The training is now a requirement for all agencies who employ PCAs. The training is available on the Community Options webpage. (<https://portal.ct.gov/DSS/Health-And-Home-Care/Long-Term-Care/Community-Options/Documents>)

Most Common Critical Incidents

Allegations of abuse, neglect or exploitation may be reported to Protective Services for the Elderly available for participants age 60 and older. An average of 18% of critical incidents were reported to PSE over the past three years. Connecticut does not have protective services for adults.

Self-neglect is a worldwide, serious public health issue that can have serious and devastating health outcomes. Interventions may be challenging as evidenced by narratives in the critical incident. Community Options distributed a PowerPoint presentation to the Access Agencies to help with these situations.

Participant aggressive behavior toward caregiver, may result from the personality changes from Alzheimer’s disease and other forms of dementia. Certain prescription medications may have



negative side effects including aggression.. Mood may be affected by anxiety or depression over worsening health conditions.

The unexpected absence of a caregiver may result in serious health and wellness risks for participants who cannot be left alone. Critical incident reporting allows Community Options Quality Assurance staff to know about and intervene in these situations.

Evictions are most often due to financial limitations, financial exploitation and theft. These issues are investigated.

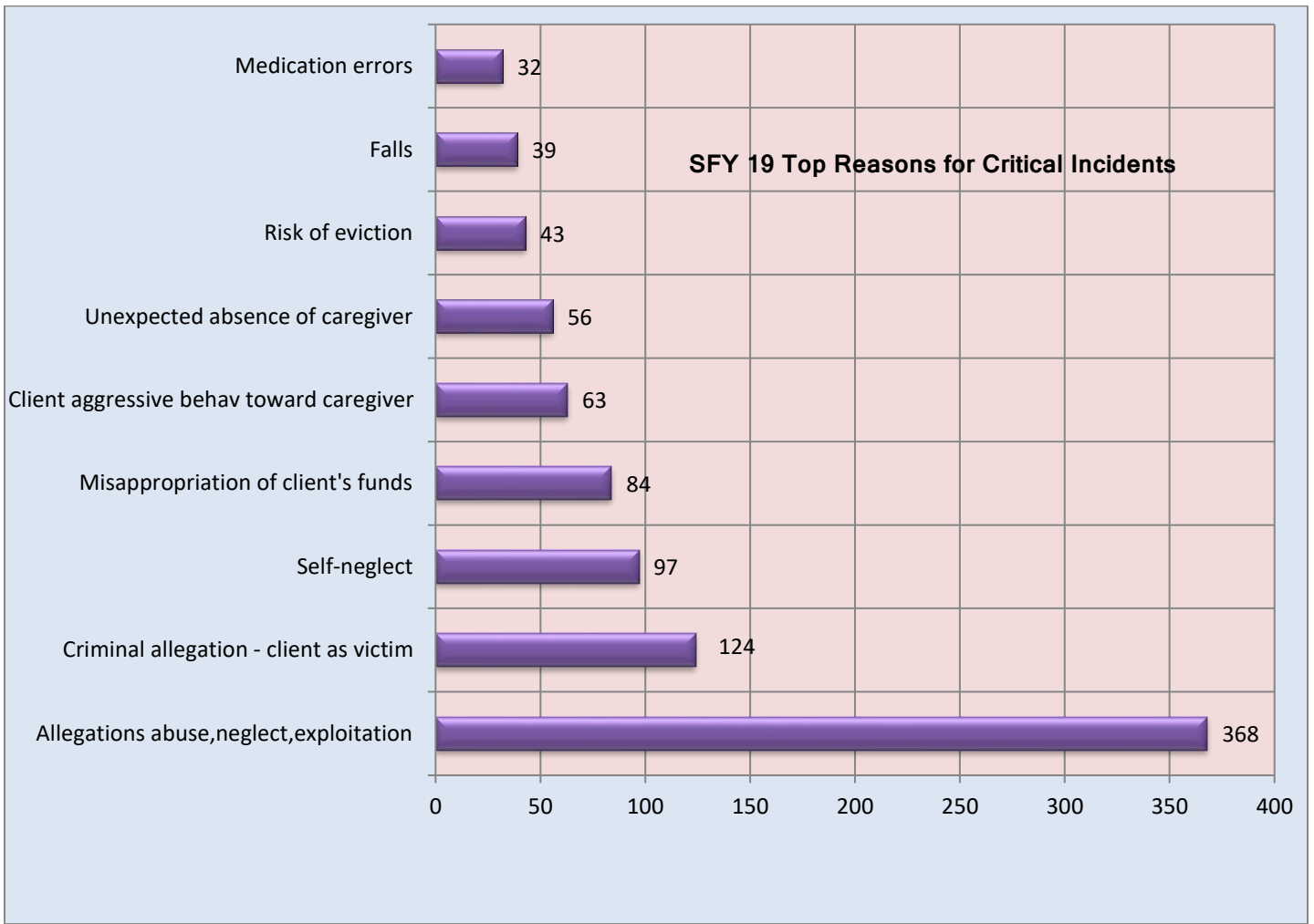
Falls, a preventable and the leading cause of injuries in seniors, may result in fractures, cuts, serious head and brain injuries that can be fatal. There has been an average of 35 falls during the past couple of years. Access Agency care managers have a variety of fall prevention assistive technology. Community Options Quality Assurance staff review the critical incident and may make recommendations for prevention strategies.

Medication errors are prevalent because most elderly people take five or more medications a day and are treated by several physicians at once.. The most common errors are related to the wrong frequency of administration, therapeutic duplication, and drug omission.

Types of Critical Incidents

Unexpected absence of the primary caregiver Untimely death Emergency room visit or unplanned hospitalization Suicide attempt Serious criminal allegation - client as victim Serious criminal allegation - client as perpetrator Allegations of abuse, neglect, or exploitation of client Risk of eviction Homelessness Self-neglect (client refusing to care for self, refusing needed services) Bug infestation Unhealthy/unsanitary living conditions Falls	Fire in residence with significant risk to client Missing person reported to police Misappropriation of client's funds Seclusion Restraint Client aggressive behavior toward caregiver Caregiver under the influence of alcohol/drugs Motor vehicle accident Domestic dispute Medication errors Cancellation of utilities (heat, electricity) Timesheet Fraud
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APPENDIX J

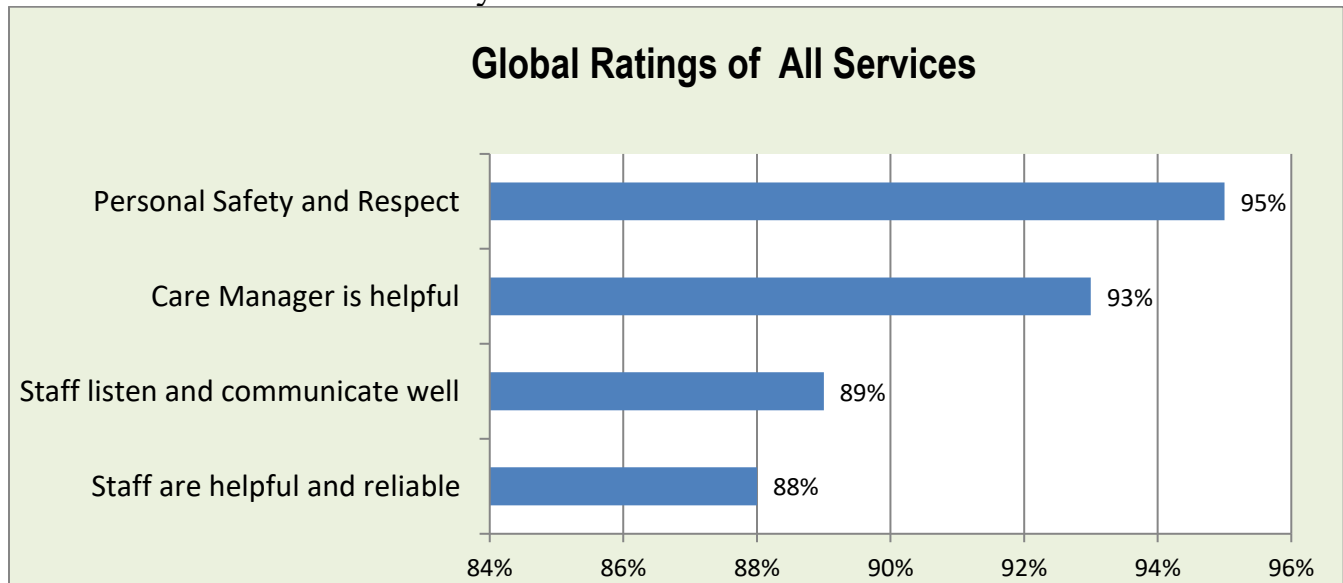
Consumer Assessment of Health Provider Systems Home and Community-Based Services (HCBS CAHPS) Survey

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

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

SFY 2019 was the first year the survey was utilized. For global ratings, respondents were asked to rate the help they get from each type of staff based on a scale from 0 to 10, or using a worded scale from poor to excellent or definitely no, probably no, probably yes, or definitely yes.

Results from the CHCPE survey:





The survey results demonstrate a high level of satisfaction with services, including care management, central to the connection to other services and supports.