STATE OF CONNECTICUT
LONG TERM CARE PLANNING COMMITTEE

December 17, 2021

The Honorable Patricia Billie Miller, Senate Chair
The Honorable Quentin W. Phipps, House Chair
Aging Committee
State Capitol, Room 011
Hartford, CT 06106

The Honorable Marilyn Moore, Senate Chair
The Honorable Catherine F. Abercrombie, House Chair
Human Services Committee, Legislative Office Building, Room 2000
Hartford, CT 06106

The Honorable Mary Daugherty Abrams, Senate Chair
The Honorable Jonathan Steinberg, House Chair
Public Health Committee, Legislative Office Building, Room 3000
Hartford, CT 06106

Dear Committee Chairs:

Enclosed please find the Long-Term Care Planning Committee's Long-Term Services and Supports Plan entitled "*Balancing the System: Working Toward Real Choice for Long-Term Services and Supports in Connecticut*" as required by Section 17b-337 of the Connecticut General Statutes. The first section of the Plan also serves as an Executive Summary.

If you have any questions on the report, please call me at the Office of Policy and Management at 860-418-6286.

Sincerely,

David Guttchen
Chair, Long-Term Care Planning Committee
Office of Policy and Management

cc: Members and Clerks of the Aging, Human Services, and Public Health Committees
Long-Term Care Planning Committee
Long-Term Care Advisory Council
Melissa McCaw, Secretary, Office of Policy and Management
Claudio Gualtieri, Undersecretary, Office of Policy and Management
Clerk of the Senate
Clerk of the House
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State Librarian

Connecticut Long-Term Care Planning Committee

Balancing the System:

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

A Report to the General Assembly

January 2022

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ACKNOWLEDGEMENTS

Many individuals and organizations provided invaluable assistance in the development of this Plan. Thanks to all the members of the Long-Term Care Planning Committee for their efforts. In addition, appreciation is extended to the members of the Long-Term Care Advisory Council who worked in partnership with the Planning Committee to enhance the quality of this Plan. Thanks also to all the individuals, organizations, and members of the public who took the time to review drafts of the Plan throughout its development and provided very helpful recommendations and advice.

I. EXECUTIVE SUMMARY

A. Balancing the System

People of all ages and from all socio-economic, racial and ethnic backgrounds need long-term services and supports (LTSS). They are our parents, siblings, children, co-workers and neighbors. Whether challenged with limitations due to injuries, developmental disabilities, mental illness, chronic health conditions, or the aging process, they all share a common need for support in order to live, work and play.

LTSS are needed to help people carry out basic functions such as eating, dressing or bathing, the tasks necessary for independent community living, such as shopping, managing finances and house cleaning and the tasks necessary to lead a normal life, such as work and recreation. Likewise, needs range from minimal personal assistance with basic activities to virtually total care. These needs for LTSS are being met at home, in the community, in congregate residences and in institutional settings.

This Long-Term Services and Supports Plan (Plan) addresses the needs for LTSS of the citizens of Connecticut. Developed by the Long-Term Care Planning Committee with input from members of the Long-Term Care Advisory Council, various organizations and individuals in need of LTSS and their family members and members of the public, this Plan was produced to educate and provide recommendations to policymakers regarding what steps Connecticut should initiate and continue to take in order to achieve a balanced and person-centered LTSS system over time through 2025.

It is Connecticut's goal to establish a LTSS system that offers individuals the services and supports of their choice in the least restrictive and most enhancing setting. This means providing real choices to Connecticut residents regarding the types of supports that they need and requires a system that is person-focused and driven.

As in previous versions of the Plan, the 2022 Plan is committed to balancing the LTSS system in terms of the ratio of home and community-based and institutional care and the ratio of public and private resources. By balancing the ratio of community-based and institutional services, what is meant is not a system with an equal split between community and institutional services. Instead, a more balanced system in Connecticut would meet the Planning Committee's long-standing goal of having 75 percent of individuals receiving Medicaid LTSS in the community and 25 percent receiving LTSS in institutions by 2025. Central to achieving this balance is a commitment to independence and choice for all individuals seeking services and supports. Towards this end, this new Plan continues to address the development and maintenance of a person-centered system of LTSS across the lifespan and across all disabilities with the focus on informed choice, least restrictive and most enhancing settings, and community inclusion.

Three years have passed since the last Plan and much has changed to improve Connecticut's LTSS system, yet there is more to be done. Changes in policy and funding on the federal and state level have fostered progress in creating a balanced LTSS system in Connecticut. Despite this progress and the many highlights which are described later in this Executive Summary, Connecticut's LTSS system still faces many of the same rules, barriers and challenges that were in place three years ago. The continuing global public health emergency (PHE) that impacted the nation in 2020 and 2021 served to further highlight these barriers.

The Coronavirus (COVID-19) pandemic presented Connecticut's LTSS system with unprecedented challenges for consumers, family members and the LTSS system that supports them. During this time, Connecticut learned valuable lessons about the strengths and gaps in the current LTSS system that will be used to make system improvements beyond the period of the PHE. As the presence of the virus continues to persist into 2022, and the State continues to reflect on lessons learned. one thing is clear: Connecticut has come far but still has much work to do.

To address these challenges, this Plan centers around two central themes.

1. Long-Term Services and Supports Affects Everyone

LTSS will affect all of us at some point in our lives. Whether it is because we need services and supports ourselves, or we are providing care for someone in need, regardless of age, health or wealth, it is unlikely that we will be able to escape the issue.

In keeping with this theme, this Plan is designed to address the current and future needs of all individuals in need of LTSS, regardless of their age or disability. This is the seventh Plan developed by the Long-Term Care Planning Committee under the Committee's expanded mandate to go beyond the needs of just older adults and address the system as a whole, encompassing all individuals with disabilities and their families.

Therefore, all of the recommendations and action steps put forward in this Plan apply to individuals of all ages and disabilities, unless specifically noted. While we recognize that historically certain populations have not received the equal footing they deserve in terms of attention and resources in LTSS planning and program development, we have deliberately been inclusive in our recommendations and have not segmented out certain groups of individuals or disabilities. This strategy is designed to break down some of the barriers experienced by individuals with certain disabilities and promote a philosophy that is person-centered and focused on the needs of individuals and their families.

It is important to note that not only will virtually everyone be touched by the LTSS system at some point in their lives, but improvements in this system also benefit society at large. For example, addressing the shortage of LTSS workers also addresses the need

for health professionals in other settings, and improving access to public transportation benefits everyone, not only individuals with disabilities.

Accordingly, the critical terms used in this Plan are defined as follows:

- *Long-term services and supports (LTSS)* refer to a broad range of paid and unpaid services for persons who need assistance due to a physical, cognitive or mental disability or condition. LTSS consist largely of personal assistance with the routine tasks of life as well as additional activities necessary for living independently at home, at work, at school and at recreational activities. Unlike medical care where the goal is to cure or control an illness, the goal of LTSS is to allow an individual to attain and maintain the highest reasonable level of functioning in the course of everyday activities and to contribute to independent living.
- *Home and community-based care* encompasses home care, adult day care, respite, community housing options, transportation, personal assistants, assistive technology and employment services.
- *Institutional care* includes nursing facilities, intermediate care facilities for people with intellectual disabilities (ICF/IDs), psychiatric hospitals, and chronic disease hospitals.

2. The Current System Is Out of Balance

While Connecticut has made great strides in providing real choices and options for older adults and individuals with disabilities, there is still work to be done to be balance the LTSS in two important areas.

Balancing the Ratio of Home and Community-Based and Institutional Care

In order to provide real choices to individuals and families there needs to be equal access to community and institutional care, regardless of age and disability. While there are several sources of payment for LTSS, Medicaid is by far the largest payer and therefore is the focus of this discussion. Though significant changes have been made in the last several years, traditionally, in Connecticut and nationwide, Medicaid has made access to institutional care easier than home and community-based care. Largely, this is a result of federal Medicaid rules and regulations. Consequently, the ratio between care and supports provided in the home and community and those provided in institutions has consistently been out of balance and skewed towards institutional care.

It is important to note that while the Medicaid program provides a critical benchmark for the balancing of the LTSS system, there are other important sources of funding for LTSS in Connecticut. For example, the mental health system is substantially funded with State dollars, and the Department of Developmental Services (DDS) provides many services for individuals with intellectual disability with State funds. Also, a number of services for older adults are funded through the federal Older Americans Act. Programs

and services funded by other sources are discussed when relevant and appropriate throughout this Plan.

In order to realize the Vision and Mission provided in Section II of this Plan, Connecticut must continue its efforts not only to balance the mix between home and community-based and institutional care, but must strive for a system that provides more options for home and community-based care so that individuals with disabilities and their families have real choices and control over the services and supports they receive. Institutional care plays a vital role in the continuum of LTSS. However, Connecticut should develop a system whereby individuals enter institutions by choice and not because the necessary and reasonable supports are unavailable for them to live in the community.

In addition, the LTSS system must provide support to the network of informal caregivers and ensure the recruitment and retention of formal caregivers, whose respective roles are essential, complementary and form the backbone of the LTSS system. This will become increasingly critical as the number of individuals receiving home and community-based care increases over the next several decades. It is also important as the demographics of Connecticut shift, that all levels of the LTSS system implement strategies that address cultural competence to ensure that consumers and caregivers, regardless of race, ethnicity or primary language have equal access to high quality LTSS.

Balancing the Ratio of Public and Private Resources

The second area of imbalance involves the resources spent on LTSS. The need for LTSS is one of the most complex and difficult issues for individuals and families to understand and discuss. Many people are under the false impression that Medicare, and other health insurance programs, will cover their LTSS needs. This misunderstanding, coupled with the fact that most individuals understandably would rather not face, or discuss, the possibility of becoming disabled and dependent, leads most people to do little or no planning for their future LTSS costs.

The lack of Medicare and health insurance coverage for LTSS, combined with high costs of care, accessibility of affordable long-term care insurance policies and the lack of planning, has created a LTSS financing system that is overly reliant on the Medicaid program. Medicaid, by default, has become the primary public program for LTSS. However, in order to access Medicaid, individuals must first impoverish themselves. Therefore, we have a system that requires individuals to spend all their savings first in order to receive government support for their ongoing needs.

If our current system continues unchanged, not only will we experience more and more impoverishment as increasing numbers of Connecticut residents need LTSS, but the Medicaid safety net will start to erode. The financing of our LTSS system must be based on a balanced public/private alliance that stresses personal responsibility for those who can afford it coupled with the necessary obligation of government to provide supports for those who lack the resources to meet their needs.

B. Facts and Trends

- People of all ages and from all socio-economic, racial and ethnic backgrounds need LTSS.
- Disabilities affect 11.9 percent of all Connecticut residents – 419,252 individuals in 2019. (See page 33)
- Among older adults living to age 65 during the period of 2020-2024, it is estimated that 57 percent will need paid LTSS over the course of their lifetime. In general, 70% of individuals living beyond age 65 will develop some form of LTSS need. Women and low-income individuals have a greater chance of needing LTSS (61.1 percent and 61.6 percent respectively) than men (50.9 percent). (See page 33)
- Home and community-based services (HCBS) help people with LTSS needs stay in their homes and communities while reducing LTSS spending. Medicaid pays the majority of LTSS expenses. In Connecticut, in state fiscal year (SFY) 2021, Medicaid LTSS expenses accounted for 15 percent of the state budget and 39 percent of the Medicaid budget. (See page 48)

C. What's New in Connecticut

Some of the major changes that have been made to the system of LTSS in Connecticut in the last three years are described below (also see Appendix G). Although significant progress has been made in improving choice, opportunities for self-direction, community inclusion and access to community-based services, many inequities remain in access to services and many individuals have unmet needs for LTSS. More progress is needed if we are to meet our goals for achieving real choice and truly balancing the LTSS system.

The Coronavirus (COVID-19) Pandemic

The final two years of the preceding LTSS Plan (2019-2021) were marked by the onset of the COVID-19 pandemic. The pandemic spread across the globe and eventually the State of Connecticut, resulting in Governor Lamont declaring a public health emergency (PHE) on March 10, 2020. The State's LTSS system had to rapidly shift focus to activities related to infection control and prevention and emergency management. Consumers of LTSS were among the most vulnerable populations and their health and safety became paramount at the State and local levels. As the 2022 Plan period begins, the public health emergency is still underway, but almost two years later, the State has learned valuable lessons that can be used to improve the quality of the Connecticut's LTSS system now and beyond the time of COVID-19. The 2022 LTSS Plan does not attempt to explore the State's COVID-19 response in-depth as this could be a report of its own and other researchers have undertaken this task. This Plan does, however, take into consideration the valuable lessons learned from the pandemic as voiced by the State agency staff, community organizations, advocacy groups and members of the public who submitted recommendations for this Plan.

- ***Lessons Learned During the COVID-19 Pandemic***

The following non-exhaustive list of lessons learned during the pandemic, reflects topics that were most frequently raised in public comments and are subsequently reflected in the recommendations driving this 2022 Plan.

(1) Workforce Development: Although this has been an important recommendation in previous versions of the Plan, the need to focus on workforce development as a short-term priority was highlighted during the pandemic and was the number one area of concern raised in public feedback from all respondents regardless of whether they were community organizations, advocates, informal caregivers or consumers. Developing and retaining a quality LTSS workforce across the State's LTSS system was included in prior versions of the Plan in recognition of the fact that the direct care workforce was not increasing at a rate that would keep pace with the rapidly growing aging population (See section III for demographics). However, the LTSS workforce across institutional and HCBS settings was one the industries negatively impacted by the PHE, as many workers chose to leave the workforce. The majority of consumers who provided public comment for this Plan noted losing workers during COVID-19 due to resignation and/or being unable to find new workers to provide needed daily supports. Individuals representing the nursing home industry also stressed during the comment period that workforce development and retention is an immediate and critical priority. Therefore, the need to bolster the LTSS workforce has moved from a long-term recommendation as it was categorized in previous Plans to a short-term and urgent recommendation of the 2022 Plan.

(2) Improve Back-Up Planning for Consumers Self-Directing Their Services: A key theme across all public listening sessions, comprised of 40 members of the general public with direct experience with the State's system of LTSS, was that consumers and their informal caregivers/family members need assistance with the development and implementation of back-up plans when scheduled formal and informal caregivers become suddenly unavailable to provide care. Listening session participants noted that the need for an actionable back-up plan resulting in the rapid provision of substitute workers has been exacerbated during the PHE as consumers were faced with workers resigning without notice or becoming ill. Informal caregivers shared that in the absence of a method to secure immediate worker replacements they became 24/7 caregivers and lived in fear of what would happen if they became unavailable to provide support. Consumers and informal caregivers universally reported not having an actionable back-up plan to deal with emergency absences and difficulty quickly finding replacement staff willing to work. Once interested and qualified staff were found, consumers on Medicaid HCBS programs reported waiting several weeks to get through the State mandated hiring process. This left some consumers without care for

periods of time during the day and informal caregivers in fear of what would happen to their loved one if they unexpectedly became incapacitated.

(3) Visitation Policies at Nursing Facilities: In March 2020, in response to the COVID-19 outbreak, Connecticut nursing homes implemented strict visitor restrictions in an effort to contain the spread of the virus. However, many caregivers who provided comment on the LTSS Plan urged the Planning Committee to include recommendations related to the right of nursing home residents to have at least one designated caregiver able to visit in order to reduce the negative impacts that isolation was having on their loved ones' mental and physical health. Visitor restrictions were also stressful on family and caregivers who did not feel an outside party was on premises to make sure their loved one was receiving adequate care. Recommendations regarding caregiver and resident rights have been added to the Plan in response to this feedback.

- ***A Study of the COVID-19 Outbreak and Response in Connecticut Long-Term Care Facilities***

Residents in institutional settings were among the most effected by the onset of COVID-19. As of July 30, 2020, nursing home residents accounted for 72% of COVID-19 deaths in Connecticut[1]. It became evident early in the pandemic that residents in nursing facilities were at greater risk of experiencing complications from COVID-19 for a variety of reasons, including the presence of underlying health conditions and the level of interaction that occurs in congregate care settings[2]. In response to the disproportionate effects of COVID-19 on these facilities, on June 8, 2020, Governor Ned Lamont ordered an independent assessment on the impact of COVID-19 on Connecticut's nursing homes and assisted living facilities[3]. The assessment, conducted in partnership with the University of Connecticut, Center on Aging, took place from July 13, 2020 – September 15, 2020 and resulted in the release of a final report on September 30, 2020 consisting of 23 short-term and 22 long-term recommendations to assist long-term care facilities and the State to improve readiness to handle any future disease related outbreaks[4]. The full report can be accessed at the following link: https://portal.ct.gov/-/media/Coronavirus/20201001-Mathematica-final-report.pdf.

[1] Mathematica Final Report: *A Study of the COVID-19 Outbreak and Response in Connecticut Long-Term Care Facilities;* September 30, 2020. https://portal.ct.gov/-/media/Coronavirus/20201001-Mathematica-final-report.pdf
[2] Ibid
[3] Governor Lamont Press Release, June 8, 2020. https://portal.ct.gov/Office-of-the-Governor/News/Press-Releases/2020/06-2020/Governor-Lamont-Orders-Independent-Analysis-of-COVID19-in-Nursing-Homes
[4] Mathematica Final Report: *A Study of the COVID-19 Outbreak and Response in Connecticut Long-Term Care Facilities*; September 30, 2020. https://portal.ct.gov/-/media/Coronavirus/20201001-Mathematica-final-report.pdf

- **Nursing Home and Assisted Living Oversight Working Group (NHALOWG):**

NHALOWG was formed by legislators, in conjunction with the Executive Branch, to make recommendations on proposed legislation for the 2021 legislative session addressing lessons learned from COVID-19 based upon the Mathematica final report, *A Study of the COVID-19 Outbreak and Response in Connecticut Long-Term Care Facilities,* and other related information concerning: (1) Structural challenges in the operation and infrastructure of nursing homes and assisted living facilities; and (2) Changes needed to meet the demands of any future pandemic[5]. To achieve the stated goals, NHALOWG formed four subcommittees each focusing on specific areas of concerns. The subcommittees were comprised of key stakeholders who developed topic area specific recommendations that were submitted to legislature prior to the start of 2021 legislative session. The subgroups and links to their final recommendations are as follows:

(1) ***Infrastructure and Capital Improvement Subcommittee:***
https://cga.ct.gov/app/tfs/20201109_Nursing%20Home%20and%20Assisted%20Living%20Oversight%20Working%20Group/Subcommittee%20Recommendations/NHALOWG%20Infrastructure%20and%20Capital%20Improvement%20Subcommittee%20Recommendations.pdf.

(2) ***Outbreak Response and Surveillance Subcommittee:***
https://cga.ct.gov/app/tfs/20201109_Nursing%20Home%20and%20Assisted%20Living%20Oversight%20Working%20Group/Subcommittee%20Recommendations/NHALOWG%20Outbreak%20Response%20and%20Surveillance%20Subcommittee%20Recommendations.pdf

(3) ***Socialization, Visitation and Caregiver Engagement Subcommittee:***
https://cga.ct.gov/app/tfs/20201109_Nursing%20Home%20and%20Assisted%20Living%20Oversight%20Working%20Group/Subcommittee%20Recommendations/NHALOWG%20Socialization,%20Visitation%20and%20Caregiver%20Engagement%20Subcommittee%20Policy%20Recommendations.pdf.

(4) ***Staffing Levels Subcommittee:***
https://cga.ct.gov/app/tfs/20201109_Nursing%20Home%20and%20Assisted%20Living%20Oversight%20Working%20Group/Subcommittee%20Recommendations/NHALOWG%20Staffing%20Subcommittee%20Recommendations.pdf.

[5] NHALOWG web page on the CT General Assembly web site https://cga.ct.gov/app/taskforce.asp?TF=20201109_Nursing%20Home%20and%20Assisted%20Living%20Oversight%20Working%20Group.

- ***Federal Funding Related to COVID-19:***

During the PHE, the federal government provided multiple aid packages to assist states and the public respond to and obtain relief from the effects of COVID-19. The three overarching relief packages passed by Congress during the PHE and impacting LTSS were: (1) the Families First Coronavirus Response Act (FFCRA)[6], (2) the Coronavirus Aid Relief and Economic Security (CARES) Act[7], and (3) the American Rescue Plan Act (ARPA)[8].

President Biden signed ARPA on March 11, 2021. Section 9817 of ARPA provides states with a temporary 10 percentage point increase to the federal medical assistance percentage (FMAP) for certain Medicaid expenditures for HCBS. ARPA funding is available to enhance, expand and/or improve person-centered HCBS. ARPA provides Connecticut with timely access to funds to support the immediate stabilization of the HCBS workforce and to urgently expand needed growth in HCBS capacity given the shift in preference to HCBS in lieu of institutionalization that occurred during the COVID-19 public health emergency. ARPA requires that states use the federal funds attributable to the increased FMAP to supplement, not supplant, existing state funds expended for Medicaid HCBS in effect as of April 1, 2021 and requires states to use state funds equivalent to the amount of federal funds attributable to the increased FMAP to implement or supplement the implementation of one or more activities to enhance, expand, or strengthen HCBS under the Medicaid program.

Connecticut's ARPA plan invests in several key areas of HCBS infrastructure with three human service specific State agencies: the Department of Social Services (DSS), the Department of Developmental Services (DDS) and the Department of Mental Health and Addiction Services (DMHAS). Specific components related to State investments focus on the following areas: (1) enhance HCBS workforce; (2) expand and integrate the use of assistive technology; (3) enhance self-direction; (4) enhance and expand HCBS delivery transformation; (5) enhance provider infrastructure and (6) strengthen quality[9].

For more information on ARPA and to view individual state spending plans and narratives visit the dedicated CMS ARPA web page https://www.medicaid.gov/medicaid/home-community-based-services/guidance/strengthening-and-investing-home-and-community-based-services-for-medicaid-beneficiaries-american-rescue-plan-act-of-2021-section-9817-spending-plans-and-narratives/index.html.

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[6] Public Law 116–127, FFCRA, March 18, 2020. https://www.congress.gov/116/plaws/publ127/PLAW-116publ127.pdf.
[7] Public Law 116–136, CARES Act, March. 27, 2020. https://www.congress.gov/116/plaws/publ136/PLAW-116publ136.pdf.
[8] Public Law 117-2, ARPA, March 11, 2021. https://www.congress.gov/117/plaws/publ2/PLAW-117publ2.pdf.
[9] Summary provided by the Department of Developmental Services, November 2021.

Progress in Meeting the Balancing Goals

This Plan advocates that by 2025, by providing more choices for those with LTSS needs and assuring access to needed services, the Connecticut Medicaid program should be serving 75 percent of LTSS clients in home and community-based settings[10], with only 25 percent choosing institutional care[11]. Since SFY 2003, the percentage of Medicaid clients receiving care in the community has increased by 52%: from 46% in SFY 2003 to 70% in SFY 2021. The percentage of Medicaid LTSS clients receiving services in the community since the last Plan, has increased from 64 percent in SFY 2018 to 70 percent in SFY 2021. Slowly, but surely, the Connecticut Medicaid program is moving in the right direction and meeting the Plan's goal.

With regard to public spending on LTSS, between SFY 2003 and SFY 2021 the proportion of Medicaid LTSS expenditures for home and community-based services increased by 94 percent, rising from 31 percent to 60 percent of all Medicaid LTSS expenditures. Likewise, there was a 41 percent decrease in the proportion of expenditures for LTSS provided in institutional settings. Overall, total Medicaid LTSS expenditures increased by approximately 75 percent between SFY 2003 and SFY 2021 ($1.914 billion to $3.344 billion).

Long-Term Services and Supports Scorecard for Connecticut

As part of a national survey, a State Long-Term Services and Supports Scorecard based on the experience of older adults and people with physical disabilities (a subset of the population using LTSS) was published by AARP in 2020[12]. Connecticut received an overall ranking of 6 among all the 50 states in the country. The score card looks at five areas of measurement, with each number ranking the state among all 50 states:

1) Affordability and access (CT = 2);

2) Choice of setting and provider (CT = 11);

3) Quality of life and quality of care (CT = 15);

4) Support for family caregivers (CT = 11); and

5) Effective transitions (CT = 26).

[10] The Medicaid long-term care community services include home health services, hospice, home and community-based waiver programs, and targeted case management for mental health and developmental disabilities.

[11] The Medicaid long-term care institutional services include nursing facilities, hospice, intermediate care facilities for persons with developmental disabilities (ICF/IDs), and chronic disease hospitals.

[12] *Advancing Action, 2020: A State Scorecard on Long-Term Services and Supports for Older Adults, People with Physical Disabilities, and Family Caregivers*; AARP Public Policy Institute, 2020

Money Follows the Person Rebalancing Demonstration

The Money Follows the Person (MFP) Rebalancing Demonstration, which began operation in December 2008, has been a leading force in Connecticut's efforts to rebalance the LTSS system to reflect consumer needs and choice. The program, located within the Department of Social Services (DSS), serves Medicaid eligible individuals across the age span with physical disabilities, mental illness and intellectual and cognitive disabilities. Under MFP, as of September 2021, over 6,800 individuals have been transitioned from a nursing facility to community living, exceeding the initial goal of 5,200 transitions. Connecticut has established five rebalancing benchmarks under MFP that are aligned with the goals of this 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 an institution.

Progress in meeting these benchmarks is monitored through ongoing evaluations by the University of Connecticut Center on Aging at https://health.uconn.edu/aging/research-reports/.

Housing Initiatives

- ***Section 811 Project-Based Rental Assistance (PRA) program***

The Department of Housing (DOH), in conjunction with the Department of Developmental Services (DDS), and DSS, 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. 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.

- ***Connecticut Housing Engagement and Support Services (CHESS)***

CHESS is a new initiative to cover supportive housing benefits under Medicaid by combining both Medicaid services and non-Medicaid housing subsidies. Housing plus supports have historically been instrumental in helping Medicaid members to achieve housing stability, improve health, community integration and life satisfaction[13]. CHESS

[13] Department of Social Services, *CHESS Frequently Asked Questions*, https://www.ctchessdss.com.

aims to achieve housing stability, improved health, and community integration and life satisfaction.

To participate in CHESS, individuals must be 18 or older, have active Medicaid status, and meet all the requirements for CHESS. The requirements for CHESS include:

- being at risk of homelessness,
- have a Modified Charlson Comorbidity Index score of more than 4,
- have a behavioral health diagnosis recognized by the International Classification of Diseases, and
- have at least 2 critical needs[14].

Long-Term Services and Supports Rightsizing Initiative

The Rightsizing Initiative, under the direction of the MFP Rebalancing Demonstration, was developed to respond to the projected rapid growth in the need for community-based LTSS over the next 10 to 15 years in Connecticut.

- ***Rightsizing Strategic Plan***

In January 2013, then Governor Malloy and DSS released the State's first Rightsizing Plan, *Rebalancing Long-Term Services and Supports*, *2013-2015*. It was the result of a multi-month process of stakeholder briefings, engagement, and data and systems analysis. It also met the requirements of Public Act 11-242, which required DSS to develop a strategic plan, consistent with this LTSS Plan, to rebalance the Medicaid LTSS system[15]. In January 2020, Governor Lamont, the Office of Policy and Management (OPM) Secretary and DSS Commissioner released an updated copy of the State's Strategic Plan to Rebalance Long-Term Services and Supports as part of an initiative by Governor Ned Lamont and the General Assembly to expand long-term care options and assist the nursing home industry to diversify its business model to meet changing service needs. The 2020 Plan, which will be updated annually, reflects collaboration and coordination across multiple State departments, the federal government, home health providers, nursing home administrators, consumers and other stakeholders to address the anticipated, unprecedented demand for Medicaid-funded long-term care through 2040 and accelerate the pace of rebalancing. According to the 2020 Rightsizing Plan[16]:

- By 2040 more than 50,488 individuals in Connecticut are expected to need Medicaid LTSS – an increase of more than 4,481 individuals over 2017 levels.
- The ratio of clients receiving Medicaid home and community-based and institutional services is expected to shift from 70%/30% respectively in SFY 2021 to 76%/24% by 2025 and 82%/18% by 2040.

[14] Ibid.
[15] Department of Social Services, *Strategic Rebalancing Plan, 2013 – 2015*; January 29, 2013.
[16] Department of Social Services, *Strategic Rebalancing Plan: A Plan to Rebalance Long Term Services and Supports, 2020*; January 29, 2020.

- Currently, the key initiative driving these results is the Money Follows the Person Rebalancing Initiative.

DSS continues its efforts to meet the updated strategies identified in the 2020 Plan through various strategies including a strong commitment to continued partnership with local communities and other stakeholders to facilitate change at the community level. The full Plan can be accessed at this link: https://portal.ct.gov/-/media/Departments-and-Agencies/DSS/Health-and-Home-Care/Medicaid-Long-Term-Care-Demand-Projections/strategic_rebalancing_plan-2020.pdf?la=en.

Private Financing of Long Term Services and Supports

- **Short-Term Care Insurance[17]:** Effective October 1, 2016, "short-term care insurance" became available as a new type of insurance providing certain health benefits for 300 or fewer days. Short-term care insurance works similarly to long-term care insurance except that it covers a maximum 300 days of care. Long-term care insurance policies in Connecticut are required to cover a minimum of 365 days.

- **Long-Term Care Insurance:** The Connecticut Partnership for Long-Term Care (Partnership) was developed to constrain the growth in Medicaid long-term care expenditures by educating Connecticut residents about the importance of planning ahead for future long-term care costs and by offering, through private insurers, high-quality, affordable long-term care insurance that provides protection against impoverishment. 2021 was the 29th full year that Connecticut Partnership policies were available for purchase by Connecticut residents and over 60,500 policies have been sold.

  The Connecticut Partnership continued its proactive efforts to educate Connecticut residents, agents, financial planners and other interested parties about the need to plan ahead to meet future long-term care costs. Despite the challenges posed by COVID-19, in 2021, Partnership staff (OPM) provided 14 virtual presentations and trainings to professionals and the public, reaching more than 300 people across the state[18].

Home and Community-Based Services Programs

- **Acquired Brain Injury Waiver II (ABI II):** Effective December 1, 2014, DSS implemented the Acquired Brain Injury (ABI) Waiver II in order to increase the number of available waiver slots for individuals ages 18-64 with disability due to an ABI. ABI Waiver II varies from ABI Waiver I in the following ways: (1) offers a lower

[17] Text of the P.A.16-63 – An Act Concerning Short-Term Care Insurance, can be found at https://www.cga.ct.gov/2016/ACT/pa/2016PA-00063-R00HB-05521-PA.htm

[18] Office of Policy and Management, *Connecticut Partnership for Long-Term Care Annual Progress Report to the General Assembly*; January, 2022.

cost cap, at 150% of the cost of institutional care vs. 200% of the cost of institutional care for ABI Waiver I; (2) does not cover Transitional Living Services due to underutilization of the services in ABI Waiver I; and (3) includes five additional services: adult day health, ABI Recovery Assistant, ABI Recovery Assistant II, consultation services and agency-based personal care. In SFY 2021, there were 218 active clients enrolled in the ABI II program.

- **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 federal Patient Protection and Affordable Care Act (ACA), enables 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 Systems, and assistive technology. In SFY 2021, CFC served over 4,000 individuals. Of those individuals, a monthly average of 1,686 consumers participated in CFC without the additional support of a Medicaid waiver[19].

- Behavioral Health Homes (BHHs): The Affordable Care Act, enacted in March of 2010, created an optional Medicaid State Plan benefit for states to establish "health homes" to coordinate care for Medicaid participants who have chronic conditions. Under this authority, the Department of Mental Health and Addiction Services (DMHAS) along with its State Partners, DSS and the Department of Children and Families (DCF), created the Connecticut Behavioral Health Home Initiative (BHH). Connecticut implemented BHH utilizing the existing infrastructure of its private/non-profit and state operated Local Mental Health Authorities (LMHAs) and one of their affiliates. There are fourteen BHH provider agencies across the state. In SFY 2021, the average monthly enrollment in BHH was over 7,000 individuals.

  A BHH is an integrated healthcare service delivery model that aims to treat the whole person by incorporating physical healthcare into the care individuals receive at their established behavioral health provider. The model promises better patient experience and outcomes than those achieved in traditional service delivery models. Connecticut's State Plan Amendment to provide BHH was approved by federal Centers for Medicare and Medicaid Services (CMS) in September 2016 with an effective date of October 1, 2015. BHH services are targeted to individuals with severe and persistent mental illness who are eligible for Medicaid with annual claims of at least $10,000 per year. The services available through BHH include: (1)

[19] Department of Social Services, Community Options Unit, Annual CFC Statistical Report to the Office of Policy and Management, Health and Human Services Policy and Planning Division, November, 2021.

comprehensive care management; (2) care coordination; (3) health promotion; (4) transitional care; (5) patient and family support and (6) referral to community support services.

The use of health information and data are an integral part of the BHH model. DMHAS works closely with the BHH provider agencies to use Medicaid and other related health data to identify clients in need of a medical screen or exam, clients who have visited the emergency room, and clients who are at risk of developing chronic conditions in order to tailor outreach, engagement and treatment.

In calendar year 2019, the most recent year for which data is available at this time, 78% of BHH enrollees hospitalized for treatment of a mental illness had a follow-up visit with a mental health practitioner within 30 days of discharge. BHH enrollees receive regular health assessments that include tracking of Body Mass Index (BMI), offering smoking cessation services, monitoring and controlling high blood pressure and depression screening. Ninety-six percent (96%) of BHH enrollees identified as tobacco users received smoking cessation intervention. Lastly, 91% of BHH enrollees who completed the satisfaction survey stated overall satisfaction with their healthcare experience.

As the BHH initiative moves into its sixth year of operation, the focus will be to work with BHH providers to target populations at risk of developing chronic conditions, to strive to decrease inequities in care through special initiatives such as health literacy, and to continuously improve the integrated care delivery model design/system through ongoing feedback from providers and enrollees.[20]

- **The Senior Outreach and Engagement Program (SOEP):** The SOEP 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 individually tailored community treatment options. Services include education, support, counseling (including in-home counseling) referrals to senior service networks and referrals for treatment. The goal of the program is to provide the services in a person-centered, strengths-based, culturally sensitive manner that reduces substance misuse, stabilizes behavioral health symptoms and improves quality of life, while assisting the participants with remaining integrated in the community in the least restrictive setting possible. The program complements existing DMHAS programs that focus on diverting older adults from long-term care institutions and the ongoing development of home and community-based services to assist older adults with "aging in place." The Senior Outreach and Engagement staff also provides education and consultation to local agencies within the

[20] Behavioral Health Home update submitted to OPM, Health and Human Services Policy and Planning Division, by the Department of Mental Health and Addiction Services, Managed Services Division, November, 2021.

designated geographic region to promote integration and collaboration of services for seniors and develop a system of aftercare for older adults identified by the program. This past year the program has worked with the FEMA funded COACH program (COVID Assistance for Community Health) to reach out to older adults negatively impacted by the COVID-19 pandemic. The two programs worked in tandem to ensure seniors had information about vaccinations, assistance with obtaining vaccinations, as well as access to individual short-term support to address issues and the stress related to the pandemic.

Nursing Facilities

- ***Moratorium:*** The moratorium on new nursing facility beds was extended indefinitely during the 2015 legislative session.[21] DSS continues to analyze and monitor the need for beds. Several methods are used to reduce unneeded capacity such as de-licensing or reclassifying beds.

- ***Nursing Facility Closures:*** According to the Connecticut Annual Nursing Facility Census Survey, there were a total of sixteen nursing facilities in the state that closed since the last LTSS Plan (2019-2021)[22]. As of September 30, 2021, there were 205 licensed nursing facilities in the State.

Workforce

- **Personal Care Attendant Collective Bargaining Agreement:** In April 2014 the first ever Collective Bargaining Agreement (CBA)[23] covering Personal Care Attendants (PCAs) hired by consumer-employers of the State's publicly funded programs was signed between the State of Connecticut Personal Care Attendant Workforce Council and the New England Health Care Employees Union, District 1199, SEIU (1199). A Successor Agreement[24] was adopted by the legislature[25] during the 2018 legislative session and extended the CBA through June 30, 2021. As of November 2021, negotiations for the next CBA were underway and parties were operating under an agreement to extend certain provisions of the prior contract.

State Government

[21] Section 391, Public Act 15-5
[22] State of Connecticut Annual Nursing Facility Census, Office of Policy and Management, Health and Human Services Policyand Planning Division, 2021.
[23] Text of the Original 2014 CBA https://portal.ct.gov/-/media/Malloy-Archive/Personal-Care-Attendant-Workforce-Council/PCAWC_Collective_Bargaining_Agreement.pdf?sc_lang=en&hash=53E5EE0A5D0F620DC87F17C142028ADE.
[24] Text of the 2018 Successor Agreement https://portal.ct.gov/-/media/Malloy-Archive/Personal-Care-Attendant-Workforce-Council/PCAWC-Doc---Collective-Bargaining-Agreement-2018.pdf
[25] House Resolution No. 8 and Senate Resolution No. 7, 2018 legislative session.

- **Community Ombudsman Program:** Special Act 19-18 required the State Long-Term Care Ombudsman and the Department of Social Services to develop a Community Long-Term Care Ombudsman program to investigate complaints concerning care received by recipients of home and community-based services administered by the Department of Social Services. Not later than January 1, 2020, the State Long-Term Care Ombudsman and the Commissioner of Social Services shall submit a report to the joint standing committees of the General Assembly having cognizance of matters relating to aging and human services identifying: (1) The persons to be served in the Community Long-Term Care Ombudsman program, (2) the types of services to be offered under such program, and (3) appropriations needed to staff the 12 Community Long-Term Care Ombudsman program. The report was completed and submitted to the General Assembly on January 1, 2020 and can be found at this link https://portal.ct.gov/-/media/LTCOP/PDF/Community-Ombudsman-report-per-Special-Act-19-18.pdf.

- **Renaming of to the Department of Aging and Disability Services (ADS) Department of Rehabilitation Services:** During the 2018 legislative session, Public Act 18-169 eliminated the State Department on Aging as a stand-alone State agency and consolidated all functions under the Department of Rehabilitation Services (DORS) and designated DORS to serve as Connecticut's State Unit on Aging, effective July 1, 2018. Public Act 19-157 officially changed the name of DORS to the Department of Aging and Disability Services to better capture the nature and scope of the services provided by the consolidated agencies.

Federal Government

- **21st Century Cures Act:** In 2016, Congress passed the 21st Century Cures Act (Cures Act), designed to improve the quality of care provided to individuals through further research, enhanced quality control and the strengthening of mental health parity.[26] Section 12006 of the Cures Act, P.L. 114-255 added Section 1903(l) to the Social Security Act (SSA) and has significant implications on the delivery of agency-based and self-directed LTSS by requiring states to implement electronic visit verification (EVV) time keeping for home health services by January 1, 2023 and personal care services by January 1, 2019. Failure to comply with statewide utilization of EVV by specified timelines will result in reduced Medicaid reimbursement called Federal Medical Assistance Percentage (FMAP)[27]. In 2018, Congress passed an amendment to Section 1903(l) of the SSA to delay the timeline for states to implement EVV for personal care services by one year from January 1, 2019 to January 1, 2020[28]. The

[26] Centers for Medicare & Medicaid Services, *Disabled and Elderly Health Programs Presentation,* December 2017. https://www.medicaid.gov/sites/default/files/2019-12/evv-presentation-part-1.pdf.
[27] Ibid.
[28] The complete Amendment to the 21 Century CURES Act can be viewed here: https://www.congress.gov/bill/115th-congress/house-bill/6042?q=%7B%22search%22%3A%5B%22hr+6042%22%5D%7D&r=1

Amendment did not affect the timeline for implementing EVV for agency-based home health services[29]. Connecticut was well prepared for the federal EVV requirement and, in 2017, implemented EVV across the agency-based home health industry. Over the last year, the State has been engaged in a phased implementation of EVV for self-directed Medicaid services. There was a brief delay in implementation due to the pandemic. However, Connecticut is on track to achieve full implementation in early 2022.

- Federal Information on EVV can be found on the CMS website: https://www.medicaid.gov/medicaid/hcbs/guidance/electronic-visit-verification/index.html.

- State specific EVV information can be found on the DSS dedicated EVV implementation web page: https://portal.ct.gov/DSS/Health-And-Home-Care/Electronic-Visit-Verification/Electronic-Visit-Verification

Other State Plans Addressing Long-Term Services and Supports

- State Plan on Aging: October 1, 2021 – September 30, 2023 https://portal.ct.gov/-/media/AgingandDisability/AgingServices/State-Plans/2021-2023-CT-State-Plan-on-Aging.pdf

- 2020-2024 Consolidated Plan for Housing and Community Development https://portal.ct.gov/-/media/DOH/20-24-ConPlan-Action-Plan-for-Publication-and-Comment.pdf

- 2021 – 2022 Action Plan for Housing and Community Development, August 11, 2021 https://portal.ct.gov/-/media/DOH/Combined-AP---Attachments---Allocation-Plan.pdf

D. Goals, Recommendations and Action Steps

The goals and recommendations provided in this Plan are put forward to improve the balance of the LTSS system in Connecticut for individuals of all ages and across all types of disabilities and their families.

In addition to the two rebalancing goals, this Plan provides a set of long-term and short-term recommendations. The long-term recommendations provide a high level view of the essential components of a well-balanced and person-centered system of LTSS. These recommendations are reflective of a system of services and supports and, as such, must be viewed as both interrelated and interdependent. The short-term

[29] Centers for Medicare & Medicaid Services, *EVV Update,* August, 2018. https://www.medicaid.gov/sites/default/files/2019-12/evv-update-aug-2018.pdf

recommendations reflect strategic priorities identified for action over the next three years (2022-2024).

In 2005, a broad philosophical statement was enacted in Connecticut statute to guide policy and budget decisions. It states, *"that Connecticut's long-term care plan and policy must 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 simple statement, designed to make real choices for individuals a reality, provides a larger framework for Connecticut upon which the Plan's goals and recommendations rest.

Overall, the recommendations in this Plan are primarily focused on initiatives State government can undertake. While the focus of this Plan is on State government, it is important to recognize the vital role that cities, towns, the private sector and individuals and families play in the LTSS system. Government at all levels must work in partnership with individuals, families and the private sector in order to develop a quality and effective system.

Goals

1. Balance 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 70 percent in 2021 to 75 percent by 2025.

2. Balance the ratio of public and private resources:

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, spending from private long-term care insurance and other public sources (State and local programs) for nursing facilities and home health services represented 20 percent of LTSS expenditures in 2021[30] (Figure 7).

Long-Term Recommendations

Optimally, a robust LTSS system that is able to maximize autonomy, choice and dignity will provide a full range of services and supports. Individuals, regardless of disability or age, should have the options that allow them to live their lives as meaningfully and

[30] "Other dedicated sources of private funds" means private long-term care insurance, other types of private insurance and other private spending for nursing facilities and home health services. It does not include "out-of-pocket" spending or informal care. Source: Hado, Edem & Komisar, Harriet, AARP Public Policy Institute; AARP Long-Term Services and Supports Fact Sheet 634, August 2019.

productively as possible in the settings that best suit their needs and preferences, in the least restrictive environment. As in any system, all the constituent parts are interrelated and interdependent. In order to meet the growing demand for LTSS, and the goals set forth in this Plan, investment in the community-based infrastructure is critical. Over the long-term, to realize the vision and achieve the goals set out in this Plan, actions must be taken on the following fronts:

- Provide true individual choice and self-direction to all users of LTSS, regardless of funding source.

- Promote efforts to enhance quality of life in various LTSS settings.

- Ensure the availability of a wide array of support services for those living in the community.

- Ensure quality of LTSS in the context of a flexible and person-centered service delivery system that acknowledges changing needs and the dignity of risk.

- Provide individuals, caregivers and persons on nursing home waitlists options counseling and decision support to encourage advanced person-centered planning LTSS to prevent institutionalization and to extend the availability of private funds for care.

- Achieve greater integration and uniformity of administration of State LTSS serving both older adults and people with disabilities and their families, and emphasize policies related to function as opposed to age, diagnosis or State agency silos.

- Encourage communities to take an active role in planning and supporting LTSS for their residents and provide state level technical assistance and financial incentives.

- Address the long-term services and supports education and information needs of the Connecticut public, including specialized educational efforts to specific groups, such as informal caregivers, baby boomers and employers.

- Provide support to informal caregivers that increase caregiver knowledge and confidence to deliver quality care, navigate the LTSS system and avoid burnout.

- Preserve and expand affordable, accessible, culturally appropriate housing in local communities across the State for older adults and individuals with disabilities, including assisted living, residential care homes, and other supportive housing and emergency housing options for older adults.

- Encourage and enable the provider community to transform and develop services and supports that will help to achieve the goals of this Plan.

- Expand and improve employment opportunities and vocational rehabilitation for persons with disabilities and older adults and ensure employment options match individual interests and include appropriate job site supports.

- Support state and local efforts to improve and expand accessible, affordable, and inclusive transportation that accommodates the needs of residents, family and direct care worker companions.

- Improve quality of life and reduce utilization of LTSS and health care services by focusing on health promotion, disease prevention and early diagnosis and intervention.

- Address emergency preparedness/disaster planning for older adults and persons with disabilities.

- Improve access to medical benefits and services to older adults and persons with disabilities being released from incarceration.

- Encourage insurance carriers to include options counseling, care transition or ongoing case management as a service covered by long-term care insurance policies.

- Prioritize and improve back-up planning resources and assistance and access to emergency supports in the State's self-directed Medicaid programs.

Short-Term Recommendations

These short-term recommendations provide an action agenda for improving the LTSS system in Connecticut in the three years spanning 2022 through 2024. Criteria for proposing these targeted priority recommendations are that they will help to ensure the success of the LTSS system and can be acted upon in the next three years.

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 by reducing or eliminating waitlists.

- Improve transparency throughout the assessment process by ensuring that consumers understand the criteria being used to make decisions regarding their budgets and supports and that consumers and/or their authorized representatives

are present at all planning meetings where level of care or service revision decisions are made.

- Ensure access to all levels of the State-funded Connecticut Home Care Program for Elders.

- Study the impact of the 2021 copay reduction from 9% to 4.5% for the State-funded tiers of the Connecticut Home Care Program for Elders, and determine the need for further reductions or elimination of the copay.

- Support the continued implementation of the 1915(k) state plan option, Community First Choice.

- Identify skills needed for residents of institutions who desire to transition back to the community and provide appropriate skills training and resources.

- Expand funding for State-funded respite services, such as the Statewide Respite Program and the Department of Developmental Services' in-home and out-of-home respite services in order to provide support to informal caregivers.

- Provide family caregivers with access to training, ongoing coaching support, respite care, mental health services and counseling, financial assistance, and encourage employers to offer workplace flexibility and opportunities for benefits.

- Continue to measure the effectiveness of the Adult Family Living model to determine future resource allocation, policy and programmatic enhancements and potential growth.

- 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.

- Strengthen the aging and disability networks within the No Wrong Door system including the collaboration between State agencies, support of person-centered counseling training and support of funding opportunities.

- Identify and remove barriers, such as insurance/entitlement reimbursements and licensing requirements that prevent or limit access to LTSS.

- Support efforts to implement person-centered planning and care regardless of the setting or service.

- Ensure equity in all LTSS programs and services through the availability of accessible materials, addressing social determinants of health and ongoing evaluation of equity in LTSS access and health outcomes among traditionally underserved populations.

- Support a robust local LTSS 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.

- 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 in-home hands-on assistance or institutionalization.

- Promote nutrition services to address malnutrition and food security through use of uniform prioritization protocols.

- Support and expand continued funding for the Senior Outreach and Engagement program to address, identify, reduce and treat substance abuse and misuse among adults ages 55 and over.

- Increase earlier access to Hospice services in the community and institutional settings.

Infrastructure

- Engage in coordinated outreach and education efforts among State agencies to provide unbiased information to Connecticut residents on the LTSS available and how to access them.

- Coordinate efforts among various entities impacting No Wrong Door development and monitor progress on the state's No Wrong Door endeavors.

- Continue the Balancing Incentive Program (BIP), to create infrastructure investments of a consumer friendly statewide No Wrong Door system, a conflict free case management, and a uniform assessment tool.

- With a focus upon hospital admission and discharge, use best efforts to assist individuals with discharge to an appropriate care setting of their choice and develop the capacity in the post-acute setting for the discharge of patients with complex care needs.

- Address the historical fragmentation of the Medicaid home and community-based waivers, which are associated with specific age and diagnostic eligibility criteria and

administered through varying State agencies and application processes. Coordination of programs and application and renewal processes between State agencies must occur to create a streamlined system that addresses the needs of the total person.

- Provide timely eligibility decisions regarding eligibility in all government sponsored LTSS programs. Consider development and use of a presumptive eligibility model.

- Continue to support the widespread adoption of telehealth and other assistive technologies to improve access to care, coordination, quality and outcomes for residents, while reducing health costs.

- Ensure the Aging and Disability Resource Center initiative under the CHOICES program continues to offer information, referral, assistance and LTSS options counseling services statewide and is integrated within the state's No Wrong Door system.

- Achieve greater integration of employment of persons with disabilities into the Money Follows the Person Rebalancing Initiative and home and community-based services.

- Eliminate the benefits cliff so that older adults and individuals with disabilities can participate in meaningful employment without risking the supports and services they need to remain active, contributing members of the community.

- Support improved coordination, communication and guidance among the medical care, behavioral health and LTSS systems across the lifespan.

    - Ensure that current and future initiatives affecting the LTSS system are well coordinated and complementary.

    - Support the utilization of evidence-based practices.

    - Support the development of electronic health records by providers of LTSS and exchange of electronic health records among providers across the Connecticut health care system to streamline care transitions, coordinate care delivery and improve quality and outcomes.

    - Support a learning collaborative approach to bring together providers across disciplines and perspectives, and to learn from older adults and individuals with disabilities.

    - Support state program coordination to ensure that individuals with dual diagnoses have the same access to LTSS and social opportunities as individuals with only a physical health diagnosis.

- Develop new, and enhance and promote existing mobility management programs, to help consumers learn how to access and navigate transportation options, including the Department of Transportation Mobility Ombudsmen program.

- 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.

- Establish on-call supports for Medicaid recipients who self-direct their LTSS so that they have someone to call with questions and concerns in order to succeed as an employer.

- Review, and modify as necessary, the current Certificate of Need process for skilled nursing homes to allow the State to work more collaboratively with nursing home providers as they seek to transition and transform their facilities.

Financing

- Study the economic status of the aging demographic to understand the future demand that will be placed on public financing of LTSS and the supply of affordable senior housing.

- Achieve adequate and sustainable provider reimbursement levels that support the cost of LTSS and quality requirements for all segments of the LTSS continuum, including nursing homes, group homes and supportive housing in order to ensure access to care and provider capacity to meet the evolving needs and demographics of Connecticut residents.

- Provide greater flexibility in the budgeting and use of Medicaid funds for LTSS.

- Capture and reinvest cost savings across the LTSS continuum.

    - Reinvest savings resulting from Money Follows the Person, the Balancing Incentive Program and other emerging Medicaid LTSSS programs to enhance the availability and capacity of home and community-based services and ensure an adequate provider network.

- Continue efforts to reform the Medicaid rate setting system to reflect quality, reimbursement related to the actual costs of care, the acuity level of the consumers and uncompensated care for all LTSS providers across the continuum consistent with LTSS 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 LTSS.

- Explore the development of tax incentives for the purchase of private long-term care insurance, including tax incentives for employer-based coverage.

- Support the continued flexible use of Older Americans Act funding for services.

- Provide increased funding to school systems so that they can hire additional social work and special education staff and train them on the programs and services available to parents and students with special needs so that they can provide meaningful assistance to families.

- Implement a caregiver tax credit or establish a State-managed fund to reimburse unpaid family caregivers who provide services that keep people in their homes and avoid the need for institutional care.

- Address the LTSS needs of immigrants who do not qualify for traditional sources of public funding and, therefore, lack access to care.

- Explore the development of LTSS programs, like the State's assisted living pilot program, that utilize private and public partnerships.

- Increase funding for behavioral health services across the LTSS continuum.

- Explore adjusting Medicaid spousal assessment rules, especially for spouses under age 65.

- Explore the provision of Medicaid reimbursement for paid caregivers to visit consumers in the hospital and other institutional settings to reduce isolation and promote better health outcomes.

Quality

- Enable a collaborative, flexible and efficient regulatory environment that is adaptive and receptive to individual providers' forward-thinking ideas and planning. Such an environment would encourage providers of the LTSS 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, Aging and Disability Services, Consumer Protection, Social Services, and the State Long-Term Care Ombudsman, should continue to work together to ensure consistency among their respective regulatory and oversight activities.

- Expand State oversight of services to individuals receiving LTSS, including those provided in group homes, to include employee job performance in the areas of

quality interactions with consumers and efforts at promoting consumer social engagement and stimulation.

- Explore using a third-party, non-State entity to conduct group home evaluations.

- 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.

- 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, including the development of multi-disciplinary teams, implementing recommendations from the Coalition for Elder Justice in Connecticut and increasing resources, training for, and collaboration with Protective Services for the Elderly, the Office of the Chief State's Attorney, and other relevant agencies to identify, investigate and prosecute cases of abuse, neglect, and exploitation.

- 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.

- Ensure all LTSS care settings, such as nursing homes, group homes and supportive housing options, have the ability, in accordance with applicable state and federal laws, to reasonably accommodate non-English speaking and deaf and hard of hearing residents by providing or arranging for appropriate interpretation services.

- Study whether the oversight and enforcement provided by Protective Services for the Elderly and Department of Consumer Protection are sufficient and adequately resourced to reduce abuse and neglect among recipients of home care services.

Housing

- Support programs that divert or transition individuals from nursing facilities or other institutions to community housing options, such as CT811.

- Develop new housing alternatives for persons with serious and persistent mental illness who do not need nursing facility level of care.

- Continue to support and strengthen the current models of affordable housing with assisted living services to ensure their viability.

- Address the needs of the aging skilled nursing facility infrastructure through maintenance, infection control, and modernization.

- Adopt policies that encourage incorporation of accessible housing features into new construction in all communities so that new housing can support its residents throughout the lifespan and in the neighborhood of their choosing.

- Continue and expand State investment in the development of housing for older adults and persons with disabilities that is affordable, accessible, culturally appropriate and located in the community of the individual's choosing.

- Encourage the growth and development of community- based service models that bring LTSS to housing residents. Work with the federal government to secure at-risk housing subsidies, preservation, and development funds.

- Reduce isolation and quality of life among older adults and individuals with disabilities by including them directly in the placement process to ensure that individuals are placed in housing where they feel most comfortable.

- Increase Medicaid and State funding for home modifications and expand the qualifying criteria for home modifications to include health and safety measures related to cognitive and behavioral needs as well as physical disabilities.

Workforce

- Address the healthcare workforce shortage across the LTSS continuum to support to improve access to and quality of LTSS.

- Develop a comprehensive and safe direct care workforce-consumer on-line matching system with details on special qualifications, such as experience working with individuals with Alzheimer's or training in behavior management.

- Develop a registry of pre-certified emergency back-up workers that can be accessed by employers of record in the State's Medicaid self-directed programs that enables them to rapidly access emergency direct care services without having to go through

the lengthy hiring process or resort to consumer hospitalization or institutionalization for care.

- 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.

- Engage in innovative workforce recruitment practices, including the recruitment and training of home care workers from local communities who will be familiar with local neighborhoods, supports and culture and individuals who currently or previously served as community health workers or informal caregivers to be paid peer supports and/or service providers for individuals participating in the State's self-directed Medicaid programs.

- Address the need for both paid skilled health care and unskilled care (e.g., companionship) to provide stimulation and increase psycho-social health outcomes.

- Engage local Boards of Education and school systems in the promotion of direct service home care as a career option for students.

- Reduce the amount of time it takes to hire staff through self-directed programs.

- Promote workforce training that addresses physical and mental health needs across the lifespan.

- Promote flexibility in workplace employment policies and practices to accommodate the circumstances of unpaid family caregivers.

- Develop and maintain a well-trained and equitably reimbursed agency-based home and community-based services workforce for individuals who do not wish to self-direct care.

- Provide education and training to direct care workers and unpaid family caregivers on skills and competencies related to the physical, cultural, cognitive, and behavioral health care needs of consumers of LTSS.

- Create and communicate career advancement opportunities for direct service providers across settings so that dedicated workers can grow in their skills and compensation while continuing to provide needed services in both community and institutional settings.

E. Development and Implementation of the Plan

Development

The Long-Term Care Planning Committee, created under Public Act 98-239, is charged with developing for the General Assembly a LTSS plan for Connecticut every three years. Committee membership is comprised of representatives of ten State agencies and the Chairs and Ranking Members of the General Assembly's Human Services, Public Health and Aging Committees (see Appendix B for a list of Planning Committee members). The Long-Term Care Advisory Council, created under Public Act 98-239, is composed of providers, consumers and advocates and provides advice and recommendations to the Planning Committee (see Appendix C for a list of Advisory Council members).

In 2021, the Long-Term Care Planning Committee embarked on the development of its ninth long-term care plan with input from the Advisory Council, various organizations, individuals in need of LTSS and their families and members of the public. The Advisory Council worked with the Planning Committee in four essential areas: providing data, identifying areas of need, developing recommendations, and obtaining public input.

Members of the Advisory Council assisted the Planning Committee with gathering broad public input on the draft Plan from diverse organizations and individuals throughout Connecticut with an interest in LTSS. Public comment was solicited multiple times during the planning: on the draft recommendations through a written survey and four public listening sessions in July, September and October of 2021 and the full Plan in December of 2021. (*See Appendix D – Sources of Public Comment).*

Implementation

To implement the majority of the recommendations and action steps included in this Plan, the Governor and General Assembly will need to make decisions regarding statutory changes and allocation of resources. For those items that the Governor and the General Assembly choose to pursue, the State agencies represented on the Planning Committee, in collaboration with the Long-Term Care Advisory Council, will work together to implement those recommendations and action steps.

For those aspects of the Plan that do not require legislative changes or allocation, or reallocation, of resources, the State agencies represented on the Planning Committee, in collaboration with the Long-Term Care Advisory Council, will work together to address these items and periodically review their progress. In addition, annually, from 2022 through 2024, the Long-Term Care Planning Committee will choose to focus on several strategic priorities among the short- term recommendations based on: 1) timeliness; 2) readiness for implementation or change; 3) availability of funding; and 4) need for coordination with other entities or programs.

II. VISION, MISSION AND GOVERNING PRINCIPLES

The Long-Term Care Planning Committee developed and continues to refine its Vision, Mission and Governing Principles to guide the development of its Long-Term Services and Supports (LTSS) Plan and recommendations for enhancing the LTSS system in Connecticut. The vision, mission and governing principles provide a philosophical framework that values choice, person-centered care, and a seamless continuum of services and supports for all individuals in need of LTSS, regardless of disability and across the lifespan of fluctuating needs.

A. Vision

Connecticut residents have access to a full range of high-quality LTSS that maximize autonomy, choice and dignity.

B. Mission

To provide guidance for the development of a comprehensive system of community-based and institutional LTSS options. Such a system should promote access to affordable, high-quality, cost-effective services and supports that are delivered in the most integrated, life-enhancing setting.

C. Principles Governing the System of Long-Term Services and Supports

The system must:

1. Provide equal access to home and community-based care and institutional care.
2. Assure that people have control and choice with respect to their own lives.
3. Be adequately financed and structured to assure that decision-making and service delivery are based on the needs of the individuals and families served and on the needs of employees who provide care and services.
4. Deliver services in a culturally competent manner to meet the needs of a diverse population.
5. Assure that individuals have meaningful rights and protections.
6. Include an information component to educate individuals about available services and financing options.
7. Assure mechanisms for integration with related services and systems including acute medical care, housing and transportation services.
8. Include a prevention component to educate individuals regarding actions that can be taken to reduce the chances of needing LTSS.
9. Include a strong independent advocacy component for those in need.
10. Include meaningful consumer input at all levels of system planning and implementation.

III. LONG-TERM SERVICES AND SUPPORTS IN CONNECTICUT

A. The People

People of all ages and from all socio-economic, racial and ethnic backgrounds need long-term services and supports (LTSS). They are our parents, siblings, children, co-workers, veterans and neighbors. They are us. Whether challenged with limitations due to injuries, developmental disabilities, mental illness, chronic health conditions, or the aging process, they all share a common need for assistance in order to live, learn, work and play.

Assistance may be needed to carry out basic functions such as eating, dressing or bathing (activities of daily living -- ADLs) or tasks necessary for independent community living, such as shopping, managing finances and house cleaning (instrumental activities of daily living -- IADLs). Likewise, needs range from minimal personal assistance with basic activities to virtually total care. These LTSS needs are being met at home, in the community, at work, in congregate residences and in institutional settings.

It is important to note that LTSS is different from medical care. The major distinction is that the goal of LTSS is to allow an individual to attain and maintain an optimal level of functioning in everyday living. The goal of medical care is to cure or control an illness.

A Word about the Data

Currently, there is no single source of information on the need for LTSS among individuals with disabling chronic illness and conditions in Connecticut. There is also no one source of information that looks at needs across the lifespan or across types of disabilities. In order to develop a picture of the need for LTSS in Connecticut, regardless of disability, limitation or age, a broad array of sources have been consulted.

Complicating our understanding of who needs LTSS is the fact that there is no single accepted definition of disability or way of defining the need for LTSS. Research findings vary from study to study depending on how the population in need is defined and whether the focus is on individuals with disabilities in general or those with LTSS needs specifically. Disability, which is most commonly defined in terms of long-standing limitations in tasks and activities, is used in this Plan as a measure for the need for LTSS, unless otherwise specified, although it is acknowledged that not everyone with a disability will need supports at any given time.

Much of the data on disability in Connecticut used in this Plan is drawn from the U.S. Census Bureau 2019 American Community Survey (ACS). In this survey, disability is defined as "the product of interactions among individuals' bodies; their physical, emotional, and mental health; and the physical and social environment in which they live, work, or play. Disability exists where this interaction results in limitations of

activities and restrictions to full participation at school, at work, at home, or in the community." The ACS uses six disability items to determine an individual's disability status: 1) hearing difficulty, 2) vision difficulty, 3) cognitive difficulty, 4) ambulatory difficulty, 5) self-care difficulty, and 6) independent living difficulty.[31]

Who Needs Long-Term Services and Supports?

National Perspective

Approximately 14 million adults, or about 4 percent of the total U.S. population, are in need of some level of LTSS[32]. Of these individuals, 56% were over the age of 65 and 44 percent were ages 18-64. 12.6 million adults received LTSS in the community compared to only 1.4 million in a nursing facility[33].

Among older adults living to age 65 during the period of 2020-2024, it is estimated that 57 percent will need paid LTSS over the course of their lifetime. In general, 70% of individuals living beyond age 65 will develop some form of LTSS need. Women and low-income individuals have a greater chance of needing LTSS (61.1 percent – 61.6 percent respectively) than men (50.9 percent). On average, 10% of adults are projected to need LTSS for less than one year and 22 percent will need services for five or more years. It is estimated that the average individual age 65 and older will experience a disability for 2.8 years, however, individuals will only use paid care for 1.1 of those years, relying on informal caregiver support for more than half of their period of disability[34].

TABLE 1

Number of Persons with Disabilities in Connecticut by Age, 2019

Age	Total Population	Persons with a Disability	Percentage
<18	726,917	32,138	4.4%
18 to 64	2,178,548	205,546	9.4%
65+	609,097	181,568	29.8%
Total	3,514,562	419,252	11.9%

Source: U.S. Census Bureau, 2019 American Community Survey, One Year Estimates, Connecticut, Custom Table from B18101

Connecticut

Disabilities affect 11.9 percent of Connecticut residents, lower than the national average of 12.7 percent. In 2019, there were 419,252 individuals living in Connecticut with some type of long-lasting condition or disability (Table 1).

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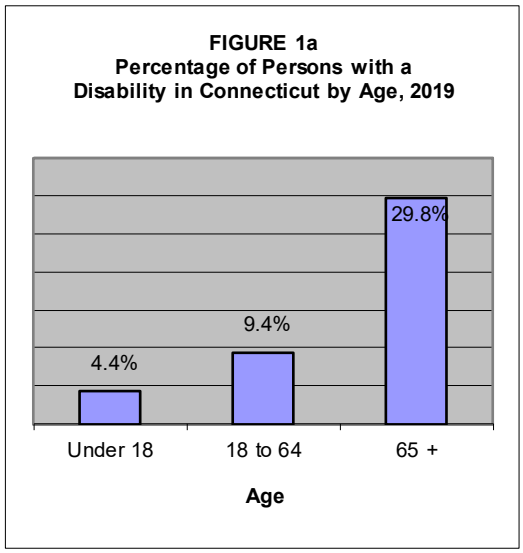
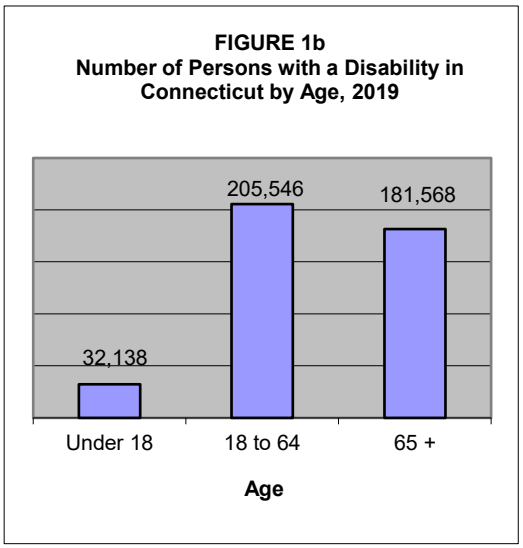
[31] U.S. Census Bureau, American Community Survey, 2019 Subject Definitions, pages 61-63. http://www2.census.gov/programs-surveys/acs/tech_docs/subject_definitions/2019_ACSSubjectDefinitions.pdf

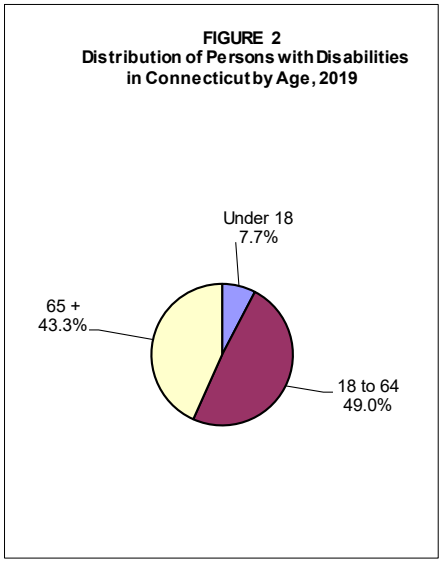
[32] Hado, Edem & Komisar, Harriet, AARP Public Policy Institute*; AARP Long-Term Services and Supports Fact Sheet 634, August 2019 https://www.aarp.org/content/dam/aarp/ppi/2019/08/long-term-services-and-supports.doi.10.26419-2Fppi.00079.001.pdf*

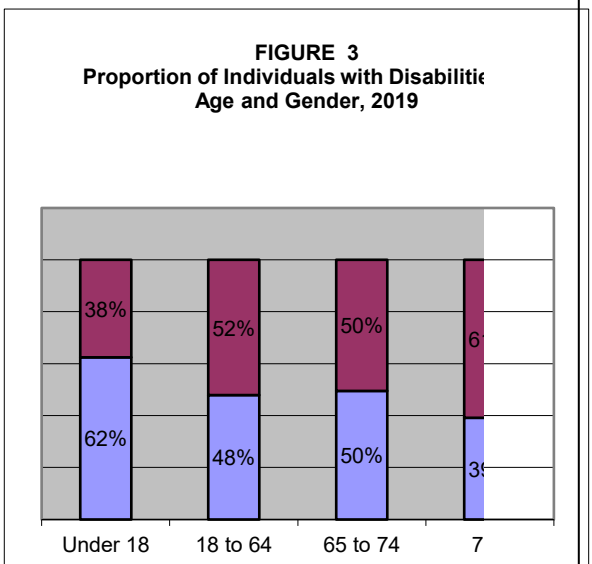
[33] Ibid..

[34] Favreault, Melissa, M., & Johnson, Richard, W., Urban Institute on behalf of the Department of Health & Human Services, Assistant Secretary for Planning & Evaluation, January 31, 2021.









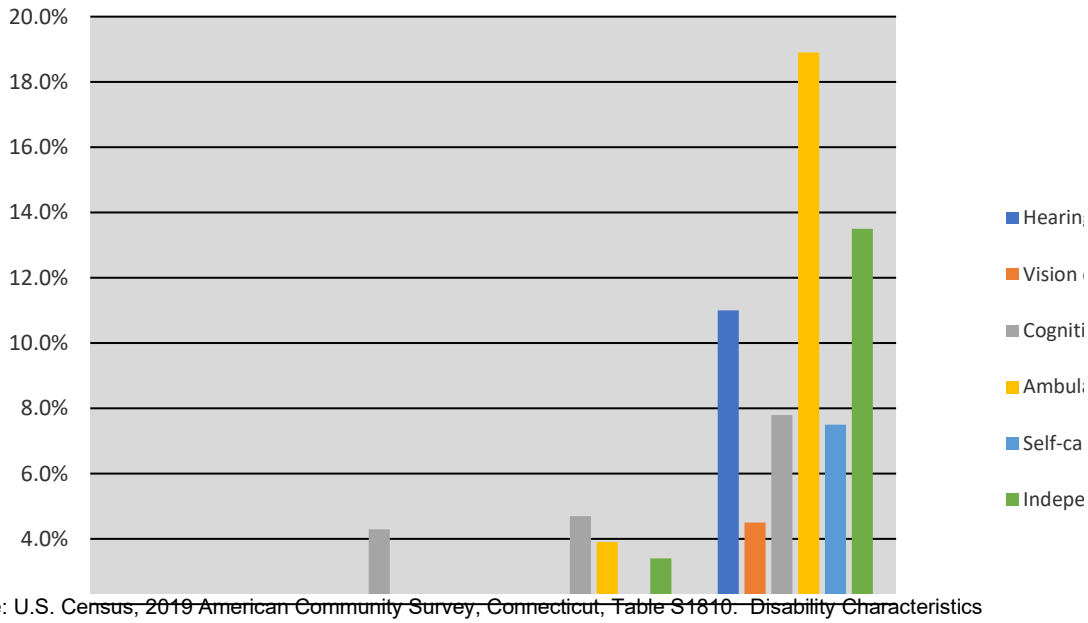
Source: U.S. Census Bureau, American Community Survey, Connecticut, 2019

Disability rates rise with age, with 4.4 percent of children and youth under age 18 reporting a disability, 9.4 percent of adults age 18 to 64, and 29.8 percent of older adults age 65 and over (Figure 1a).

Although the largest proportion of the Connecticut population with a disability is found among those ages 65 and over (Figure 1a), 49 percent of the total numbers of persons with a disability are adults between the ages of 18 and 64 (Figures 1b and 2).

Among individuals with disabilities, the ratio of males to females shifts as the population ages, as is the case in the general population. Among children and youth with disabilities, 62 percent are males. By the senior years, this proportion is reversed, with females comprising 61 percent of those with disabilities age 75 and older (Figure 3).

Figure 4
Percent Distribution of Types of Disabilities in CT by Age 2019



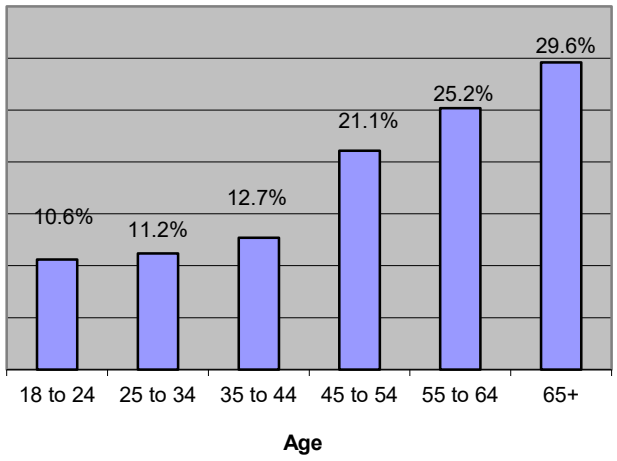
Source: U.S. Census, 2019 American Community Survey, Connecticut, Table S1810. Disability Characteristics

The distribution of types of disabilities in the population varies considerably by age (Figure 4). Among individuals in the 5 to 17 year old group, the greatest reported difficulty is cognitive (4.3 percent). Among adults age 18 to 64, the greatest difficulty is cognitive (4.7 percent) followed by ambulatory (3.9 percent). Among individuals age 65 and older, ambulatory difficulties are most prevalent (18.9 percent) followed by independent living difficulties (13.5 percent). Cognitive difficulties were experienced by a similar proportion of individuals in the 5 to 17 and the 18 to 64 age groups (4.3 and 4.7 percent, respectively) and increased noticeably in the over 65 age group (7.2 percent). The 2019 American Community Survey determined those with cognitive difficulty by asking individuals if due to a physical, mental or emotional condition, they had "serious difficulty concentrating, remembering or making decisions." [35,36]

[35] U.S. Census Bureau, 2019 American Community Survey, uses six items to determine an individual's disability status: 1) hearing difficulty, 2) vision difficulty, 3) cognitive difficulty, 4) ambulatory difficulty, 5) self-care difficulty, and 6) independent living difficulty. Source: U.S. Census Bureau, American Community Survey, 2019 Subject Definitions, page 61 to 63.

Another picture of individuals with disabilities is provided by the Connecticut Behavioral Risk Factor Surveillance System (BRFSS), which surveys adults age 18 and over living in the community (Figure 5). Overall, in 2015 (the last year this question was asked on the survey), 19.4 percent of Connecticut adults answered yes when asked if they are "limited in any way in any activities because of physical, mental or emotional problems." [37] This translates into approximately 540,083 Connecticut adults age 18 and older living in the community with some degree of activity limitation. This compares to the 2019 Connecticut Census estimate of 387,114 individuals with disabilities age 18 and over.

FIGURE 5
Connecticut Residents Limited Due to a Physical, Mental or Emotional Problems by Age, 2015



Source: Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System Survey, 2015
Percentages weighted to population characteristics

B. Long-Term Services and Supports

Home and community-based services

Although LTSS traditionally have been associated with nursing facilities or other institutions, the fact is that the vast majority of LTSS is provided at home and in the community by informal and formal caregivers. Over the last decade, opportunities to live and obtain supports in community settings have increased significantly, with a growing emphasis on independent living and individual choice. Increased availability of home and personal care supports has allowed greater numbers of individuals to remain in their homes and avoid or delay moving to an institutional setting.

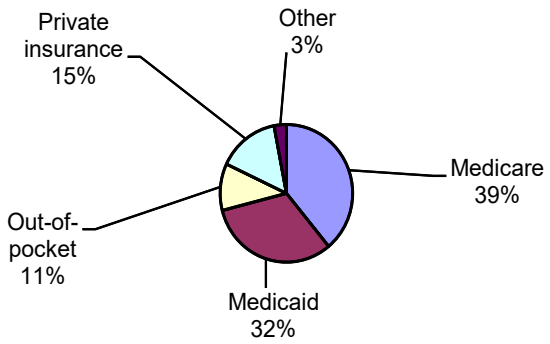
Home and community-based care includes a range of varied services and supports provided either formally by paid individuals or informally by family and friends. Typically, the level of formal support used increases with age, functional impairment and income. In addition to private homes, community settings can include adult day care, assisted living, residential care homes, continuing care retirement communities, small group homes and congregate housing.

[36] It should be noted that an individual may have one or more disabilities, so the percentages in any particular age group could exceed 100 percent. For example, a person with severe asthma may have difficulty climbing stairs and difficulty working at a job.
[37] Centers for Disease Control and Prevention (CDC). Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, 2015. http://www.cdc.gov/brfss/brfssprevalence/index.html .

Home Care Services

Nationally, 71 percent of home health care costs incurred in 2019 were covered by Medicare and Medicaid. Medicare paid the largest share of home care costs, covering 39 percent of the total payments. Private sources, including private insurance and out-of-pocket payment, represented 26 percent of payments (Figure 6). It is important to note that home health care represents only a portion of home care services and generally addresses more medically oriented needs.

FIGURE 6
Sources of Payment for Home Health Care in the U.S., 2019



Source: California Health Care Foundation, *Infographic - U.S. Health Care Spending: Who Pays?*; June 28, 2021. CHCF used National Health Expenditure Data obtained from the Centers for Medicare and Medicaid Services.

In Connecticut, paid home care services are provided by home health care agencies, homemaker-home health aide agencies, homemaker-companion agencies, and privately hired caregivers.

- *Home health care agencies*, which are licensed by DPH, provide care in the home that is typically prescribed by an individual's physician as part of a written plan of care. These agencies offer skilled nursing, home health aide services, physical therapy, occupational therapy, speech therapy, and hospice services. Non-medical services include helping individuals with activities of daily living such as bathing, dressing and eating; assistance with cooking, cleaning, and other housekeeping jobs; and managing medications. Although home health care may include some non-medical home care services, such as homemakers and companions, home health care is more medically oriented, helping individuals recover from an illness or injury. Home health care agencies, unlike homemaker-home health aide agencies and homemaker-companion agencies, may be eligible for Medicare reimbursement. As of June 30, 2021 there were 93 agencies licensed by DPH to provide home health care services in Connecticut.[38]

- *Homemaker-home health aide agencies*, which are licensed by DPH, are similar to homemaker-companion agencies in that they provide non-medical assistance to individuals. In addition, they have the authority to provide training programs and competency evaluations for home health aides. As of June 30, 2021, there were no licensed agencies in Connecticut.[39]

[38] Connecticut Department of Public Health, 2021.
[39] Connecticut Department of Public Health, 2021.

- *Homemaker-companion agencies* provide non-medical assistance to persons with disabilities and older adults and must be registered with the Department of Consumer Protection. Tasks generally include grocery shopping, meal preparation, laundry, light housekeeping and transportation to appointments. As of June 30, 2021, there were 818 registered homemaker-companion agencies active in Connecticut.[40]

- *Privately hired caregivers* often provide personal care and are hired directly by an individual in need of support. The individual who hires them is the employer and is responsible for paying for unemployment, social security, workers' compensation insurance, taxes and liability insurance.

Adult Day Care

Adult day services are an option for adults in need of a variety of health and social services who want to remain in their homes. They provide respite to family caregivers as well as therapeutic care for cognitive and physically impaired older adults. Health, personal care and social services are provided to adults who do not need the continuous services of a nursing facility or institutional setting and are able to leave their homes. Individuals receive professional services ranging from social activities and therapeutic recreation to nursing care and rehabilitation services, representing a blend of traditional health and social services.[41]

Adult day care centers are not regulated by DPH. Instead, the Connecticut Association of Adult Day Centers (CAADC) is authorized by DSS to provide a program of peer review and certification, which is required in order for an adult day center to receive State funds. As of November 2021, there were 40 adult day centers certified by CAADC serving people who receive State assistance and two additional certifications pending.[42]

Public Home and Community-Based Programs - Medicaid Waivers and State-Funded Programs

An array of Medicaid and State-funded programs have been developed in Connecticut to address the need for LTSS for those living at home or in other community settings. Medicaid, through its home and community-based waiver programs, is the major public financing mechanism for providing LTSS in community settings. Under both Medicaid and State-funded programs, individuals who would otherwise require the level of care provided in an institutional setting are served in the community. Most people express a strong preference for home and community-based services over institutional care since

[40] Connecticut Department of Consumer Protection, 2021.
[41] The Connecticut Association of Adult Day Centers, http://www.ctadultday.org, November, 2021.
[42] Leading Age Connecticut, November 2021.

it allows them to live in their own homes, participate in community life and exert more control over their own affairs.[43]

- **For Ages 65 and Older**

Connecticut Home Care Program for Elders (CHCPE): provides home and community-based services to frail older adults age 65 and over as an alternative to nursing facility admission. The program has a Medicaid waiver as well as State-funded component. A no waiting list policy was established in 1997.

1. *Medicaid Elder Waiver*: constitutes the Medicaid portion of the CHCPE. As of June 30, 2021, it provided community-based services to over 13,000 older adults age 65 and older, who would otherwise be institutionalized. Available services include adult day care, homemaker, companion, chore, home delivered meals, emergency response systems, care management, home health, skilled nursing, respite, assisted living and minor home modifications. The monthly average number of participants for SFY 2021 was 13,632.

2. *State-Funded CHCPE*: constitutes the State-funded portion of the CHCPE and provides the same services as the Medicaid Elder Waiver except that plans of care are capped at lower levels. The program serves adults age 65 and older with higher income and asset levels than permitted under the Waiver portion. The program will also cover individuals with fewer needs than under the Medicaid Elder Waiver. On June 30, 2021 there were 2,202 people enrolled.

- **For Ages 18 to 64**

Connecticut Home Care Program for Disabled Adults (CHCPDA): is a State-funded pilot program that provides services based upon the CHCPE model. The program serves up to 50 individuals age 18 to 64 with degenerative, neurological conditions who are not eligible for other programs and who need case management and other supportive services. On June 30, 2021, there were 70 people enrolled.

Medicaid Acquired Brain Injury (ABI) Waiver and ABI II: provides 23 specific behavioral and support services to persons between the ages of 18 and 64 with acquired brain injury. The monthly average number of participants during SFY 2021 was 353 for ABI and 218 for ABI II.

Medicaid Personal Care Assistance Services (PCA) Waiver: provides personal care services to persons with physical disabilities who are age 18 to 64 years of age. In this

[43] Joanne Binette & Kerri Vasold, 2018 *Home and Community Preferences: A National Survey of Adults Age 18-Plus, AARP*, August, 2018.

person-directed program, participants hire and direct their own care. The monthly average number of participants during SFY 2021 was 994.

- **For All Ages**

DDS Individual and Family Support (IFS) Waiver: provides in-home, day, vocational and family supports services for people who live in their own or family home. In SFY 2021, the monthly average number of participants was 3,599.

DDS Comprehensive Supports Waiver: provides for the vocational and in-home services needed for people who need a more intensive level of support to remain in their own family home. These services are delivered in licensed settings (community living arrangements, community companion homes and assisted living) and include residential and family support services, vocational and day services and specialized and support services. In SFY 2021, the monthly average number of participants was 5,162.

DDS Employment and Day Supports (EDS) Waiver: provides support to individuals who live with family or in their own homes and have a strong natural support system. This includes children under the age of 21 with complex medical needs who would otherwise require institutional placement and individuals over the age of 18 who require career development, supported employment or community-based day supports, respite, and/or behavioral supports to remain in their own or their family home. In SFY 2021, the monthly average number of participants was 1,965.

Mental Health Waiver: administered by the Department of Mental Health and Addiction Services, this program diverts people with serious mental illness from nursing facilities and works to discharge those who no longer need to live in a nursing facility. The program began on April 1, 2009. In SFY 2021, the monthly average number of participants was 593.

Community First Choice: administered by the Department of Social Services, is a Medicaid State Plan option that enables Medicaid members requiring institutional level of care to self-direct community-based services through the utilization of individual budgets. The program began in July 2015. In SFY 2021, the monthly average number of program participants was 1,686.

- **For Children**

Medicaid Katie Beckett Waiver: offers case management and home health services primarily to children with disabilities who would normally only qualify for Medicaid in an institution. The waiver itself offers only case management services, but the families have access to full Medicaid benefits, including home health and physical therapy. The program operates within available appropriations. In SFY 2021, the monthly average number of participants was 325.

State Long-Term Care Programs

In addition to the programs listed above, there are a wide range of LTSS that support individuals with disabilities and chronic health conditions that are funded or operated by State agencies. A description of these State agencies can be found in Appendix G as well as charts describing State LTSS programs, their eligibility requirements and participants and program expenditures.

Municipal, Non-Profit, Private Sector and Volunteer Services

In addition to the State programs, a wide array of statewide, regional and local LTSS exist throughout Connecticut that are administered by government agencies, non-profit and for-profit organizations, as well as volunteer groups. Each city and town provides services and accommodations to address the needs of older adults and persons with disabilities. Connecticut has five regional Centers for Independent Living, five Area Agencies on Aging, and a number of statewide and local mental health councils and advisory councils for persons with disabilities. There is also the Corporation for Independent Living, which is a non-profit partner focused on new housing initiatives for persons with disabilities. Also indispensable to the system of care are the myriad of volunteer organizations that address the needs of individuals with specific chronic illnesses and conditions, providing support and companionship that foster "sustainable" independent living.

Community Housing Options

A number of housing options with LTSS are available in Connecticut, enabling individuals with LTSS needs the opportunity to avoid entering an institution. Residential housing is considered community living, where the goal is to provide an environment where people can live with maximum independence and minimum restrictions.

In fostering choice, self-determination, independence and community integration, it is important to assure that residential housing is community-based and not institutional. In distinguishing between residential and institutional settings, five aspects can be considered: 1) residential scale and characteristics; 2) privacy; 3) autonomy, choice and control within the residential settings; 4) integration with the greater community; and 5) resident control over moving to, remaining in, or leaving the setting.[44]

[44] Rosalie A. Kane et al, *Community-Based Residential Care Settings as Rebalancing Vehicles: State Strategies to Make Them More like Home than like Institutions*, Submitted to the Division of Advocacy and Special Programs, Centers for Medicare and Medicaid Services, August 2008, page 7.

TABLE 2
Community Housing Options in Connecticut, June 30, 2021

	# Facilities	# Units/ Beds/ Residents	Age
State Funded Congregate Housing	25	1,048 residents	62 and older
Managed Residential Communities (Assisted Living)	143	N/A	Adults and older adults
Residential Care Homes	96	2,695 beds	Adults and older adults
Continuing Care Retirement Communities	20	N/A	Older adults
Nursing Facilities	205 (as of 9/30/21)	24,444 beds (as of 9/30/21)	All ages

Source: Office of Policy and Management, 2021

The community housing options described below all provide some common meals, housekeeping, and some degree of personal services, but vary with respect to the extent and range of services and staffing provided, the types of accommodations available, and requirements for residency.

Congregate Housing

Congregate housing provides frail older adults with private living arrangements, moderate supportive services, and common areas of dining, socialization and other activities. These facilities furnish at least one daily meal, which is usually included in the monthly fee, housekeeping services and a variety of social and recreational activities. They are generally meant for individuals who are basically self-sufficient but need a few services to help them to live independently.

As of June 30, 2021, 1,048 people age 62 and over lived in 25 State-funded congregate housing facilities in Connecticut. Residents were all low-income and had a minimum of one ADL limitation. Beginning in 2001, DOH (formerly DECD) and DSS introduced assisted living services within State-funded congregate housing facilities and some federal Housing and Urban Development (HUD) communities. Six of the 25 congregate

facilities are participating in this service expansion, along with several HUD communities. As of September 30, 2021, 145 congregate housing and HUD residents were actively enrolled in the assisted living program. In order to participate in the assisted living program, residents must be eligible for DSS' Connecticut Home Care Program for Elders. Additionally, residents may choose to privately pay for these services.[45]

Assisted Living Services/ Managed Residential Communities

Assisted Living Services Agencies (ALSAs) are an alternative for older adults who need assistance with activities of daily living (e.g. bathing, dressing), but who do not require the intensive medical and nursing care provided in a nursing facility. In Connecticut, ALSAs are licensed to provide assisted living services in managed residential communities (MRCs). Assisted living services can be provided in a number of different settings, such as continuing care retirement communities or elderly housing, as long as the facility provides the services to qualify as a MRC. Services provided by the MRC include laundry, transportation, housekeeping, meals, and recreational activities. Individuals choosing to live in an MRC may purchase LTSS from the ALSA allowing them to live in their own apartment. However, generally the MRC and ALSA are the same entity and the cost for room and board and ALSA services are included together with the costs increasing as the need for ALSA services increases. Primarily, assisted living services in the MRC are available to individuals age 55 and older.

As of June 30, 2021, there were 113 ALSAs licensed in Connecticut providing services in 143 managed residential facilities.[46]

Since the cost of living in a MRC and the assisted living services purchased are virtually all paid out of pocket, these community living arrangements are available to individuals who can afford the cost of both room and board and services. Through a collaborative effort of the Connecticut Housing Finance Authority (CHFA), DOH, DPH, OPM and DSS, Connecticut has made assisted living services available to lower-income individuals through the Assisted Living Demonstration Project, State-funded congregate housing, HUD complexes and the Private Pay Assisted Living Pilot.

Residential Care Homes

Residential care homes are facilities that provide a room, meals and supervision, but no nursing services, for individuals whose limitations prevent them from living alone. Services vary from facility to facility but may include dietary and housekeeping services, monitoring of prescription medication, social and recreational opportunities, and assistance with activities of daily living. Residential care homes in Connecticut are

[45] Connecticut Department of Housing, 2021.
[46] Connecticut Department of Public Health, 2021.

licensed by DPH. As of June 30, 2021, there were 96 residential care homes in Connecticut with a total of 2,695 beds.[47]

Continuing Care Retirement Communities

Continuing Care Retirement Communities (CCRCs) provide residents, through contractual agreements, lifetime shelter and access to a wide variety of services, including long-term health services. Each resident pays a substantial entrance fee and monthly fees in exchange for a living unit and access to services. Various levels of care such as, independent living, assistance with daily activities and nursing facility care are typically provided on CCRC campuses. As their needs change, residents are usually able to move from one level of care to another without leaving the community. If a CCRC does not have a nursing facility on campus, it often has an arrangement with a nearby nursing facility to admit its residents on a priority basis. Each CCRC is mandated to register with DSS by filing an annual disclosure statement. Although CCRCs are not licensed by the State, various components of their LTSS packages, such as residential care beds, assisted living services, and nursing facility care are licensed by DPH. As of June 30, 2021 there were 20 CCRCs operating in Connecticut, and three "CCRC at Home" providers. [48]

Supportive Housing

Designed to enable individuals and families to live independently in the community, supportive housing provides permanent, affordable rental housing with access to individualized health, support and employment services. People living in supportive housing usually hold their own leases and have all the rights and responsibilities of tenants. In addition, they have the option to use a range of training and support services such as case management, budgeting and independent living skills, health care and recovery services, and employment services.

Residential Settings for Individuals with Intellectual Disabilities

DDS administers or contracts for residential services from independent living, individualized home supports, continuous residential supports, community living arrangements, community companion homes, and residential center settings.[49]

- *Individualized Home Supports* -- Some people need minimal hours of staff support to live in their own place or family home. This staff support may be in the form of assistance with budgets, shopping and/or leisure activities. People receiving Individualized Home Supports get staff support from a few hours a day to only a few hours a month, depending on the needs of the person. As of June 2021, 2,853 individuals received Individualized Home Supports.

[47] Connecticut Department of Public Health, 2021.
[48] Connecticut Department of Social Services, 2021.
[49] Connecticut Department of Developmental Services, 2021

- *Community Companion Homes* -- People with an intellectual disability live in a family setting that is not within their own family. People in these settings live with a family that has received training and licensing from DDS. As of June 2021, 392 individuals lived in Community Companion Homes.

- *Continuous Residential Supports*-- People who need overnight support and live with three or fewer people share an apartment or house and have staff from an agency or hired privately. As of June 2021, 737 individuals lived in Continuous Residential Supports.

- *Community Living Arrangements* -- People who need 24-hour support are provided with staff in group home settings. Usually, two to six people share an apartment or house and have staff available to them 24 hours a day. As of June 2021, 3,614 individuals lived in Community Living Arrangements.

Residential Settings for Individuals with Psychiatric or Addiction Disorders

DMHAS funds several types of residential settings for individuals age 18 and older with psychiatric or addiction disorders. In SFY 2021, a total of 51,596 individuals received mental health services in the community and 834 received services in inpatient settings. Also, in SFY 2021, a total of 45,863 individuals received substance abuse services in the community and 556 received inpatient services.[50]

Psychiatric disorders

- *Group Homes* – A community-based residence with on-site staffing 24 hours per day, seven days a week. In SFY 2021, 236 individuals lived in these group home settings.

- *Supervised Housing* – Services are provided in intensively managed housing where individuals live in private or shared apartments with staff co-located 24 hours per day, seven days a week. In SFY 2021, 805 individuals lived in supervised housing.

Addiction disorders

- *Long-Term Care* – A 24-hour per day, seven days a week staffed residence with a structured recovery environment providing substance abuse intermediate and long-term residential treatment or care. In SFY 2021, 835 individuals participated in this program.

[50] Connecticut Department of Mental Health and Addiction Services, December 2021.

Institutional Care Settings

Nursing Facilities

Nursing facilities provide personal and skilled nursing care 24 hours a day. This level of care is often used when an individual has a condition that requires 24-hour supervision, substantial needs based on activities of daily living (ADL) or cognitive status, inadequate informal support, or insufficient financial resources to pay for home and community-based services. In addition to serving LTSS needs, nursing facilities are also relied upon for short term post-acute rehabilitation services. There are two types of nursing facilities licensed in Connecticut: chronic and convalescent nursing facilities (skilled nursing facilities) and rest homes with nursing supervision (intermediate care facilities).

TABLE 3

Percent Distribution of Residents in Connecticut Nursing Facilities by Payment Source on September 30, 1995 and 2021

Payment Source	1995	2020
Medicaid	68	72
Medicare	11	15
Private Pay	20	9
Insurance	2	1
Other	< 1	2

Source: State of Connecticut Nursing Facility Registry and Connecticut Annual Nursing Facility Census, Office of Policy and Management, Health and Human Services Policy and Planning Division September 30, 2021.

On September 30, 2021, there were 19,078 individuals residing in Connecticut nursing facilities. The majority of residents were white (79 percent), female (63 percent), and without a spouse (81 percent), a profile that has remained consistent over the years. Sixteen percent of the residents were under age 65, 46 percent were between age 65 and 84 and 38 percent were age 85 or older.[51]

Connecticut had a total of 24,444 licensed nursing facility beds as of September 30, 2021. Since 1991, efforts have been made to reduce the number of residents in Connecticut's nursing facilities by placing a moratorium on additional beds. Despite the moratorium, from 1991 to 1994, the total number of licensed beds increased from

[51] State of Connecticut Annual Nursing Facility Census, Office of Policy and Management, Health and Human Services Policy and Planning Division, 2021.

29,391 to 32,149. This was due to the addition of beds that had been approved before the moratorium went into effect. From 1994 to 2021, the total number of licensed beds decreased by 7,705, or 24 percent. [52]

In 2021, the average daily cost to a nursing facility resident paying privately in Connecticut was $462 a day for a semi-private room, or over $168,000 a year. Medicaid was the primary source of payment for 72 percent of nursing facility residents in Connecticut as of September 30, 2021, with Medicare covering 15 percent and private pay covering 9 percent.[53] (Table 3)

Intermediate Care Facilities for Persons with Mental Retardation – ICF/ID

On June 30, 2021, a total of 607 people over the age of 18 in Connecticut resided in either a DDS or private provider operated ICF/ID. Of these individuals, 271 people resided in an ICF/ID operated by DDS in one of six locations throughout the state. Another 336 individuals resided in group homes operated at an ICF/ID level of care by private agencies. Of all of the people living in an ICF/ID, 204 (34 percent) were between the age of 19 and 54, 193 (32 percent) were between the ages of 55 and 64, and 210 (35 percent) were age 65 and over. At this level of care, individuals received residential and day habilitation services, prevocational services and supported employment services. All services are financed through the State Medicaid Program.[54]

Chronic Disease Hospitals

On June 30, 2021, there were three chronic disease hospitals in Connecticut with a total of 430 beds.[55] These long-term hospitals provide diagnosis, care and treatment of a wide range of chronic diseases.

C. Financing

In the U.S., $235 billion was spent on LTSS in 2017[56], representing 8 percent[57] of all personal health care spending. Medicaid is the dominant source of payment for LTSS (57%), followed by out-of-pocket payments by individuals and families (23%). Other private and public sources cover the balance of expenditures (20%). Medicare plays no role in financing LTSS, since Medicare's purpose is to cover acute and post-acute medical care for people age 65 and older and for younger individuals who qualify for

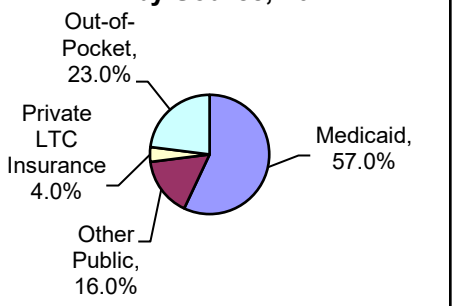
[52] State of Connecticut Nursing Facility Registry and Connecticut Annual Nursing Facility Census, Office of Policy and Management, Health and Human Services Policy and Planning Division, 2021.
[53] State of Connecticut Annual Nursing Facility Census, Office of Policy and Management, Health and Human Services Policy and Planning Division, 2021.
[54] Connecticut Department of Developmental Services, 2021
[55] Connecticut Department of Public Health, 2021.
[56] Hado, Edem & Komisar, Harriet, AARP Public Policy Institute; AARP Long-Term Services and Supports Fact Sheet 634, August 2019.
[57] Number arrived at by dividing the total amount of LTSS spending in 2017 as reported by AARP in the 2019 LTSS Fact Sheet ($235B) divided by the 2017 total health care spending amount reported by the California Health Foundation, *U.S. Health Care Spending: Who Pays?* ($2928B) = 8%.

Social Security because of disability (Figure 7).[58] In addition to these expenditures is the unpaid care provided by family members and other informal caregivers.

Nationally, most LTSS spending goes to the relatively small minority of individuals in nursing facilities. In contrast, the vast majority of community residents needing LTSS receive only unpaid assistance.

At the individual level, those who have sufficient income and assets are likely to pay for their LTSS needs on their own, out of their own personal resources or through a long-term care insurance policy. Medicaid will pay for those who meet the financial eligibility criteria and have limited financial resources, or deplete them paying for their care.

FIGURE 7
National Spending for LTSS, by Source, 2017



Source: Hado, Edem & Komisar, Harriet, AARP Public Policy Institute; AARP Long-Term Services and Supports Fact Sheet 634, August 2019.

Medicare may pay for individuals who are eligible and require skilled or recuperative care for a short time, but do not cover individuals with stable chronic conditions. The Older Americans Act is another Federal program that helps pay for LTSS services. As financial circumstances and the need for care changes, a variety of payment sources may be used.[59]

Medicaid

The Medicaid program, jointly funded by the state and federal government, is the primary payer for LTSS in the U.S. and the major public program providing coverage for nursing facility care, accounting for 57 percent of all LTSS spending in 2017 (Figure 7). Medicaid provides coverage for people who are poor and disabled. It also provides LTSS for individuals who qualify for Medicaid because they have 'spent down' their assets due to the high costs of such care and have become nearly impoverished. For example, many older adults become eligible for Medicaid as a result of depleting their assets to pay for nursing facility care that Medicare does not cover.

In SFY 2021, the Connecticut Medicaid program spent $3.344 billion[60] on LTSS. These Medicaid LTSS expenses account for 39 percent of all Medicaid spending and 15% percent of total expenditures for the State of Connecticut. [61]

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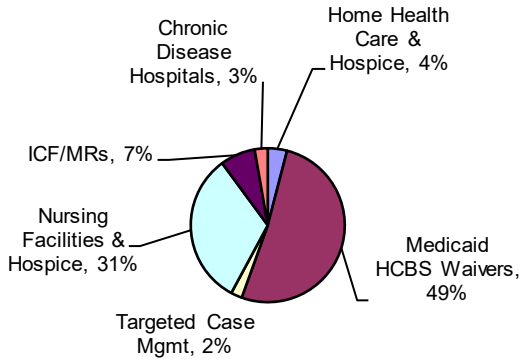
[58]. Hado, Edem & Komisar, Harriet, AARP Public Policy Institute; AARP Long-Term Services and Supports Fact Sheet 634, August 2019.
[59] U.S. Department of Health and Human Services, Long Term Care Costs and How to Pay online resource, accessed November, 2021. https://acl.gov/ltc/costs-and-who-pays/who-pays-long-term-care
[60] Unless otherwise noted, Medicaid expenditures referenced in this document are total gross expenditures.

Looking at Connecticut's expenses for Medicaid LTSS in more detail, 60 percent was spent on home and community-based services and 40 percent on institutional care (Figure 8). In analyzing all Medicaid LTC expenditures, we see that services for individuals with developmental disabilities account for 34 percent of total long-term care expenses, in contrast to 16 percent for the Elder, Personal Care Assistance, Katie Beckett, Acquired Brain Injury, and Mental Health waivers combined. Over time, the proportion of Medicaid LTSS expenses for home and community-based services has increased from 23 percent in SFY 1996 to 60 percent in SFY 2021.

FIGURE 8
Proportion of CT Medicaid LTC Expenditures, SFY 2021



Source: Office of Policy and Management, 2021
Does not total 100% due to rounding

A consistent conclusion from research on Medicaid home and community-based services waivers is that these services provide savings over care in institutional settings over the long term.[62]

Medicare

The federal Medicare program provides health care coverage for people age 65 and older. Individuals under age 65 with disabilities are also covered, however, only after they have received Social Security disability benefits for two years. Although Medicare is the major health insurance program for older adults and certain persons with disabilities, it does not cover LTSS costs. Medicare covers medically necessary care and focuses on medical acute care, such as doctor visits, drugs, and hospital stays. Medicare covers nursing facility stays for no more than 100 days following a hospital stay of at least three days, paying for all of the first 20 days and a portion of the next 80 days. Assisted living costs are not covered. With regard to home health care, coverage is limited by type and duration. For homebound persons needing part-time skilled nursing care or physical therapy services, Medicare pays for home health care, including personal care services provided by home health aides.

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[61] Office of Policy and Management, Policy Development and Planning Division, 2021.
[62] Julie Robison, PhD et al, *Transition from Home Care to Nursing Home: Unmet Needs in a Home- and Community-Based Program for Older Adults*, Journal of Aging & Social Policy, 24:251-270, 2012, pages 252-253.

Out-Of-Pocket Spending / Private Pay

Nationally, in 2017 approximately 23 percent of spending for LTSS was paid directly by individuals (about $54.1 billion), rendering out-of-pocket payments as the second largest source of long-term care financing (Figure 7). This includes direct payment of services but does not include the uncompensated costs of informal caregivers.

Private Long-Term Care Insurance and Other Sources of Public Spending

In 2017, coverage from private long-term care insurance and other public sources for nursing facilities and home health services represented 20 percent of LTSS expenditures in the U.S. (Figure 7). Other public sources includes state and local programs[63].

Private Long-Term Care Insurance

Long-term care insurance covers services needed by people who cannot perform everyday activities on their own due to a chronic condition, limited ability to function or deterioration in mental capacity. It covers a wide range of services that include bathing, dressing, eating, using the toilet, continence, and transferring from a bed to a chair. Since individuals in need of LTSS do not usually require skilled help, these services are not generally covered by private health insurance or Medicare. Depending upon the policy, care can be provided in a variety of places, including: a person's home, a nursing facility, through community-based services (i.e., adult day care) and in a variety of assisted living settings (i.e., continuing care retirement communities, residential care homes, assisted living facilities).[64]

In Connecticut, the number of individuals who purchased long-term care insurance in 2020 was 1,491. As of December 31, 2020, there were 101,848 Connecticut residents with a private long-term care insurance policy in force.[65]

Connecticut Partnership for Long-Term Care[66]

The Partnership is a unique alliance between State government and the private insurance industry developed to:

- Provide individuals with a way to plan for their long-term care needs without the risk of impoverishment;
- Enhance the standards of private long-term care insurance;
- Provide public education about long-term care; and
- Conserve State Medicaid funds.

The most unique aspect of a Connecticut Partnership policy is the Medicaid Asset Protection feature. This feature provides dollar for dollar Medicaid asset protection: for

[63] Hado, Edem & Komisar, Harriet, AARP Public Policy Institute; AARP Long-Term Services and Supports Fact Sheet 634, August 2019.
[64] Connecticut Partnership for Long-Term Care, *Frequently Asked Questions*, April 2021
[65] Office of Policy and Management, Health and Human Services Policy and Planning Division, 2021
[66] Office of Policy and Management, Connecticut Partnership for Long-Term Care, 2021

every dollar that a Partnership policy pays out in benefits, a dollar of assets can be protected from Medicaid spend down rules. When determining Medicaid eligibility, any assets a policyholder has up to the amount the Partnership insurance policy paid in benefits will be disregarded. The Partnership Medicaid Asset Protection feature is not available under non-Partnership policies.

As of June 30, 2021, there were over 60,596 Partnership policies sold in Connecticut. Purchasers of Partnership policies range in age from 20 to 86 years old, with the average age at purchase being 57 years old. 5,323 Partnership policyholders have utilized benefits under their policies, with over $665 million in benefits paid. Only 326 Partnership policyholders have accessed Medicaid utilizing the Asset Protection earned under their policies. This has helped the Partnership save the State over $77.5 million in Medicaid long-term care funds with larger savings projected for the future.

Connecticut was the first state to implement a Partnership. From 1992, when the Partnership was first launched, through 2006, New York, Indiana and California developed similar Partnership programs. Due to changes in federal law (Deficit Reduction Act of 2005) making it easier for states to establish Partnership programs, 41 new states have developed Partnership programs. Connecticut currently has reciprocity with all the Partnership states, except California, for the granting of Medicaid Asset Protection under the program.

Older Americans Act

Another major source of federal LTSS funds is the Older Americans Act (OAA), enacted in 1965 to promote the well-being of older persons and help them remain independent in their communities. The OAA provides federal funds to pay for home and community-based LTSS for older adults, generally 60 and older, and their families. States are required to target assistance to persons with the greatest social or economic need. Services funded under the OAA include information and referral, counseling, outreach, congregate meal sites and home-delivered meals, transportation, long-term care ombudsman services, legal services, elderly protective services, and employment services programs for older adults.

The federal Administration for Community Living provided $19.65 million in FFY 2021 to the Department of Aging and Disability Services, State Unit on Aging (ADS/SUA). Of these funds, $17 million of Older Americans Act Title III dollars were distributed by formula to the Area Agencies on Aging who in turn contract with community-based organizations to provide social and nutritional services. The remaining $2.65 million of these funds were special grants received by ADS/SUA, including State Health Insurance Program, Senior Medicare Patrol, Aging and Disability Resource Center/No Wrong Door, Social Isolation Grant Funds, Senior Community Services Employment, and Elder Abuse Prevention. Both federal and State funds for ADS/SUA provided a multitude of services to 65,093 seniors.

State Supplement Program/ Aid to the Aged, Blind and Disabled (AABD)

The State Supplement Program provides a monthly cash benefit for basic living expenses to low-income individuals who are age 65 and over, individuals who are disabled and between the ages of 18 and 64, or individuals who are blind. Benefit amounts vary based on an individual's needs and expenses. Those eligible for State Supplement benefits are also eligible for Medicaid. Those receiving a State Supplement benefit live in a variety of settings, including their own apartments, housing for older adults or persons with disabilities, or residential care homes.

Rental Subsidies

Many individuals with disabilities need assistance with covering their rental costs if they are going to be able to live in the community. While federal Medicaid law prohibits home and community-based services waiver programs from covering the costs of room and board (room and board expenses are only covered in institutional settings under Medicaid), there are both state and federal sources of rental support in the form of Section 8 vouchers, rental subsidies in State-funded congregate facilities, the State's rental assistance program, State Supplement funds and other sources.

Veterans Affairs

The federal Department of Veterans Affairs (VA) pays for LTSS for service-related disabilities and for certain other eligible veterans, and other health programs such as nursing facility care and at-home care for aging veterans with LTSS needs. Veterans who do not have service-related disabilities but who are unable to pay for the cost of necessary care may also receive LTSS. In Connecticut, the VA funds the Veteran-Directed Care (VDC) program through the ADS/SUA, the federal Veteran's Healthcare System in West Haven and the five Area Agencies on Aging. Veterans served through this program have the opportunity to self-direct their own care and receive services in their home by the caregiver of their choice. The Sgt. John L. Levitow Veterans' Health Center at the Connecticut State Veterans' Home provides long-term quality health care to veterans with chronic and disabling medical conditions. These conditions include, but are not limited to, chronic obstructive pulmonary disease (COPD), congestive heart disease (CHF), Cardiovascular Accident, Parkinson's disease, Alzheimer's disease and other dementias. The facility also provides End-of-Life care, Palliative care and Respite care. The Health Center is licensed by the Department of Public Health as a Chronic Disease Hospital and is recognized by the U.S. Department of Veterans' Affairs as a Nursing Facility.

IV. FUTURE DEMAND FOR LONG-TERM SERVICES AND SUPPORTS

A. Population and Disability Trends

Although LTSS are needed by people of all ages and may be required as a result of a diverse array of disabilities or chronic illnesses, it is important to recognize the significant impact the aging of our society will have on the future demand for LTSS. In 1900, adults age 65 and older accounted for a little over four percent of the total U.S. population. A century later, the proportion of older adults in the U.S. population had grown to over 12 percent or 35 million[67]. By 2030, the older adult population is expected to have grown to over 20 percent of the U.S. population, or 73 million. [68] By 2035, for the first time, older adults are projected to outnumber children with 76.7 million people under the age of 18 and almost 78 million 65 and older. [69]

In Connecticut, between 2019 and 2025, the total population is projected to grow by 104,200, an increase of three percent. The percentage of individuals under age 65 will increase by three percent, while the percentage of adults 65 and over will increase by two percent (Table 4).

In Connecticut, between 2019 and 2025, the proportion of older adults in the population is expected to remain stable at 17 percent. (Table 5).

TABLE 4
Connecticut Population Projections: 2019 - 2025

Age Group	2019	2020	2025	Pop. Growth 2019-2025	Percent Change 2019-2025
<65	2,905,465	3,024,944	2,997,889	92,424	3%
65+	609,097	579,659	620,873	11,776	2%
Total	3,514,562	3,604,603	3,618,762	104,200	3%

Source: Office of Policy and Management calculations based on: 1) U.S. Census 2019 American Community Survey 1-year Estimates, DP02 and 2) Connecticut Population Projections: Statewide 2015-2040, Developed by CT State Data Center – July 31, 2017 edition (data revised on 9/19/2017)

[67] U.S. Bureau of the Census; Older Population by Age Group: 1900-2050.
[68] U.S. Bureau of the Census; Projected Age Groups and Sex Composition of the Population: Main Projections Series for the United States, 2017-2060
[69] U.S. Bureau of the Census; Projected Age Groups and Sex Composition of the Population: Main Projections Series for the United States, 2017-2060

TABLE 5
Connecticut Population Projections,
Percent Distribution of Population by Age: 2019 – 2025

Age	2019	2020	2025
<65	83%	84%	83%
65+	17%	16%	17%

Source: Connecticut Population Projections: Statewide 2015 - 2040, Developed by the CT State Data Center - July 31, 2017 edition (data revised on 9/19/2017)

TABLE 6
Projection of Non-Institutionalized Persons with Disabilities in Connecticut by Age: 2019 – 2025

Age	2019 Disabled Population	2025 Projected Disabled Pop.	2019 / 2025 Increase	Percent Increase
<65	237,684	245,245	7,561	3.2%
65+	181,568	185,078	3,510	1.9%
Total	419,252	430,323	11,071	2.6%

*Note: May not total due to rounding

Source: Office of Policy and Management based on Sources: 1) U.S. Census Bureau, 2019 American Community Survey DP02, 2) Connecticut Population Projections: Statewide 2015 - 2040, Developed by the CT State Data Center - July 31, 2017 edition (data revised on 9/19/2017)

In 2019, the U.S. Census estimated that there were 419,252 individuals in Connecticut with one or more disabilities (excluding individuals living in institutions). Between 2019 and 2025, this number is expected to grow by 2.6 percent, or 11,071 people, to an estimated 430,323.[70] The number of individuals with disabilities under age 65 is projected to increase by 3.2 percent (7,561) while the number of individuals with disabilities age 65 and over is projected to increase by 1.9 percent (3,510). (See Table 6).

[70] These projections are based on the 2019 Census disability data applied to State Population Projections through 2025. The Census does not tabulate disability status for individuals in institutions. Disability projections assume a constant rate of disability over time.

B. Demand for Long-Term Services and Supports

Ideally, an estimate of the future demand for LTSS in Connecticut would include all aspects of the system in a single picture, including publicly and privately financed services and formal and informal care. However, creating such a comprehensive picture is not possible without more complete data on privately financed services and the use of informal care. Short of this, what is critical in terms of public policy is an understanding of the impact of future demand on the Medicaid financed long-term community and institutional services and supports once the baby boom generation ages.

By focusing on Medicaid, what is not accounted for is the demand for LTSS among individuals who either depend upon unpaid caregivers and family, those with private long-term care insurance, those who pay out of pocket and those who depend upon other sources of federal and state funds.

TABLE 7
Connecticut Gross Medicaid Long-Term Care Clients and Expenditures: SFY 2021

	SFY 2021 Medicaid LTC Clients, Monthly Average	SFY 2021 Medicaid LTC Expenditures
Community-based Care	31,276	$1.992 billion
Institutional Care	13,663	$1.352 billion
Total	44,939	$3.344 billion

Source: Office of Policy and Management, 2021.
Does not total due to rounding

As discussed in Section III, Medicaid is the largest and most significant payer of LTSS at both the state and national level. Of the 44,939 Medicaid clients who received LTSS in Connecticut each month in SFY 2021, 70 percent received services in the community and 30 percent received care in an institutional setting (Table 7). If these ratios remain steady over the four years and disability rates do not vary, U.S. Census Bureau disability data and population projections for Connecticut suggest that in the year 2025 there will be a 3 percent increase in individuals receiving Medicaid LTSS: an additional 938 Medicaid clients receiving LTSS in the community and an additional 410 receiving care in institutions (Table 8). To meet this additional demand for LTSS, Medicaid expenditures are expected to grow from $3.344 billion in SFY 2021 to $6.371 billion in 2025, assuming current ratios of institutional and community care and a five percent annual inflation rate (Table 9).

TABLE 8
Projections of Connecticut Medicaid Long-Term Care Clients by Current and Optimal Ratios of Community and Institutional Care SFY 2021 and SFY 2025

	2021 Client Ratio	2025 clients/ monthly average	Change from 2018 to 2025	Optimal Client Ratio	2025 Optimal clients/ monthly Average	Change from 2021 to 2025
Community-based Care	**70%**	32,214	938	75%	34,715	3,439
Institutional Care	**30%**	14,073	410	25%	11,572	-2,091
Total	**100%**	46,287	1,348		46,287	1,348

Source: Office of Policy and Management, Policy and Planning Division, 2015 based on: (1) Department of Social Services Medicaid data for SFY 2021; (2) U.S. Census Bureau, 2019 American Community Survey DP02, (3) Connecticut Population Projections: Statewide 2015 - 2040, Developed by the CT State Data Center - July 31, 2017 edition (data revised on 9/19/2017)

TABLE 9
Projections of Connecticut Gross Medicaid Long-Term Care Expenditures by Current and Optimal Client Ratios of Community and Institutional Care SFY 2021 and SFY 2025 in Billions

	Current Client Ratio	2025 Expenditures with Current Client Ratio	Change from 2021 to 2025	Optimal Client Ratio	2025 Expenditures with Optimal Client Ratio	Change from 2018 to 2025
Community-based Care	**70%**	$3,684,862,430	$1,692,756,333	**75%**	$3,970,952,950	$1,978,846,853
Institutional Care	**30%**	$2,500,329,570	$1,148,604,265	**25%**	$2,055,959,720	$704,234,415
Total	**100%**	$6,185,192,000	$2,841,360,599		$6,026,912,670	$2,683,081,269

Note: Expenditure projections include a 5 percent annual compound rate increase. Numbers do not total due to rounding.
Source: Office of Policy and Management, Policy and Planning Division, 2021 based on: (1) Department of Social Services Medicaid data for SFY 2021; (2) U.S. Census Bureau, 2019 American Community Survey DP02,
(3) Connecticut Population Projections: Statewide 2015 - 2040, Developed by the CT State Data Center - July 31, 2017 edition (data revised on 9/19/2017).

If current ratios of Medicaid community and institutional LTSS were to evolve over time to reflect the greater emphasis on home and community-based services achieved in other states, Connecticut could develop a LTSS system that provides community-based care to 75 percent instead of 70 percent of its Medicaid long-term care clients. If the number of Medicaid clients receiving LTSS in 2025 reflected this optimal ratio, Connecticut could expect an additional 3,439 clients receiving community-based services and supports, and a decrease of 2,091 individuals receiving care in institutions when compared to actual 2021 levels (Table 8). By holding the number of individuals served in 2025 constant and increasing the proportion of individuals receiving community-based care to 75 percent, Medicaid LTSS expenditures are projected to be $6.027 billion, instead of $6.185 billion; $158 million less than the State might otherwise have spent (Table 9).

Total Medicaid LTSS expenditures in 2025 are projected to be lower under the optimal ratios because in general, although the same numbers of people are served, the cost of serving people at home and in the community, on average,[71] is significantly lower than serving them in institutions.

In forecasting future demand for LTSS in Connecticut, it is important to note that there are many variables that will affect these estimates, whether related to changes in public policy, demographics, medical advances, or health status. On an individual level, not all people with a disability, whether it is physical, developmental, or psychiatric, will require LTSS. Those who do need LTSS often have needs that fluctuate over time, depending on their health, the nature of their disability and personal circumstances. Individuals vary in the level of supports they need, with the majority of people requiring support with instrumental activities of daily living (IADLs), and others requiring more intense support. Furthermore, the amount and type of informal care available from family and friends will influence the amount of paid care that is required. Additionally, we are waiting to see what long-term effects, if any, the COVID-19 pandemic will have on people's decision to keep family members home rather than utilize nursing facility care.

By way of comparison, in federal fiscal year 2018 the U.S., Medicaid spending for community-based LTSS amounted to 56.1 percent of all expenditures for Medicaid LTSS. A comparison of states provided in Table 10 shows Oregon to have the highest proportion of Medicaid long-term spending for home and community-based services (83.4 percent) and Rhode Island to be the lowest (30.0 percent). Among the states, Connecticut ranks 21st, with 55.5 percent of Medicaid LTSS expenditures for home and community-based services. [72] Although no one other state's model can be totally

[71] Although the average cost of serving people in the community is less expensive than care in institutions, this is not the case in all circumstances, such as the cost of caring at home for a person with Alzheimer's disease or other severe disabilities.

[72] Due to different methodology, this analysis calculated that the Connecticut Medicaid program spent 55.5 percent for community-based long-term services and supports in 2018, in contrast to the analysis by the CT

replicated in Connecticut, spending patterns in other states illustrate that greater ratios of home and community-based care are achievable. If Connecticut is to reach a ratio of 75 percent for community-based care sooner than 2025, balancing efforts will need to be more aggressive.

TABLE 10
Percent of Medicaid and State Long-Term Care Spending for Home and Community-Based Services, FY 2016*

State	Percent	U.S. Rank
Oregon	83.4	1
Minnesota	77.4	2
New Mexico	75.7	3
Wisconsin	75.3	4
Arizona	75.2	5
Massachusetts	71.1	16
Maine	57.6	18
U.S.	56.1	N/A
Vermont	55.8	20
Connecticut	55.5	21
New Hampshire	46.6	33
Rhode Island	30.0	46

Source: Centers for Medicare & Medicaid Services, *Medicaid LTSS Annual Expenditures Report – FFY 2017 and 2018;* January 7, 2021.

As required by Public Act 17-123, a more narrow analysis of the State's rebalancing costs was conducted by comparing only nursing facility data with Medicaid HCBS waiver data. (Table 11). In SFY 2021, nursing facility care currently accounted for 29% of the total Medicaid LTSS population and nursing facility expenditures accounted for 20% of total net Medicaid costs.

Conversely, HCBS Waiver participants account for 30% of the total Medicaid LTSS population but only 9% of total net Medicaid expenditures.

Office of Policy and Management, which reviewed spending on the state fiscal year vs the federal fiscal year, along with other methodological differences, calculated a percentage of 53 percent in 2018. Additionally, Rhode Island is the lowest ranked state coming in at number 46 as other states are reported N/A for 2018 data by CMS.

Table 11
Connecticut Net Medicaid Expenditure for Nursing Homes vs. HCBS Waiver and Associated Client Percentages SFY 2021

Type	2021 Client Numbers	Current Client Ratio Total LTSS Population	2021 Net Medicaid Expenditures	Current Total Net Medicaid Expenditure Ratio
HCBS Waiver Care*	13,632	30%	$216,264,938	9%
Nursing Facility Care	12,718	28%	$578,075,398	20%

Source: Office of Policy and Management, Health and Human Services Policy and Planning Division, 2021.

Note: Percentages are in relation to the total SFY 2021 Medicaid LTSS client population (44,939) and Total Net Medicaid expenditures ($2,444,122,147). Expenditures reflect state share assuming 50% federal reimbursement.

C. Caregiver Supply and Demand

Informal Caregivers

Relatives, friends and other unpaid caregivers account for the vast majority of individuals providing LTSS to individuals across the lifespan. Looking at this another way, only 13 percent of people needing any type of LTSS use paid helpers in either a primary or secondary role.[73] In 2017, there were 41 million family caregivers in the U.S providing care to an adult with limitations in daily activities at any one time. Over this time, the estimated economic value of unpaid contributions from informal caregivers was approximately $470 billion, stable from the last update in 2013. However, to provide perspective, previous tracking has shown the following growth in the estimated economic value of unpaid caregivers since 2006: $470 billion in 2013, $450 billion in 2009, $375 billion in 2007, and $354 billion in 2006. In fact, the economic value of caregiving exceeded total Medical spending in the U.S. for both medical and LTSS. In Connecticut, in 2017, there were an estimated 460,000 informal caregivers at any given time, accounting for an estimated $5.9 million in unpaid contributions.[74]

Paid Direct Caregivers

While the majority of LTSS are provided by unpaid family members or other informal caregivers, paid direct caregivers form a large and growing percentage of the workforce, both in Connecticut and nationally.

[73] H. Stephen Kay, Charlene Harrington, and Mitchell P. LaPlante; *Long-Term Care: Who Gets It, Who Providers It, Who Pays, and How Much?*; Health Affairs, Vol. 29:1; January 2010; page 15.
[74]Susan C. Reinhard et al, *Valuing the Invaluable: 2019 Update; Charting a Path Forward*, AARP Public Policy Institute 2019.

Table 12
Connecticut 2018 and Projected 2028 Occupations

Occupational Title	Employment		Change	
	2018	2028	Number	Percent
Personal Care Aides	29,532	39,844	10,312	34.9%
Home Health Aides	7,158	8,891	1,733	24.2%
Registered Nurses	39,003	41,859	2,856	7.3%
Nursing Assistants and Orderlies	16,969	18,086	1,119	6.6%
Occupational Therapists	2,866	23,184	318	11.1%
Occupational Therapist Assistants	894	1,138	244	27.3%
Physical Therapists	4,511	5,111	600	13.3%
Physical Therapist Aides	458	508	50	10.9%
Physical Therapist Assistants	698	845	149	21.1%
Respiratory Therapists	1,525	1,797	272	17.8%
Speech-Language Pathologists	2,511	2,991	480	19.1%

Source: Office of Policy and Management, from Connecticut Department of Labor, *Connecticut Statewide Forecast: 2016 –2026*, https://www1.ctdol.state.ct.us/lmi/projections.asp

Paid direct caregivers go by a number of titles, including nurses' aides, personal care assistants and home health aides. In 2020, there were an estimated 55,430 direct-care workers in Connecticut providing daily services and supports to older adults and individual with disabilities who needed assistance with personal care and other daily activities of living. [75] In 2020, 2.4 million home care workers provided services across the United States. It is predicted that between 2019 and 2040, the national demand for paid direct care workers will grow as the number of individuals ages 65 and over increases from 54.1 million in 2019 to 80.8 million in 2040 and 94.7 million in 2060[76].

Current efforts to balance the institutional bias of the LTSS system are leading to a greater percentage of people receiving LTSS at home. As a result, LTSS occupations in Connecticut will see double-digit figure growth between 2018 and 2028. The impact of

PHI Workforce Data Center Web Site https://phinational.org/policy-research/workforce-data-center/#states=09.

[76] U.S. Administration for Community Living, *2020 Profile of Older Americans;* May 2021. https://acl.gov/sites/default/files/Aging%20and%20Disability%20in%20America/2020ProfileOlderAmericans.Final_.pdf.

this shift on the paid caregiver workforce in Connecticut is reflected in a predicted 34.9 percent rise in personal aide positions and a 24.2 percent increase in home health aide positions (Table 12).

However, there may be challenges to ensuring the home care workforce is large enough to meet growing demand. The following are some of the obstacles facing the home care industry that have the potential to create a workforce shortage in the future: (1) from 2016 – 2060, the population of individuals age 65 and over is projected to double and those 85 and over triple, while the number of working aged adults (ages 18-64) are projected to only experience an increase of 15 percent;[77] (2) wages for home care workers have seen a modest increase from 2010-2020, with the median hourly wages increasing by 16 percent from $11.23 in 2010 to $12.98 in 2020 resulting in 17 percent of homecare workers living in poverty[78] (this is compared to 11.4 percent of all U.S workers[79]) and; (3) the home care labor force is also aging. 34 percent of home care workers are 55 or older (this is compared to the 23 percent of the total U.S labor market).[80]

Over the course of the next decade, building workforce capacity will be a critical component to ensuring Connecticut's home and community-based LTSS system is able to meet the demand for services.

V. GOALS and RECOMMENDATIONS

A. Introduction

The goals and recommendations provided in this Plan are put forward to improve the balance of the LTSS system in Connecticut for individuals of all ages and across all types of disabilities and their families. In addition to the two rebalancing goals, this Plan provides a set of long-term and short-term recommendations. The long-term recommendations provide a high level view of the essential components of a well-balanced and person centered system of LTSS. These recommendations are reflective of a system of services and supports, and as such, must be viewed as both interrelated and interdependent. The short-term recommendations reflect strategic priorities identified for action over the next three years (2022-2024).

In 2005, a broad philosophical statement was enacted in Connecticut statute to guide policy and budget decisions. It states that *"Connecticut's long-term care plan and policy must provide that individuals with long-term care needs have the option to choose and*

[77] Stephen, Campbell et al., PHI National; *Caring for the Future: The Power and Potential of America's Direct Care Workforce*; January 12, 2021.
[78] Ibid
[79] Shrider, Emily A., et al. U.S. Census Bureau, *Income and Poverty in the United States: 2020*; September 14, 2021.
[80] Stephen, Campbell et al., PHI National; *Direct Care Workers in the United States: Key Facts 2021; September 7, 2021.*

receive long-term care and support in the least restrictive, appropriate setting." This simple statement provides a larger framework for Connecticut to make the necessary changes to the laws and regulations that govern the State's system of LTSS to make real choices for people a reality.

As Connecticut continues its work to balance its system of LTSS, progress must be made on multiple fronts. A balanced system of LTSS is one where policies, incentives and services are aligned to allow individuals with LTSS needs to live fulfilling and productive lives. Balancing the mix of home and community-based and institutional care as well as the mix of public and private resources is needed if Connecticut hopes to provide real LTSS choices for its residents and to achieve the long-standing Vision, Mission and Governing Principles put forth by this and previous LTSS Plans. Over the years, Connecticut has made notable progress towards this goal, but more must be done to meet needs today as well as to anticipate the demands on the LTSS system that will be made by the aging of the baby boom generation.

Overall, the recommendations are primarily focused on initiatives State government can undertake. While the focus of this Plan is on State government, it is important to recognize the vital role that cities, towns, the private sector and individuals and families play in the LTSS system. Government at all levels must work in partnership with individuals, families and the private sector in order to develop a quality and effective system.

B. Goals

1. Balance the ratio of home and community-based and institutional care

GOAL #1: *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 70 percent in 2021 to 75 percent by 2025.*

Over the last decade, Connecticut has made significant progress in developing home and community-based and residential alternatives to institutional care. Examples abound. Connecticut eliminated its waiting list for home care for elders; expanded income eligibility for State-funded home care for elders; introduced subsidized assisted living in State-funded congregate facilities, HUD complexes and private pay assisted living communities; developed affordable assisted living units; increased funding and capacity for various Medicaid home and community-based services waiver programs; expanded access to personal care services for individuals eligible for Medicaid; developed a LTSS website and is in the midst of a robust and ongoing effort to rebalance the system of LTSS through the Money Follows the Person Rebalancing Initiative.

In the 19 years since the establishment of the Plan's goal of improving the balance between home and community-based services and institutional care (SFY 2003 – 2020), this goal has been met, with a steady increase in the percentage of Medicaid long-term care clients served in the community from 46 percent to 70 percent (Table 12). However, to meet the goal of 75 percent of Medicaid clients receiving LTSS in the community by 2025, this pace must accelerate.

With regard to expenditures, between SFY 2003 and SFY 2020, the percentage of Medicaid dollars for LTSS spent on services received in the community increased by 75 percent (Table 13).

TABLE 12
Percentage of Connecticut Medicaid LTSS Clients over Time

SFY	Home & Community Care	Institutional Care	Total Monthly Average LTSS Medicaid Clients
2002-2003	46%	54%	37,969
2003-2004	49%	51%	39,305
2004-2005	50%	50%	40,417
2005-2006	51%	49%	41,773
2006-2007	52%	48%	41,335
2007-2008	52%	48%	40,057
2008-2009	53%	47%	40,097
2009-2010	54%	46%	40,442
2010-2011	55%	45%	41,402
2011-2012	56%	44%	41,725
2012-2013	58%	42%	42,577
2013-2014	59%	41%	44,712
2014-2015	60%	40%	45,876
2015-2016	60%	40%	46,024
2016-2017	61%	39%	45,598
2017-2018	64%	36%	46,270
2018-2019	64%	36%	46,194
2019-2020	65%	35%	46,373
2020-2021	70%	30%	44,939

Source: Office of Policy and Management, Health and Human Services Policy and Planning Division, 2021

TABLE 13
Percentage of Connecticut Gross Medicaid LTSS Expenditures over Time

SFY	Home & Community Care	Institutional Care	Total LTSS Medicaid Expenses in billions
2002-2003	31%	69%	$1.914
2003-2004	33%	67%	$1.955
2004-2005	35%	65%	$1.977
2005-2006	32%	68%	$2.227
2006-2007	33%	67%	$2.299
2007-2008	33%	67%	$2.404
2008-2009	35%	65%	$2.498
2009-2010	38%	62%	$2.587
2010-2011	40%	60%	$2.695
2011-2012	41%	59%	$2.770
2012-2013	43%	57%	$2.894
2013-2014	45%	55%	$2.877
2014-2015	45%	55%	$2.889
2015-2016	49%	51%	$3.064
2016-2017	50%	50%	$3.215
2017-2018	53%	47%	$3.259
2018-2019	52%	48%	$3.203
2019-2020	54%	46%	$3.385
2020-2021	60%	40%	$3.344

Source: Office of Policy and Management, Health and Human Services Policy and Planning Division, 2021

If Connecticut is able to meet the goal of serving three out of every four Medicaid LTSS clients in the community, the impact on future LTSS expenditures will be significant. Additionally, Connecticut would be offering more choice to its residents. Based on U.S. Census Bureau disability data and population projections, and assuming the proportion of individuals with disabilities remains the same, it is estimated that by 2025 the number of persons with disabilities in Connecticut will grow by 11,071 or 2.6% percent, with a 1.9% percent increase among individuals age 65 and older. For individuals with disabilities under age 65, an estimated 3.2 percent increase is projected between 2019 and 2025 (Table 6). Assuming current ratios of community-based to institutional care, a five percent per year inflation rate and a 3 percent increase in the number of individuals with disabilities, Medicaid expenditures for LTSS are anticipated to grow from $3.344 billion in SFY 2021 to $6.185 billion by SFY 2025 to meet the expected increase in demand for long-term care. (Tables 7 and 9)

However, if 75 percent of Medicaid clients receive community care in 2025, these LTSS expenditures are only expected to be $6.027 billion, which is $158 million less than the State might otherwise have spent that year. This cost avoidance over time not only allows Connecticut to provide relief to the Medicaid budget but also allows Connecticut to meet the needs of a larger group of individuals. (Table 9)

This Plan takes a conservative approach to projecting the numbers of individuals with disabilities over the next eight years by holding the percentage of persons with disabilities constant over time. As described in Section IV, the percentage of older adults with disabilities has fallen over the last two decades. Experts disagree whether this decline in the rate of disability will continue or whether the expected demographic changes will overwhelm these gains. Fluctuations in either direction in the rate of disability will have an impact on the cost of providing LTSS.

2. Balancing the ratio of public and private resources

> ***GOAL #2:*** *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, spending from private long-term care insurance and other public sources (State and local programs) for nursing facilities and home health services represented 20 percent of LTSS expenditures in 2021 (Figure 7)*[81]

LTSS is one of the most complex and difficult issues for individuals and families to understand and discuss. Many people are under the false impression that Medicare, and other health insurance programs, will cover their LTSS needs. This misunderstanding, coupled with the fact that most individuals would rather not face, or discuss, the possibility of becoming disabled and dependent, leads most people to do little or no planning for their future LTSS costs.

The lack of Medicare and health insurance coverage for LTSS, combined with the lack of planning, has created a LTSS financing system that is overly reliant on the Medicaid program. Medicaid, by default, has become the primary public program for LTSS. However, in order to access Medicaid, individuals must first impoverish themselves. Therefore, we have a system that requires individuals to spend all their savings first in order to receive government support for their ongoing needs.

[81] "Other dedicated sources of private funds" means private long-term care insurance, other types of private insurance and other private spending for nursing homes and home health services. It does not include "out-of-pocket" spending or informal care. Source: Hado, Edem & Komisar, Harriet, AARP Public Policy Institute; AARP Long-Term Services and Supports Fact Sheet 634, August 2019.

In order for Connecticut residents to have real choices about what type of LTSS they receive and where those services are provided, there needs to be a better balance between public and private resources. An over reliance on the Medicaid program as the primary source for LTSS financing threatens to reduce choices as budget pressures will only mount as the need for LTSS increases. Resources such as insurance benefits and other dedicated sources of private LTSS funding (i.e. reverse annuity mortgages) are needed to help balance the ratio of public and private funds in the system.

If enough individuals would plan for their LTSS needs through long-term care insurance or dedicated savings, there would be more Medicaid funding for community-based care and people would not have to deplete their assets if they required prolonged LTSS. For example, the burden for paying for LTSS on both the state Medicaid program (57 percent) and individuals paying out-of-pocket (23 percent) would be significantly reduced if the proportion of LTSS costs covered by other non-Medicaid insurance/programs (long-term care insurance, other health insurance, and State and local programs – 20 percent) successfully reached 25 percent (See Figure 7). If these reductions in expenses were evenly divided between Medicaid and out-of-pocket costs for individuals, then Medicaid's share of the costs could be reduced by 12 percent. Using today's dollars, and a Medicaid LTSS budget of approximately $3.344 billion, that would equate to $401 million in annual savings. These savings could be partially allocated to the General Fund and partially used to help fund enhancements to the LTSS system, such as infrastructure and service improvements, leading to more choices for individuals and their families.

Private long-term care insurance specifically covers the personal and custodial care services and supports that comprise most of what is referred to as LTSS, including both home-based and institutional services. However, private long-term care insurance (LTCI) has its limitations. The premium for LTCI is priced based on the purchaser's age. The older someone is the more expensive the policy. Therefore, for many individuals who wait too long to plan for their LTSS, LTCI may not be affordable. Also, there will always be a portion of the population where LTCI is not affordable at any age.

In addition, in order to purchase LTCI an individual must generally pass a medical underwriting screen (there are some exceptions to this in large group/employer offerings). Individuals who are already in need of LTSS, or have conditions, such as Multiple Sclerosis or Parkinson's Disease, that, even if there are no symptoms at the time the individual applies for coverage, will very likely lead to needing LTSS, aren't able to purchase the coverage.

Given its limitations, private LTCI is not a panacea. However, it can play a more significant role than it does today in financing LTSS. In Connecticut, the presence of the Partnership for Long-Term Care program makes LTCI more affordable for many since they need only purchase an amount of coverage equal to the amount of assets they wish to protect.

In addition to LTCI as a planning tool, Connecticut needs to be creative in the development of other financing options that can help to balance the ratio of public and private resources in the system.

C. Long-Term Recommendations

Optimally, a LTSS system that is able to maximize autonomy, choice and dignity will provide a full range of services and supports. Individuals, regardless of disability or age, should have the options that allow them to live their lives as meaningfully and productively as possible in the settings that best suit their needs and preferences, in the least restrictive environment. As in any system, all the constituent parts are interrelated and interdependent. In order to meet the growing demand for LTSS, and the goals set forth in this plan, investment in the community-based infrastructure is critical. Over the long term, to realize the vision and achieve the goals set out in this Plan, actions must be taken on the following fronts:

- Provide true individual choice and self-direction to all users of LTSS, regardless of funding source.
- Promote efforts to enhance quality of life in various LTSS settings.
- Ensure the availability of a wide array of support services for those living in the community. Ensure quality of LTSS in the context of a flexible and person-centered service delivery system that acknowledges the dignity of risk.
- Provide individuals, caregivers and persons on nursing home waitlists options counseling and decision support to encourage advanced person-centered planning LTSS to prevent institutionalization and to extend the availability of private funds for care.
- Achieve greater integration and uniformity of administration of State LTSS serving both older adults and people with disabilities and their families, and emphasize policies related to function as opposed to age or diagnosis.
- Encourage communities to take an active role in planning and supporting LTSS for their residents.
- 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.
- Address the LTSS workforce shortage.

- Provide support to informal caregivers.

- 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.

- Encourage and enable the provider community to transform and develop services and supports that will help to achieve the goals of this Plan.

- Expand and improve employment opportunities and vocational rehabilitation for persons with disabilities and older adults.

- Support state and local efforts to improve and expand accessible, affordable, and inclusive transportation that accommodates the needs of residents, family and direct care worker companions.

- Improve quality of life and reduce utilization of LTSS and health care services by focusing on health promotion and disease prevention.

- Address emergency preparedness/disaster planning for older adults and persons with disabilities.

- Improve access to medical benefits and services to older adults and persons with disabilities being released from incarceration.

- Encourage insurance carriers to include options counseling, care transition or ongoing case management as a service covered by long-term care insurance policies.

D. Short-Term Recommendations

These short-term recommendations provide an action agenda for improving the LTSS system in Connecticut in the three years spanning 2018 through 2020. Criteria for proposing these targeted priority recommendations are that they will help to ensure the success of the LTSS system and can be acted upon in the next three years.

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 by reducing or eliminating waitlists.

- Improve transparency throughout the assessment process by ensuring that consumers understand the criteria being used to make decisions regarding their

budgets and supports and that consumers and/or their authorized representatives are present at all planning meetings where level of care or service revision decisions are made.

- Ensure access to all levels of the State-funded Connecticut Home Care Program for Elders.

- Study the impact of the 2021 copay reduction from 9% to 4.5% for the State-funded tiers of the Connecticut Home Care Program for Elders, and determine the need for further reductions or elimination of the copay.

- Support the continued implementation of the 1915(k) state plan option, Community First Choice.

- Identify skills needed for residents of institutions who desire to transition back to the community and provide appropriate skills training and resources.

- Expand funding for State-funded respite services, such as the Statewide Respite Program and the Department of Developmental Services' in-home and out-of-home respite services in order to provide support to informal caregivers.

- Provide family caregivers with access to training, ongoing coaching support, respite care, mental health services and counseling, financial assistance, and encourage employers to offer workplace flexibility and opportunities for benefits.

- Continue to measure the effectiveness of the Adult Family Living model to determine future resource allocation, policy and programmatic enhancements and potential growth.

- 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.

- Strengthen the aging and disability networks within the No Wrong Door system including the collaboration between State agencies, support of person-centered counseling training and support of funding opportunities.

- Identify and remove barriers, such as insurance/entitlement reimbursements and licensing requirements that prevent or limit access to LTSS.

- Support efforts to implement person-centered planning and care regardless of the setting or service.

- Ensure equity in all LTSS programs and services through the availability of accessible materials, addressing social determinants of health and ongoing evaluation of equity in LTSS access and health outcomes among traditionally underserved populations.

- Support a robust local LTSS 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.

- 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 in-home hands-on assistance or institutionalization.

- Promote nutrition services to address malnutrition and food security through use of uniform prioritization protocols.

- Support and expand continued funding for the Senior Outreach and Engagement program to address identify, reduce and treat substance abuse and misuse among adults ages 55 and over.

- Increase earlier access to Hospice services in the community and institutional settings.

Infrastructure

- Engage in coordinated outreach and education efforts among State agencies to provide unbiased information to Connecticut residents on the LTSS available and how to access them.

- Coordinate efforts among various entities impacting No Wrong Door development and monitor progress on the state's No Wrong Door endeavors.

- Continue the Balancing Incentive Program (BIP), to create infrastructure investments of a consumer friendly statewide No Wrong Door system, a conflict free case management, and a uniform assessment tool.

- With a focus upon hospital admission and discharge, use best efforts to assist individuals with discharge to an appropriate care setting of their choice and develop the capacity in the post-acute setting for the discharge of patients with complex care needs.

- Address the historical fragmentation of the Medicaid home and community-based waivers, which are associated with specific age and diagnostic eligibility criteria and administered through varying State agencies and application processes. Coordination of programs and application and renewal processes between State agencies must occur to create a streamlined system that addresses the needs of the total person.

- Provide timely eligibility decisions regarding eligibility in all government sponsored LTSS programs. Consider development and use of a presumptive eligibility model.

- Continue to support the widespread adoption of telehealth and other assistive technologies to improve access to care, coordination, quality and outcomes for residents, while reducing health costs.

- Ensure the Aging and Disability Resource Center initiative under the CHOICES program continues to offer information, referral, assistance and LTSS options counseling services statewide and is integrated within the state's No Wrong Door system.

- Achieve greater integration of employment of persons with disabilities into the Money Follows the Person Rebalancing Initiative and home and community-based services.

- Eliminate the benefits cliff so that older adults and individuals with disabilities can participate in meaningful employment without risking the supports and services they need to remain active, contributing members of the community.

- Support improved coordination, communication and guidance among the medical care, behavioral health and LTSS systems across the lifespan.

    - Ensure that current and future initiatives affecting the LTSS system are well coordinated and complementary.

    - Support the utilization of evidence-based practices.

    - Support the development of electronic health records by providers of LTSS and exchange of electronic health records among providers across the Connecticut health care system to streamline care transitions, coordinate care delivery and improve quality and outcomes.

    - Support a learning collaborative approach to bring together providers across disciplines and perspectives, and to learn from older adults and individuals with disabilities.

- Support state program coordination to ensure that individuals with dual diagnoses have the same access to LTSS and social opportunities as individuals with only a physical health diagnosis.

- Develop new and enhance and promote existing mobility management programs to help consumers learn how to access and navigate transportation options, including the Department of Transportation Mobility Ombudsmen program.

- 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.

- Establish on-call supports for Medicaid recipients who self-direct their LTSS so that they have someone to call with questions and concerns in order to succeed as an employer.

- Review, and modify as necessary, the current Certificate of Need process for skilled nursing homes to allow the State to work more collaboratively with nursing home providers as they seek to transition and transform their facilities.

Financing

- Study the economic status of the aging demographic to understand the future demand that will be placed on public financing of LTSS and the supply of affordable senior housing.

- Achieve adequate and sustainable provider reimbursement levels that support the cost of LTSS and quality requirements for all segments of the LTSS continuum, including nursing homes, group homes and supportive housing in order to ensure access to care and provider capacity to meet the evolving needs and demographics of Connecticut residents.

- Provide greater flexibility in the budgeting and use of Medicaid funds for LTSS.

- Capture and reinvest cost savings across the LTSS continuum.

    - Reinvest savings resulting from Money Follows the Person, the Balancing Incentive Program and other emerging Medicaid LTSSS programs to enhance the availability and capacity of home and community-based services and ensure an adequate provider network.

- Continue efforts to reform the Medicaid rate setting system to reflect quality, reimbursement related to the actual costs of care, the acuity level of the consumers and uncompensated care for all LTSS providers across the continuum consistent with LTSS 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 LTSS.
    - Explore the development of tax incentives for the purchase of private long-term care insurance, including tax incentives for employer-based coverage.
- Support the continued flexible use of Older Americans Act funding for services.
- Provide increased funding to school systems so that they can hire additional social work and special education staff and train them on the programs and services available to parents and students with special needs so that they can provide meaningful assistance to families.
- Implement a caregiver tax credit or establish a State-managed fund to reimburse unpaid family caregivers who provide services that keep people in their homes and avoid the need for institutional care.
- Address the LTSS needs of immigrants who do not qualify for traditional sources of public funding and, therefore, lack access to care.
- Explore the development of LTSS programs, like the State's assisted living pilot program, that utilize private and public partnerships.
- Increase funding for behavioral health services across the LTSS continuum.
- Explore adjusting Medicaid spousal assessment rules, especially for spouses under age 65.
- Explore the provision of Medicaid reimbursement for paid caregivers to visit consumers in the hospital and other institutional settings to reduce isolation and promote better health outcomes.

Quality

- Enable a collaborative, flexible and efficient regulatory environment that is adaptive and receptive to individual providers' forward-thinking ideas and planning. Such an environment would encourage providers of the LTSS 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, Aging and Disability Services, Consumer Protection, Social Services, and the State Long-Term Care Ombudsman, should continue to work together to ensure consistency among their respective regulatory and oversight activities.

- Expand State oversight of services to individuals receiving LTSS, including those provided in group homes, to include employee job performance in the areas of quality interactions with consumers and efforts at promoting consumer social engagement and stimulation.

- Explore using a third-party, non-State entity to conduct group home evaluations.

- 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.

- 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, including the development of multi-disciplinary teams, implementing recommendations from the Coalition for Elder Justice in Connecticut and increasing resources, training for, and collaboration with Protective Services for the Elderly, the Office of the Chief State's Attorney, and other relevant agencies to identify, investigate and prosecute cases of abuse, neglect, and exploitation.

- 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.

- Ensure all LTSS care settings, such as nursing homes, group homes and supportive housing options, have the ability, in accordance with applicable state and federal laws, to reasonably accommodate non-English speaking and deaf and hard of hearing residents by providing or arranging for appropriate interpretation services..

- Study whether the oversight and enforcement provided by Protective Services for the Elderly and Department of Consumer Protection are sufficient and adequately resourced to reduce abuse and neglect among recipients of home care services.

Housing

- Support programs that divert or transition individuals from nursing facilities or other institutions to community housing options, such as CT811.

- Develop new housing alternatives for persons with serious and persistent mental illness who do not need nursing facility level of care.

- Continue to support and strengthen the current models of affordable housing with assisted living services to ensure their viability.

- Address the needs of the aging skilled nursing facility infrastructure through maintenance, infection control, and modernization.

- Adopt policies that encourage incorporation of accessible housing features into new construction in all communities so that new housing can support its residents throughout the lifespan and in the neighborhood of their choosing.

- Continue and expand State investment in the development of housing for older adults and persons with disabilities that is affordable, accessible, culturally appropriate and located in the community of the individual's choosing.

- Encourage the growth and development of community- based service models that bring LTSS to housing residents. Work with the federal government to secure at-risk housing subsidies, preservation, and development funds.

- Reduce isolation and quality of life among older adults and individuals with disabilities by including them directly in the placement process to ensure that individuals are placed in housing where they feel most comfortable.

- Increase Medicaid and State funding for home modifications and expand the qualifying criteria for home modifications to include health and safety measures related to cognitive and behavioral needs as well as physical disabilities.

Workforce

- Address the healthcare workforce shortage across the LTSS continuum to support to improve access to and quality of LTSS.

- Develop a comprehensive and safe direct care workforce-consumer on-line matching system with details on special qualifications, such as experience working with individuals with Alzheimer's or training in behavior management.

- Develop a registry of pre-certified emergency back-up workers that can be accessed by employers of record in the State's Medicaid self-directed programs that enables them to rapidly access emergency direct care services without having to go through

the lengthy hiring process or resort to consumer hospitalization or institutionalization for care.

- 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.

- Engage in innovative workforce recruitment practices, including the recruitment and training of home care workers from local communities who will be familiar with local neighborhoods, supports and culture and individuals who currently or previously served as community health workers or informal caregivers to be paid peer supports and/or service providers for individuals participating in the state's self-directed Medicaid programs.

- Address the need for both paid skilled health care and unskilled care (e.g., companionship) to provide stimulation and increase psycho-social health outcomes.

- Engage local Boards of Education and school systems in the promotion of direct service home care as a career option for students.

- Reduce the amount of time it takes to hire staff through self-directed programs.

- Promote workforce training that addresses physical and mental health needs across the lifespan.

- Promote flexibility in workplace employment policies and practices to accommodate the circumstances of unpaid family caregivers.

- Develop and maintain a well-trained and equitably reimbursed agency-based home and community-based services workforce for individuals who do not wish to self-direct care.

- Provide education and training to direct care workers and unpaid family caregivers on skills and competencies related to the physical, cultural, cognitive, and behavioral health care needs of consumers of LTSS.

- Create and communicate career advancement opportunities for direct service providers across settings so that dedicated workers can grow in their skills and compensation while continuing to provide needed services in both community and institutional settings.

VI. CONCLUSIONS

Over the next four years Connecticut will be challenged to continue to support and enhance a LTSS system that is person focused and directed and provides real choices for individuals with disabilities and their families as we come to the end of the timeframe for success set in the two overarching goals of this Plan. Many uncertainties could affect the level of demand for LTSS in Connecticut. Disability rates may decline, medical technologies may reduce the incidence of certain chronic diseases, or new conditions may arise that increase the demand for LTSS. The State also needs to reflect and take action upon lessons learned during the COVID-19 pandemic and determine how to respond to the potentially permanent changes to the LTSS system on both federal and state levels. However, we do know that Connecticut residents want a system that maximizes the opportunity for all persons, regardless of age or disability, to live in the community as independently as possible. We also know that current levels of Medicaid LTSS expenditures for institutional care and the significant reliance on public funds for LTSS will not allow Connecticut to reach its goal of real LTSS choices and to adequately meet a possibly growing demand for services and supports. The time to take steps to balance the system is now. As outlined in this Plan, the shifting of the ratio of home and community-based and institutional care, coupled with a larger role for private funds in the system, will position Connecticut to be responsive to the potential LTSS needs of our citizens in the short and long-term and will help realize its goal of a system driven by choice and consumer control.