Balancing the System:

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

A Report to the General Assembly
January 2022

APPENDICES

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

B. Long-Term Care Planning Committee Membership

C. Long-Term Care Advisory Council Membership

D. Sources of Public Comment

E. Long-Term Services and Supports Planning History

F. Listening Session Feedback Summary

G. State Long-Term Services and Supports Programs and Expenditures – SFY 2020-2021

APPENDIX A.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

APPENDIX B.

Long Term Care Planning Committee
Members
(November 2021)

Legislators
Senator Patricia Billie Miller, Co-Chair, Aging Committee
Representative Quentin W. Phipps, Co-Chair, Aging Committee
Senator Kevin C. Kelly, Ranking Member, Aging Committee
Representative David T. Wilson, Ranking Member, Aging Committee
Senator Mary Daugherty Abrams, Co-Chair, Public Health Committee
Representative Jonathan Steinberg, Co-Chair, Public Health Committee
Senator Tony Hwang, Ranking Member, Public Health Committee
Representative William A. Petit, Ranking Member, Public Health Committee
Senator Marilyn Moore, Co-Chair, Human Services Committee
Representative Catherine F. Abercrombie, Co-Chair, Human Services Committee
Senator Eric C. Berthel, Ranking Member, Human Services Committee
Representative Jay M. Case, Ranking Member, Human Services Committee

State Agencies Representatives
David Guttchen, Office of Policy and Management (Chair)
Jennifer Cavallaro, Department of Social Services
Dr. Stephanie Bozak, Department of Children and Families
Margy Gerundo-Murkette, Department of Aging and Disability Services
Kelley Kendall, Department of Developmental Services
Erin Leavitt-Smith, Department of Mental Health and Addiction Services
Donna Ortelle, Department of Public Health
Amy Porter, Department of Aging and Disability Services
Jessica Rival, Office of Health Strategy
Lisa Rivers, Department of Transportation
Michael Santoro, Department of Housing
Laura Watson, Department of Housing

Staff
Melissa Morton, Office of Policy and Management

APPENDIX C.

Long-Term Care Advisory Council Member Organizations

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

Friends of the Advisory Council

Representative Jonathan Steinberg

APPENDIX D.

Sources of Public Comment

With the assistance of the Long-Term Care Advisory Council, a draft of the Plan recommendations was distributed widely in August 2021 to diverse organizations and individuals throughout Connecticut with an interest in long-term services and supports (LTSS). A draft of the full Plan and appendices was distributed for comment in December 2021. In total, public comments were received from the following organizations and members of the public.

Organizations

- Long-Term Care Advisory Council Members:
    - AARP CT: Anna Doroghazi
    - CT Alzheimer's Association: Christy Kovel
    - CT Association for Healthcare at Home: Tracy Wodatch
    - CT Hospital Association: Karen Buckley
    - Leading Age CT: Margaret Morelli
    - LTC Advisory Committee (CWCS): Steve Hernandez and Michael Werner
    - LTC Ombudsman Program: Mairead Painter

- Other Community Organizations
    - The Arc of CT: Edwin Evarts
    - InterCommunity Healthcare, Common Ground Club: Dyana Hagen
    - CT Council on Developmental Disabilities: Walter Glomb
    - Health Equity Solutions: Karen Seigel & Victoria Tran
    - CT Keep the Promise Coalition: Jordan Fairchild & Holly Hackett
    - Leeway: Jay Katz
    - Living Innovations: Joanne Malise
    - Seniorlink: Rachel M. Richards

- Members of the Public
    - 9 individual members of the general public submitted written comment on the Plan recommendations.
    - 40 individuals provided comments on the Plan through participation in four long-term services and supports user and family member listening sessions held virtually in September and October 2021. Listening sessions were held in partnership with AARP CT, the ARC of CT, Keep the Promise Coalition, and PATH Parent to Parent/Family Voices of CT.

See appendix F for a summary of public comment.

APPENDIX E.

A. Long-Term Care Planning Committee History

Establishment of the Long-Term Care Planning Committee

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

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

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

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

Long-Term Care Planning Committee Products

Preliminary Long-Term Care Plan – 1999

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

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

Home Care Report – 2000

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

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

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

Long-Term Care Plan - 2001

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

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

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

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

Long-Term Care Plan – 2004

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

2004 Long-Term Care Plan Status Reports

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

Long-Term Care Website

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

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

Policy Statement Formalized into Law

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

Long-Term Care Needs Assessment

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

Long-Term Care Plan – 2007

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

2007 Long-Term Care Plan Status Reports

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

Long-Term Care Plan – 2010

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

2010 Long-Term Care Plan Status Reports

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

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

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

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

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

Long-Term Care Plan – 2019
The Long-Term Care Planning Committee's seventh plan was issued in January 2019.

2019 Long-Term Care Plan Status Reports
Due to the COVID-19 Public Health Emergency (PHE) that impacted Connecticut and the nation in 2020 and into 2021, for the first time in the history of the Planning Committee's Long-Term Care Plans, the Committee did not issue a status update on the individual Plan recommendations as State agencies were focused on response efforts related to the PHE. The Office of Policy and Management did continue to track and submit annual status reports on long-term care rebalancing statistics to the legislature as required by statute.

B. Olmstead Planning Efforts

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

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

In 2000, the Department of Social Services began developing an Olmstead Plan and the Long-Term Care Planning Committee provided oversight and leadership for the process. In order to assure that individuals with disabilities and family members of persons with disabilities were active participants in the development of the Olmstead Plan, a

Community Options Task Force was created to take the lead in the development of the Plan. The individuals on this advisory group, made up of adults of all ages with various disabilities, family members of persons with disabilities, and representatives from the elder community, worked hard on Connecticut's Community Options Plan, entitled "Choices are for Everyone," for two years.

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

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

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

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

Systems Change Grants

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

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

Connecticut Behavioral Health Partnership

Operation of the Connecticut Behavioral Health Partnership program began on January 1, 2006, serving children and families enrolled in the state HUSKY A and B programs and Department of Children and Families (DCF) involved children with special behavioral health needs. DCF and DSS have formed the Behavioral Health Partnership to oversee an integrated public behavioral health service system for children and families. The

primary goal is to provide enhanced access to and coordination of a more complete and effective system of community-based behavioral health services and supports and to improve member outcomes. Secondary goals include better management of state resources and increased federal financial participation in the funding of behavioral health services.

Money Follows the Person Rebalancing Demonstration

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

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

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

State Balancing Incentive Payments Program (BIP)

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

Community First Choice (CFC)

On July 1, 2015, DSS launched a new Medicaid State Plan service pursuant to 1915(k) of the Social Security Act. This new option, made possible by the Affordable Care Act, 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 System, and assistive technology. As a parallel component to CFC implementation, all Medicaid Waivers offering self-directed services, including Personal Care Attendant and Acquired Brain Injury, were revised to remove personal care attendant services. Effective July 1, 2015, self-directed services for individuals on the affected Waivers are provided as a Medicaid State Plan service through CFC.

APPENDIX F.

LONG-TERM SERVICES AND SUPPORTS PLANNING EFFORTS

Listening Session Feedback Summary

September and October 2021

2022 Listening Session Feedback

Total Number of Participants: 40
Co-Sponsors: AARP CT, the ARC of CT, Keep the Promise Coalition, and PATH Parent to Parent/Family Voices of CT
Groups represented: Caregivers, ID/DD, Youth, Mental Health, Older Adults, Physical Disability

Summary of Feedback Received

Access to Services: The State needs to improve access to services and supports on several levels including:

- Outreach and Education - Educate state residents on the services available to them.
- Accessibility - Have staff and materials accessible to residents who are non-English speaking and/or deaf/hard of hearing; more supports to help people enter the system and to add/drop/change services and supports as needed and in a timely manner (nimbleness of the system); Address the complexity of accessing needed services and supports and provide assistance.
- Flexibility of the Service System - the ability to quickly shift supports as needs change.
- Waitlist Reduction - reduce waitlists for waivers and housing options, and ensure that individuals with multiple conditions, including high level of need physical health conditions and cognitive, behavioral and/or mental health diagnoses, have the same access to employment, social opportunities and programs as other individuals.
- Addressing Dual Diagnoses - Multiple diagnoses can mean getting shut out of many programs or needing to work with multiple State agencies. State agencies need to coordinate services and work together to create packages of supports that meet the needs of the total person in a seamless manner. The coordination should happen on the State end and not be the responsibility of individuals with disabilities who may not have the capacity physically or cognitively to do it.
- Access to Hospice Services – The State needs to improve access to Hospice services for consumers and approve access earlier.

Allied Community Resources: (1) Need to reduce hold times; and (2) Train staff so that callers do not get wrong information or different answers every time they call.

Assessment: (a) Program assessments needs to be universal across all agencies and programs and look at the total person and not pieces of an individual that lead to programs and services being provided that only address certain needs without consideration of the total person and their preferences and goals (don't cram people into boxes). There should be one assessment and one application for all State programs. (b) Transparency also needs to be improved throughout the assessment process and this includes State agencies and providers not conducting planning meetings (such as DDS PRAT) where level of care or service revision decisions are made without the presence of the consumer or his/her authorized representative. Individuals should clearly understand the criteria being used to make decisions regarding their budgets and supports.

Back-up Planning: There needs to be an increased focus on assisting families with planning for the eventuality of the primary informal caregiver(s) and/or legal representative(s) no longer being available either through death, illness or some other occurrence, to continue providing assistance.

There should be a registry of pre-approved workers (similar to substitute teacher pool) who can be called-upon in emergencies without needing to go through new-hire paperwork.

Early Intervention and Lifelong Support: Early diagnosis and intervention is key. More State funding is needed to support agencies and schools with early detection and intervention to ensure better long-term outcomes. Additionally, services and supports need to follow individuals and be adjusted as necessary during the lifetime. Individuals under the age of 21 need regular follow-up and service plan adjustments to allow them to thrive and achieve best possible outcomes.

Employment: More effort needs to be made to match individuals with employment that matches their individual interests and goals and not just placing them in any available job slot (for example, stacking grocery shelves may be a poor fit that leads to employment ending for an individual but the person loves the socialization and atmosphere of the movies so ticket-taking may have been a better fit that would have led to steady employment and greater job satisfaction). There is also the need for staff to work with individuals in job placements and continue to grow and improve their skills sets. Employment support needs to expand beyond a check-in four hours per week where a form is filled out and that is all.

Financing: (a) Revisit Spousal assessment, especially for spouses under age 65. (b) Medicaid should reimburse paid caregivers to visit consumers in the hospital and other institutional settings. Learn from COVID lessons, COVID left informal caregivers shut out of being able to provide care and social/emotional support to their loved ones while in a hospital or other institution. This cannot happen again.

Home Modifications: More funding is required for home modifications. Home modifications need to be thought of beyond physical accessibility but to include safety measures for those with behaviors (such as flight risk and self harm behaviors such as overeating or ingesting harmful products). There needs to be a budget for families to make homes safe by installing locks, fencing, cameras etc. In many cases these modifications are what make a home safe enough for the individual to remain in the community and out of an institution and they are costly.

Housing: There needs to be increased availability of supportive, affordable housing in all communities, so people do not need to choose between remaining in their familiar communities with known informal social and support networks and housing. Additionally, consideration should be given to the compatibility of residents when making placements and to ensure that those who are non-English speaking or communicate through ASL have continual access to staff and residents with whom they can communicate to avoid isolation and promote full inclusion and the quality of life to which all people are entitled.

Informal Caregiver Support: (1) Increase supports to assist informal caregivers so they avoid burnout which could lead to institutionalization of the individual receiving support such as increased respite and more ongoing service hours, (2) assistance for informal caregivers/employers of record engaged in self-direction. There needs to be a contact person for questions and support because self-direction is not easy and there is no one to go to for help, and (3) develop and support peer-to-peer and caregiver support options in local communities. (4) To prevent informal caregivers from being shut out of hospitals and nursing homes ever again, the state should adopt and pass the language from the federal Essential Caregiver Act, H.R. 3733.

Self-direction: The state should continue to support and further expand self-direction in CT so that individuals can maintain autonomy and control over their services and supports, including who provides the support and how it is administered.

School Systems: The State and municipalities need to fund school systems so that school staff can be better educated on the supports available to students with ID/DD and not just hand parents a packet with a referral to DDS and no explanation of what DDS is and the supports that may be available. Schools need enough educated staff to help families connect to the correct services by making initial contacts or providing instruction and guidance, not just referrals.

Nutrition: Improve access to nutritious food in all communities for individuals of all abilities. This goes beyond access to home delivered meals but extends to having housing options in neighborhoods where there are grocery stores and with fresh produce and foods that are not expired or processed ready-to-eat meals.

Quality of Care: (a) Staffing ratios in facilities must be increased to meet the physical and psychological needs of residents. (b) Engage in meaningful quality assurance (QA) measures. QA is not just checking boxes and paperwork but measures of how staff interact and engage consumers and make a positive impact on their quality of life. Staff need to develop relational supports. QA should also include monitoring from an independent worker who comes to assess how the staff is doing with engaging consumers, providing stimulus, employing opportunities for the consumer to engage in lifelong learning and making the individual's home feel like home.

Transportation: (a) Must be improved and available in all communities so that individuals can truly participate in society through employment and social activity and reduce isolation and geographic limitations. (b) Need options other than public transportation that may not be a viable option for individuals with certain mental or behavioral health issues.

Workforce Development:

- Recruitment and Retention – (1) State should develop incentives, such as higher pay and benefits, that attract qualified workers to the home care profession and allow consumers who self-direct with budgets high enough to provide raises and other incentives that will allow them to retain good workers once found. Also, workers with special experience and certifications should be allowed to earn more without affecting individual service hours. (2) Incentivize community health workers and parents or other individuals who currently, or in the past, provided informal supports to individuals to join the self-directed home care workforce. (3) Recruit workers from local communities to improve cultural competence and build communities of support and inclusion. (4) Address the need for both paid health care and unskilled care (e.g., companionship) to provide stimulation and increase psycho-social health outcomes. The group recommended exploring the following models (a) Social Prescribing and Cognitive Stimulation Therapy out of the UK; (b) CVS' current exploration of the benefits of social prescribing; and (c) Zero Isolation Project out of Quinnipiac (Dr. Nicholson).
- Hiring Process – (1) Need to reduce the amount of paperwork required for employers and employees or at least streamline it between programs and offer assistance with

completion; and (2) Reduce the time it takes to hire new staff so that qualified workers are not lost because of they cannot wait six – ten weeks for a start date.

- Registry – The State should develop one universal registry that can be used to find staff regardless of the agency and program a person is using. The registry should have the following features: (1) be accessible in multiple languages and formats; (2) include worker descriptions, including any special training, certifications and experience working with special populations (i.e., behavior management, ASL certified, bilingual etc.), and (3) workers who have been pre-qualified and cleared by the State and are "ready-to-hire" who can start immediately. This is especially important when a back-up is needed. There should be a pool of pre-qualified workers to choose. Same concept as substitute teachers.
- Training – Improved training is needed for PCAs and employers, especially regarding Electronic Visit Verification (EVV). The current EVV training is too long, not engaging or easily understandable and does not focus on the issues that PCAs and employers encounter in daily utilization. EVV training needs to be revised to be shorter, include more plain language and focused on the issues that are most likely to arise when utilized in the real world.

APPENDIX G.

State Long-Term Services and Supports Programs and Expenditures

SFY 2020 - 2021

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

II. **State Long-Term Services and Supports Programs in Connecticut – SFY 2021**

III. **State Long-Term Services and Supports Program Expenditures in Connecticut – SFY 2021**

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

Department of Aging and Disability Services (ADS): ADS receives both federal and state dollars to provide a broad array of services, equipment and supports to individuals with disabilities and older adults that promote independent living, community participation, self-advocacy and employment. ADS implements these services and supports through a variety of programs. The Bureau of Rehabilitation Services (BRS) administers the Vocational Rehabilitation and Supported Employment (SE) programs of the Rehabilitation Act of 1973, as amended by Title IV of the Workforce Innovation and Opportunity Act. BRS services are provided to adults who have a mental or physical impairment that is an impediment to employment. Supports are individualized to each job seeker and may include services such as personal assistance for evaluation and training purposes. The Driver Training Program for Persons with Disabilities provides driver instruction for qualified permanent Connecticut residents who require specialized equipment to operate a motor vehicle. The BRS' Independent Living program provides comprehensive independent living services, through contracts with Connecticut's five community-based independent living centers. The Workers' Rehabilitation Program assists injured workers in a return to gainful employment in the most timely and cost effective manner possible while taking into account the needs of the individual. Deaf and Hard of Hearing Services (formerly the Commission on the Deaf and Hearing Impaired) works to advocate, strengthen and implement State policies affecting individuals who are deaf or hard of hearing. Services and supports include counseling services and assistance to persons who are deaf and hard of hearing and their families. The Bureau of Disability Determination Services is charged with deciding eligibility for the Social Security Disability Insurance (SSDI) and Supplemental Security Insurance (SSI) programs. These programs provide cash benefits to individuals who are unable to maintain employment due to the severity of their disabilities. The Bureau of Education and Services for the Blind (BESB) offers a comprehensive array of services to improve the independent living skills of adults who are legally blind and children who are legally blind or visually impaired. Services are customized to each consumer's specific situation and include vocational counseling, technology training and teaching to improve activities of daily living, training in use of devices for safe travel, provision of low vision evaluations and aides, and self-advocacy training. Rehabilitation professionals are available to come to the homes, schools and places of employment of consumers, delivering specialized independent living, educational and vocational training. In addition, the agency Business Enterprises Program offers a unique opportunity for people who are blind to become entrepreneurs. The Bureau on Aging, consisting of the State Unit on Aging (SUA) and the Long Term Care Ombudsman Program (LTCOP), ensures that Connecticut's older adults have access to the supportive services necessary to live with dignity, security, and independence. The Bureau is responsible for planning, developing, and administering a comprehensive and integrated service delivery system for older persons in Connecticut. The State Unit on Aging administers Older Americans Act programs for supportive services, in-home services, and congregate and home-delivered meals. It also administers programs that provide senior community

employment, health insurance counseling, and respite care for caregivers. The Long-Term Care Ombudsman Program provides individual advocacy to residents of skilled nursing facilities, residential care homes and assisted living facilities. The State Ombudsman also advocates for systemic changes in policy and legislation in order to protect the health, safety, welfare and rights of individuals who reside in those settings. The LTCOP and SUA work closely with the aging network partners to provide these services. Partners include Connecticut's five area agencies on aging, municipal agents for the elderly, senior centers, and many others who provide services to older adults.

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

Department of Developmental Services (DDS): DDS provides case management, residential habilitation, individualized supports, campus settings, day habilitation, prevocational services, supported employment, respite care, and family support to approximately 17,229 persons with intellectual disabilities and their families. The mission of DDS is to partner with the individuals they support and their families, to support lifelong planning, and to join with others to create and promote meaningful opportunities for individuals to fully participate as valued members of their communities.

As of June 2021, 67.6 percent of those people eligible to receive services from DDS were living in their own or their family home, 25.2 percent lived in public or private community living arrangements or received 24-hour continuous residential supports in the community, 2.3 percent lived in community companion homes, 1.6 percent lived in campus settings and 1.6 percent were in skilled nursing facilities.

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

To this end, DMHAS operates, funds, and coordinates inpatient and community-based behavioral health services for adults (18 and older) with serious substance use and/or mental health conditions as well as provides programs for individuals with special needs (e.g., AIDS/HIV, gambling, substance abusing pregnant women, etc.) and defined target populations (e.g., young adults, including those transitioning out of the DCF system, and those involved with the criminal justice system) including persons with serious mental illness residing in nursing homes, military personnel and their families, and persons who are homeless. DMHAS is responsible for the State's behavioral health general funds and SAMHSA block grant allocations and manages the clinical aspects of the Medicaid Behavioral Health Services Partnership for adults. DMHAS directly operates two inpatient hospitals and contracts with community hospitals and one private psychiatric hospital for inpatient and ambulatory care. DMHAS-operated inpatient hospitals provide psychiatric care and medically managed detoxification and residential rehabilitation services. DMHAS administers the mental health service system through a network of 13 Local Mental Health Authorities (LMHAs) statewide, six State-operated and seven non-profits, along with over 90 affiliated nonprofit community-based organizations. LMHAs are the sub-state administrative and direct care component for the delivery and coordination of mental health services across the state. T hey develop, maintain, and manage a comprehensive system of mental health treatment, rehabilitative services, and recovery support for designated local service.

Department of Housing (DOH): The Department of Housing's mission is to ensure everyone has access to quality housing opportunities and options throughout Connecticut. It is committed to strengthening and revitalizing communities by promoting inclusive affordable housing opportunities. DOH seeks to eliminate homelessness and to catalyze the creation and preservation of quality, affordable housing to meet the needs of all individuals and families statewide.

DOH works in concert with municipal leaders, public agencies, community groups, local housing authorities, and other housing developers in the planning and development of

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

Department of Transportation (CTDOT): CTDOT provides subsidies to bus and paratransit systems throughout the state. Local bus systems in Hartford, New Haven, Stamford, Waterbury, New Britain, Meriden and Wallingford are owned by CTDOT and operated under the CTtransit brand name and account for about 80% of the annual statewide bus ridership. In non-CTtransit service areas, local transit districts assume operation of bus services and enter into transit operating assistance contracts with CTDOT to obtain funding from the State. The fixed-route bus system provides discounted (half-fare) rides to seniors and people with disabilities. If an individual has a disability that precludes him or her from using the fixed-route service, he or she can apply for ADA paratransit eligibility. Paratransit is a shared ride, advanced reservation, origin-to-destination service for persons with disabilities who are unable to use the public bus service because of their disability and is mandated by the Americans with Disabilities Act of 1990. ADA paratransit services are available to origins and destinations within ¾ mile of the local bus route and are operated during the same days and hours as the fixed-route service. In addition, CTDOT administers the Section 5310 grant program and the State Matching Grant program. Section 5310 is a Federal grant program intended to improve mobility for seniors and individuals with disabilities by removing barriers to transportation service and expanding mobility options. It is open to private nonprofit organizations, local governmental authorities and operators of public transportation for qualifying projects and funds both capital and operating expenses. The State Matching Grant program, also known as the Municipal Grant Program (MGP), allows municipalities to apply for a pre-set amount of operating funding (determined by formula) on an annual basis. The funding allows municipalities to provide new or expanded transportation services to seniors and people with disabilities and requires a local match.

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

laboratories, ambulances, and environmental health entities. Resources are also dedicated to epidemiology, vital statistics, health education, and surveillance.

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

Office of Health Strategy (OHA): The Office of Health Strategy (OHS) was created in 2017 and established in 2018 by a strong bipartisan effort of the CT General Assembly to forward high-quality, affordable, and accessible healthcare for all residents. The legislation re-organized existing State resources into one body, redeploying people and programs more efficiently, and centralizing health policymaking to advance the healthcare reform initiatives that will drive down healthcare costs; close Connecticut's deeply entrenched racial, economic, and gender health disparities, and undertake technology-driven modernization efforts throughout the system. OHS has a multitude of statutory and regulatory responsibilities including Health Systems Planning and the Certificate of Need program, the development of the state's Health Information Exchange, administering the All Payer Claims Database and Consumer Information Website, and initiatives to improve drug pricing transparency. The work of OHS is funded, in part, by tens of millions of dollars in federal grants that are secured through a competitive process, positioning Connecticut as a leader in healthcare policy reform.

In many national surveys, Connecticut is a top ten state for healthcare. In 2018, U.S. News Best States ranked Connecticut fourth highest for healthcare. This is a promising statistic, but Connecticut is also among the states with the highest cost and high cost growth in the country. OHS collaborates with a variety of experts, consumers, and provider stakeholder groups to examine and address the barriers in Connecticut's health system - cost, access, and outcomes. A healthy population creates value for employers, is necessary for a strong economy, and is key to a high quality of life.
Department of Veterans' Affairs (DVA) – DVA provides health care, residential and rehabilitative services for veterans honorably discharged from the Armed Forces. An Adult Care Facility, operated by DVA, is licensed by the state DPH as a Chronic Disease Hospital and provides general medical care, Alzheimer's and related dementia care, end of life care, palliative care, long-term care, rehabilitation, respite care, mental health and psychological counseling. The Residential Facility is certified by the Federal Department of Veterans Affairs. Veterans receive substance abuse treatment, social work services, educational and vocational rehabilitation, job skills development, self-enhancement workshops, employment assistance and transitional living opportunities.

II. State Long-Term Services and Supports Programs in Connecticut – SFY 2021

State Agency	Long-Term Services and Supports Program	Services	Settings	Eligibility	Demographics July 1, 2020 – June 30, 2021
ADS	Independent Living (IL) Program	Provides comprehensive independent living services, including peer support, information and referral, advocacy, facilitated transition of youth to post-secondary life and independent living skills training.	Community-based, cross-disability, nonresidential, private nonprofit agencies	No eligibility requirements.	Total Participants 167 Age 0-5: 0 5-19: 1 20-24: 8 25-59:158 60 up: 0 Gender Female: 85 Male: 82 Race Am Ind/Alask: 0 Asian: 3 AA: 25 Hawaiian/PI: 0 White: 99 Hisp/Lat: 37 2 or more: 3 Unknown: 0 Disability Cognitive:0 Mental/Emot:0 Physical: 25 Hearing: 0 Vision: 72 Multiple: 68

State Agency	Long-Term Services and Supports Program	Services	Settings	Eligibility	Demographics July 1, 2020 – June 30, 2021
					Other: 0
ADS	Independent Living- Older Individuals who are Blind (OIB)	Provides comprehensive independent living services, including adaptive aids and devices, and training in their use, to enable individuals who are blind to maintain independence in their residences and communities.	Services are provided directly by ADS staff in the residences and communities of the individual, and through third party low vision practitioners at their medical practices.	Age 55 or older and legally blind or significantly visually impaired.	Total Participants (FFY2020) 507 Age 55-59:43 60 up: 464 Gender Female: 337 Male: 170 Race Am Ind/Alask: 0 Asian: 2 AA: 62 Hawaiian/PI: 0 White: 412 Hisp/Lat: 29 2 or more: 2 Unknown: 0 Disability Totally Blind: 15 Legally Blind:478 Severe Visual Impairment:14

State Agency	Long-Term Services and Supports Program	Services	Settings	Eligibility	Demographics July 1, 2020 – June 30, 2021
ADS	State Long-Term Care Ombudsman Program	RECEIVES and looks into complaints and assists residents in resolving problems. EDUCATES residents and families about their rights. EMPOWERS and supports residents and families to discuss concerns with nursing home staff. PROVIDES information regarding long-term care programs and services. ADVOCATES improvements in state and federal laws and regulations. REPRESENTS residents' interests before governmental agencies. IDENTIFIES and seeks to remedy gaps in facility, government, or community services. RESPECTS the privacy	Long-Term Care Communities - Nursing homes, residential care homes and assisted living communities.	A resident of a long-term care community.	About 28,000 in long-term care communities Age N/A Gender N/A Race/Ethnicity N/A

State Agency	Long-Term Services and Supports Program	Services	Settings	Eligibility	Demographics July 1, 2020 – June 30, 2021
		and confidentiality of residents.			
ADS	CHOICES	State Health Insurance assistance Program (SHIP), including Medicare Improvements for Patients & Provider Act services (MIPPA) Health insurance counseling Outreach Training Information & referral	Area Agencies on Aging CHOICES Volunteer Host Organization Locations-sites where CHOICES Team members provide counseling and outreach assistance Senior Centers Libraries Personal residences Elderly housing Assisted living Hospice facilities Nursing facilities Area Agencies on Aging	Medicare-eligible beneficiaries, and their caregivers, Providers and individuals interested in serving as program volunteers Assistance for beneficiaries with low income or residing in rural communities Age 60 and over. Under 60 if Medicare eligible.	New Team Member Trainings: 2 New Team Members Trained and Certified: 68 Total number of Beneficiary Counseling Sessions: 23,322 Beneficiaries under age 65: 3,473 Beneficiaries over age 65: 14,857 Beneficiary age not collected: 3,374 Beneficiary income below 150% FPL: 8,248 English as a Primary Language: Yes 19,349 No 2,355 Beneficiary Gender

State Agency	Long-Term Services and Supports Program	Services	Settings	Eligibility	Demographics July 1, 2020 – June 30, 2021
					Male: 6,900 Female: 13,069 Other: 18 Not Collected: 1,717 Beneficiary Race American Indian or Alaskan Native: 21 Asian: 327 Black or African American: 1,524 Hispanic or Latino: 1,740 Native Hawaiian or Other Pacific Islander: 58 White: 13,169 Not Collected: 4,902 Medicare Part D, Medicare Advantage, & Medicare Supplement Plan comparisons and enrollment contacts: 14,091 Medicare Savings Program, Extra Help/Low Income Subsidy, & Medicaid Application Assistance contacts: 1,722 Outreach events: 208 Outreach contacts (attendees): 9,867

State Agency	Long-Term Services and Supports Program	Services	Settings	Eligibility	Demographics July 1, 2020 – June 30, 2021
ADS	SMP – Senior Medicare Patrol	Information & referral Train the trainer	Congregate housing Elderly housing Assisted living Senior centers	N/A	Total Participants Presentations – 110 Beneficiaries who attended presentations 1,732 Outreach events – 155 One-on-one individual interactions - 151
ADS	CT Partnership for Long-Term Care - Information & Education Program	Information & referral One-on-one counseling Regional public forums	Personal residences Libraries Schools Senior Centers Variety of public venues	Age 18-89	Total Participants Calls for information - 148 Individuals counseled - 148 Attended public forums 0 Age NA Gender N/A Race/Ethnicity N/A

State Agency	Long-Term Services and Supports Program	Services	Settings	Eligibility	Demographics July 1, 2020 – June 30, 2021
ADS	Statewide Respite Care Program (for persons with Alzheimer's or related dementia)	Adult day care Care management Chore services Companion services Counseling Home health aide services Home delivered meals Homemaker services Information & referral Nursing services Personal emergency response system Short-term respite care Information and referral Support groups Cognitive training Self-directed care Transportation	Personal residences Adult day care centers Congregate housing Elderly housing Residential care homes Assisted living for short-term respite Hospice facilities Nursing facilities	No age requirement. Alzheimer's or a related dementia. $44,725 income $ 118,905 assets Co-pay of 20% of cost of service required (may be waived upon financial hardship)	Total Participants 709 Age N/A Gender N/A Race/Ethnicity N/A

State Agency	Long-Term Services and Supports Program	Services	Settings	Eligibility	Demographics July 1, 2020 – June 30, 2021
ADS	Supportive Services and Health and Wellness: Older Americans Act Title IIIB and Title IIID	Adult day care Care management Chore services Companion services Home health aide services Homemaker services Hospice services Information & referral Mental health counseling Nursing services PCA services Personal emergency response system Recreation services Respite care Transportation Medication monitoring Evidence-Based Health Promotion Programs	Area Agencies on Aging Personal residences Adult day care centers Congregate housing Elderly housing	Age 60 and over.	Total Participants 15,133 Age N/A Gender N/A Race/Ethnicity N/A
ADS	Elderly Nutrition Program: Older Americans Act Title IIIC and State Nutrition	Nutritionally balanced meals served through congregate meal sites and home delivery. Other nutrition services such as education and counseling provided as appropriate.	Congregate meals: senior community cafes, congregate housing, restaurants, schools, churches Home delivered meals: residential homes	Age 60 and over and their spouses/ caregivers	Total Participants Congregate meals: 276,143 meals served to 11,860 participants Home delivered meals: 1,842,877 meals served to 12,218 participants 466 units of Nutritional counseling were provided to 353 unduplicated persons

State Agency	Long-Term Services and Supports Program	Services	Settings	Eligibility	Demographics July 1, 2020 – June 30, 2021
					*Nutrition Education = 4,152 Units *Federal reporting does not require the count of people for this service, only units. Totals reflect units for FFY 2020.
ADS	CT's National Family Caregiver Support Program: Older Americans Act Title IIIE	Adult day care Assistive devices/ Supplemental services Care management Chore services Home health aide services Homemaker services Information & referral Personal emergency response system Transportation Grandparents support Support groups Cognitive training Self-directed care	Personal residences Adult day care centers Elderly housing Nursing facilities (for short term respite only)	Care recipient must be age 60 and over. Two or more ADL limitations. Children 18 yrs of age or younger for grandparent support.	Participants: Respite - 492 Supplemental services – 781 Counseling, support groups, training - 814 Caregivers caring for older adults - 1,294 Grandparents and kinship caregivers caring for children and persons 18-59 with disabilities - 154
ADS	Congregate Housing Services	Adult day care Care management Chore services Companion services	Congregate housing	Age 60 and over. Frail adults with temporary or	Total CHSP Participants served: 249 Age:

State Agency	Long-Term Services and Supports Program	Services	Settings	Eligibility	Demographics July 1, 2020 – June 30, 2021
		Home health aide services Information & referral Nutritional services Personal care attendant services Personal emergency response system Transportation Medication monitoring Foot care		permanent disabilities.	62+ - 236 18-61 - 13 Gender: Female participants - 204 Male participants - 45 Race/Ethnicity White (non-Hispanic) participants served - 244 Hispanic participants - 3 Black/African American participants (non-Hispanic) - 1 American Indian/Alaskan Native participants - 0 Asian/Pacific Islander - 1
ADS	Senior Community Service Employment Program	Employment & training	Community (AAA, Community Action Agencies, municipalities, community-based orgs.)	Age 55 and over. Income not exceeding 125% of the federal poverty level.	Total Participants 59 Age 55-64: 38 65-74: 19 75+: 2 Gender male: 15 female: 44 Race/Ethnicity White - 23 Black/African American - 27 Hispanic - 3 Asian - 1

State Agency	Long-Term Services and Supports Program	Services	Settings	Eligibility	Demographics July 1, 2020 – June 30, 2021
					American Indian - 4
ADS	Medicare Legal and Education Assistance Project	Health insurance counseling Information & referral Legal representation for Medicare appeals	Not setting specific	Medicare eligible by virtue of age or disability.	Total Participants 1,451 direct client assistance Age N/A Gender N/A Race/Ethnicity N/A
ADS	Evidenced-Based Health Program	Chronic Disease Self-Management Education Program (CDSME), Statewide Fall Prevention Program Tai Ji Quan, Moving for Better Balance (TJQMBB)	Agencies on Aging VNA's, hospitals Community centers, Senior Centers Health departments Municipal agencies		Total Participants CDSME - Due to the COVID-19 pandemic, CDSME programs were delivered telephonically with 150 course completers Tai Chi Moving for Better Balance – Due to the COVID-19 pandemic, participants attended classes either virtually or in person. **Total =** 276

State Agency	Long-Term Services and Supports Program	Services	Settings	Eligibility	Demographics July 1, 2020 – June 30, 2021
ADS	No Wrong Door (Aging & Disability Resource Centers) with funding from ACL Grants	Assessment Assistance Advocacy Care Transitions Case Consultation Decision Support Follow-Up Information Options Counseling Benefits Employment Long Term Support; Referral Short Term Support	Agencies on Aging Centers for Independent Living Some hospitals Personal residences Other public places By phone	Any person across the lifespan who is a person with a disability, older adult caregiver or planning ahead for future long term care needs. Available statewide	<u>Total Participants</u> Total unduplicated consumers of ADRC Services = 614 Consumers: 483 Caregivers: 7 Families: 85 Agencies: 18 Other: 21 No trainings were provided because it was very difficult to transition from in-person to virtual training due to COVID-19. Other state agencies are also providing this training.
ADS	Prevention of Elder Abuse, Neglect and Exploitation	Strengthen and carry out programs or activities by raising awareness to prevent, detect, intervene, investigate and respond to elder abuse, neglect and exploitation. -support of multi-disciplinary teams directed at advocacy to curtail elder abuse - financial exploitation education and training - Coalition for Elder Justice in Connecticut	Agencies on Aging State agencies Law Enforcement Aging, legal, victims, and disability networks Medical and educational organizations For-profit and non-profit, public and private organizations	Age 60+ and persons with disabilities	<u>Total Participants</u> 586

State Agency	Long-Term Services and Supports Program	Services	Settings	Eligibility	Demographics July 1, 2020 – June 30, 2021
DDS	Home and Community-Based Services Waivers	Personal support Individualized home support Adult companion services Group day services Individualized day services Respite care Residential habilitation Supported employment services Environmental accessibility adaptations Personal emergency response system (PERS) Transportation Parenting Support Senior Supports Vehicle modifications Specialized medical equipment and supplies IFS family training Behavioral support Healthcare coordination Assistive Technology Peer Support Shared Living Training and Counseling for Unpaid Caregivers	Personal residences Community living arrangement Community companion home Community day program site Community employment	Individuals over the age of three. Person with intellectual disability needing ICF/ID level of care. Medicaid program: Income less than 300% of SSI and assets less than $1600.	Total Participants As of June 2021 Comprehensive Waiver 5,181 Individual and Family Support Waiver 3,603 Employment and Supports Waiver 2,120 Age N/A Gender N/A Race/Ethnicity N/A

State Agency	Long-Term Services and Supports Program	Services	Settings	Eligibility	Demographics July 1, 2020 – June 30, 2021
DDS	Intermediate Care Facility for persons with Intellectual Disability(ICF/ID)	Residential habilitation Day habilitation Prevocational services Supported employment services	ICF/ID	No age limit. Person with intellectual disability needing ICF/ID level of care. Medicaid program: Income less than 300% of SSI and assets less than $1600.	Total Participants in DDS operated ICF/IDs 271 Age 0-18: 0 19-54: 57 55-64: 83 65+: 131 Total Participants in privately operated ICF/IDs 336 Age 0-18: 0 19-54: 147 55-64: 110 65+: 79 Gender N/A Race/Ethnicity N/A
DMHAS	Mental Health Standard Case management-and Community Support (CSP)	Info & Referral Transportation Case management Skill-Building	Personal Residences RCH NF Shelters Supportive housing sites	Adults age 18 and over. Primary diagnosis of a psychiatric disorder;	Total Participants 1,111 Age 18-20 75 21-25 146

State Agency	Long-Term Services and Supports Program	Services	Settings	Eligibility	Demographics July 1, 2020 – June 30, 2021
			Clubhouses	Requires assistance in obtaining and coordinating treatment, rehabilitation, and social services without which the individual would likely require a more intensive level of care. No private insurance to pay for comparable services.	26-34 134 35-44 136 45-54 202 55-64 262 65+ 142 Unknown 14 Gender Female 532 Male 575 Trans* 2 Unknown 2 Race Am Indian 5 Asian 100 Black 186 Multi-race 6 Hawaiian 4 Other 89 Unknown 69 White 652 Ethnicity Hispanic195 Non-Hispanic 825 Unknown 91
DMHAS	Mental Health Assertive Community Treatment (ACT)	A set of clinical, medical & psychosocial services, provided on a one-to-one basis, essential to maintaining an individual's ability to function in community settings. Services	Personal residences Community settings	Adults age 18 and over. Primary diagnosis of a psychiatric disorder; Would otherwise require more	Total Participants 1,292 Age 18-20 189 21-25 393 26-34 214 35-44 159

State Agency	Long-Term Services and Supports Program	Services	Settings	Eligibility	Demographics July 1, 2020 – June 30, 2021
		available 24/7.		intensive and restrictive services. No private insurance to pay for comparable services.	45-54 120 55-64 165 65+ 36 Gender Female 475 Male 817 Race Am Indian 11 Asian 16 Black 317 Multi-race 19 Hawaiian 6 Other 160 Unknown 35 White 728 Ethnicity Hispanic 247 Non-Hispanic 960 Unknown 85
DMHAS	Mental Health Intensive Outpatient Services	Individual, group or family psychotherapy; Psycho-educational groups; Classes on ADLs; Recovery oriented services.	Non-residential services provided in a general hospital, private free-standing psychiatric hospital, psychiatric out-patient clinic for adults, or a State-operated facility.	Adults age 18 and over. Primary diagnosis of a psychiatric disorder; Behavior does not pose an imminent risk of harm to self and other; Living environment can assure a reasonable degree of	Total Participants 131 Age 18-20 7 21-25 16 26-34 38 35-44 28 45-54 28 55-64 12 65+ 0 Gender

State Agency	Long-Term Services and Supports Program	Services	Settings	Eligibility	Demographics July 1, 2020 – June 30, 2021
				safety; Symptomology/ behavior warrants an increase in frequency and/ or intensity of clinical contact in an effort to stabilize the individual. No private insurance to pay for comparable services.	Female 80 Male 50 Unknown 1 Race/ Am Indian 1 Asian 1 Black 14 Multi-race 0 Other 7 Unknown 4 White 104 Ethnicity Hispanic 10 Non-Hispanic 115 Unknown 6
DMHAS	Mental Health Outpatient Clinical Services	Individual, group or family counseling; Education to client and family; Support with connecting to/referral to natural community supports; Assistance with obtaining/ maintaining employment.	Non-residential services provided in a general hospital, private free-standing psychiatric hospital, a State-operated facility, a facility licensed by DPH to offer "outpatient treatment," or by a private independent psychiatrist or psychologist or private group practice.	Adults age 18 and over. Primary diagnosis of a psychiatric disorder. No private insurance to pay for comparable services.	Total Participants 30,626 Age 18-20 1,039 21-25 2,476 26-34 5.304 35-44 5,467 45-54 5,845 55- 64 6,674 65+ 3,529 Unknown 292 Gender Female 16,551 Male 14,038

State Agency	Long-Term Services and Supports Program	Services	Settings	Eligibility	Demographics July 1, 2020 – June 30, 2021
					Trans* 9 Unknown 28 Race Am Indian 172 Asian 344 Black 4,322 Hawaiian 96 Multi-race 136 Other 4,525 Unknown 1,124 White 19,907 Ethnicity Hispanic 6,306 Non-Hispanic 22,843 Unknown 1,477
DMHAS	Methadone Maintenance				Total Participants 13,555 Age 18-20 30 21-25 394 26-34 3,385 35-44 3,981 45-54 2,969 55-64 2,266 65+ 591 Unknown 2 Gender Female 4,841 Male 8,702 Unknown 12

State Agency	Long-Term Services and Supports Program	Services	Settings	Eligibility	Demographics July 1, 2020 – June 30, 2021
					Race Am Indian 49 Asian 72 Black 1,087 Hawaiian 20 Multi-race 34 Other 2,438 White 9,575 Unknown 280 Ethnicity Hispanic 3,324 Non-Hispanic 9,643 Unknown 588
DMHAS	Mental Health Residential - Group Home	Rehabilitative support focusing on areas of self-care and independent living skills.	Group home	Adults age 18 and over. Primary diagnosis of a psychiatric disorder; Significant skill deficits in the area of self-care and independent living as a result of the psychiatric disability. No private insurance to pay for comparable services.	Total Participants 236 Age 18-20 4 21-25 17 26-34 67 35-44 61 45-54 30 55-64 46 65+ 11 Unknown 0 Gender Female 77 Male 159 Race Am Indian 0

State Agency	Long-Term Services and Supports Program	Services	Settings	Eligibility	Demographics July 1, 2020 – June 30, 2021
					Asian 7 Black 46 Multi-race 4 Other 23 White 149 Unknown 7 Ethnicity Hispanic 31 Non-Hispanic 190 Unknown 15
DMHAS	Mental Health Residential - Supervised Apartments	Supportive counseling directed at solving day to day problems with community living; Psycho-education groups; Assistance with employment; Rehabilitative support.	Supervised housing	Adults age 18 and over. Primary diagnosis of a psychiatric disorder; Significant skill deficits in the area of independent living as a result of severe and persistent mental illness. No private insurance to pay for comparable services.	Total Participants 805 Age 18-20 56 21-25 139 26-34 174 35-44 140 45-54 135 55-64 127 65+ 28 Unknown 6 Gender Female 278 Male 526 Trans* 0 Unknown 1 Race Am Indian 2 Asian 10 Black 207

State Agency	Long-Term Services and Supports Program	Services	Settings	Eligibility	Demographics July 1, 2020 – June 30, 2021
					Multi-race 7 Other 92 Unknown 21 White 466 Ethnicity Hispanic 126 Non-Hispanic 626 Unknown 53
DMHAS	Social Rehabilitation	Independent living and community reintegration skill development.	Community setting	Adults age 18 and over. Primary diagnosis of a psychiatric disorder; Moderate impairment in vocational, educational and/or social functioning; Needs assistance with at least 2 ADLs. No private insurance to pay for comparable services.	Total Participants 5,690 Age 18-20 57 21-25 254 26-34 732 35-44 919 45-54 1,338 55-64 1,780 65+ 573 Unknown 37 Gender Female 2,395 Male 3,287 Trans* 1 Unknown 7 Race Am Indian 49 Asian 54 Black 1,536 Hawaiian 9 Multi-race 31

State Agency	Long-Term Services and Supports Program	Services	Settings	Eligibility	Demographics July 1, 2020 – June 30, 2021
					Other 644 Unknown 140 White 3,227 Ethnicity Hispanic 915 Non-Hispanic 4,541 Unknown 234
DMHAS	Crisis Stabilization Beds (respite)	Short-term residential services to help stabilize a rapidly deteriorating behavioral health condition and avert hospitalization.	A facility of not more than 15 beds staffed 24/7.	Adults age 18 and over. Primary diagnosis of a psychiatric disorder; Increased exacerbation of symptoms within the past 24 hours; Does not present as an imminent safety risk to self or others consistent with criteria for inpatient psychiatric care. No private insurance to pay for comparable services.	Total Participants 645 Age 18-20 13 21-25 51 26-34 168 35-44 172 45-54 132 55-64 91 65+ 18 Gender Female 184 Male 461 Trans* 0 Unknown 0 Race Am Indian 2 Asian 1 Black 156 Hawaiian 2 Multi-race 5 Other 81 Unknown 20

State Agency	Long-Term Services and Supports Program	Services	Settings	Eligibility	Demographics July 1, 2020 – June 30, 2021
					White 378 Ethnicity Hispanic 109 Non-Hispanic 497 Unknown 39
DMHAS	Mobile Crisis Services	Psychiatric evaluation; Psychiatric stabilization; Brief clinical treatment; Medication evaluation; Hospital pre-screening.	Personal residences Congregate housing Elderly housing Residential care homes Nursing facilities Shelters On the streets	Adults age 18 and over. Primary diagnosis of a psychiatric disorder; Presentation of symptoms/ behaviors that place the individual at risk to self or others. No private insurance to pay for comparable services.	Total Participants 7,137 Age 18-20 457 21-25 752 26-34 1,387 35-44 1,256 45-54 1,063 55-64 1,143 65+ 771 Unknown 308 Gender Female 3,291 Male 3,830 Trans* 6 Unknown 10 Race Am Indian 19 Asian 72

State Agency	Long-Term Services and Supports Program	Services	Settings	Eligibility	Demographics July 1, 2020 – June 30, 2021
					Black 1,287 Hawaiian 7 Multi-race 7 Other 810 Unknown 1,315 White 3,576 Ethnicity Hispanic 1,136 Non-Hispanic 4,456 Unknown 1,545
DMHAS	MH Residential Support	Case management to assist people in independent housing	Community settings and people's homes	Adults age 18 and over. Primary diagnosis of a psychiatric disorder; Chronic risk of being a danger to self or to others or chronic grave disability as a result of the psychiatric disorder. No private insurance to pay for comparable services.	Total Participants 624 Age 18 – 20 9 21 – 25 29 26 – 34 99 35 – 44 116 45 – 54 131 55 – 64 184 65+ 56 Unknown 0 Gender Female 225 Male 399 Transgender 0 Race Am Indian 2 Asian 5 Black 202 Multi race 6

State Agency	Long-Term Services and Supports Program	Services	Settings	Eligibility	Demographics July 1, 2020 – June 30, 2021
					Hawaiian 1 Other 59 Unknown 4 White 345 Ethnicity Hispanic 77 Non-Hispanic 525 Unknown 22
DMHAS	Long-Term Psychiatric Hospitalization	Medication evaluation; Individual/ group counseling; Specialized treatment services.	Psychiatric hospital	Adults age 18 and over. Primary diagnosis of a psychiatric disorder; Chronic risk of being a danger to self or to others or chronic grave disability as a result of the psychiatric disorder. No private insurance to pay for comparable services.	Total Participants 835 Age 18-20 25 21-25 88 26-34 184 35-44 165 45-54 125 55-64 152 65+ 91 Unknown 5 Gender Female 241 Male 593 Unknown 1 Race Am Indian 1 Asian 18 Black 256 Multi-race 6 Other 74 Unknown 39

State Agency	Long-Term Services and Supports Program	Services	Settings	Eligibility	Demographics July 1, 2020 – June 30, 2021
					White 439 <u>Ethnicity</u> Hispanic 109 Non-Hispanic 666 Unknown 60
DMHAS	Substance Abuse Residential - Long-Term Care (3.3)	Clinical/ therapeutic services Individual/ group counseling Psychosocial programming Relapse Prevention Employment skill development Up to 6 months	Structured recovery environment	Adults age 18 and over with significant problems with behavior and functioning in major life activities due to substance abuse.	<u>Total Participants</u> 174 <u>Age</u> 18 – 20 0 21-25 5 26-34 48 35-44 48 45-54 42 55-64 31 65+ 0 <u>Gender</u> Female 40 Male 134 <u>Race</u> Am Indian 0 Asian 1 Black 17 Other 9 White 138 Unknown 9 Hawaiian 0 Multiracial 0 <u>Ethnicity</u>

State Agency	Long-Term Services and Supports Program	Services	Settings	Eligibility	Demographics July 1, 2020 – June 30, 2021
					Hispanic 18 Non-Hispanic 140 Unknown 16
DOH	Congregate Operating Subsidy Program	Assisted living services Care management Chore services Companion services Health insurance counseling Info & referral Nutritional services PCA services Recreation services Transportation	Congregate housing	Age 62 and over and frail. One ADL minimum. Annual income cannot exceed the "Low Income" for the area adjusted for family size as defined by HUD.	Total Participants 1,052 residents Age 65+: 1009 Gender N/A Race/Ethnicity N/A
DOH	Elderly Rental Registry and Counseling	Funds provided to hire a Resident Service Coordinator to assist residents of State-funded elderly facilities.	Elderly Housing	N/A	Total Participants 4,595 units in 57 communities Age N/A Gender N/A Race/Ethnicity N/A

State Agency	Long-Term Services and Supports Program	Services	Settings	Eligibility	Demographics July 1, 2020 – June 30, 2021
DOH	Elderly Rental Assistance Program	Financial Assistance to make rents affordable to low/ moderate income elderly.	Personal residences	Age 62 and over or disabled. Certified disabled by Social Security Board or other federal board or agency as being totally disabled. Annual income cannot exceed the "Low Income" for the area adjusted for family size as defined by HUD.	Total Participants 1,983 units Age 0-64: 1,218 65+: 657 Gender N/A Race/Ethnicity N/A
DOH	811 PRA	Federal Financial Assistance to make rents affordable to extremely low income (ELI) non-elderly disabled.	Personal residences	Extremely Low Income (ELI) under the age of 62 and disabled.	Total Participants 12 Gender N/A Race/Ethnicity N/A
DOT	Local Bus Services	Transportation	Community	Open to the public, inclusive of seniors and people with a qualifying disability.	Total Participants 33,503,701 (SFY 2020 Passenger Trips) Age N/A

State Agency	Long-Term Services and Supports Program	Services	Settings	Eligibility	Demographics July 1, 2020 – June 30, 2021
					Gender N/A Race/Ethnicity N/A
DOT	ADA Paratransit Services	Transportation	Community (within 3/4 mile of local public bus routes)	All ages Any person with a disability who is unable, due to physical or mental impairment, and without the assistance of another individual, to board, ride or disembark from any public local bus. Also for those with a specific impairment-related condition that prevents them from traveling to or from a bus stop.	Total Participants 839,780 (SFY 2020 Passenger Trips) Age N/A Gender N/A Race/Ethnicity N/A

State Agency	Long-Term Services and Supports Program	Services	Settings	Eligibility	Demographics July 1, 2020 – June 30, 2021
DOT	State Matching Grant Program	Demand Responsive Transportation to Seniors and People with Disabilities	Municipality applies for funds and provides matching funds	Seniors and people with disabilities of all ages.	Total Participants 80+ recipients, inclusive of municipalities that pool funding together for regional coordinated Dial-a-Ride service via local transit districts. Age N/A Gender N/A Race/Ethnicity N/A
DOT	Section 5310 Federal Grant Program	Transportation related services that go beyond traditional public transportation services and the Americans with Disabilities Act (ADA) complementary paratransit services.	Services must be derived from a locally-coordinated public transit human services transportation plan.	Seniors and people with disabilities of all ages	Total Participants 100+ recipients that provide service statewide, with over 500,000 trips provided. Age N/A Gender N/A Race/Ethnicity N/A

State Agency	Long-Term Services and Supports Program	Services	Settings	Eligibility	Demographics July 1, 2020 – June 30, 2021
DPH	Facility Licensing and Investigations Section (FLIS)	Regulatory jurisdiction for state licensing programs. Conducts surveys/ investigations of health care entities that participate in Medicare and Medicaid.	Nursing Homes Residential Care Homes Hospitals Outpatient Clinics Dialysis Units Ambulatory Surgical Facilities Substance Abuse and Mental Health Facilities Home Health Agencies Assisted Living Services Agencies Homemaker Home Health Agencies	Institutions identified under CGS 19a-490. Medicare and Medicaid entitlement enrollment is a voluntary participation program open to various types of providers.	N/A

State Agency	Long-Term Services and Supports Program	Services	Settings	Eligibility	Demographics July 1, 2020 – June 30, 2021
DSS	Connecticut Home Care Program for Elders (CHCPE)	Adult day health care Adult Family Living Assisted living services Assistive Technology Care Transitions Chronic Disease Self Management Programs Care management Chore services Companion services Home health aide services Home delivered meals Homemaker services Home Delivered Meals MH counseling Minor home modifications Nursing services PCA services Personal emergency response system Physical, speech, respiratory & occupational therapy Respite care Transportation	Personal residences Adult day care centers Congregate housing Elderly housing Residential care homes Managed Residential Communities (Assisted Living) Alzheimer's units within Assisted Living Communities	Age 65 and over. Must have at least one critical need (bathing, dressing, toileting, transferring, eating/ feeding, meal preparation, medication administration). Medicaid Waiver income limit = $2250/ month. Medicaid asset limit = Indiv $1,600/ couple $3,200. Medicaid 1915(i) income limit = 150% of FPL, $1,518/month. Medicaid asset limit = indiv. $1,600. State funded income limit = no limit. State funded asset limit = Indiv $37,080/ couple $49,440 (one or both receiving services)	Total Participants Total – 13,395 Waiver – 12,612 State –1,942 1915i- 311 Age 65-84: 60% 85+: 40% Gender male: 26% female: 74% Race/Ethnicity – A - Asian 10% B - Black 28% C - Caucasian 48% N - Native American 6% O - Other 9%

State Agency	Long-Term Services and Supports Program	Services	Settings	Eligibility	Demographics July 1, 2020 – June 30, 2021
DSS	CT Home care Program for adults with Disabilities (CHCPD)	Adult day health care Adult Family Living Assisted living services Assistive Technology Care Transitions Chronic Disease Self Management Programs Care management Chore services Companion services Home health aide services Home delivered meals Homemaker services MH counseling Minor home modifications Nursing services Nutritional services PCA services Personal emergency response system Physical, speech, respiratory & occupational therapy Respite care Transportation	Personal residences Adult day care centers Congregate housing Elderly housing Residential care homes Assisted living Alzheimer's facilities with private assisted living	Ages 18-64 Must be diagnosed with a degenerative neurological condition Must need assistance with at least 3 critical needs Must not be Medicaid active or eligible Financial eligibility is the same as the state funded portion of the CT Home care Program for elders	Total Participants 70 Age Under 50: 16% 50-64: 84% Gender N/A Race/Ethnicity N/A
DSS	Personal Care Assistance Waiver	Care Management Independent Support Broker Adult Family Living	Personal residences	Age 18-64. Chronic severe and permanent disabilities. Would otherwise	Total Participants 1,022 Age Under 50: 51% Over 50: 49%

State Agency	Long-Term Services and Supports Program	Services	Settings	Eligibility	Demographics July 1, 2020 – June 30, 2021
				require nursing facility care. Capable of self-direction. Medicaid income limit = 300% of SSI . Income in excess of 200% FPL applied to care.	Gender Male: 47% Female: 53% Race/Ethnicity N/A
DSS	Home and Community Supports Waiver for Persons with Autism	Clinical Behavioral Support Service Community Mentor Individual Goods and Services Personal Emergency Response System Social Skills Group Specialized Driving Assessment Live In Companion Respite Assistive Technology	Personal Residences	Functional Eligibility: Self-care, Understanding and use of language, Learning Mobility Self-direction, or Capacity for independent living. The functional impairments must have been diagnosed before age 22 and be expected to continue indefinitely.	Total Participants 123 Age 50-70 -11 49-30 – 29 29- 20 – 67 20 & under - 16 Gender Female: 10% Male: 79% Transgender: 1% Race/Ethnicity Black – 8% Caucasian – 79% Hispanic – 5% Other – 8% (Asian, Pacific Islander)

State Agency	Long-Term Services and Supports Program	Services	Settings	Eligibility	Demographics July 1, 2020 – June 30, 2021
DSS	Acquired Brain Injury Waivers (ABI + ABI II)	Case-management Chore Cognitive behavioral program Community living supports Companion Day Habilitation Durable medical equipment Family training Homemaker services Home delivered meals Independent living skill training Information and referral Personal care assistance Personal emergency response system Pre-vocational services Respite care Substance abuse Supported employment Transportation Vehicle modification Transitional living	Personal care residence Group residence	Age 18-64. Brain injury that is not a result of a developmental disability or degenerative condition. Dysfunction is not primarily the result of a mental illness. Would otherwise be institutionalized. Medicaid income limit = Less than 200% FPL. Medicaid asset limit = Individual $1,600	Total Participants 568 Age 18-49: 45% 50+: 55% Gender Male: 66% Female: 34% Race/Ethnicity N/A

State Agency	Long-Term Services and Supports Program	Services	Settings	Eligibility	Demographics July 1, 2020 – June 30, 2021
DSS	Katie Beckett Model Waiver	Case management & Medicaid State Plan services	Personal Residences	Birth to 22 years old (those who are over age 22 as of 12/31/11 have the option to remain on the waiver) Would otherwise require care in a nursing home ICF/ID or chronic disease hospital. Medicaid income limit = $1,692. 300% of SSI? Medicaid asset limit = $1,000. $1,600? Income of parent or spouse not counted.	Total Participants 328 Age N/A Gender N/A Race/Ethnicity N/A
DSS	Community First Choice	Personal care assistance Worker's Compensation Home delivered meals Support and Planning coach Health Coach-nurse/PT/OT/ST Assistive technology Environmental modifications Transitional services	Personal Residences	At Institutional Level of care: 1. Supervision or cueing ≥ 3 ADLs + need factor 2. Hands-on ≥ 3 ADLs 3. Hands-on ≥ 2 ADLs +need factor 4. A cognitive impairment which requires daily supervision to	Total Participants Grand Total: 5319 W/Waiver: 2441 CFC w/out waiver: 2878 Age N/A Gender N/A Race/Ethnicity N/A

State Agency	Long-Term Services and Supports Program	Services	Settings	Eligibility	Demographics July 1, 2020 – June 30, 2021
				prevent harm Living in a community setting Choosing to self-direct and manage an individual budget Active on Husky Medicaid	
DSS	Money Follows the Person	Transition Services Housing Services Peer Support Services Addiction & Substance Abuse Services and Supports Informal Caregiver's Support	Personal Residences	Title 19 Active (pays the last day) Institutionalized at least 90 consecutive days Approved Plan of Care Returning to Qualified housing Approved Transition plan	Total Participants 459 (only those enrolled in MFP) Age N/A Gender N/A Race/Ethnicity N/A
DVA	Veterans' Health Care Services	Licensed Chronic Disease Hospital provides continuous professional comprehensive healthcare services	John L. Levitow Healthcare Center (onsite)	Veterans as defined by CGS 27-103 who served honorably, are residents of Connecticut, and have a chronic disease/illness.	Average Monthly Census 84 Total Participants 101 Age

State Agency	Long-Term Services and Supports Program	Services	Settings	Eligibility	Demographics July 1, 2020 – June 30, 2021
		including: General medical care Alzheimer's/dementia care End of life care Palliative care Long term care Rehabilitation Respite care Mental health and Psychological counseling			18-61: 9 62+: 92 Gender 3 Female, 98 Male Race/Ethnicity Caucasian: 87 Hispanic: 2 Black: 11 Other: 1
DVA	Residential and Rehabilitative Services	Provides domiciliary level of care to facilitate rehabilitation and return to independent living including: Residential services General medical care Substance abuse treatment Social work services Educational support Employment skill development	Residential domicile (onsite)	Veterans as defined by CGS 27-103 who served honorably and are residents of Connecticut	Average Monthly Census 110 Total Participants 135 Age 18-61: 44 62+: 91 Gender 7 Female, 128 Male Race/Ethnicity Caucasian: 95 Hispanic: 9 Black: 29 Other: 2

III. State Long-Term Services and Supports Program Expenditures in Connecticut – SFY 2021

State Agency	Long-Term Care Program	Total Expenditures SFY 2021	State Expenditures	Medicaid Expenditures	OAA Title III Expenditures	Other Federal Expenditures	Other Expenditures
ADS	Independent Living (IL) Program	$798,851	$612,972			$185,251	$628
ADS	Independent Living – Older Individuals who are Blind (OIB)	$487,271	$44,847			$442,329	$95
ADS	CHOICES	$935,359	$423,177			$512,182	
ADS	SMP – Senior Medicare Patrol	$264,089				$264,089	
ADS	CT Partnership for LTC - Information & Education Program	$0				$0	
ADS	Statewide Respite Care Program and Alzheimer's Aide Program (for persons with Alzheimer's or related dementia)	$1,982,539	$1,982,539				
ADS	Supportive Services and Administration	$4,165,927	$153,273		$2,993,410	$870,774	
ADS	Health and Wellness						

State Agency	Long-Term Care Program	Total Expenditures SFY 2021	State Expenditures	Medicaid Expenditures	OAA Title III Expenditures	Other Federal Expenditures	Other Expenditures
	(Title IIID)	$190,814	$4,789		$190,814		
ADS	Elderly Nutrition Program (Title IIIC and NSIP)	$17,960,034	$3,035,746		$8,284,557	$6,783,411	
ADS	CT's National Family Caregiver Support Program (Title IIIE)	$2,005,897			$1,873,436	$132,461	
ADS	Congregate Housing Services	$542,167	$134,230			$407,937	
ADS	Senior Community Service Employment Program	$912,697				$912,697	
ADS	Medicare Legal and Education Assistance Project	$277,606	$277,606				
ADS	Elderly Health Promotion	$84,560	$84,560				
ADS	Evidenced Based Health Program:	$50,000					$50,000

State Agency	Long-Term Care Program	Total Expenditures SFY 2021	State Expenditures	Medicaid Expenditures	OAA Title III Expenditures	Other Federal Expenditures	Other Expenditures
	Fall Prevention						
ADS	No Wrong Door: Aging & Disability Resource Centers	$329,743				$329,743	
ADS	Prevention of Elder Abuse, Neglect and Exploitation	$518,072			$133,230	$384,842	
ADS	Long-Term Care Ombudsman Program	$1,812,009	$1,461,904		$175,947	$174,158 (Title VII)	
DSS	Connecticut Home Care Program (CHCPE)	$478,450,956	$31,872,007 (includes CHCPD expenditures)	$446,578,949			
DSS	Connecticut Home Care Program for Adults with Disabilities (CHCPD)	$1,884,657	$1,884,657 (Included in CHCPE expenditures)	NA			
DSS	Personal Care Assistance Waiver	$3,804,837	NA	$3,804,837			

State Agency	Long-Term Care Program	Total Expenditures SFY 2021	State Expenditures	Medicaid Expenditures	OAA Title III Expenditures	Other Federal Expenditures	Other Expenditures
DSS	Acquired Brain Injury Waiver (ABI)	$42,056,370	NA	$42,056,370			
DSS	ABI II	$23,953,019	NA	$23,953,019			
DSS	Katie Beckett Model Waiver	$72,928	NA	$72,928			
DSS	Autism Waiver	$1,477,893	NA	$1,477,893			
DSS	Community First Choice	$159,610,161	NA	$159,610,161			
DSS	Money Follows the Person	$34,175,006	NA	$34,175,006			
DDS	Home and Community Based Services Waivers	$1,241,540,000		$1,241,540,000			

State Agency	Long-Term Care Program	Total Expenditures SFY 2021	State Expenditures	Medicaid Expenditures	OAA Title III Expenditures	Other Federal Expenditures	Other Expenditures
DDS	Intermediate Care Facility for Persons with Mental Retardation (ICF/MR)	$171,440,000		$171,440,000 Does not include private ICF/IDs which are funded by DSS			
DMHAS	Case Management	$41,230,467	$36,737,056	$111,205	$0	$2,859,927	$1,522,279
DMHAS	Assertive Community Treatment	$23,969,151	$23,638,329	$178,508	$0	$16,468	$135,846
DMHAS	Home and Community Based Services Waivers	$16,023,882	$0	$16,023,882	$0	$0	$0
DMHAS	MH Intensive Outpatient	$456,854	$26,139	$0	$0	$15,819	$414,896
DMHAS	MH Outpatient Therapy	$93,383,394	$66,907,243	$5,887,836	$0	$3,318,595	$17,269,720

State Agency	Long-Term Care Program	Total Expenditures SFY 2021	State Expenditures	Medicaid Expenditures	OAA Title III Expenditures	Other Federal Expenditures	Other Expenditures
DMHAS	MH Residential Group Home	$41,034,567	$30,014,527	$5,681,947	$0	$771,314	$4,566,779
DMHAS	MH Supervised Housing	$57,326,447	$53,205,549	$0	$0	$157,845	$3,963,053
DMHAS	MH Supported Housing	$44,118,461	$23,405,838	$ 0	$0	$19,883,297	$829,326
DMHAS	MH Psychosocial Rehabilitation	$19,473,549	$17,934,545	$0	$0	$811,823	$727,181
DMHAS	Crisis Stabilization	$11,005,932	$10,493,168	$0	$0	$430,814	$81,950
DMHAS	Mobile Crisis Services	$12,843,062	$11,369,243	$13,625	$0	$1,066,188	$394,006
DMHAS	Long Term Psychiatric Hospitalization	$167,055,394	$165,918,837	$0	$0	$1,136,557	$0

State Agency	Long-Term Care Program	Total Expenditures SFY 2021	State Expenditures	Medicaid Expenditures	OAA Title III Expenditures	Other Federal Expenditures	Other Expenditures
DMHAS	Substance Abuse Residential Long Term Care	$3,330,876	$1,577,642	$0	$0	$219,148	$1,534,086
DMHAS	Substance Abuse Residential Long Term Treatment	$18,573,881	$12,196,906	$0	$0	$4,581,703	$1,795,271
DMHAS	Substance Abuse Residential Transitional / Halfway House	$1,647,685	$1,044,679	$0	$0	$152,115	$450,891
DOH	Congregate Operating Subsidy Program	$9,434,641	$8,823,041			$611,600	
DOH	Elderly Rental Registry and Counseling	$1,011,170	$1,011,170				
DOH	Elderly Rental Assistance Program	$1,935,625	$1,935,625				

State Agency	Long-Term Care Program	Total Expenditures SFY 2021	State Expenditures	Medicaid Expenditures	OAA Title III Expenditures	Other Federal Expenditures	Other Expenditures
DOH	811 PRA	$746,851	$0			$746,851	
DOT	Local Bus Services	$246,773,279 SFY 2020 Data	$205,745,356 SFY 2020 Data			$1,849,699 SFY 2020 Data	$27,737,582 (Fare Revenue) $7,137,118 (Other Revenue) $437,425 (Other Subsidies) $3,866,098 (Local) SFY 2020 Data
DOT	ADA Paratransit Services	$41,189,111 SFY 2020 Data	$39,230,209 SFY 2020 Data				$1,738,188 (Fare Revenue) $197,753 (Other Revenue) $22,961 (Local) SFY 2020 Data
DOT	State Matching Grant Program	$8,778,660 SFY 2020 Data	$4,389,330 SFY 2020 Data				$4,389,330 (Local) SFY 2020 Data

State Agency	Long-Term Care Program	Total Expenditures SFY 2021	State Expenditures	Medicaid Expenditures	OAA Title III Expenditures	Other Federal Expenditures	Other Expenditures
DOT	Section 5301 Program	$4,688,113 Data projections for FFY 2019 Award Cycle (most recent)	$590,439 Data projections for FFY 2019 Award Cycle (most recent)			$3,261,248 Data projections for FFY 2019 Award Cycle (most recent)	$836,426 Data projections for FFY 2019 Award Cycle (most recent)
DVA	Veterans' Health Care Services	$13,264,997	$10,634,280			$539,547	$2,091,171
DVA	Residential and Rehabilitative Services	$3,382,368	$1,110,848			$1,472,327	$799,193