STATE OF CONNECTICUT
LONG TERM CARE PLANNING COMMITTEE

December 30, 2024

The Honorable Jan Hochadel, Senate Chair
The Honorable Jane M. Garibay, House Chair
Aging Committee
State Capitol, Room 011
Hartford, CT 06106

The Honorable Matthew L. Lesser, Senate Chair
The Honorable Jillian Gilchrest, House Chair
Human Services Committee
Legislative Office Building, Room 2000
Hartford, CT 06106

The Honorable Saud Anwar
The Honorable Cristin McCarthy Vahey
Public Health Committee, Legislative Office Building, Room 3000
Hartford, CT 06106

Dear Committee Chairs:

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

If you have any questions on the report, please call me at the Office of Policy and Management at 860-418-6442.

Sincerely,

Melissa Morton

Melissa Morton
Chair, Long-Term Care Planning Committee
Office of Policy and Management

cc: Members and Clerks of the Aging, Human Services, and Public Health Committees
Long-Term Care Planning Committee
Long-Term Care Advisory Council
Jeffrey R. Beckham, Secretary, Office of Policy and Management
Claudio Gualtieri, Senior Policy Advisor to the Secretary of the Office of Policy and Management
Clerk of the Senate
Clerk of the House
Office of Legislative Research
State Librarian

Connecticut Long-Term Care Planning Committee

Balancing the System:

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

A Report to the General Assembly

January 2025

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TABLE OF CONTENTS

Appendices

ACKNOWLEDGEMENTS

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

I. EXECUTIVE SUMMARY

A. Balancing the System

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

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

This Long-Term Services and Supports Plan (Plan) addresses the needs for LTSS of the citizens of Connecticut. Developed by the Long-Term Care Planning Committee with input from members of the Long-Term Care Advisory Council, various organizations and individuals in need of LTSS and their family members and members of the public, this Plan was produced to educate and provide recommendations to policymakers regarding what steps Connecticut should initiate and continue to take in order to achieve a balanced and person-centered LTSS system over time through 2028.

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

As in previous versions of the Plan, the 2025 Plan is committed to balancing the LTSS system in terms of the ratio of home and community-based and institutional care and the ratio of public and private resources. By balancing the ratio of community-based and institutional services, what is meant is not a system with an equal split between community and institutional services. Instead, a more balanced system in Connecticut would meet the Planning Committee's long-standing goal of having 75 percent of individuals receiving Medicaid LTSS in the community and 25 percent receiving LTSS in institutions by 2028. Central to achieving this balance is a commitment to independence and choice for all individuals seeking services and supports. Towards this end, this new Plan continues to address the development and maintenance of a person-centered system of LTSS across the lifespan and across all disabilities with the focus on informed choice, least restrictive and most enhancing settings, and community inclusion.

Three years have passed since the last Plan and much has changed to improve Connecticut's LTSS system, yet there is more to be done. Changes in policy and funding on the federal and state level have fostered progress in creating a balanced LTSS system in Connecticut. Despite this progress and the many highlights which are described later in this Executive Summary, Connecticut's LTSS system still faces some of the same rules, barriers and challenges that were in place three years ago. The onset and recovery from a global public health emergency (PHE) that impacted the nation in 2020 and 2021 served to further highlight these barriers. However, passage of PA 24-39 will result in further reforms, establishing presumptive eligibility for people applying for services under the Connecticut Home Care Program for Elders waiver, promoting consumer choice of setting, improving the quality of LTSS, and enhancing the LTSS workforce. In addition, pursuant to the ARPA HCBS reinvestment plan, both the Department of Social Services (DSS) and the Department of Developmental Services (DDS) have made significant investments in workforce development and stabilization, and DSS is implementing evidence-based models like Community Aging in Place – Advancing Better Living for Elders (CAPABLE) and Care of Persons with Dementia in their Environment (COPE) into our home care services.

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

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

1. Long-Term Services and Supports Affects Everyone

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

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

Therefore, all of the recommendations and action steps put forward in this Plan apply to individuals of all ages and disabilities, unless specifically noted. While we recognize that historically certain populations have not received the equal footing they deserve in terms of attention and resources in LTSS planning and program development, we have

deliberately been inclusive in our recommendations and have not segmented out certain groups of individuals or disabilities. This strategy is designed to break down some of the barriers experienced by individuals with certain disabilities and promote a philosophy that is person-centered and focused on the needs of individuals and their families.

It is important to note that not only will virtually everyone be touched by the LTSS system at some point in their lives, but improvements in this system also benefit society at large. For example, addressing the shortage of LTSS workers also addresses the need for health professionals in other settings, and improving access to public transportation benefits everyone, not only individuals with disabilities.

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

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

2. The Current System Is Out of Balance

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

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

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

and supports provided in the home and community and those provided in institutions has consistently been out of balance and skewed towards institutional care.

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

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

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

Balancing the Ratio of Public and Private Resources

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

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

Therefore, we have a system that requires individuals to spend all their savings first in order to receive government support for their ongoing needs.

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

B. Facts and Trends

- People of all ages and from all socio-economic, racial and ethnic backgrounds need LTSS.
- Disabilities affect 12.5 percent of all Connecticut residents – 446,445 individuals in 2022. (See page 32)
- Among older adults living to age 65 during the period of 2020-2024, it is estimated that 57 percent will need paid LTSS over the course of their lifetime. In general, 70% of individuals living beyond age 65 will develop some form of LTSS need. Women and low-income individuals have a greater chance of needing LTSS (61.1 percent and 61.6 percent respectively) than men (50.9 percent). (See page 32)
- Home and community-based services (HCBS) help people with LTSS needs stay in their homes and communities while reducing LTSS spending. Medicaid pays the majority of LTSS expenses. In Connecticut, in state fiscal year (SFY) 2024, Medicaid LTSS expenses accounted for 16 percent of the state budget and 38 percent of the Medicaid budget. (See page 47)

C. What's New in Connecticut

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

The Coronavirus (COVID-19) Pandemic

The preceding years of the LTSS Plan (2022-2024) were marked by the ongoing and eventual end of the COVID-19 pandemic. The pandemic spread across the globe and eventually the State of Connecticut, resulting in Governor Lamont declaring a public health emergency (PHE) on March 10, 2020. The State's LTSS system had to rapidly shift focus to activities related to infection control and prevention and emergency management. Consumers of LTSS were among the most vulnerable populations and

their health and safety became paramount at the State and local levels. As the 2022 Plan period began, the public health emergency was still underway, officially ending on May 11, 2023. The post PHE period has focused on economic and social recovery and an opportunity for the State to use the valuable lessons to improve the quality of Connecticut's LTSS system now and into the future. The 2025 LTSS Plan does not attempt to explore the State's COVID-19 response in-depth as this could be a report of its own and other researchers have undertaken this task. This Plan does, however, take into consideration the valuable lessons learned from the pandemic as voiced by the State agency staff, community organizations, advocacy groups and members of the public who submitted recommendations for this Plan.

- ***Lessons Learned During the COVID-19 Pandemic and Recovery Period***

The following two areas were the most frequently identified areas of concern flagged by during and post the pandemic, reflects topics that were most frequently raised in public comments and are subsequently reflected in the recommendations driving this 2025 Plan.

(1) Focus on Workforce Development: This has been an important recommendation in previous versions of the Plan, however, the need to focus on workforce development as a short-term priority was highlighted during the pandemic and was the number one area of concern raised in public feedback from all respondents regardless of whether they were community organizations, advocates, informal caregivers or consumers as the need has not eased post pandemic. Developing and retaining a quality LTSS workforce across the State's LTSS system was included in prior versions of the Plan in recognition of the fact that the direct care workforce was not increasing at a rate that would keep pace with the rapidly growing aging population (See section III for demographics). However, the LTSS workforce across institutional and HCBS settings was one the industries negatively impacted by the PHE, as many workers chose to leave the workforce. The majority of consumers who provided public comment for this Plan noted losing workers during COVID-19 due to resignation and/or being unable to find new workers to provide needed daily supports and are still not seeing improvement in this area. Individuals representing home care industries also stressed during the comment period that workforce development and retention is an immediate and critical priority. Therefore, the need to bolster the LTSS workforce remains a short-term and urgent recommendation of the 2025 Plan.

(2) Improve Back-Up Planning for Consumers Self-Directing Their Services: A key theme across all public listening sessions, comprised of 15 members of the general public with direct experience with the State's system of LTSS, was that consumers and their informal caregivers/family members need assistance with the development and implementation of back-up plans when scheduled formal

and informal caregivers become suddenly unavailable to provide care. Listening session participants noted that the need for an actionable back-up plan resulting in the rapid provision of substitute workers has been exacerbated during the PHE as consumers were faced with workers resigning without notice or becoming ill. Informal caregivers shared that in the absence of a method to secure immediate worker replacements they became 24/7 caregivers and lived in fear of what would happen if they became unavailable to provide support. Consumers and informal caregivers universally reported not having an actionable back-up plan to deal with emergency absences and difficulty quickly finding replacement staff willing to work. Once interested and qualified staff were found, consumers on Medicaid HCBS programs reported waiting several weeks to get through the State mandated hiring process. This left some consumers without care for periods of time during the day and informal caregivers in fear of what would happen to their loved one if they unexpectedly became incapacitated.

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

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

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

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[1] Public Law 116–127, FFCRA, March 18, 2020. https://www.congress.gov/116/plaws/publ127/PLAW-116publ127.pdf.
[2] Public Law 116–136, CARES Act, March. 27, 2020. https://www.congress.gov/116/plaws/publ136/PLAW-116publ136.pdf.
[3] Public Law 117-2, ARPA, March 11, 2021. https://www.congress.gov/117/plaws/publ2/PLAW-117publ2.pdf.

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

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

Progress in Meeting the Balancing Goals

This Plan advocates that by 2025, by providing more choices for those with LTSS needs and assuring access to needed services, the Connecticut Medicaid program should be serving 75 percent of LTSS clients in home and community-based settings[5], with only 25 percent choosing institutional care[6]. Since SFY 2003, the percentage of Medicaid clients receiving care in the community has increased by 52%: from 46% in SFY 2003 to 70% in SFY 2024. The percentage of Medicaid LTSS clients receiving services in the community since the last Plan, has increased from 69 percent in SFY 2022 to 70 percent in SFY 2024. Slowly, but surely, the Connecticut Medicaid program is moving in the right direction and meeting the Plan's goal.

With regard to public spending on LTSS, between SFY 2003 and SFY 2024 the proportion of Medicaid LTSS expenditures for home and community-based services increased by 90 percent, rising from 31 percent to 59 percent of all Medicaid LTSS expenditures. Likewise, there was a 41 percent decrease in the proportion of expenditures for LTSS provided in institutional settings. Overall, total Medicaid LTSS expenditures increased by approximately 75 percent between SFY 2003 and SFY 2024 ($1.914 billion to $3.964 billion).

Long-Term Services and Supports Scorecard for Connecticut

As part of a national survey, a State Long-Term Services and Supports Scorecard based on the experience of older adults and people with physical disabilities (a subset of the

[4] Summary provided by the Department of Developmental Services, November 2021.
[5] The Medicaid long-term care community services include home health services, hospice, home and community-based waiver programs, and targeted case management for mental health and developmental disabilities.
[6] The Medicaid long-term care institutional services include nursing facilities, hospice, intermediate care facilities for persons with developmental disabilities (ICF/IDs), and chronic disease hospitals.

population using LTSS) was published by AARP in 2023[7]. Connecticut received an overall ranking of 13 among all the 50 states in the country. The score card looks at five areas of measurement, with each number ranking the state among all 50 states:

1) Affordability and access (CT = 8);

2) Choice of setting and provider (CT = 22);

3) Quality of life and quality of care (CT = 19);

4) Support for family caregivers (CT = 9); and

5) Community Integration (CT = 22).

Money Follows the Person Rebalancing Demonstration

The Money Follows the Person (MFP) Rebalancing Demonstration, which began operation in December 2008, has been a leading force in Connecticut's efforts to rebalance the LTSS system to reflect consumer needs and choice. The program, located within the Department of Social Services (DSS), serves Medicaid eligible individuals across the age span with physical disabilities, mental illness and intellectual and cognitive disabilities. Under MFP, as of September 2024, over 8,200 individuals have been transitioned from a nursing facility to community living, exceeding the initial goal of 5,200 transitions. Connecticut has established five rebalancing benchmarks under MFP that are aligned with the goals of this Plan:

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

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

Housing Initiatives

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

The Department of Housing (DOH), in conjunction with the Department of Developmental Services (DDS), and DSS, is implementing the federal Section 811 Project-Based Rental Assistance (PRA) program. DOH received an additional $8 million

[7] *Innovation and Opportunity: A State Scorecard on Long-Term Services and Supports for Older Adults, People with Physical Disabilities, and Family Caregivers*; AARP Public Policy Institute, 2023

as part of the most recent awards expanding this program. In addition, DOH, in conjunction with DDS, is administering $15 million in State Bond Funds for the creation of deep income targeted permanent supportive housing.

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

CHESS started in 2019 as an initiative to cover supportive housing benefits under Medicaid by combining both Medicaid services and non-Medicaid housing subsidies. Housing plus supports have historically been instrumental in helping Medicaid members to achieve housing stability, improve health, community integration and life satisfaction[8]. CHESS aims to achieve housing stability, improved health, and community integration and life satisfaction.

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

- being at risk of homelessness,
- have a Modified Charlson Comorbidity Index score of more than 4,
- have a behavioral health diagnosis recognized by the International Classification of Diseases, and
- have at least 2 critical needs[9].

As of June 30, 2023, 220 individuals were receiving housing through CHESS[10].

Long-Term Services and Supports Rightsizing Initiative

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

- ***Rightsizing Strategic Plan***

In January 2013, then Governor Malloy and DSS released the State's first Rightsizing Plan, *Rebalancing Long-Term Services and Supports*, *2013-2015*. It was the result of a multi-month process of stakeholder briefings, engagement, and data and systems analysis. It also met the requirements of Public Act 11-242, which required DSS to develop a strategic plan, consistent with this LTSS Plan, to rebalance the Medicaid LTSS system[11]. In January 2020, Governor Lamont, the Office of Policy and Management (OPM) Secretary and DSS Commissioner released an updated copy of the State's Strategic Plan to Rebalance Long-Term Services and Supports as part of an initiative by

[8] Department of Social Services, *CHESS Frequently Asked Questions*, https://www.ctchessdss.com.
[9] Ibid.
[10] Department of Social Services, *FY 2023 Annual Report, https://portal.ct.gov/-/media/departments-and-agencies/dss/reports/annual-reports/dss-annual-report-sfy-2023.pdf?rev=6cb16c6027274b40ad1c2661de1bf5e8*
[11] Department of Social Services, *Strategic Rebalancing Plan, 2013 – 2015*; January 29, 2013.

Governor Ned Lamont and the General Assembly to expand long-term care options and assist the nursing home industry to diversify its business model to meet changing service needs. The 2020 Plan, which will be updated annually, reflects collaboration and coordination across multiple State departments, the federal government, home health providers, nursing home administrators, consumers and other stakeholders to address the anticipated, unprecedented demand for Medicaid-funded long-term care through 2040 and accelerate the pace of rebalancing. According to the 2020 Rightsizing Plan[12]:

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

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

Private Financing of Long Term Services and Supports

- **Short-Term Care Insurance[13]:** Effective October 1, 2016, "short-term care insurance" became available as a new type of insurance providing certain health benefits for 300 or fewer days. Short-term care insurance works similarly to long-term care insurance except that it covers a maximum 300 days of care. Long-term care insurance policies in Connecticut are required to cover a minimum of 365 days.

- **Long-Term Care Insurance:** The Connecticut Partnership for Long-Term Care (Partnership) was developed to constrain the growth in Medicaid long-term care expenditures by educating Connecticut residents about the importance of planning ahead for future long-term care costs and by offering, through private insurers, high-quality, affordable long-term care insurance that provides protection against impoverishment. 2024 was the 32nd full year that Connecticut Partnership policies were available for purchase by Connecticut residents and over 60,900 policies have been sold.

[12] Department of Social Services, *Strategic Rebalancing Plan: A Plan to Rebalance Long Term Services and Supports, 2020*; January 29, 2020.
[13] Text of the P.A.16-63 – An Act Concerning Short-Term Care Insurance, can be found at https://www.cga.ct.gov/2016/ACT/pa/2016PA-00063-R00HB-05521-PA.htm

The Connecticut Partnership continued its proactive efforts to educate Connecticut residents, agents, financial planners and other interested parties about the need to plan ahead to meet future long-term care costs. To date, the Partnership has responded to over 63,800 calls, trained and certified over 6,900 agents, and has given 1,694 presentations to a total of 60,954 people[14].

Home and Community-Based Services Programs

- **Acquired Brain Injury Waiver II (ABI II):** Effective December 1, 2014, DSS implemented the Acquired Brain Injury (ABI) Waiver II in order to increase the number of available waiver slots for individuals ages 18-64 with disability due to an ABI. ABI Waiver II varies from ABI Waiver I in the following ways: (1) offers a lower cost cap, at 150% of the cost of institutional care vs. 200% of the cost of institutional care for ABI Waiver I; (2) does not cover Transitional Living Services due to underutilization of the services in ABI Waiver I; and (3) includes five additional services: adult day health, ABI Recovery Assistant, ABI Recovery Assistant II, consultation services and agency-based personal care. On June 30, 2024, there were 249 active clients enrolled in the ABI II program.

- **Community First Choice (CFC):** On July 1, 2015, DSS launched a new Medicaid State Plan service pursuant to 1915(k) of the Social Security Act. This new option, made possible by the federal Patient Protection and Affordable Care Act (ACA), enables Medicaid beneficiaries who require nursing facility, or other institutional level of care, to self-direct community-based services utilizing individual budgets, with the support of a fiscal intermediary. Services include transitional supports when moving from institutions to the community, as well as services that increase independence or substitute for human assistance such as, personal care assistants, support and planning coaches, nurse coaches, home delivered meals, environmental accessibility modifications, Personal Emergency Response Systems, and assistive technology. In SFY 2024, CFC served over 5,000 individuals. Of those individuals, a monthly average of 2,453 consumers participated in CFC without the additional support of a Medicaid waiver[15].

- **Behavioral Health Homes (BHHs):** The Affordable Care Act, enacted in March of 2010, created an optional Medicaid State Plan benefit for states to establish "health homes" to coordinate care for Medicaid participants who have chronic conditions. Under this authority, the Department of Mental Health and Addiction Services (DMHAS) along with its State Partners, DSS and the Department of Children and Families (DCF), created the Connecticut Behavioral Health Home Initiative (BHH).

[14] Office of Policy and Management, *Connecticut Partnership for Long-Term Care Annual Progress Report to the General Assembly*; January 2025.
[15] Department of Social Services, Community Options Unit, Annual CFC Statistical Report to the Office of Policy and Management, Health and Human Services Policy and Planning Division, November, 2024.

Connecticut implemented BHH utilizing the existing infrastructure of its private/non-profit and state operated Local Mental Health Authorities (LMHAs) and one of their affiliates. There are fourteen BHH provider agencies across the state. In SFY 2024, the average monthly enrollment in BHH was over 5,500 individuals.

A BHH is an integrated healthcare service delivery model that aims to treat the whole person by incorporating physical healthcare into the care individuals receive at their established behavioral health provider. The model promises better patient experience and outcomes than those achieved in traditional service delivery models. Connecticut's State Plan Amendment to provide BHH was approved by federal Centers for Medicare and Medicaid Services (CMS) in September 2016 with an effective date of October 1, 2015. BHH services are targeted to individuals with severe and persistent mental illness who are eligible for Medicaid with annual claims of at least $10,000 per year. The services available through BHH include: (1) comprehensive care management; (2) care coordination; (3) health promotion; (4) transitional care; (5) patient and family support and (6) referral to community support services.

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

In calendar year 2023, the most recent year for which data is available at this time, 63% of BHH enrollees hospitalized for treatment of a mental illness had a follow-up visit with a mental health practitioner within 30 days of discharge. BHH enrollees receive regular health assessments that include tracking of Body Mass Index (BMI), offering smoking cessation services, monitoring and controlling high blood pressure and depression screening. Eighty-seven (87%) of BHH enrollees identified as tobacco users received smoking cessation intervention. Lastly, 93% of BHH enrollees who completed the satisfaction survey stated overall satisfaction with their healthcare experience.

As the BHH initiative moves into its tenth year of operation, the focus will be to work with BHH providers to increase BHH enrollment, conduct outreach and education to increase preventive cancer screenings, to strive to decrease inequities in care through special initiatives such as health literacy, and to continuously improve the integrated care delivery model design/system through ongoing feedback from providers and enrollees.[16]

[16] Behavioral Health Home update submitted to OPM, Health and Human Services Policy and Planning Division, by the Department of Mental Health and Addiction Services, Managed Services Division, December 2024.

- **The Senior Outreach and Engagement Program (SOEP):** The SOEP provides assessment and case management services to at risk older adults (55 and older) by utilizing proactive approaches to identify, engage and refer seniors for various individually tailored community treatment options. Services include education, support, counseling (including in-home counseling) referrals to senior service networks and referrals for treatment. The goal of the program is to provide the services in a person-centered, strengths-based, culturally sensitive manner that reduces substance misuse, stabilizes behavioral health symptoms and improves quality of life, while assisting the participants with remaining integrated in the community in the least restrictive setting possible. The program complements existing DMHAS programs that focus on diverting older adults from long-term care institutions and the ongoing development of home and community-based services to assist older adults with "aging in place." The Senior Outreach and Engagement staff also provides education and consultation to local agencies within the designated geographic region to promote integration and collaboration of services for seniors and develop a system of aftercare for older adults identified by the program. After the FEMA funded COACH program (COVID Assistance for Community Health) ended in 2023, the program was able to add one (1) additional staff in each region that allowed for greater outreach across the state[17].

Nursing Facilities

- ***Moratorium:*** The moratorium on new nursing facility beds was extended indefinitely during the 2015 legislative session.[18] DSS continues to analyze and monitor the need for beds. Several methods are used to reduce unneeded capacity such as de-licensing or reclassifying beds. While the state may continue to have sufficient capacity in aggregate, there may local areas of need requiring additional flexibility in the future.

- ***Nursing Facility Closures:*** According to the Connecticut Annual Nursing Facility Census Survey, there were a total of ten nursing facilities in the state that closed since the last LTSS Plan (2022-2024). As of September 30, 2024, there were 195 licensed nursing facilities in the State[19].

[17] Senior Outreach and Engagement Program update submitted to OPM, Health and Human Services Policy and Planning Division, by the Department of Mental Health and Addiction Services, Managed Services Division, December 2024.
[18] Section 391, Public Act 15-5
[19] State of Connecticut Annual Nursing Facility Census, Office of Policy and Management, Health and Human Services Policy and Planning Division, 2024.

Workforce

- **Personal Care Attendant Collective Bargaining Agreement:** In April 2014 the first ever Collective Bargaining Agreement (CBA)[20] covering Personal Care Attendants (PCAs) hired by consumer-employers of the State's publicly funded programs was signed between the State of Connecticut Personal Care Attendant Workforce Council and the New England Health Care Employees Union, District 1199, SEIU (1199). A Successor Agreement[21] was adopted by the legislature[22] during the 2024 legislative session and extended the CBA through June 30, 2026. This Agreement seeks to address PCA recruitment and retention through the provision of a competitive wage, increases in paid time off and health insurance premium support and the provision of a longevity stipend for workers who provide services to the same consumer-employer for a specific two-year period.

State Government

Community Ombudsman Program: The Community Ombudsman Program was established through legislative efforts in 2022 to address the needs of individuals receiving long-term services and supports (LTSS) in community settings. Key provisions in Public Act 22-118 and Public Act 22-146 laid the groundwork by allocating resources and defining the program's purpose. By 2023, additional appropriations enabled the hiring of the first Regional Community Ombudsman, leading to the program's official launch in winter 2024. This milestone marked the beginning of targeted support for individuals navigating home and community-based services (HCBS), connecting them to essential resources like Medicaid waivers, housing, and the Money Follows the Person (MFP) program. In 2024, the passage of Public Act 24-39 provided the State Ombudsman with flexibility to assign Community and Regional Ombudsmen to areas of greatest need, ensuring effective crisis intervention during nursing facility closures and facilitating safe transitions, including those returning to their homes with LTSS.

Currently, the program supports approximately 26,766 individuals across Medicaid waivers and congregate housing settings, offering advocacy, transition assistance, and support to residents during crisis such as closures. However, the program's capacity remains limited, with a projected 30% increase in Medicaid beneficiaries opting to remain at home by 2040, alongside rapid growth in home care agencies. To meet these demands, Connecticut will need at least 14 Community Ombudsmen to align with

[20] Text of the Original 2014 CBA https://portal.ct.gov/-/media/Malloy-Archive/Personal-Care-Attendant-Workforce-Council/PCAWC_Collective_Bargaining_Agreement.pdf?sc_lang=en&hash=53E5EE0A5D0F620DC87F17C142028ADE.

[21] Text of the 2024 Successor Agreement https://portal.ct.gov/-/media/opm/pca/2023-cba/pca-submission.pdf?rev=2a762b6f8ab043dba69d677d54dfdeac&hash=B89927E78C366438E680D544A99F17A4

[22] House Resolution No. 9 and Senate Resolution No. 7, 2024 legislative session.

national staffing standards. Expansion of the program is not only essential to address oversight challenges, uphold residents' rights, and adapt to the evolving long-term care landscape, but also fiscally forward-thinking. By strengthening the program, Connecticut can:

- Address systemic gaps in HCBS oversight.
- Enhance the quality of life for individuals receiving care in their communities.
- Meet national standards for ombudsman staffing and advocacy.
- Support rebalancing efforts by intervening at the lowest levels of need, promoting stability through cost-effective support.

When individuals understand their right to live in the least restrictive environment, they experience improved autonomy, choice, and quality of life, which are directly linked to better health outcomes. Strengthening the Community Ombudsman Program ensures Connecticut's commitment to safeguarding the dignity, well-being, and fiscal sustainability of its long-term care system[23].

Passage of Public Act 24-39 (HB 5001) An Act Supporting Connecticut Seniors And The Improvement of Nursing And Home-Based Care. (Signed by the Governor May 21, 2024)[24]: The 2024 legislative session was a standout year in the advancement of legislation that promotes improvements in LTSS access and quality. The most sweeping piece of legislation was Public Act 24-39 that included the following:

§§ 1-3 — Home Care Provider Registry And Data Processing System: Requires Department of Social Services Commissioner to develop and maintain a home care provider registry and data processing system for people receiving Medicaid home and community-based services (HCBS) that (1) promotes awareness of and access to qualified home care providers and (2) may support the recruitment, retention, and oversight of qualified home care providers. The bill also (a) details specific information that must be included in such registry, (b) requires that it be developed in consultation with the Departments of Consumer Protection and Public Health and (c) allows the commissioner to apply the to the federal Centers for Medicare and Medicaid Services for enhanced federal financial participation related to the registry's development, maintenance, and ongoing operation. Effective Date: January 1, 2025

§§ 4 & 5 — Medicare Nursing Home Care Compare Website Link: Requires the Department of Public Health and the Department of Social Services to prominently post on their websites a link to the Medicare Nursing Home Care Compare website using a five-star rating system for public comparison. Effective Date: October 1, 2024

§§ 7-9 — Home Care Employee Badges and Photographs: Requires home health care, home health aide, homemaker-companion, and hospice agencies to require their employees to wear an identification badge with their name and photograph during

[23] Community Ombudsman Program update submitted to OPM, Health and Human Services Policy and Planning Division, by LTCOP staff, December 2024.

[24] Public Act 24-39 can be found here https://www.cga.ct.gov/2024/ACT/PA/PDF/2024PA-00039-R00HB-05001-PA.PDF

client appointments. Effective July 1, 2025, for homemaker-companion agency employees and October 1, 2024, for all other agency employees.

§§ 10-13 — Presumptive Medicaid Eligibility For Homecare: Requires the DSS commissioner to establish a presumptive Medicaid eligibility system for people applying to the Medicaid-funded portion of Connecticut Home Care Program for Elders (CHCPE); requires the state to pay for up to 90 days of home care for applicants determined to be presumptively Medicaid eligible; expands DSS annual CHCPE reporting requirements to include data on the presumptive Medicaid eligibility system and requires the commissioner, to the extent federal law allows, to seek a federal Medicaid waiver or state plan amendment needed to try to get federal reimbursement for the costs of providing coverage to those determined presumptively eligible for Medicaid. Under the bill, the presumptive eligibility system does not take effect until the commissioner gets the federal reimbursement. Effective Date: July 1, 2024

§ 14 — ADS Study on Financial Assistance for Nonparent Caretaker Relatives: Requires the Department on Aging and Disability Services (ADS) commissioner to study reimbursement rate options for nonparent caretaker relatives (e.g., grandparents) receiving DSS Temporary Family Assistance (TFA) benefits and report on the study to the Aging and Human Services committees by January 1, 2025. Effective Date: Upon passage.

§ 17 — Municipal Agents for The Elderly: Makes the duties of municipal agents for the elderly mandatory and expands them to include helping seniors access housing assistance resources, requires the Department of Aging and Disability Services commissioner to create a directory with these agents' contact information and post it on the department's website by January 1, 2025. Effective Date: October 1, 2024

§ 18 — Long-Term Care Ombudsman Notification of ALSA Licensure: Requires the Department of Public Health commissioner to notify the Long-Term Care Ombudsman within 30 days after granting a license to an Assisted Living Services Agency (ALSA). Effective Date: October 1, 2024

§ 19 — Managed Residential Community Resident Notification: Requires managed residential communities (MRCs) to give residents and their legal representatives at least 30 days' notice before changing the facility's operator or ALSA that provides facility services. Effective Date: October 1, 2024

§ 20 — Managed Residential Community Consumer Guide: Requires the Long-Term Care Ombudsman, in consultation with the public health commissioner, to develop an MRC consumer guide and post it on specified agency websites by January 1, 2025. Effective Date: Upon passage

§ 21 — Regional Long-Term Care Ombudsmen Duties: Expands the duties of regional long-term care ombudsmen to include activities related to the Community Ombudsman program, which supports adults receiving DSS-administered home and community-based services. Effective Date: October 1, 2024

§ 22 — Office of The Long-Term Care Ombudsman Client Records Disclosure: Allows nursing home residents or complainants to give consent visually or by using auxiliary aids for the Office of Long-Term Care Ombudsman to disclose their files or records';

requires an office representative to document the consent in writing. Effective Date: October 1, 2024

§ 23 — Community Ombudsman Program: Allows recipients of home and community-based services with specified medical conditions or disabilities to give consent visually or by using auxiliary aids for the Community Ombudsman to disclose their files or records; specifies that this data includes medical, social, or other client-related data; allows the Long-Term Care Ombudsman to assign a community regional ombudsman the duties of a long-term care regional ombudsman. Effective Date: October 1, 2024

§ 24 — Study on Medicaid Family Caregiver Support Benefits: Requires the DSS commissioner to (1) study the feasibility of providing a family caregiver support benefit through a Medicaid Section 1115 waiver that would provide respite services and support to residents not otherwise eligible for these services under Medicaid and (2) report the results to the Aging and Human Services Committees by January 1, 2025. The study must include (1) Oregon's Project Independence and Family Caregiver Assistance Program, which is operated under this type of Medicaid waiver; (2) other options to expand eligibility for respite services for those not Medicaid-eligible, and (3) potential state-funded long-term care services that could be used to offset the costs of a family caregiver support benefit. Effective Date: Upon passage.

§ 25 — Nursing Home Center of Excellence Program: Requires the public health commissioner to design a Center of Excellence Program for licensed nursing homes to provide incentives for those that meet certain criteria. While designing the program, the commissioner must study (1) how much a Center of Excellence Program could improve the quality of care at nursing homes and (2) what other states with similar programs consider to be best practices for nursing homes. The bill also details entities the commissioner must consult when developing the program, specifies the functions of the program's design, authorizes the DSS commissioner to seek a Medicaid state plan amendment, or a waiver from federal law, to provide incentives for the program participants, and clarifies that program is voluntary and nursing homes will not be penalized if they choose not to participate. Effective Date: July 1, 2024

§ 26 — Online Nursing Home Consumer Dashboard: Requires the Department of Public Health (DPH), in consultation with the Office of the Long-Term Care Ombudsman and the Long-Term Care Advisory Council, to establish an online nursing home consumer dashboard, within available appropriations, that includes: (1) comprehensive information on the quality of care for people in need of nursing home care and their families and (2) industry leading practices. The bill also required that DPH include a link to the dashboard in a prominent place on the department's website. Effective Date: July 1, 2024

Federal Government

- **21st Century Cures Act:** In 2016, Congress passed the 21st Century Cures Act (Cures Act), designed to improve the quality of care provided to individuals through further

research, enhanced quality control and the strengthening of mental health parity.[25] Section 12006 of the Cures Act, P.L. 114-255 added Section 1903(l) to the Social Security Act (SSA) and has significant implications on the delivery of agency-based and self-directed LTSS by requiring states to implement electronic visit verification (EVV) time keeping for home health services by January 1, 2023 and personal care services by January 1, 2019. Failure to comply with statewide utilization of EVV by specified timelines will result in reduced Medicaid reimbursement called Federal Medical Assistance Percentage (FMAP)[26]. In 2018, Congress passed an amendment to Section 1903(l) of the SSA to delay the timeline for states to implement EVV for personal care services by one year from January 1, 2019 to January 1, 2020[27]. The Amendment did not affect the timeline for implementing EVV for agency-based home health services[28]. Connecticut was well prepared for the federal EVV requirement and, in 2017, implemented EVV across the agency-based home health industry. The State phased in implementation of EVV for self-directed Medicaid services and achieved full implementation in 2022.

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

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

Other State Plans Addressing Long-Term Services and Supports

- State Plan on Aging: October 1, 2024 – September 30, 2027 https://portal.ct.gov/-/media/aginganddisability/agingservices/ffy-2025-2027-state-plan-on-aging-w-approval.pdf?rev=b02488b0fba740928eeb6cbde1224fe2&hash=DC49EBDBF8799E42DC143C85724809A7

- 2020-2024 Consolidated Plan for Housing and Community Development – (2025-2029 Plan Under Development)

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[25] Centers for Medicare & Medicaid Services, *Disabled and Elderly Health Programs Presentation,* December 2017. https://www.medicaid.gov/sites/default/files/2019-12/evv-presentation-part-1.pdf.
[26] Ibid.
[27] The complete Amendment to the 21 Century CURES Act can be viewed here: https://www.congress.gov/bill/115th-congress/house-bill/6042?q=%7B%22search%22%3A%5B%22hr+6042%22%5D%7D&r=1
[28] Centers for Medicare & Medicaid Services, *EVV Update,* August, 2018. https://www.medicaid.gov/sites/default/files/2019-12/evv-update-aug-2018.pdf

https://portal.ct.gov/-/media/DOH/20-24-ConPlan-Action-Plan-for-Publication-and-Comment.pdf

- 2024 – 2025 Action Plan for Housing and Community Development, July 1, 2024 https://portal.ct.gov/-/media/doh/draft-24-25-action-plan.pdf

Planning for the Future

- **Multisector Planning for Aging and Disability:** A multisector plan on aging and disability creates a roadmap that helps state and local governments transform policy, infrastructure and service coordination. The process of multisector planning convenes stakeholders across multiple sectors to collaboratively address the needs of older adults and people with disabilities. Multisector plans typically span 10 years and ensure ongoing accountability and evaluation. They elevate common goals, reduce duplication and streamline efforts across interconnected planning processes. Connecticut was selected to participate in a multi-state learning collaborative on multisector planning, led by the Center for Health Care Strategies. Along with Iowa, Maryland, Massachusetts, Missouri, Nevada, New Hampshire, Pennsylvania, Utah, and Washington, Connecticut participated from 2023-2024 in this unique opportunity for peer-to-peer exchange, access to a network and experts and technical assistance. Connecticut's representation included the Connecticut Age Well Collaborative, the Department of Aging and Disability Services, Department of Social Services, Office of Policy and Management Intergovernmental Planning and Policy Division, Connecticut Council on Developmental Disabilities, and the Commission on Women, Children, Seniors, Equity and Opportunity. Connecticut researched best practices, investments and outcomes in other states. Connecticut is using this information to explore formalizing and making a sustaining investment in multisector planning for aging and disability, inclusive of an equity focus and strong community connections.

D. Goals, Recommendations and Action Steps

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

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

recommendations reflect strategic priorities identified for action over the next three years (2025 - 2028).

In 2005, a broad philosophical statement was enacted in Connecticut statute to guide policy and budget decisions. It states, *"that Connecticut's long-term care plan and policy must provide that individuals with long-term care needs have the option to choose and receive long-term care and support in the least restrictive, appropriate setting*." This simple statement, designed to make real choices for individuals a reality, provides a larger framework for Connecticut upon which the Plan's goals and recommendations rest.

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

Goals

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

Develop a system that provides for more choice and opportunities for community integration as alternatives to all institutional settings, and increases the proportion of individuals receiving Medicaid long-term home and community-based care from 70 percent in 2024 to 75 percent by 2028.

2. Balance the ratio of public and private resources:

Increase the proportion of costs for long-term services and supports covered by private insurance and other dedicated sources of private funds to 25 percent by 2028. Such an increase in private insurance and other sources of private funding would reduce the burden both on Medicaid and on individuals' out-of-pocket expenses. Nationally, spending from private long-term care insurance, other private sources and other public sources (State and local programs) for nursing facilities and home health services represented 22 percent of LTSS expenditures in 2021[29] (Figure 7).

Long-Term Recommendations

Optimally, a robust LTSS system that is able to maximize autonomy, choice and dignity will provide a full range of services and supports. Individuals, regardless of disability or

[29] "Other dedicated sources of private funds" means private long-term care insurance, other types of private insurance and other private spending for nursing facilities and home health services. It does not include "out-of-pocket" spending or informal care. Source: Congressional Research Services, Who Pays for Long-Term Services and Supports?; September 19, 2023.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Short-Term Recommendations

These short-term recommendations provide an action agenda for improving the LTSS system in Connecticut in the three years spanning 2025 through 2028. Criteria for proposing these targeted priority recommendations are that they will help to ensure the success of the LTSS system and can be acted upon in the next three years.

Programs and Services

- Adequately support and increase the number of and funding for slots of all the existing Medicaid home and community-based services waivers to meet the needs of all eligible applicants by reducing or eliminating waitlists.

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

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

- Explore implementing a universal waiver with eligibility criteria based on need rather than primary diagnosis.

- Support the continued implementation of self-direction in Medicaid programs.

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

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

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

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

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

- Implement person-centered goal setting, planning and care practices regardless of the setting or service.

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

- Support a robust local LTSS system to address community needs through strategic collaborations among and between other municipal departments and divisions such as parks and recreation, public health and transportation services and community leaders and explore opportunities for regional collaboration.

- Provide advocacy and financial support for increased use of assistive technology to meet the needs of individuals within their homes and avoid or defer the need for in-home hands-on assistance or institutionalization and increased use of basic

technology for connectivity to increase access to services, telehealth, and social connectedness.

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

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

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

- Explore adding coverage of palliative care under Medicaid.

- Explore capacity of community agencies providing LTSS to implement oral health literacy training programs by dental professionals to improve the capacity of consumers and their caregivers to perform their own oral health care.

Infrastructure

- Explore the development of a Multisector Plan for Aging and Disability.

- Engage in coordinated outreach and education efforts among State agencies to provide unbiased information to Connecticut residents on the LTSS available and how to access them, including the availability of MyPlaceCT as an online tool.

- Work with hospitals to facilitate the discharge of patients with ongoing and complex LTSS needs to an appropriate care setting of their choice.

- While exploring a transition to a universal waiver, address the historical fragmentation of existing Medicaid home and community-based waivers, which are associated with specific age and diagnostic eligibility criteria and administered through varying State agencies and application processes, by coordinating programs and application and renewal processes between State agencies to addresses the needs of the total person.

- Provide timely eligibility decisions regarding eligibility in all government sponsored LTSS programs.

- Implement presumptive eligibility for the Connecticut Home Care Program as required by Public Act No. 24-39, study impact on consumers and the state Medicaid program and explore expansion of the presumptive eligibility model.

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

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

- Achieve greater integration of employment of persons with disabilities into the Medicaid home and community-based services.

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

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

- Identify funding streams to sustain, coordinate, grow and make more convenient both fixed route and demand-responsive transportation options (including providing door-to-door service), and provide technical assistance to support regionalization.

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

- Continuously review, and modify as necessary, the current Certificate of Need process for skilled nursing homes to ensure that it is efficient and allows the State to work more collaboratively with nursing home providers as they seek to achieve the goals of the LTSS plan.

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

Financing

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

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

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

- Capture and reinvest cost savings across the LTSS continuum to enhance the availability and capacity of home and community-based services and ensure an adequate provider network.

- Continue efforts to reform the Medicaid rate setting system to reflect quality, reimbursement related to the actual costs of care, the acuity level of the consumers and uncompensated care for all LTSS providers across the continuum consistent with LTSS rebalancing, rightsizing and a range of home and community-based service initiatives.

- Explore various methods to increase the private sector's greater involvement as a payer of LTSS.

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

- Support the continued flexible use of Older Americans Act funding for services and, where possible, utilize Older Americans Act programs to supplement LTSS for consumers who do not qualify for Medicaid programs.

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

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

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

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

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

- Explore adjusting Medicaid spousal asset rules.
- Explore the provision of Medicaid reimbursement for paid caregivers to visit consumers in the hospital and other institutional settings to reduce isolation and promote better health outcomes.
- Explore incentivizing quality of care and care coordination through implementation of Value-Based Payment models.

Quality

- Enable a collaborative, flexible and efficient regulatory environment that is adaptive and receptive to individual providers' forward-thinking ideas and planning. Such an environment would encourage providers of the LTSS continuum to adjust, modernize and diversify their models of care to address current and future consumer needs and expectations, which in turn should lead to higher quality care.
- The Departments of Public Health, Aging and Disability Services, Consumer Protection, Social Services, and the State Long-Term Care Ombudsman, should continue to work together to ensure consistency among their respective regulatory and oversight activities.
- Recognize and incorporate the recommendations in the "State Plan to Address Alzheimer's Disease and Related Dementias."
- Expand State oversight of services to individuals receiving LTSS, including those provided in group homes, to include employee job performance in the areas of quality interactions with consumers and efforts at promoting consumer social engagement and stimulation.
- Continue supporting and explore increasing funding for the Community Ombudsman program to provide individuals on LTSS with the necessary information, education and protection of their individual rights related to LTSS in the greater community.
- Support an integrated approach to CT's response to abuse, neglect and exploitation, including the development of multi-disciplinary teams, implementing recommendations from the Coalition for Elder Justice in Connecticut and increasing resources, training for, and collaboration with Protective Services for the Elderly, the Office of the Chief State's Attorney, and other relevant agencies to identify, investigate and prosecute cases of abuse, neglect, and exploitation.
- Explore an adult protective services model that responds to abuse, neglect and exploitation for adults over the age of 18 who have disabilities.

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

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

Housing

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

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

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

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

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

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

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

Workforce

- Address the healthcare workforce shortage across the LTSS continuum to support to improve access to and quality of LTSS by building a strong, large LTSS workforce pool through accessible, affordable training options and wide outreach. Consider a public relations campaign to entice students and residents to work in the LTSS field.

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

- Develop a registry of pre-certified emergency back-up workers that can be accessed by employers of record in the State's Medicaid self-directed programs that enables them to rapidly access emergency direct care services without having to go through the lengthy hiring process or resort to consumer hospitalization or institutionalization for care.

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

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

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

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

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

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

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

- Address digital literacy needs among older workers and unpaid family caregivers to improve access to sector-based skills training and resources.

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

E. Development and Implementation of the Plan

Development

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

In 2023, the Long-Term Care Planning Committee embarked on the development of its ninth long-term care plan with input from the Advisory Council, various organizations, individuals in need of LTSS and their families and members of the public. The Advisory Council worked with the Planning Committee in four essential areas: providing data, identifying areas of need, developing recommendations, and obtaining public input.

Members of the Advisory Council assisted the Planning Committee with gathering broad public input on the draft Plan from diverse organizations and individuals throughout Connecticut with an interest in LTSS. Public comment was solicited multiple times during the planning: on the draft recommendations through a written survey and two public listening sessions in September and October of 2024. (See Appendix D – Sources of Public Comment*).*

Implementation

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

For those aspects of the Plan that do not require legislative changes or allocation, or reallocation, of resources, the State agencies represented on the Planning Committee, in collaboration with the Long-Term Care Advisory Council, will work together to address these items and periodically review their progress. In addition, annually, from 2025 through 2028, the Long-Term Care Planning Committee will choose to focus on several strategic priorities among the short- term recommendations based on: 1) timeliness; 2) readiness for implementation or change; 3) availability of funding; and 4) need for coordination with other entities or programs.

II. VISION, MISSION AND GOVERNING PRINCIPLES

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

A. Vision

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

B. Mission

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

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

The system must:

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

III. LONG-TERM SERVICES AND SUPPORTS IN CONNECTICUT

A. The People

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

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

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

A Word about the Data

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

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

Much of the data on disability in Connecticut used in this Plan is drawn from the U.S. Census Bureau 2022 American Community Survey (ACS). In this survey, disability is defined as “the product of interactions among individuals’ bodies; their physical, emotional, and mental health; and the physical and social environment in which they live, work, or play. Disability exists where this interaction results in limitations of activities and restrictions to full participation at school, at work, at home, or in the

community." The ACS uses six disability items to determine an individual's disability status: 1) hearing difficulty, 2) vision difficulty, 3) cognitive difficulty, 4) ambulatory difficulty, 5) self-care difficulty, and 6) independent living difficulty.[30]

Who Needs Long-Term Services and Supports?

National Perspective

Approximately 14 million adults, or about 4 percent of the total U.S. population, are in need of some level of LTSS[31]. Of these individuals, 56% were over the age of 65 and 44 percent were ages 18-64. 12.6 million adults received LTSS in the community compared to only 1.4 million in a nursing facility[32].

Among older adults living to age 65 during the period of 2020-2024, it is estimated that 57 percent will need paid LTSS over the course of their lifetime. In general, 70% of individuals living beyond age 65 will develop some form of LTSS need. Women and low-income individuals have a greater chance of needing LTSS (61.1 percent – 61.6 percent respectively) than men (50.9 percent). On average, 10% of adults are projected to need LTSS for less than one year and 22 percent will need services for five or more years. It is estimated that the average individual age 65 and older will experience a disability for 2.8 years, however, individuals will only use paid care for 1.1 of those years, relying on informal caregiver support for more than half of their period of disability[33].

TABLE 1

Number of Persons with Disabilities in Connecticut by Age, 2022

Age	Total Population	Persons with a Disability	Percentage
<18	729,521	37,302	5.1%
18 to 64	2,207,845	217,350	9.8%
65+	644,870	191,793	29.7%
Total	3,582,236	446,445	12.5%

Source: U.S. Census Bureau, 2022 American Community Survey, One Year Estimates, Connecticut, Custom Table from B18101

Connecticut

Disabilities affect 12.5 percent of Connecticut residents, lower than the national average of 13.4 percent[34]. In 2022, there were 446,445 individuals living in Connecticut with some type of long-lasting condition or disability (Table 1).

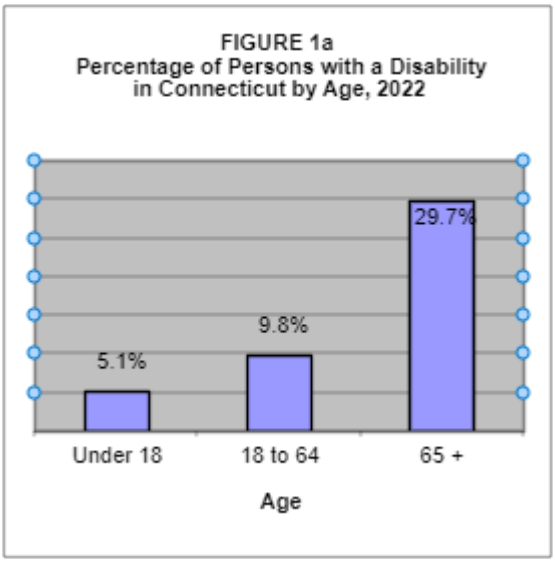
[30] U.S. Census Bureau, American Community Survey, 2022 Subject Definitions, pages 64-66. American Community Survey and Puerto Rico Community Survey 2022 Subject Definitions

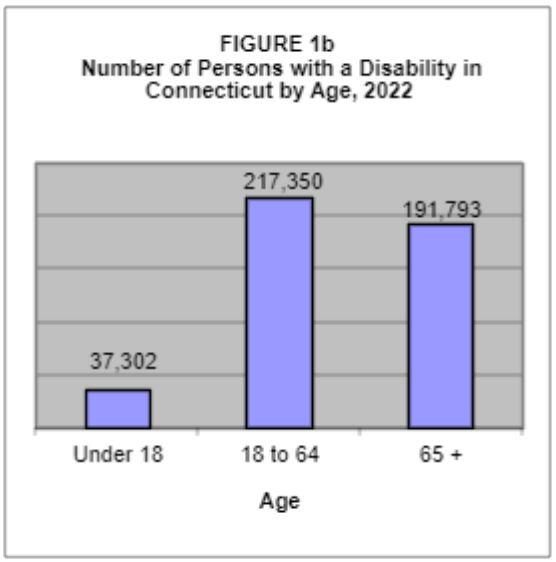
[31] Hado, Edem & Komisar, Harriet, AARP Public Policy Institute*; AARP Long-Term Services and Supports Fact Sheet 634, August 2019 https://www.aarp.org/content/dam/aarp/ppi/2019/08/long-term-services-and-supports.doi.10.26419-2Fppi.00079.001.pdf*

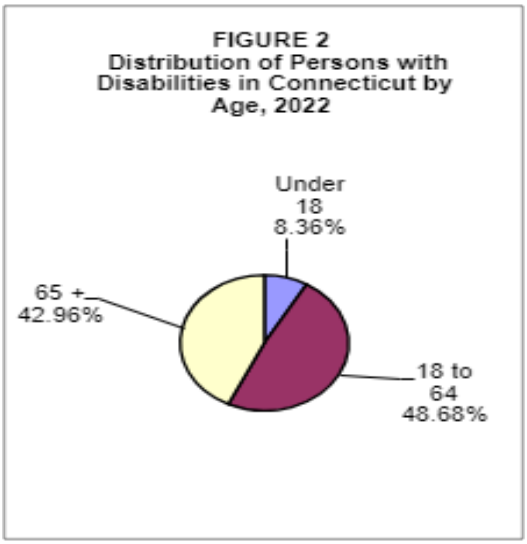
[32] Ibid..

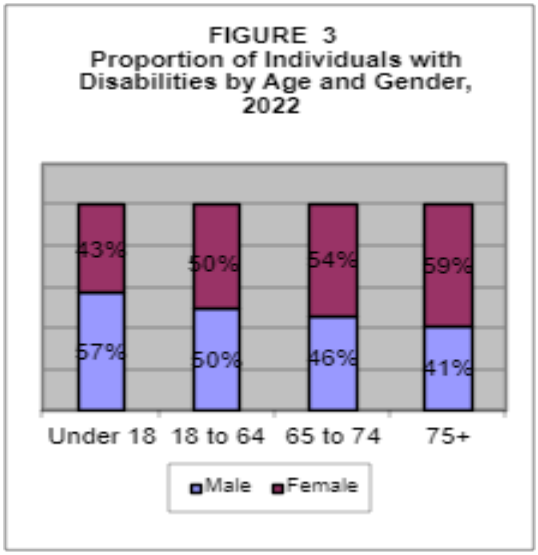
[33] Favreault, Melissa, M., & Johnson, Richard, W., Urban Institute on behalf of the Department of Health & Human Services, Assistant Secretary for Planning & Evaluation, January 31, 2021.

[34]U.S. Census Bureau, American Community Survey, 2022, One Year Estimates, S1810







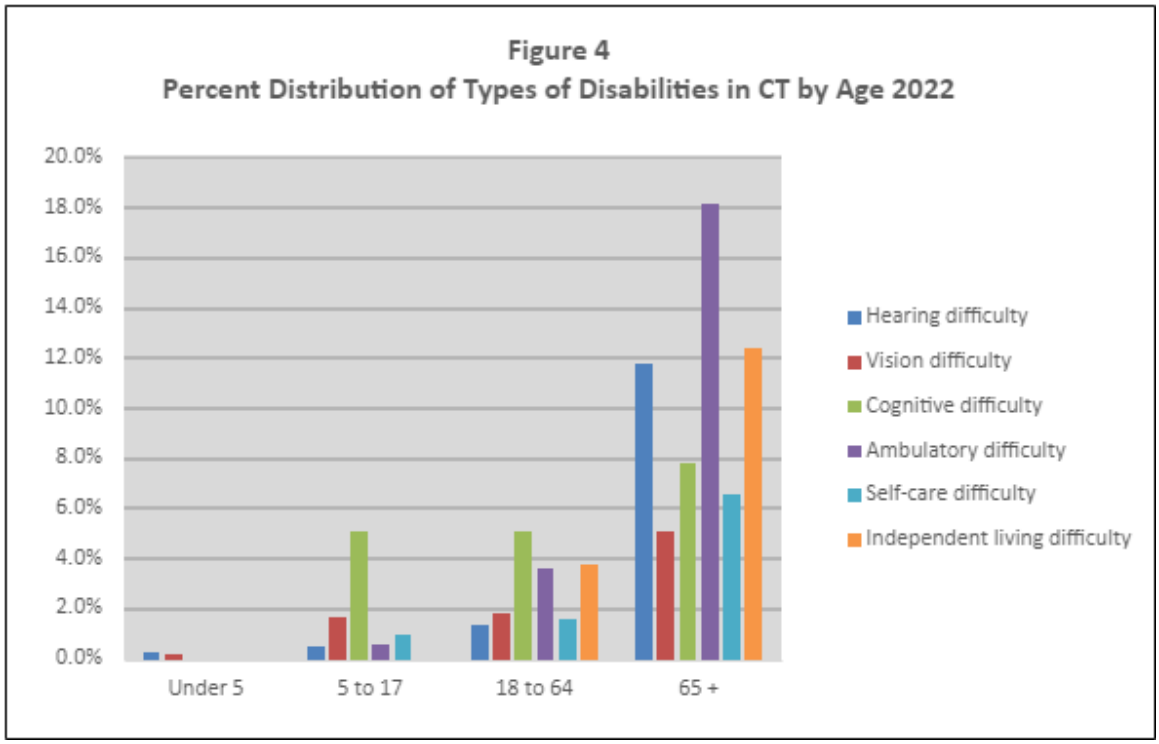


Source: U.S. Census Bureau, American Community Survey, Connecticut, 2022

Disability rates rise with age, with 5.1 percent of children and youth under age 18 reporting a disability, 9.8 percent of adults age 18 to 64, and 29.7 percent of older adults age 65 and over (Figure 1a).

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

Among individuals with disabilities, the ratio of males to females shifts as the population ages, as is the case in the general population. Among children and youth with disabilities, 57 percent are males. By the senior years, this proportion is reversed, with females comprising 59 percent of those with disabilities age 75 and older (Figure 3).



Source: U.S. Census, 2022 American Community Survey, Connecticut, Table S1810: Disability Characteristics

The distribution of types of disabilities in the population varies considerably by age (Figure 4). Among individuals in the under 18-year-old group, the greatest reported difficulty is cognitive (5.1 percent). Among individuals age 65 and older, ambulatory difficulties are most prevalent (18.9 percent) followed by independent living difficulties (13.5 percent). Cognitive difficulties were experienced by the same proportion of individuals in the under 18 and the 18 to 64 age groups (5.1 percent) and increased noticeably in the over 65 age group (7.8 percent). The 2022 American Community Survey determined those with cognitive difficulty by asking individuals if due to a

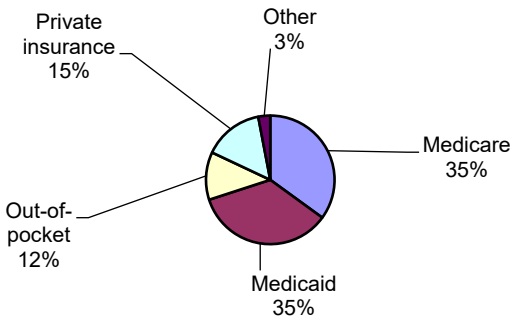
physical, mental or emotional condition, they had "serious difficulty concentrating, remembering or making decisions." [35,36]

B. Long-Term Services and Supports

Home and community-based services

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

FIGURE 6
Sources of Payment for Home Health Care in the U.S., 2023



Source: National Health Expenditure Data obtained from the Centers for Medicare and Medicaid Services, 2023. https://www.cms.gov/data-research/statistics-trends-and-reports/national-health-expenditure-data/historical

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

Home Care Services

Nationally, 70 percent of home health care costs incurred in 2023 were covered by Medicare and Medicaid with each covering 35 percent of total payments respectively.

[35] U.S. Census Bureau, 2022 American Community Survey, uses six items to determine an individual's disability status: 1) hearing difficulty, 2) vision difficulty, 3) cognitive difficulty, 4) ambulatory difficulty, 5) self-care difficulty, and 6) independent living difficulty. Source: U.S. Census Bureau, American Community Survey, 2022 Subject Definitions, page 64 to 66.

[36] It should be noted that an individual may have one or more disabilities, so the percentages in any particular age group could exceed 100 percent. For example, a person with severe asthma may have difficulty climbing stairs and difficulty working at a job.

Private sources, including private insurance and out-of-pocket payment, represented 27 percent of payments (Figure 6). It is important to note that home health care represents only a portion of home care services and generally addresses more medically oriented needs.

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

- *Home health care agencies*, which are licensed by DPH, provide care in the home that is typically prescribed by an individual's physician as part of a written plan of care. These agencies offer skilled nursing, home health aide services, physical therapy, occupational therapy, speech therapy, and hospice services. Non-medical services include helping individuals with activities of daily living such as bathing, dressing and eating; assistance with cooking, cleaning, and other housekeeping jobs; and managing medications. Although home health care may include some non-medical home care services, such as homemakers and companions, home health care is more medically oriented, helping individuals recover from an illness or injury. Home health care agencies, unlike homemaker-home health aide agencies and homemaker-companion agencies, may be eligible for Medicare reimbursement. As of December 2024, there were 88 agencies licensed by DPH to provide home health care services in Connecticut.[37]

- *Homemaker-home health aide agencies*, which are licensed by DPH, are similar to homemaker-companion agencies in that they provide non-medical assistance to individuals. In addition, they have the authority to provide training programs and competency evaluations for home health aides. As of June 30, 2024, there were no licensed agencies in Connecticut.[38]

- *Homemaker-companion agencies* provide non-medical assistance to persons with disabilities and older adults and must be registered with the Department of Consumer Protection. Tasks generally include grocery shopping, meal preparation, laundry, light housekeeping and transportation to appointments. As of October 2024, there were 1,048 registered homemaker-companion agencies active in Connecticut.[39]

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

[37] Connecticut Department of Public Health, 2024.
[38] Connecticut Department of Public Health, 2024.
[39] Connecticut Department of Consumer Protection, 2024.

Adult Day Care

Adult day services are an option for adults in need of a variety of health and social services who want to remain in their homes. They provide respite to family caregivers as well as therapeutic care for cognitive and physically impaired older adults. Health, personal care and social services are provided to adults who do not need the continuous services of a nursing facility or institutional setting and are able to leave their homes. Individuals receive professional services ranging from social activities and therapeutic recreation to nursing care and rehabilitation services, representing a blend of traditional health and social services.[40]

Adult day care centers are not regulated by DPH. Instead, the Connecticut Association of Adult Day Centers (CAADC) is authorized by DSS to provide a program of peer review and certification, which is required in order for an adult day center to receive State funds. As of December 2024, there were 37 adult day centers certified by CAADC serving people who receive State assistance, three of which are currently undergoing certification renewal.[41]

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

An array of Medicaid and State-funded programs have been developed in Connecticut to address the need for LTSS for those living at home or in other community settings. Medicaid, through its home and community-based waiver programs, is the major public financing mechanism for providing LTSS in community settings. Under both Medicaid and State-funded programs, individuals who would otherwise require the level of care provided in an institutional setting are served in the community. Most people express a strong preference for home and community-based services over institutional care since it allows them to live in their own homes, participate in community life and exert more control over their own affairs.[42]

- **For Ages 65 and Older**

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

1. *Medicaid Elder Waiver*: constitutes the Medicaid portion of the CHCPE. As of June 30, 2024, it provided community-based services to over 17,000 older adults age 65 and older, who would otherwise be institutionalized. Available services include

[40] The Connecticut Association of Adult Day Centers, http://www.ctadultday.org, December 2024.
[41] Leading Age Connecticut, November 2024.
[42] Joanne Binette & Kerri Vasold, 2018 *Home and Community Preferences: A National Survey of Adults Age 18-Plus, AARP*, August, 2018.

adult day care, homemaker, companion, chore, home delivered meals, emergency response systems, care management, home health, skilled nursing, respite, assisted living and minor home modifications. The monthly average number of participants for SFY 2024 was 13,692.

2. *State-Funded CHCPE*: constitutes the State-funded portion of the CHCPE and provides the same services as the Medicaid Elder Waiver except that plans of care are capped at lower levels. The program serves adults age 65 and older with higher income and asset levels than permitted under the Waiver portion. The program will also cover individuals with fewer needs than under the Medicaid Elder Waiver. On June 30, 2024 there were 2,056 people enrolled.

- **For Ages 18 to 64**

Connecticut Home Care Program for Disabled Adults (CHCPDA): is a State-funded pilot program that provides services based upon the CHCPE model. The program serves a limited number of individuals age 18 to 64 with degenerative, neurological conditions who are not eligible for other programs and who need case management and other supportive services. On June 30, 2024, there were 108 people enrolled.

Medicaid Acquired Brain Injury (ABI) Waiver and ABI II: provides 23 specific behavioral and support services to persons between the ages of 18 and 64 with acquired brain injury. The monthly average number of participants during SFY 2024 was 284 for ABI and 247 for ABI II.

Medicaid Personal Care Assistance Services (PCA) Waiver: provides personal care services to persons with physical disabilities who are age 18 to 64 years of age. In this person-directed program, participants hire and direct their own care. The monthly average number of participants during SFY 2024 was 1,023.

- **For All Ages**

DDS Individual and Family Support (IFS) Waiver: provides in-home, day, vocational and family supports services for people who live in their own or family home. In SFY 2024, the monthly average number of participants was 3,617.

DDS Comprehensive Supports Waiver: provides for the vocational and in-home services needed for people who need a more intensive level of support to remain in their own family home. These services are delivered in licensed settings (community living arrangements, community companion homes and assisted living) and include residential and family support services, vocational and day services and specialized and support services. In SFY 2024, the monthly average number of participants was 5,012.

DDS Employment and Day Supports (EDS) Waiver: provides support to individuals who live with family or in their own homes and have a strong natural support system. This includes children under the age of 21 with complex medical needs who would otherwise require institutional placement and individuals over the age of 18 who require career development, supported employment or community-based day supports, respite, and/or behavioral supports to remain in their own or their family home. In SFY 2024, the monthly average number of participants was 2,379.

Mental Health Waiver: administered by the Department of Mental Health and Addiction Services, this program diverts people with serious mental illness from nursing facilities and works to discharge those who no longer need to live in a nursing facility. The program began on April 1, 2009. In SFY 2024, the monthly average number of participants was 568.

Community First Choice: administered by the Department of Social Services, is a Medicaid State Plan option that enables Medicaid members requiring institutional level of care to self-direct community-based services through the utilization of individual budgets. The program began in July 2015. In SFY 2024, the monthly average number of program participants was 2,453.

- **For Children**

Medicaid Katie Beckett Waiver: offers case management and home health services primarily to children with disabilities who would normally only qualify for Medicaid in an institution. The waiver itself offers only case management services, but the families have access to full Medicaid benefits, including home health and physical therapy. The program operates within available appropriations. In SFY 2024, the monthly average number of participants was 331.

State Long-Term Care Programs

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

Municipal, Non-Profit, Private Sector and Volunteer Services

In addition to the State programs, a wide array of statewide, regional and local LTSS exist throughout Connecticut that are administered by government agencies, non-profit and for-profit organizations, as well as volunteer groups. Each city and town provides services and accommodations to address the needs of older adults and persons with disabilities. Connecticut has five regional Centers for Independent Living, five Area Agencies on Aging, and a number of statewide and local mental health councils and

advisory councils for persons with disabilities. There is also the Corporation for Independent Living, which is a non-profit partner focused on new housing initiatives for persons with disabilities. Also indispensable to the system of care are the myriad of volunteer organizations that address the needs of individuals with specific chronic illnesses and conditions, providing support and companionship that foster "sustainable" independent living.

Community Housing Options

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

In fostering choice, self-determination, independence and community integration, it is important to assure that residential housing is community-based and not institutional. In distinguishing between residential and institutional settings, five aspects can be considered: 1) residential scale and characteristics; 2) privacy; 3) autonomy, choice and control within the residential settings; 4) integration with the greater community; and 5) resident control over moving to, remaining in, or leaving the setting.[43]

TABLE 2
Community Housing Options in Connecticut, June 30, 2024

	# Facilities	# Units/ Beds/ Residents	Age
State Funded Congregate Housing	25	1,053 Units	62 and older
Managed Residential Communities (Assisted Living)	152	N/A	Adults and older adults
Residential Care Homes	92	2,646 beds	Adults and older adults
Continuing Care Retirement Communities	21	N/A	Older adults
Nursing Facilities	195 (as of 9/30/24)	22,760 beds (as of 9/30/24)	All ages

Source: Office of Policy and Management, 2024

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

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

Congregate Housing

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

As of June 30, 2024, 1,053 people age 62 and over lived in 25 State-funded congregate housing facilities in Connecticut. Residents were all low-income and had a minimum of one ADL limitation.[44]

Assisted Living Services/ Managed Residential Communities

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

As of June 30, 2024, there were 122 ALSAs licensed in Connecticut providing services in 152 managed residential facilities.[45]

Since the cost of living in a MRC and the assisted living services purchased are virtually all paid out of pocket, these community living arrangements are available to individuals who can afford the cost of both room and board and services. Through a collaborative effort of the Connecticut Housing Finance Authority (CHFA), DOH, DPH, OPM and DSS,

[44] Connecticut Department of Housing, 2024.
[45] Connecticut Department of Public Health, 2024.

Connecticut has made assisted living services available to lower-income individuals through the Assisted Living Demonstration Project, State-funded congregate housing, HUD complexes and the Private Pay Assisted Living Pilot.

Residential Care Homes

Residential care homes are facilities that provide a room, meals and supervision, but no nursing services, for individuals whose limitations prevent them from living alone. Services vary from facility to facility but may include dietary and housekeeping services, monitoring of prescription medication, social and recreational opportunities, and assistance with activities of daily living. Residential care homes in Connecticut are licensed by DPH. As of August 2024, there were 92 residential care homes in Connecticut with a total of 2,646 beds.[46]

Continuing Care Retirement Communities

Continuing Care Retirement Communities (CCRCs) provide residents, through contractual agreements, lifetime shelter and access to a wide variety of services, including long-term health services. Each resident pays a substantial entrance fee and monthly fees in exchange for a living unit and access to services. Various levels of care such as, independent living, assistance with daily activities and nursing facility care are typically provided on CCRC campuses. As their needs change, residents are usually able to move from one level of care to another without leaving the community. If a CCRC does not have a nursing facility on campus, it often has an arrangement with a nearby nursing facility to admit its residents on a priority basis. Each CCRC is mandated to register with DSS by filing an annual disclosure statement. Although CCRCs are not licensed by the State, various components of their LTSS packages, such as residential care beds, assisted living services, and nursing facility care are licensed by DPH. As of June 30, 2024 there were 21 CCRCs operating in Connecticut, and three "CCRC at Home" providers. [47]

Supportive Housing

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

[46] Connecticut Department of Public Health, 2024.
[47] Connecticut Department of Social Services, 2024.

Residential Settings for Individuals with Intellectual Disabilities

DDS administers or contracts for residential services from independent living, individualized home supports, continuous residential supports, community living arrangements, community companion homes, and residential center settings.[48]

- *Individualized Home Supports* -- Some people need minimal hours of staff support to live in their own place or family home. This staff support may be in the form of assistance with budgets, shopping and/or leisure activities. People receiving Individualized Home Supports get staff support from a few hours a day to only a few hours a month, depending on the needs of the person. As of June 2024, 2,853 individuals received Individualized Home Supports.

- *Community Companion Homes* -- People with an intellectual disability live in a family setting that is not within their own family. People in these settings live with a family that has received training and licensing from DDS. As of June 2024, 406 individuals lived in Community Companion Homes.

- *Continuous Residential Supports*-- People who need overnight support and live with three or fewer people share an apartment or house and have staff from an agency or hired privately. As of June 2024, 721 individuals lived in Continuous Residential Supports.

- *Community Living Arrangements* -- People who need 24-hour support are provided with staff in group home settings. Usually, two to six people share an apartment or house and have staff available to them 24 hours a day. As of June 2024, 3,497 individuals lived in Community Living Arrangements.

Residential Settings for Individuals with Psychiatric or Addiction Disorders

DMHAS funds several types of residential settings for individuals age 18 and older with psychiatric or addiction disorders. In SFY 2023, a total of 53,819 individuals received mental health services in the community and 971 received services in inpatient settings. Also, in SFY 2023, a total of 41,669 individuals received substance abuse services in the community and 1,150 received inpatient services.[49]

<u>Psychiatric disorders</u>

- *Group Homes* – A community-based residence with on-site staffing 24 hours per day, seven days a week. In SFY 2024, 205 individuals lived in these group home settings.

[48] Connecticut Department of Developmental Services, 2024

[49] Connecticut Department of Mental Health and Addiction Services, *2023 Annual Statistical Report;* March 2024.

- *Supervised Housing* – Services are provided in intensively managed housing where individuals live in private or shared apartments with staff co-located 24 hours per day, seven days a week. In SFY 2024, 825 individuals lived in supervised housing.

Addiction disorders

- *Long-Term Care* – A 24-hour per day, seven days a week staffed residence with a structured recovery environment providing substance abuse intermediate and long-term residential treatment or care. In SFY 2024, 824 individuals participated in this program.

Institutional Care Settings

Nursing Facilities

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

TABLE 3

Percent Distribution of Residents in Connecticut Nursing Facilities by Payment Source on September 30, 1995 and 2024

Payment Source	1995	2024
Medicaid	68	73
Medicare	11	16
Private Pay	20	9
Insurance	2	1
Other	< 1	2

Source: State of Connecticut Nursing Facility Registry and Connecticut Annual Nursing Facility Census, Office of Policy and Management, Health and Human Services Policy and Planning Division September 30, 2024.

On September 30, 2024, there were 19,834 individuals residing in Connecticut nursing facilities. The majority of residents were white (77 percent), female (61 percent), and without a spouse (82 percent), a profile that has remained consistent over the years. Fifteen percent of the residents were under age 65, 51 percent were between age 65 and 84 and 35 percent were age 85 or older.[50]

Connecticut had a total of 22,760 licensed nursing facility beds as of September 30, 2024. Since 1991, efforts have been made to reduce the number of residents in Connecticut's nursing facilities by placing a moratorium on additional beds. Despite the moratorium, from 1991 to 1994, the total number of licensed beds increased from 29,391 to 32,149. This was due to the addition of beds that had been approved before the moratorium went into effect. From 1994 to 2021, the total number of licensed beds decreased by 9,443, or 29 percent. [51]

In 2024, the average daily cost to a nursing facility resident paying privately in Connecticut was $510 a day for a semi-private room, or over $186,000 a year. Medicaid was the primary source of payment for 73 percent of nursing facility residents in Connecticut as of September 30, 2024, with Medicare covering 16 percent and private pay covering 9 percent.[52] (Table 3)

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

On June 30, 2024, a total of 561 people over the age of 18 in Connecticut resided in either a DDS or private provider operated ICF/ID. Of these individuals, 232 people resided in an ICF/ID operated by DDS in one of six locations throughout the state. Another 329 individuals resided in group homes operated at an ICF/ID level of care by private agencies. Of all of the people living in an ICF/ID, 195 (35 percent) were between the age of 18 and 54, 165 (29 percent) were between the ages of 55 and 64, and 201 (36 percent) were age 65 and over. At this level of care, individuals received residential and day habilitation services, prevocational services and supported employment services. All services are financed through the State Medicaid Program.[53]

Chronic Disease Hospitals

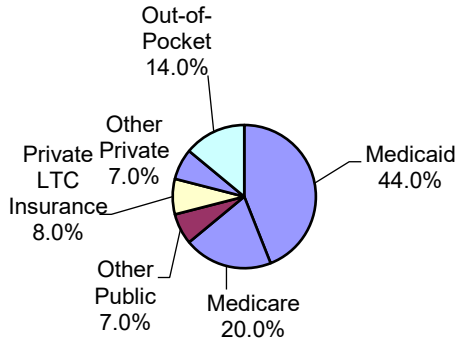
On June 30, 2024, there were two chronic disease hospitals in Connecticut with a total of 368 beds.[54] These long-term hospitals provide diagnosis, care and treatment of a wide range of chronic diseases.

[50] State of Connecticut Annual Nursing Facility Census, Office of Policy and Management, Health and Human Services Policy and Planning Division, 2024.
[51] State of Connecticut Nursing Facility Registry and Connecticut Annual Nursing Facility Census, Office of Policy and Management, Health and Human Services Policy and Planning Division, 2024.
[52] State of Connecticut Annual Nursing Facility Census, Office of Policy and Management, Health and Human Services Policy and Planning Division, 2024.
[53] Connecticut Department of Developmental Services, 2024.
[54] Connecticut Department of Public Health, 2024.

C. Financing

In the U.S., $467.4 billion was spent on LTSS in 2021[55], representing 13.2 percent[56] of all personal health care spending. Medicaid is the dominant source of payment for LTSS (44%), followed by out-of-pocket payments by individuals and families (14%). Other private and public sources cover the balance of expenditures (20%). Although Medicare appears to account for 20% of LTSS expenditures it can be misleading and must be considered in proper context. Medicare covers only short-term nursing facility and home health coverage under certain conditions. In reality the benefit plays no role in financing LTSS, since Medicare's purpose is to cover acute and post-acute medical care for people age 65 and older and for younger individuals who qualify for Social Security because of disability (Figure 7).[57] In addition to these expenditures is the unpaid care provided by family members and other informal caregivers.

FIGURE 7
National Spending for LTSS, by Source, 2021



Congressional Research Services, *Who Pays for Long-Term Services and Supports?;* September 19, 2023

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

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

Medicare may pay for individuals who are eligible and require skilled or recuperative care for a short time, but do not cover individuals with stable chronic conditions. The Older Americans Act is another Federal program that helps pay for LTSS services. As financial circumstances and the need for care changes, a variety of payment sources may be used.[58]

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[55] Congressional Research Services (CRS), *Who Pays for Long-Term Services and Supports?;* September 19, 2023. https://sgp.fas.org/crs/misc/IF10343.pdf
[56] ibid.
[57] Congressional Research Services (CRS), *Who Pays for Long-Term Services and Supports?;* September 19, 2023. https://sgp.fas.org/crs/misc/IF10343.pdf
[58] U.S. Department of Health and Human Services, Long Term Care Costs and How to Pay online resource, accessed November, 2021. https://acl.gov/ltc/costs-and-who-pays/who-pays-long-term-care

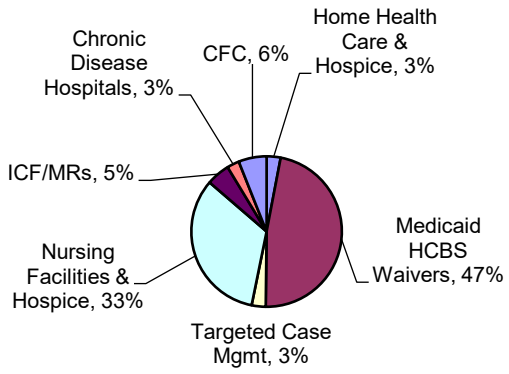
Medicaid

The Medicaid program, jointly funded by the state and federal government, is the primary payer for LTSS in the U.S. and the major public program providing coverage for nursing facility care, accounting for 44 percent of all LTSS spending in 2021 (Figure 7). Medicaid provides coverage for people who are poor and disabled. It also provides LTSS for individuals who qualify for Medicaid because they have 'spent down' their assets due to the high costs of such care and have become nearly impoverished. For example, many older adults become eligible for Medicaid as a result of depleting their assets to pay for nursing facility care that Medicare does not cover.

In SFY 2024, the Connecticut Medicaid program spent $3.965 billion[59] on LTSS. These Medicaid LTSS expenses account for 38 percent of all Medicaid spending and 16% percent of total expenditures for the State of Connecticut. [60]

Looking at Connecticut's expenses for Medicaid LTSS in more detail, 59 percent was spent on home and community-based services and 41 percent on institutional care (Figure 8). In analyzing all Medicaid LTC expenditures, we see that services for individuals with developmental disabilities account for 30 percent of total long-term care expenses, in contrast to 17 percent for the Elder, Personal Care Assistance, Katie Beckett, Acquired Brain Injury, and Mental Health waivers combined. Over time, the proportion of Medicaid LTSS expenses for home and community-based services has increased from 23 percent in SFY 1996 to 59 percent in SFY 2024.

FIGURE 8
Proportion of CT Medicaid LTC Expenditures, SFY 2024



Source: Office of Policy and Management, 2024
Does not total 100% due to rounding

[59] Unless otherwise noted, Medicaid expenditures referenced in this document are total gross expenditures.
[60] Office of Policy and Management, Policy Development and Planning Division, 2024.

A consistent conclusion from research on Medicaid home and community-based services waivers is that these services provide savings over care in institutional settings over the long term.[61]

Medicare

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

Out-Of-Pocket Spending / Private Pay

Nationally, in 2021 approximately 14 percent of spending for LTSS was paid directly by individuals (about $63.6 billion), rendering out-of-pocket payments (Figure 7). This includes direct payment of services but does not include the uncompensated costs of informal caregivers.

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

In 2021, coverage from private long-term care insurance, other private insurance and other public sources for nursing facilities and home health services represented 22 percent of LTSS expenditures in the U.S. (Figure 7). Other public sources includes state and local programs[62].

Private Long-Term Care Insurance

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

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

[62] Congressional Research Services (CRS), Who Pays for Long-Term Services and Supports?; September 19, 2023. https://sgp.fas.org/crs/misc/IF10343.pdf

assisted living settings (i.e., continuing care retirement communities, residential care homes, assisted living facilities).[63]

In Connecticut, the number of individuals who purchased long-term care insurance in 2023 was 1,247. As of December 31, 2023, there were 96,678 Connecticut residents with a private long-term care insurance policy or certificate in force.[64]

Connecticut Partnership for Long-Term Care[65]

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

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

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

As of June 30, 2024, there were over 60,984 Partnership policies sold in Connecticut. Purchasers of Partnership policies range in age from 20 to 86 years old, with the average age at purchase being 57 years old. 7,031 Partnership policyholders have utilized benefits under their policies, with over $1 billion in benefits paid. Only 375 Partnership policyholders have accessed Medicaid utilizing the Asset Protection earned under their policies. This has helped the Partnership save the State over $131 million in Medicaid long-term care funds with larger savings projected for the future.

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

[63] Connecticut Partnership for Long-Term Care, *Frequently Asked Questions*, April 2024
[64] Office of Policy and Management, Health and Human Services Policy and Planning Division, 2024
[65] Office of Policy and Management, Connecticut Partnership for Long-Term Care, 2024

Older Americans Act

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

The Department of Aging and Disability Services, Bureau of Aging (ADS/BOA) received $18.47 million in funding in FFY 2023 through the Older Americans Act, primarily provided by the federal Administration for Community Living. Of these funds, $16.5 million of Older Americans Act Title III dollars were distributed by formula to the Area Agencies on Aging who in turn contract with community-based organizations to provide social and nutritional services. The remaining $1.97 million of these funds were special grants received by ADS/BOA, including State Health Insurance Program, Senior Medicare Patrol, Aging and Disability Resource Center/No Wrong Door, Senior Community Services Employment, and Elder Abuse Prevention. Both federal and State funds for ADS/BOA provided a multitude of services to 72,975 seniors.

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

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

Rental Subsidies

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

Veterans Affairs

The federal Department of Veterans Affairs (VA) pays for LTSS for service-related disabilities and for certain other eligible veterans, and other health programs such as

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

IV. FUTURE DEMAND FOR LONG-TERM SERVICES AND SUPPORTS

A. Population and Disability Trends

Although LTSS are needed by people of all ages and may be required as a result of a diverse array of disabilities or chronic illnesses, it is important to recognize the significant impact the aging of our society will have on the future demand for LTSS. In 1900, adults age 65 and older accounted for a little over four percent of the total U.S. population. A century later, the proportion of older adults in the U.S. population had grown to over 12 percent or 35 million[66]. By 2030, the older adult population is expected to have grown to over 20 percent of the U.S. population, or 73 million. [67] By 2035, for the first time, older adults are projected to outnumber children with 76.7 million people under the age of 18 and almost 78 million 65 and older. [68]

In Connecticut, between 2022 and 2028, the total population is projected to grow by 48,862 an increase of one percent. The percentage of individuals under age 65 will decrease by two percent, while the percentage of adults 65 and over will increase by 16 percent (Table 4).

In Connecticut, between 2022 and 2028, the proportion of older adults in the population is expected to grow from 19 percent to 21 percent. (Table 5).

TABLE 4
Connecticut Population Projections: 2022 - 2028

Age Group	2022	2025	2028	Pop. Growth 2022-2028	Percent Change: 2022-2028
<65	2,938,942	2,913,798	2,878,412	-60,530	-2%
65+	670,919	738,691	780,311	109,392	16%
Total	3,609,861	3,652,489	3,658,723	48,862	1%

Source: S&P Global Forecast/HIS Markit, November 2024

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

TABLE 5
Connecticut Population Projections, Percent Distribution by Age: 2022 - 2028

Age	2022	2025	2028
<65	81%	80%	79%
65+	19%	20%	21%

Source: S&P Global Forecast/IHS Markit, November 2024

TABLE 6
Projection of Non-Institutionalized Persons with Disabilities in Connecticut by Age: 2022 – 2028

Age	2022 Disabled Population	2028 Projected Disabled Pop.	2022 / 2028 Change	Percent Change
<65	254,652	249,541	-5,111	-2.0%
65+	191,793	232,075	40,282	21.0%
Total	446,445	481,616	35,171	7.9%

Source: Office of Policy and Management based on Sources: 1) U.S. Census Bureau, 2022 American Community Survey DP02, 2) Connecticut Population Projections: S&P Global Forecast/IHS Markit, November 2024

In 2022, the U.S. Census estimated that there were 446,445 individuals in Connecticut with one or more disabilities (excluding individuals living in institutions). Between 2022 and 2028, this number is expected to grow by 7.9 percent, or 35,171 people, to an estimated 481,616.[69] The number of individuals with disabilities under age 65 is projected to decrease by 2.0 percent (-5,111) while the number of individuals with disabilities age 65 and over is projected to increase by 21 percent (40,282). (See Table 6).

[69] These projections are based on the 2022 Census disability data applied to State Population Projections through 2028. The Census does not tabulate disability status for individuals in institutions. Disability projections assume a constant rate of disability over time.

B. Demand for Long-Term Services and Supports

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

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

TABLE 7
Connecticut Gross Medicaid Long-Term Care Clients and Expenditures: SFY 2024

	SFY 2024 Medicaid LTC Clients, Monthly Average	SFY 2024 Medicaid LTC Expenditures
Community-based Care	32,925	$2.328 billion
Institutional Care	14,210	$1.637 billion
Total	47,135	$3.965 billion

Source: Office of Policy and Management, 2024.
Does not total due to rounding

As discussed in Section III, Medicaid is the largest and most significant payer of LTSS at both the state and national level. Of the 47,135 Medicaid clients who received LTSS in Connecticut each month in SFY 2024, 70 percent received services in the community and 30 percent received care in an institutional setting (Table 7). If these ratios remain steady over the four years and disability rates do not vary, U.S. Census Bureau disability data and population projections for Connecticut suggest that in the year 2025 there will be a 8 percent increase in individuals receiving Medicaid LTSS: an additional 2,634 Medicaid clients receiving LTSS in the community and an additional 1,137 receiving care in institutions (Table 8). To meet this additional demand for LTSS, Medicaid expenditures are expected to grow from $3.965 billion in SFY 2024 to $7.689 billion in 2028, assuming current ratios of institutional and community care and a five percent annual inflation rate (Table 9).

TABLE 8
Projections of Connecticut Medicaid Long-Term Care Clients by Current and Optimal Ratios of Community and Institutional Care SFY 2024 and SFY 2028

	2024 Client Ratio	2028 clients/ monthly average	Change from 2024 to 2028	Optimal Client Ratio	2028 Optimal clients/ monthly Average	Change from 2024 to 2028
Community-based Care	**70%**	35,559	2,634	**75%**	36,412	3,487
Institutional Care	**30%**	15,347	1,137	**25%**	12,137	-2,073
Total	**100%**	50,906	3,771		48,549	1,414

Source: Office of Policy and Management, Policy and Planning Division, 2024 based on: (1) Department of Social Services Medicaid data for SFY 2024; (2) U.S. Census Bureau, 2022 American Community Survey DP02, (3) Connecticut Population Projections: S&P Global Forecast/IHS Markit, November 2024

TABLE 9
Projections of Connecticut Gross Medicaid Long-Term Care Expenditures by Current and Optimal Client Ratios of Community and Institutional Care SFY 2024 and SFY 2028 in Billions

	Current Client Ratio	2028 Expenditures with Current Client Ratio	Change from 2024 to 2028	Optimal Client Ratio	2028 Expenditures with Optimal Client Ratio	Change from 2024 to 2028
Community-based Care	**70%**	$4,514,520,590	$2,186,878,005	**75%**	$4,622,789,300	$2,295,146,715
Institutional Care	**30%**	$3,174,633,180	$1,537,823,417	**25%**	$2,510,709,480	$873,899,717
Total	**100%**	$7,689,153,770	$3,724,701,422		$7,133,498,780	$3,169,046,432

Note: Expenditure projections include a 5 percent annual compound rate increase. Numbers do not total due to rounding.
Source: Office of Policy and Management, Policy and Planning Division, 2024 based on: (1) Department of Social Services Medicaid data for SFY 2024; (2) U.S. Census Bureau, 2022 American Community Survey DP02, (3) Connecticut Population Projections: S&P Global Forecast/IHS Markit, November 2024

If current ratios of Medicaid community and institutional LTSS were to evolve over time to reflect the greater emphasis on home and community-based services achieved in other states, Connecticut could develop a LTSS system that provides community-based care to 75 percent instead of 70 percent of its Medicaid long-term care clients. If the number of Medicaid clients receiving LTSS in 2028 reflected this optimal ratio, Connecticut could expect an additional 3,487 clients receiving community-based services and supports, and a decrease of 2,073 individuals receiving care in institutions when compared to actual 2024 levels (Table 8). By holding the number of individuals served in 2028 constant and increasing the proportion of individuals receiving community-based care to 75 percent, Medicaid LTSS expenditures are projected to be $7.134 billion, instead of $7.689 billion; $555.7 million less than the State might otherwise have spent (Table 9).

Total Medicaid LTSS expenditures in 2028 are projected to be lower under the optimal ratios because in general, although the same numbers of people are served, the cost of serving people at home and in the community, on average,[70] is lower than serving them in institutions.

In forecasting future demand for LTSS in Connecticut, it is important to note that there are many variables that will affect these estimates, whether related to changes in public policy, demographics, medical advances, or health status. On an individual level, not all people with a disability, whether it is physical, developmental, or psychiatric, will require LTSS. Those who do need LTSS often have needs that fluctuate over time, depending on their health, the nature of their disability and personal circumstances. Individuals vary in the level of supports they need, with the majority of people requiring support with instrumental activities of daily living (IADLs), and others requiring more intense support. Furthermore, the amount and type of informal care available from family and friends will influence the amount of paid care that is required.

By way of comparison, in federal fiscal year 2020 the U.S., Medicaid spending for community-based LTSS amounted to 62.5 percent of all expenditures for Medicaid LTSS. A comparison of states provided in Table 10 shows Oregon to have the highest proportion of Medicaid long-term spending for home and community-based services (83.9 percent) and Mississippi to be the lowest (32.0 percent). Among the states, Connecticut ranks 22nd, with 56.8 percent of Medicaid LTSS expenditures for home and community-based services. [71] Although no one other state's model can be totally

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

[71] Due to different methodology, this analysis calculated that the Connecticut Medicaid program spent 56.8 percent for community-based long-term services and supports in 2020, in contrast to the analysis by the CT Office of Policy and Management, which reviewed spending on the state fiscal year vs the federal fiscal year, along with other methodological differences, calculated a percentage of 54.3 percent in 2020. Additionally, Mississippi is the lowest ranked state coming in at number 49 as Virginia was reported N/A for 2020 data by CMS.

replicated in Connecticut, spending patterns in other states illustrate that greater ratios of home and community-based care are achievable. If Connecticut is to reach a ratio of 75 percent for community-based care sooner than 2028, balancing efforts will need to be more aggressive.

TABLE 10
Percent of Medicaid and State Long-Term Care Spending for Home and Community-Based Services, FY 2020*

State	Percent	U.S. Rank
Oregon	83.9	1
Minnesota	80.2	2
Arizona	77.9	3
Wisconsin	76.2	4
Washington	75.1	5
Massachusetts	71.7	8
Vermont	69.2	13
U.S.	62.5	N/A
Maine	60.8	17
Connecticut	56.8	22
Rhode Island	55.7	25
New Hampshire	48.6	37
Mississippi	32.0	49

*Source: Murray, Caitlin, Michelle Eckstein, Debra Lipson, and Andrea Wysocki. "*Medicaid Long Term Services and Supports Annual Expenditures Report: Federal Fiscal Year 2020."* Chicago, IL: Mathematica, June 9, 2023.

As required by Public Act 17-123, a more narrow analysis of the State's rebalancing costs was conducted by comparing only nursing facility data with Medicaid HCBS waiver data. (Table 11). In SFY 2024, nursing facility care accounted for 28% of the total Medicaid LTSS population and nursing facility expenditures accounted for 19% of total net Medicaid costs.

Conversely, HCBS Waiver participants account for 29% of the total Medicaid LTSS population but only 8% of total net Medicaid expenditures.

Table 11
Connecticut Net Medicaid Expenditure for Nursing Homes vs. HCBS Waiver and Associated Client Percentages SFY 2024

Type	2024 Client Numbers	Current Client Ratio Total LTSS Population	2024 Net Medicaid Expenditures	Current Total Net Medicaid Expenditure Ratio
HCBS Waiver Care*	13,692	29%	$275,355,784	8%
Nursing Facility Care	12,718	28%	$627,065,059	19%

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

Note: Percentages are in relation to the total SFY 2021 Medicaid LTSS client population (47,135) and Total Net Medicaid expenditures ($3,380,807,402). Expenditures reflect state share assuming 50% federal reimbursement.

C. Caregiver Supply and Demand

Informal Caregivers

Relatives, friends and other unpaid caregivers account for the vast majority of individuals providing LTSS to individuals across the lifespan. Looking at this another way, only 13 percent of people needing any type of LTSS use paid helpers in either a primary or secondary role.[72] In 2021, there were 38 million family caregivers in the U.S providing care to an adult with limitations in daily activities at any one time. Over this time, the estimated economic value of unpaid contributions from informal caregivers was approximately $600 billion, up from the last update that reported $470 billion in 2017. However, to provide perspective, previous tracking has shown the following growth in the estimated economic value of unpaid caregivers since 2006: $470 billion in 2013, $450 billion in 2009, $375 billion in 2007, and $354 billion in 2006. In fact, the economic value of caregiving exceeded total Medical spending in the U.S. for both medical and LTSS. In Connecticut, in 2021, there were an estimated 420,000 informal caregivers at any given time, accounting for an estimated $7.2 million in unpaid contributions.[73]

Paid Direct Caregivers

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

[72] H. Stephen Kay, Charlene Harrington, and Mitchell P. LaPlante; *Long-Term Care: Who Gets It, Who Providers It, Who Pays, and How Much?*; Health Affairs, Vol. 29:1; January 2010; page 15.
[73]Susan C. Reinhard, Selena Caldera, Ari Houser, Rita B. Choula, *Valuing the Invaluable: 2023 Update; Strengthening Supports for Family Caregivers*, AARP Public Policy Institute 2023.

Table 12
Connecticut 2018 and Projected 2028 Occupations

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

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

Paid direct caregivers go by a number of titles, including nurses' aides, personal care assistants and home health aides. In 2023, there were an estimated 61,740 direct-care workers in Connecticut providing daily services and supports to older adults and individual with disabilities who needed assistance with personal care and other daily activities of living. [74] In 2023, 5 million home care workers provided services across the United States. It is predicted that between 2022 and 2040, the national demand for paid direct care workers will grow as the number of individuals ages 65 and over increases from 57.8 million in 2022 to 78.3 million in 2040 and 88.8 million in 2060[75].

Current efforts to balance the institutional bias of the LTSS system are leading to a greater percentage of people receiving LTSS at home. As a result, LTSS occupations in Connecticut will see double-digit figure growth between 2018 and 2028. The impact of this shift on the paid caregiver workforce in Connecticut is reflected in a predicted 34.9

[73] PHI Workforce Data Center Web Site https://phinational.org/policy-research/workforce-data-center/#states=09.
[75] U.S. Administration for Community Living, *2020 Profile of Older Americans;* May 2021. https://acl.gov/sites/default/files/Aging%20and%20Disability%20in%20America/2020ProfileOlderAmericans.Final_.pdf.

percent rise in personal aide positions and a 24.2 percent increase in home health aide positions (Table 12).

However, there may be challenges to ensuring the home care workforce is large enough to meet growing demand. The following are some of the obstacles facing the home care industry that have the potential to create a workforce shortage in the future: (1) from 2016 – 2060, the population of individuals age 65 and over is projected to double and those 85 and over triple, while the number of working aged adults (ages 18-64) are projected to only experience an increase of 15 percent;[76] (2) wages for home care workers have seen a modest increase from 2010-2020, with the median hourly wages increasing by 16 percent from $11.23 in 2010 to $12.98 in 2020 resulting in 17 percent of homecare workers living in poverty[77] (this is compared to 11.4 percent of all U.S workers[78]) and; (3) the home care labor force is also aging. 34 percent of home care workers are 55 or older (this is compared to the 23 percent of the total U.S labor market).[79]

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

V. GOALS and RECOMMENDATIONS

A. Introduction

The goals and recommendations provided in this Plan are put forward to improve the balance of the LTSS system in Connecticut for individuals of all ages and across all types of disabilities and their families. In addition to the two rebalancing goals, this Plan provides a set of long-term and short-term recommendations. The long-term recommendations provide a high level view of the essential components of a well-balanced and person centered system of LTSS. These recommendations are reflective of a system of services and supports, and as such, must be viewed as both interrelated and interdependent. The short-term recommendations reflect strategic priorities identified for action over the next three years (2025-2028).

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

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

simple statement provides a larger framework for Connecticut to make the necessary changes to the laws and regulations that govern the State's system of LTSS to make real choices for people a reality.

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

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

B. Goals

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

GOAL #1: *Develop a system that provides for more choice and opportunities for community integration as alternatives to all institutional settings, and increases the proportion of individuals receiving Medicaid long-term home and community-based care from 70 percent in 2024 to 75 percent by 2028.*

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

In the 21 years since the establishment of the Plan's goal of improving the balance between home and community-based services and institutional care (SFY 2003 – 2024), this goal has been met, with a steady increase in the percentage of Medicaid long-term care clients served in the community from 46 percent to 70 percent (Table 12). However, to meet the goal of 75 percent of Medicaid clients receiving LTSS in the community by 2028, this pace must accelerate.

With regard to expenditures, between SFY 2003 and SFY 2024, the percentage of Medicaid dollars for LTSS spent on services received in the community increased by 90 percent (Table 13).

TABLE 12
Percentage of Connecticut Medicaid LTSS Clients over Time

SFY	Home & Community Care	Institutional Care	Total Monthly Average LTSS Medicaid Clients
2002-2003	46%	54%	37,969
2003-2004	49%	51%	39,305
2004-2005	50%	50%	40,417
2005-2006	51%	49%	41,773
2006-2007	52%	48%	41,335
2007-2008	52%	48%	40,057
2008-2009	53%	47%	40,097
2009-2010	54%	46%	40,442
2010-2011	55%	45%	41,402
2011-2012	56%	44%	41,725
2012-2013	58%	42%	42,577
2013-2014	59%	41%	44,712
2014-2015	60%	40%	45,876
2015-2016	60%	40%	46,024
2016-2017	61%	39%	45,598
2017-2018	64%	36%	46,270
2018-2019	64%	36%	46,194
2019-2020	65%	35%	46,373
2020-2021	70%	30%	44,939
2021-2022	69%	31%	44,420
2022-2023	69%	31%	45,241
2023-2024	70%	30%	47,135

Source: Office of Policy and Management, Health and Human Services Policy and Planning Division, 2024

TABLE 13
Percentage of Connecticut Gross Medicaid LTSS Expenditures over Time

SFY	Home & Community Care	Institutional Care	Total LTSS Medicaid Expenses in billions
2002-2003	31%	69%	$1.914
2003-2004	33%	67%	$1.955
2004-2005	35%	65%	$1.977
2005-2006	32%	68%	$2.227
2006-2007	33%	67%	$2.299
2007-2008	33%	67%	$2.404
2008-2009	35%	65%	$2.498
2009-2010	38%	62%	$2.587
2010-2011	40%	60%	$2.695
2011-2012	41%	59%	$2.770
2012-2013	43%	57%	$2.894
2013-2014	45%	55%	$2.877
2014-2015	45%	55%	$2.889
2015-2016	49%	51%	$3.064
2016-2017	50%	50%	$3.215
2017-2018	53%	47%	$3.259
2018-2019	52%	48%	$3.203
2019-2020	54%	46%	$3.385
2020-2021	60%	40%	$3.344
2021-2022	58%	42%	$3.510
2022-2023	56%	44%	$3.705
2023-2024	59%	41%	$3.965

Source: Office of Policy and Management, Health and Human Services Policy and Planning Division, 2024

If Connecticut is able to meet the goal of serving three out of every four Medicaid LTSS clients in the community, the impact on future LTSS expenditures will be significant. Additionally, Connecticut would be offering more choice to its residents. Based on U.S. Census Bureau disability data and population projections, and assuming the proportion of individuals with disabilities remains the same, it is estimated that by 2028 the number of persons with disabilities in Connecticut will grow by 35,171 or 7.9% percent, with a 21% percent increase among individuals age 65 and older. For individuals with disabilities under age 65, an estimated 2.0 percent decrease is projected between 2022 and 2028 (Table 6). Assuming current ratios of community-based to institutional care, a five percent per year inflation rate and an 8 percent increase in the number of individuals with disabilities, Medicaid expenditures for LTSS are anticipated to grow

from $3.965 billion in SFY 2024 to $7.689 billion by SFY 2025 to meet the expected increase in demand for long-term care. (Tables 7 and 9)

However, if 75 percent of Medicaid clients receive community care in 2025, these LTSS expenditures are only expected to be $7.134 billion, which is $555.7 million less than the State might otherwise have spent that year. This cost avoidance over time not only allows Connecticut to provide relief to the Medicaid budget but also allows Connecticut to meet the needs of a larger group of individuals. (Table 9)

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

2. Balancing the ratio of public and private resources

> ***GOAL #2:*** *Increase the proportion of costs for long-term services and supports covered by private insurance and other dedicated sources of private funds to 25 percent by 2028. Such an increase in private insurance and other sources of private funding would reduce the burden both on Medicaid and on individuals' out-of-pocket expenses. Nationally, spending from private long-term care insurance, other private sources and other public sources (State and local programs) for nursing facilities and home health services represented 22 percent of LTSS expenditures in 2021 (Figure 7)*[80]

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

The lack of Medicare and health insurance coverage for LTSS, combined with the lack of planning, has created a LTSS financing system that is overly reliant on the Medicaid program. Medicaid, by default, has become the primary public program for LTSS.

[80] "Other dedicated sources of private funds" means private long-term care insurance, other types of private insurance and other private spending for nursing homes and home health services. It does not include "out-of-pocket" spending or informal care. Source: Congressional Research Services, Who Pays for Long-Term Services and Supports?; September 19, 2023

However, in order to access Medicaid, individuals must first impoverish themselves. Therefore, we have a system that requires individuals to spend all their savings first in order to receive government support for their ongoing needs.

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

If enough individuals would plan for their LTSS needs through long-term care insurance or dedicated savings, there would be more Medicaid funding for community-based care and people would not have to deplete their assets if they required prolonged LTSS. For example, the burden for paying for LTSS on both the state Medicaid program (44% percent) and individuals paying out-of-pocket (14 percent) would be significantly reduced if the proportion of LTSS costs covered by other non-Medicaid insurance/programs (long-term care insurance, other health insurance, and State and local programs – 22 percent) successfully reached 25 percent (See Figure 7). If these reductions in expenses were evenly divided between Medicaid and out-of-pocket costs for individuals, then Medicaid's share of the costs could be reduced by 12 percent. Using today's dollars, and a Medicaid LTSS budget of approximately $3.965 billion, that would equate to $555.7 million in annual savings. These savings could be partially allocated to the General Fund and partially used to help fund enhancements to the LTSS system, such as infrastructure and service improvements, leading to more choices for individuals and their families.

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

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

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

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

C. Long-Term Recommendations

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

D. Short-Term Recommendations

These short-term recommendations provide an action agenda for improving the LTSS system in Connecticut in the three years spanning 2025 through 2028. Criteria for proposing these targeted priority recommendations are that they will help to ensure the success of the LTSS system and can be acted upon in the next three years.

Programs and Services

- Adequately support and increase the number of and funding for slots of all the existing Medicaid home and community-based services waivers to meet the needs of all eligible applicants by reducing or eliminating waitlists.

- Improve transparency throughout the assessment process by ensuring that consumers understand the criteria being used to make decisions regarding their budgets and supports and that consumers and/or their authorized representatives are present at all planning meetings where level of care or service revision decisions are made.

- Explore implementing a universal waiver with eligibility criteria based on need rather than primary diagnosis.

- Support the continued implementation of self-direction in Medicaid programs.

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

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

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

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

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

- Implement person-centered goal setting, planning and care practices regardless of the setting or service.

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

- Support a robust local LTSS system to address community needs through strategic collaborations among and between other municipal departments and divisions such as parks and recreation, public health and transportation services and community leaders and explore opportunities for regional collaboration.

- Provide advocacy and financial support for increased use of assistive technology to meet the needs of individuals within their homes and avoid or defer the need for in-home hands-on assistance or institutionalization and increased use of basic technology for connectivity to increase access to services, telehealth, and social connectedness.

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

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

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

- Explore adding coverage of palliative care under Medicaid.

- Explore capacity of community agencies providing LTSS to implement oral health literacy training programs by dental professionals to improve the capacity of consumers and their caregivers to perform their own oral health care.

Infrastructure

- Explore the development of a Multisector Plan for Aging and Disability

- Engage in coordinated outreach and education efforts among State agencies to provide unbiased information to Connecticut residents on the LTSS available and how to access them, including the availability of MyPlaceCT as an online tool.

- Work with hospitals to facilitate the discharge of patients with ongoing and complex LTSS needs to an appropriate care setting of their choice.

- While exploring a transition to a universal waiver, address the historical fragmentation of existing Medicaid home and community-based waivers, which are associated with specific age and diagnostic eligibility criteria and administered through varying State agencies and application processes, by coordinating programs and application and renewal processes between State agencies to addresses the needs of the total person.

- Provide timely eligibility decisions regarding eligibility in all government sponsored LTSS programs.

- Implement presumptive eligibility for the Connecticut Home Care Program as required by Public Act No. 24-39, study impact on consumers and the state Medicaid program and explore expansion of the presumptive eligibility model.

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

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

- Achieve greater integration of employment of persons with disabilities into the Medicaid home and community-based services.

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

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

- Identify funding streams to sustain, coordinate, grow and make more convenient both fixed route and demand-responsive transportation options (including providing door-to-door service), and provide technical assistance to support regionalization.

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

- Continuously review, and modify as necessary, the current Certificate of Need process for skilled nursing homes to ensure that it is efficient and allows the State to work more collaboratively with nursing home providers as they seek to achieve the goals of the LTSS plan.
- Review, and modify as necessary, the current Certificate of Need process for skilled nursing homes to allow the State to work collaboratively with nursing home providers as they seek to transition and transform their facilities.

Financing

- Study the economic status of the aging demographic to understand the future demand that will be placed on public financing of LTSS and the supply of affordable and accessible senior housing.
- Achieve adequate and sustainable provider reimbursement levels that support the cost of LTSS and quality requirements for all segments of the LTSS continuum, including nursing homes, group homes and supportive housing in order to ensure access to care and provider capacity to meet the evolving needs and demographics of Connecticut residents.

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

- Capture and reinvest cost savings across the LTSS continuum to enhance the availability and capacity of home and community-based services and ensure an adequate provider network.

- Continue efforts to reform the Medicaid rate setting system to reflect quality, reimbursement related to the actual costs of care, the acuity level of the consumers and uncompensated care for all LTSS providers across the continuum consistent with LTSS rebalancing, rightsizing and a range of home and community-based service initiatives.

- Explore various methods to increase the private sector's greater involvement as a payer of LTSS.

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

- Support the continued flexible use of Older Americans Act funding for services and, where possible, utilize Older Americans Act programs to supplement LTSS for consumers who do not qualify for Medicaid programs.

- Provide increased funding to school systems so that they can hire additional social work and special education staff and train them on the programs and services

available to parents and students with special needs so that they can provide meaningful assistance to families.

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

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

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

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

- Explore adjusting Medicaid spousal asset rules.

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

- Explore incentivizing quality of care and care coordination through implementation of Value-Based Payment models.

Quality

- Enable a collaborative, flexible and efficient regulatory environment that is adaptive and receptive to individual providers' forward-thinking ideas and planning. Such an environment would encourage providers of the LTSS continuum to adjust, modernize and diversify their models of care to address current and future consumer needs and expectations, which in turn should lead to higher quality care.

- The Departments of Public Health, Aging and Disability Services, Consumer Protection, Social Services, and the State Long-Term Care Ombudsman, should continue to work together to ensure consistency among their respective regulatory and oversight activities.

- Recognize and incorporate the recommendations in the "State Plan to Address Alzheimer's Disease and Related Dementias."

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

- Continue supporting and explore increasing funding for the Community Ombudsman program to provide individuals on LTSS with the necessary information, education and protection of their individual rights related to LTSS in the greater community.

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

- Explore an adult protective services model that responds to abuse, neglect and exploitation for adults over the age of 18 who have disabilities.

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

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

Housing

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

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

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

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

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

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

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

Workforce

- Address the healthcare workforce shortage across the LTSS continuum to support to improve access to and quality of LTSS by building a strong, large LTSS workforce pool through accessible, affordable training options and wide outreach. Consider a public relations campaign to entice students and residents to work in the LTSS field.

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

- Develop a registry of pre-certified emergency back-up workers that can be accessed by employers of record in the State's Medicaid self-directed programs that enables them to rapidly access emergency direct care services without having to go through the lengthy hiring process or resort to consumer hospitalization or institutionalization for care.

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

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

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

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

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

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

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

- Address digital literacy needs among older workers and unpaid family caregivers to improve access to sector-based skills training and resources.

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

VI. CONCLUSIONS

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

Balancing the System:

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

A Report to the General Assembly
January 2025

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. State Long-Term Services and Supports Programs and Expenditures – SFY 2023 - 2024

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 2024)

Legislators

Senator Jan Hochadel, Co-Chair, Aging Committee
Representative Jane M. Garibay, Co-Chair, Aging Committee
Senator Lisa Seminara, Ranking Member, Aging Committee and Human Services Committee
Representative Mitch Bolinsky, Ranking Member, Aging Committee
Senator Saud Anwar, Co-Chair, Public Health Committee
Representative Cristin McCarthy Vahey, Co-Chair, Public Health Committee
Senator Heather S. Somers, Ranking Member, Public Health Committee
Representative Nicole Klarides-Ditria, Ranking Member, Public Health Committee
Senator Matthew L. Lesser, Co-Chair, Human Services Committee
Representative Jillian Gilchrest, Co-Chair, Human Services Committee
Representative Jay M. Case, Ranking Member, Human Services Committee

State Agencies Representatives

Melissa Morton, Office of Policy and Management (Chair of Planning Committee)
Christine Weston, Department of Social Services
William Seals, 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
Barbara Cass, 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

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

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 2024 to diverse organizations and individuals throughout Connecticut with an interest in long-term services and supports (LTSS). In total, public comments were received from the following organizations and members of the public.

Organizations

- Long-Term Care Advisory Council Members:
  - AARP CT
  - CCC, Inc.
  - Connecticut Age Well Collaborative
  - CT Alzheimer's Association
  - CT Association for Healthcare at Home
  - Leading Age CT
  - LTC Advisory Committee (CWCS)
  - LTC Ombudsman Program

- Other Community Organizations
  - The Arc of CT
  - Careforth, Lori Sims
  - Citizens Coalition for Equal Access
  - CT Council on Developmental Disabilities
  - Disabilities Network of Eastern CT
  - Disability Rights Connecticut
  - Independence Northwest
  - Keep the Promise Coalition
  - NAMI Connecticut
  - Odonnell Company
  - UConn Center on Aging

- Members of the Public
  - 7 individual members of the general public submitted written comment on the Plan recommendations.
  - 20 individuals provided comments on the Plan through participation in two LTSS user and family member listening sessions held in-person and virtually September and October 2024. Listening sessions were held in partnership with the ARC of CT, the CT Council on Developmental Disabilities and Change Inc.

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.

Long-Term Care Plan – 2022
The Long-Term Care Planning Committee's eight plan was issued in January 2022.

2022 Long-Term Care Plan Status Reports
Following the release of the 2022 Long-Term Care Plan, a status update was issued in September 2024.

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.

State Long-Term Services and Supports Programs and Expenditures

SFY 2023 - 2024

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

II. **State Long-Term Services and Supports Programs in Connecticut – SFY 2024**

III. **State Long-Term Services and Supports Program Expenditures in Connecticut – SFY 2024**

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 timeliest and cost-effective manner possible while considering the needs of the individual.

Deaf and Hard of Hearing Services 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, as well as maintenance of the state's Interpreter Registry for Deaf and Hard of Hearing Interpreters.

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) is responsible for the coordination and provision of services to all Connecticut residents who are legally blind or have significant visual impairments through four separate service programs which provide a full range of services to clients of all ages: Vocational Rehabilitation, Business Enterprise Program, Adult Services, and Children Services. These services include comprehensive training and specialized equipment that enable individuals with blindness and visual impairments to live independently in their homes and communities, specialized instruction for children on how to adapt and excel in environments tailored to their needs both in and outside of school, and assistance in securing and maintaining employment.

The Bureau of Aging, (BOA) and the Long-Term Care Ombudsman Program (LTCOP), ensure that Connecticut's older adults have access to the supportive services necessary to live with dignity, security, and independence. The Bureau of Aging is responsible for planning, developing, and administering a comprehensive and integrated service delivery system for older persons in Connecticut. The Bureau of Aging administers Older Americans Act and state programs that provide for supportive services, in-home services, congregate and home-delivered meals and health promotion programs. 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, Managed Residential Communities and for individuals receiving Long Term Services and Supports in the community. The State Ombudsman also advocates for systemic changes in policy and legislation to protect the health, safety, welfare and rights of individuals who reside in those settings. The LTCOP and BOA work closely with the aging network partners to provide these services. Partners include Connecticut's five area agencies on aging, community-based providers, 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.

The Department of Developmental Services (DDS): DDS has approximately 17,400 individuals with intellectual disability that are active with the agency. For those eligible, DDS offers a comprehensive array of supports and services based on need that may include case management, individualized supports, residential supports, employment and day supports, children's services, respite care, and family support.

The mission of DDS is to partner with the individuals supported by the agency and their families to facilitate lifelong planning. By collaborating with others, DDS aims to create and promote meaningful opportunities for individuals to fully participate as valued members of their communities.

As of March 2024, among those eligible for DDS services:

- 68.8% were living in their own or their family homes.
- 24.2% resided in public or private community living arrangements or received 24-hour continuous residential supports within the community.
- 2.3% lived in community companion homes
- 0.7% resided in campus settings.
- 1.7% were in skilled nursing facilities

These statistics highlight DDS' commitment to supporting individuals in the least restrictive settings possible, promoting independence and community life.

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 using 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 experiencing homelessness. 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. They develop, maintain, and manage a comprehensive system of mental health treatment, rehabilitative services, and recovery support for designated local service.

Department of Housing (DOH): DOH'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. The State continues to emphasize rapid re-housing and supportive housing as the primary means to prevent and end homelessness in Connecticut.

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 and supportive 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. CTDOT launched a 2 year pilot program for microtransit services in 10 areas of the state. These services provide accessible trips on-demand with their service area.

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 (OHS): 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 2024

State Agency	Long-Term Services and Supports Program	Services	Settings	Eligibility	Demographics July 1, 2023– June 30, 2024
ADS	Independent Living (IL) Program	BESB: 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. BRS: 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.	BESB: Services are provided directly by ADS staff in the residences and communities of the individual, and through third party vendors, and low vision practitioners at their medical practices. BRS: Community-based, cross-disability, nonresidential, private nonprofit agencies	BESB: Under age 55, legally blind or significantly visually impaired. BRS: No eligibility requirements.	**BESB** Total Participants 144 Age 0-5: 0 5-19: 1 20-24: 5 25-59:138 60 up: 0 Gender Female: 72 Male: 72 Race Am Ind/Alask: 0 Asian: 0 AA: 34 Hawaiian/PI: 0 White: 55 Hisp/Lat: 48 2 or more: 2 Unknown:5 Disability Cognitive:0 Mental/Emot:0 Physical: 3 Hearing: 0 Vision: 72

State Agency	Long-Term Services and Supports Program	Services	Settings	Eligibility	Demographics July 1, 2023– June 30, 2024
					Multiple: 68 Other:1 **BRS** <u>Total Participants</u> 1,697 <u>Age</u> 0-5: 7 5-19: 36 20-24: 45 25-59: 737 60 up: 836 Unknown: 36 <u>Gender</u> Female: 904 Male: 753 Unknown: 40 <u>Race</u> Am Ind/Alask: 0 Asian: 14 AA: 6 Hawaiian/PI: 0 White: 895 Hisp/Lat: 219 Unknown: 563 <u>Disability</u> Cognitive: 186 Mental/Emot: 322 Physical: 921 Hearing: 173 Vision: 57

State Agency	Long-Term Services and Supports Program	Services	Settings	Eligibility	Demographics July 1, 2023– June 30, 2024
					Multiple: 6 Other: 7 Unknown: 25
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 vendors, and low vision practitioners at their medical practices.	Age 55 or older and legally blind or significantly visually impaired.	BESB Total Participants (FFY 23) 576 Age 55-59: 49 60 up: 527 Gender Female: 375 Male: 201 Race Am Ind/Alask:0 Asian: 4 AA: 100 Hawaiian/PI: 1 White: 466 Hisp/Lat: 46 2 or more: 4 Unknown: 1 Disability Totally Blind: 19 Legally Blind: 512 Severe Visual Impairment:45

State Agency	Long-Term Services and Supports Program	Services	Settings	Eligibility	Demographics July 1, 2023– June 30, 2024
ADS	State Long-Term Care Ombudsman Program	RECEIVES and investigates complaints and provides information and consultation to individuals receiving LTSS in an institution and for some community recipients to resolve problems. EDUCATES individuals and families about their rights. EMPOWERS and supports individuals and families to discuss concerns with nursing home staff. PROVIDES information regarding long-term care programs and services. ADVOCATES for improvements in state and federal laws and regulations. REPRESENTS individuals' interests	Long-Term Care Communities - Nursing homes, residential care homes, Managed Residential Care Homes and in the greater community.	A resident of a long-term care community or individuals receiving LTSS in the community.	Total Participants About 28,000 in long-term care communities About 20,000 in the greater community Age N/A Gender N/A Race/Ethnicity N/A

State Agency	Long-Term Services and Supports Program	Services	Settings	Eligibility	Demographics July 1, 2023– June 30, 2024
		before governmental agencies. IDENTIFIES and seeks to remedy gaps in facility, government, or community services. RESPECTS the privacy and confidentiality of individuals.			
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	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	New Team Member Trainings: 2 New Team Members Trained and Certified: 38 Total number of Beneficiary Counseling Sessions: 17,155 Beneficiaries under age 65: 1,240 Beneficiaries over age 65:14,675 Beneficiary age not collected: 1,240 Beneficiary income below 150% FPL: 5,626 English as a Primary Language: Yes 14,637 No 2,518

State Agency	Long-Term Services and Supports Program	Services	Settings	Eligibility	Demographics July 1, 2023– June 30, 2024
			Hospice facilities Nursing facilities Area Agencies on Aging	Medicare eligible.	Beneficiary Gender Male: 4,745 Female: 8,747 Other: 14 Not Collected: 802 Beneficiary Race American Indian or Alaskan Native: 22 Asian: 275 Black or African American: 1,047 Hispanic or Latino: 970 Native Hawaiian or Other Pacific Islander: 65 White: 10,702 Not Collected: 3,028 Medicare Part D, Medicare Advantage, & Medicare Supplement Plan comparisons and enrollment contacts: 19,534 Medicare Savings Program, Extra Help/Low Income Subsidy, & Medicaid Application Assistance contacts: 4,057 Outreach events: 356 Outreach contacts (attendees): 71,969

State Agency	Long-Term Services and Supports Program	Services	Settings	Eligibility	Demographics July 1, 2023– June 30, 2024
ADS	SMP – Senior Medicare Patrol	Outreach, counseling, and education. Outreach activities may include workshops, presentations, distribution of educational materials, and community events to raise awareness. Individual Counseling may include reviewing a beneficiary's MSN, EOB, billing statements. Reporting services may include, calling Medicare, the health care provider or the company that issued the bill.	Community events including, but not limited to, health and senior fairs, staffing information booths, and information booths. Area Agencies on Aging Senior centers Libraries Residential settings including elderly housing and assisted living.	N/A	Total Participants Beneficiaries who attended Group outreach and Education events: 11,907 Group Outreach and Education events – 207 One-on-one individual interactions – 326 Media Outreach and Education contacts: 105

State Agency	Long-Term Services and Supports Program	Services	Settings	Eligibility	Demographics July 1, 2023– June 30, 2024
ADS	CT Statewide Respite Care Program (for persons with Alzheimer's or related dementia)	Adult day centers 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. $55,561income $147,715 assets Co-pay of 20% of cost of service required (may be waived upon financial hardship)	Total Participants 563 Age N/A Gender N/A Race/Ethnicity N/A

State Agency	Long-Term Services and Supports Program	Services	Settings	Eligibility	Demographics July 1, 2023– June 30, 2024
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 14,455 served with Title III-B funds. 1,104 served with Title III-D funds. 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: 523,558 meals served to 14,799 participants Home delivered meals: 1,554,949 meals served to 8,795 participants 87 units of Nutritional counseling were provided to 87 unduplicated persons *Nutrition Education = 8,131 Units

State Agency	Long-Term Services and Supports Program	Services	Settings	Eligibility	Demographics July 1, 2023– June 30, 2024
					*Federal reporting does not require the count of people for this service, only units. Totals reflect units for FFY 2023.
ADS	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 – 452 Supplemental services – 681 Counseling, support groups, training – 2,490 Caregivers caring for older adults, grandparents and kinship caregivers caring for children and persons 18-59 with disabilities - 1,005
ADS	Congregate Housing Services Program	Adult day care Case management Homemaker services Companion services	Congregate housing	Adults age 60+ or adults under 60	Total CHSP Participants served: 250 Age: 62+ - 239

State Agency	Long-Term Services and Supports Program	Services	Settings	Eligibility	Demographics July 1, 2023– June 30, 2024
		Home health aide/Personal care assistant services Information & referral Nutritional services Personal Emergency Response System (PERS)Transportation Medication monitoring Foot care		with a permanent or temporary disability who require assistance with 3 or more Activities of Daily Living (ADLs) and reside within an eligible housing community.	18-61 – 11 <u>Gender:</u> Female participants – 203 Male participants – 47 <u>Race/Ethnicity</u> White (non-Hispanic) participants served – 241 Hispanic participants – 5 Black/African American participants (non-Hispanic) – 3 American Indian/Alaskan Native participants – 1 Asian/Pacific Islander – 0
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. Unemployed.	<u>Total Participants</u> 58 <u>Age</u> 55-64: 34 65-74: 23 75+: 1 <u>Gender</u> male: 21 female: 37 <u>Race/Ethnicity</u> White – 30 Black/African American - 21 Hispanic – 6 Asian – 0 American Indian – 2

State Agency	Long-Term Services and Supports Program	Services	Settings	Eligibility	Demographics July 1, 2023– June 30, 2024
					More than one race – 1
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 760 direct client assistance Age N/A Gender N/A Race/Ethnicity N/A
ADS	Evidenced-Based Health Promotion Programs	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 - 151 participants served through in-person, virtual, and telephonic workshops Tai Chi Moving for Better Balance –203 participants **Total =** 354
ADS	No Wrong Door (Service Navigator/Aging & Disability Resource Centers) with funding from ACL Grants	Application Assistance Benefits Counseling Case Consultation Options Counseling Short Term Support	Agencies on Aging Some hospitals Personal residences	Any person across the lifespan who is a person with a disability, older adult caregiver or planning ahead	Total Participants Total unduplicated consumers of Service Navigation Services = 1,883 Agencies: 2

State Agency	Long-Term Services and Supports Program	Services	Settings	Eligibility	Demographics July 1, 2023– June 30, 2024
			Other public places By phone	for future long term care needs. Available statewide	
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> 398 participations
DDS	Home and Community-Based Services Waivers	Personal support Individualized home support Adult companion services Group day services Individualized day services Respite care Community Living	Personal residences Community living arrangement Community companion home Community day program site Community	Individuals over the age of three. Person with intellectual disability needing ICF/ID level of care.	<u>Total Participants</u> All Waivers 11,038 Comprehensive Waiver 5,013 Individual and Family Support Waiver 3,634 Employment and Supports Waiver 2,391

State Agency	Long-Term Services and Supports Program	Services	Settings	Eligibility	Demographics July 1, 2023– June 30, 2024
		Arrangements Continuous Residential Support Supported employment services Environmental accessibility adaptations Personal emergency response system (PERS) Transportation Parenting Support Senior Supports Vehicle modifications Specialized medical equipment and supplies Behavioral support Healthcare coordination Assistive Technology Peer Support Shared Living Training and Counseling for Unpaid Caregivers Assistive Technology Remote Supports	employment	Medicaid program: Income less than 300% of SSI and assets less than $1600.	
DDS	Intermediate Care Facility for persons with Intellectual	Residential habilitation Day habilitation	ICF/ID	No age limit. Person with	Total Participants in DDS operated ICF/IDs: 232

State Agency	Long-Term Services and Supports Program	Services	Settings	Eligibility	Demographics July 1, 2023– June 30, 2024
	Disability(ICF/ID)	Prevocational services Supported employment services		intellectual disability needing ICF/ID level of care. Medicaid program: Income less than 300% of SSI and assets less than $1600.	Age 0-17: 0 18- 54: 49 55-64: 66 65+: 117 Total Participants in privately operated ICF/IDs: 329 Age 0-17: 0 18- 54: 146 55-64: 99 65+: 84
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 Clubhouses	Adults age 18 and over. Primary diagnosis of a psychiatric disorder; Requires assistance in obtaining and coordinating treatment, rehabilitation, and social services without which the	Total Participants 1,210 Age 18-20 57 21-25 130 26-34 148 35-44 181 45-54 206 55-64 277 65+ 196 Unknown 15 Gender

State Agency	Long-Term Services and Supports Program	Services	Settings	Eligibility	Demographics July 1, 2023– June 30, 2024
				individual would likely require a more intensive level of care. No private insurance to pay for comparable services.	Female 590 Male 606 Trans* 2 Unknown 12 <u>Race</u> Am Indian 4 Asian 147 Black 217 Multi-race 17 Hawaiian 1 Other 101 Unknown 109 White 614 <u>Ethnicity</u> Hispanic 210 Non-Hispanic 840 Unknown 160
DMHAS	Mental Health Assertive Community Treatment (ACT)	A set of clinical, medical & psychosocial services, provided on a one-to-one basis, essential to maintaining an individual's ability to function in community settings. Services available 24/7.	Personal residences Community settings	Adults age 18 and over. Primary diagnosis of a psychiatric disorder; Would otherwise require more intensive and restrictive services. No private insurance to pay for comparable	<u>Total Participants</u> 1,282 <u>Age</u> 18-20 202 21-25 386 26-34 211 35-44 167 45-54 129 55-64 122 65+ 46 Unknown 19 <u>Gender</u> Female 488

State Agency	Long-Term Services and Supports Program	Services	Settings	Eligibility	Demographics July 1, 2023– June 30, 2024
				services.	Male 782 Transgender 9 Unknown 3 <u>Race</u> Am Indian 6 Asian 8 Black 317 Multi-race 24 Hawaiian 1 Other 130 Unknown 87 White 709 <u>Ethnicity</u> Hispanic 254 Non-Hispanic 910 Unknown 118
DMHAS	Mental Health Intensive Outpatient Services	Individual, group or family psychotherapy; Psycho-educational groups; Classes on ADLs; Recovery oriented services.	Non-residential services provided in a general hospital, private free-standing psychiatric hospital, psychiatric out-patient clinic for adults, or a State-operated facility.	Adults age 18 and over. Primary diagnosis of a psychiatric disorder; Behavior does not pose an imminent risk of harm to self and other; Living environment can assure a reasonable degree of safety; Symptomology/	<u>Total Participants</u> 195 <u>Age</u> 18-20 17 21-25 41 26-34 50 35-44 39 45-54 30 55-64 17 65+ 1 <u>Gender</u> Female 90 Male 105 Unknown 0

State Agency	Long-Term Services and Supports Program	Services	Settings	Eligibility	Demographics July 1, 2023– June 30, 2024
				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.	<u>Race/</u> Am Indian 0 Asian 0 Black 36 Multi-race 0 Hawaiian 0 Other 24 Unknown 7 White 128 <u>Ethnicity</u> Hispanic 40 Non-Hispanic 135 Unknown 20
DMHAS	Mental Health Outpatient Clinical Services	Individual, group or family counseling; Education to client and family; Support with connecting to/referral to natural community supports; Assistance with obtaining/ maintaining employment.	Non-residential services provided in a general hospital, private free-standing psychiatric hospital, a State-operated facility, a facility licensed by DPH to offer "outpatient treatment," or by a private independent psychiatrist or psychologist or private group practice.	Adults age 18 and over. Primary diagnosis of a psychiatric disorder. No private insurance to pay for comparable services.	<u>Total Participants</u> 31,487 <u>Age</u> 18-20 1,137 21-25 2,558 26-34 5,544 35-44 5,879 45-54 5,242 55- 64 6,399 65+ 4,467 Unknown 260 <u>Gender</u> Female 16,548 Male 14,871 Trans* 23 Unknown 45

State Agency	Long-Term Services and Supports Program	Services	Settings	Eligibility	Demographics July 1, 2023– June 30, 2024
					Race Am Indian 196 Asian 370 Black 4,596 Hawaiian 106 Multi-race 192 Other 3,921 Unknown 1,992 White 20,114 Ethnicity Hispanic 6,487 Non-Hispanic 22,316 Unknown 2,684
DMHAS	Methadone Maintenance				Total Participants 12,637 Age 18-20 16 21-25 193 26-34 2,287 35-44 4,069 45-54 2,794 55-64 2,388 65+ 888 Unknown 2 Gender Female 4,351 Male 8,275 Unknown 11 Race Am Indian 43

State Agency	Long-Term Services and Supports Program	Services	Settings	Eligibility	Demographics July 1, 2023– June 30, 2024
					Asian 57 Black 1,154 Hawaiian 19 Multi-race 44 Other 2,348 White 8,583 Unknown 389 Ethnicity Hispanic 3,161 Non-Hispanic 8,718 Unknown 758
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 205 Age 18-20 0 21-25 10 26-34 70 35-44 48 45-54 37 55-64 28 65+ 12 Unknown 0 Gender Female 64 Male 141 Race Am Indian 0 Asian 4 Black 130 Multi-race 1

State Agency	Long-Term Services and Supports Program	Services	Settings	Eligibility	Demographics July 1, 2023– June 30, 2024
					Other 19 White 44 Unknown 7 <u>Ethnicity</u> Hispanic 30 Non-Hispanic 162 Unknown 13
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 824 Age 18-20 71 21-25 147 26-34 145 35-44 153 45-54 120 55-64 134 65+ 44 Unknown 10 Gender Female 283 Male 538 Trans* 1 Unknown 2 Race Am Indian 2 Asian 8 Black 202 Multi-race 15 Other 99 Unknown 43

State Agency	Long-Term Services and Supports Program	Services	Settings	Eligibility	Demographics July 1, 2023– June 30, 2024
					White 455 Ethnicity Hispanic 146 Non-Hispanic 618 Unknown 60
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 5,368 Age 18-20 104 21-25 331 26-34 794 35-44 896 45-54 1,007 55-64 1,515 65+ 692 Unknown 29 Gender Female 2,396 Male 2,940 Trans* 8 Unknown 24 Race Am Indian 48 Asian 49 Black 1,319 Hawaiian 10 Multi-race 40

State Agency	Long-Term Services and Supports Program	Services	Settings	Eligibility	Demographics July 1, 2023– June 30, 2024
					Other 509 Unknown 211 White 3,182 <u>Ethnicity</u> Hispanic 821 Non-Hispanic 4,184 Unknown 363
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.	<u>Total Participants</u> 678 <u>Age</u> 18 - 20 21 21 - 25 43 26 - 34 166 35 - 44 188 45 - 54 132 55 - 64 112 65+ 14 Unknown 2 <u>Gender</u> Female 214 Male 463 Trans* 0 Unknown 1 <u>Race</u> Am Indian 2 Asian 3 Black 172 Hawaiian 1 Multi-race 8

State Agency	Long-Term Services and Supports Program	Services	Settings	Eligibility	Demographics July 1, 2023– June 30, 2024
					Other 65 Unknown 29 White 398 <u>Ethnicity</u> Hispanic 98 Non-Hispanic 526 Unknown 54
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.	<u>Total Participants</u> 8,074 <u>Age</u> 18 - 20 489 21 - 25 854 26 - 34 1619 35 - 44 1486 45 - 54 1155 55 - 64 1226 65+ 1039 Unknown 206 <u>Gender</u> Female 3,878 Male 4,158 Trans* 24 Unknown 14 <u>Race</u> Am Indian 21 Asian 81 Black 1,502

State Agency	Long-Term Services and Supports Program	Services	Settings	Eligibility	Demographics July 1, 2023– June 30, 2024
					Hawaiian 14 Multi-race 50 Other 752 Unknown 1,710 White 3,944 <u>Ethnicity</u> Hispanic 1,139 Non-Hispanic 4,945 Unknown 1,990
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 582 <u>Age</u> 18 - 20 11 21 - 25 26 26 - 34 97 35 - 44 130 45 - 54 126 55 - 64 144 65+ 48 Unknown 0 <u>Gender</u> Female 230 Male 352 Transgender 0 <u>Race</u> Am Indian 0 Asian 4 Black 166

State Agency	Long-Term Services and Supports Program	Services	Settings	Eligibility	Demographics July 1, 2023– June 30, 2024
					Multi race 6 Hawaiian 1 Other 56 Unknown 18 White 331 <u>Ethnicity</u> Hispanic 79 Non-Hispanic 474 Unknown 29
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.	<u>Total Participants</u> 995 <u>Age</u> 18 - 20 32 21 - 25 66 26 - 34 219 35 - 44 233 45 - 54 127 55 - 64 194 65+ 120 Unknown 4 <u>Gender</u> Female 296 Male 695 Unknown 1 Transgender 3 <u>Race</u> Am Indian 8 Asian 15

State Agency	Long-Term Services and Supports Program	Services	Settings	Eligibility	Demographics July 1, 2023– June 30, 2024
					Black 285 Multi-race 7 Hawaiian 2 Other 103 Unknown 72 White 503 <u>Ethnicity</u> Hispanic 154 Non-Hispanic 747 Unknown 94
DMHAS	Substance Use 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 substanceuse.	<u>Total Participants</u> 103 <u>Age</u> 18 – 20 0 21-25 2 26-34 19 35-44 30 45-54 19 55-64 30 65+ 3 <u>Gender</u> Female 42 Male 61 <u>Race</u> Am Indian 0 Asian 0 Black 13

State Agency	Long-Term Services and Supports Program	Services	Settings	Eligibility	Demographics July 1, 2023– June 30, 2024
					Other 10 White 77 Unknown 3 Hawaiian 0 Multiracial 0 <u>Ethnicity</u> Hispanic 11 Non-Hispanic 85 Unknown 7
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.	<u>Total Participants</u> 1.032 residents <u>Age</u> 65+: 1009 <u>Gender</u> N/A <u>Race/Ethnicity</u> 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	<u>Total Participants</u> 4,511 units in 58 communities <u>Age</u> N/A

State Agency	Long-Term Services and Supports Program	Services	Settings	Eligibility	Demographics July 1, 2023– June 30, 2024
					Gender N/A Race/Ethnicity N/A
DOH	Elderly Rental Assistance Program	Financial Assistance to make rents affordable to low/ moderate income elderly.	Personal residences	Age 62 and over or disabled. Certified disabled by Social Security Board or other federal board or agency as being totally disabled. Annual income cannot exceed the "Low Income" for the area adjusted for family size as defined by HUD.	Total Participants 1,838 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.	The program provides rental assistance to persons with disabilities from three targeted population groups:	Extremely Low Income (ELI) under the age of 62 and disabled.	Total Participants The portfolio currently has 71 units with 105 participants Gender N/A Race/Ethnicity N/A

State Agency	Long-Term Services and Supports Program	Services	Settings	Eligibility	Demographics July 1, 2023– June 30, 2024
			individuals who are homeless or at risk of homelessness referred by the Coordinated Access Network (CAN), those transitioning out of institutions with services through the Money Follows the Person Program (MFP), and individuals diagnosed with Autism Spectrum Disorder (ASD) with services through the Medicaid Lifespan Waiver.		
DOT	Local Bus Services	Transportation	Community	Open to the public, inclusive of seniors and people with a qualifying disability.	<u>Total Participants</u> 38,553,603 (SFY 2023 Passenger Trips) <u>Age</u> N/A

State Agency	Long-Term Services and Supports Program	Services	Settings	Eligibility	Demographics July 1, 2023– June 30, 2024
					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 854,896 (SFY 2024 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, 2023– June 30, 2024
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 400,000 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, 2023– June 30, 2024
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, 2023– June 30, 2024
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 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	<u>Total Participants</u> Total – 20,054 Waiver – 17,553 State – 2,269 1915i- 232 <u>Age</u> 65-84: 65% 85+: 35% <u>Gender</u> male: 26% female: 74% <u>Race/Ethnicity –</u> A - Asian 3% B - Black 15% C - Caucasian 72% N - Native American 0% O - Other 10%

State Agency	Long-Term Services and Supports Program	Services	Settings	Eligibility	Demographics July 1, 2023– June 30, 2024
				both receiving services)	
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	Personal residences Adult day care centers Congregate housing Elderly housing Residential care homes Assisted living Alzheimer's	Ages 18-64 Must be diagnosed with a degenerative neurological condition Must need assistance with at least 3 critical	<u>Total Participants</u> 108 <u>Age</u> Under 50: 18% 50-64: 82% <u>Gender</u> Male: 39% Female: 61%

State Agency	Long-Term Services and Supports Program	Services	Settings	Eligibility	Demographics July 1, 2023– June 30, 2024
		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	facilities with private assisted living	needs Must not be Medicaid active or eligible Financial eligibility is the same as the state funded portion of the CT Home care Program for elders	<u>Race/Ethnicity</u> Asian 2% Black 6% Caucasian 79% Native American 1% Other 12%
DSS	Personal Care Assistance Waiver	Care Management Independent Support Broker Adult Family Living	Personal residences	Age 18-64. Chronic severe and permanent disabilities. Would otherwise require nursing facility care. Capable of self-direction. Medicaid income limit = 300% of SSI .	<u>Total Participants</u> 1,455 <u>Age</u> Under 50: 29% Over 50: 71% <u>Gender</u> Male: 49% Female: 51% <u>Race/Ethnicity</u> A – Asian 1% B – Black 25%

State Agency	Long-Term Services and Supports Program	Services	Settings	Eligibility	Demographics July 1, 2023– June 30, 2024
				Income in excess of 200% FPL applied to care.	C – Caucasian 59% N - Native American 1% O – Other 14%
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 194 Age 50-70 - 4% 49-30 – 56% 29- 20 – 29% 20 & under – 9% Over 70 - 2% Gender Female: 19% Male: 81% Transgender: Race/Ethnicity Black – 8% Caucasian – 83% Other – 9% Asian, Pacific Islander – 0%

State Agency	Long-Term Services and Supports Program	Services	Settings	Eligibility	Demographics July 1, 2023– June 30, 2024
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 544 Age 18-49: 38% 50+: 62% Gender Male: 70% Female: 30% Race/Ethnicity Asian: 1% Black: 15% Caucasian: 78% Other: 6%

State Agency	Long-Term Services and Supports Program	Services	Settings	Eligibility	Demographics July 1, 2023– June 30, 2024
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 = $2,829. 300% of FPL.Medicaid asset limit = $ $1000.Income of parent or spouse not counted.	Total Participants 255 Age N/A Gender Male: 61% Female: 39% Race/Ethnicity Asian 5% Black 6% Caucasian 66% Other 23% Pacific Islander 0%
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	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	Total Participants Grand Total: 6124 (Includes Waiver and non-Waiver) W/Waiver: 3167 CFC w/out waiver: 2957 Age N/A Gender

State Agency	Long-Term Services and Supports Program	Services	Settings	Eligibility	Demographics July 1, 2023– June 30, 2024
		Transitional services		impairment which requires daily supervision to prevent harm Living in a community setting Choosing to self-direct and manage an individual budget Active on Husky Medicaid	Male: 39% Female: 61% Race/Ethnicity A – Asian 3% B – Black 22% C – Caucasian 54% N - Native American 0% O – Other 21% P - Pacific Islander 0%
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 1070 (only those enrolled in MFP) Age N/A Gender Male : 50% Female : 50% Race/Ethnicity A – Asian 1% B – Black 25% C – Caucasian 57% N - Native American

State Agency	Long-Term Services and Supports Program	Services	Settings	Eligibility	Demographics July 1, 2023– June 30, 2024
					0% O – Other 17% P - Pacific Islander 0%
DVA	Veterans' Health Care Services	Licensed Skilled Nursing Facility provides continuous professional comprehensive healthcare services including: General medical care Alzheimer's/dementia care End of life care Palliative care Long term care Rehabilitation Respite care Mental health and	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 85 Total Participants 108 Age 18-61: 5 62+: 103 Gender 3 Female 105 Male Race/Ethnicity Caucasian: 94 Hispanic: 3 Black: 10 Other: 1

State Agency	Long-Term Services and Supports Program	Services	Settings	Eligibility	Demographics July 1, 2023– June 30, 2024
		Psychological counseling			
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 109 Total Participants 144 Age 18-61: 35 62+: 109 Gender 10 Female, 134 Male Race/Ethnicity Caucasian: 96 Hispanic: 4 Black: 42 Other: 2

III. State Long-Term Services and Supports Program Expenditures in Connecticut – SFY 2024

State Agency	Long-Term Care Program	Total Expenditures SFY 2024	State Expenditures	Medicaid Expenditures	OAA Title III Expenditures	Other Federal Expenditures	Other Expenditures
ADS	Independent Living (IL) Program	BESB: $36,326 BRS: $1,867,511	BESB: $36,326 BRS: $1,488,454			BRS: $379,057	
ADS	Independent Living – Older Individuals who are Blind (OIB)	BESB: $609,219.88				BESB: $609,219.88	
ADS	CHOICES	$1,023,278	$445,801			$577,477	
ADS	SMP – Senior Medicare Patrol	$427,985				$427,985	
ADS	Statewide Respite Care Program and Alzheimer's Aide Program (for persons with Alzheimer's or related dementia)	$1,907,096	$1,907,096				
ADS	Supportive Services and Administration (Title III-B)	$5,925,662	$113,205		$3,966,903	$1,845,554	

State Agency	Long-Term Care Program	Total Expenditures SFY 2024	State Expenditures	Medicaid Expenditures	OAA Title III Expenditures	Other Federal Expenditures	Other Expenditures
ADS	Health Promotion Programs (Title IIID)	$306,029			$306,029		
ADS	Elderly Nutrition Program (Title IIIC and NSIP)	$17,787,414	$3,150,349		$10,032,595	$2,354,470	State ARPA: $2,250,000
ADS	National Family Caregiver Support Program (Title IIIE)	$853,773			$2,194,979	$658,794	
ADS	Congregate Housing Services Program	$598,093	$134,230			$463,863	
ADS	Senior Community Service Employment Program	$735,779				$735,779	
ADS	Medicare Legal and Education Assistance Project	$641,117	$634,117			$7,000	
ADS	Elderly Health Promotion	$132,065	$132,065				
ADS	Fall Prevention	$50,000	$50,000				

State Agency	Long-Term Care Program	Total Expenditures SFY 2024	State Expenditures	Medicaid Expenditures	OAA Title III Expenditures	Other Federal Expenditures	Other Expenditures
ADS	No Wrong Door: Service Navigator/Aging & Disability Resource Centers	$563,475	$391,149			$172,326	
ADS	Prevention of Elder Abuse, Neglect and Exploitation	$55,852				$55,852 (Title VII)	
ADS	Long-Term Care Ombudsman Program	$2,304,010	$1,754,006		$154,997	$233,255 (Title VII)	
DSS	Connecticut Home Care Program (CHCPE)	$598,095,037	$43,480,047 (includes CHCPD expenditures)	$554,614,963			
DSS	Connecticut Home Care Program for Adults with Disabilities (CHCPD)	$2,431,371	$2,431,371 (Included in CHCPE expenditures)	NA			
DSS	Personal Care Assistance Waiver	$20,135,697	NA	$20,135,697			

State Agency	Long-Term Care Program	Total Expenditures SFY 2024	State Expenditures	Medicaid Expenditures	OAA Title III Expenditures	Other Federal Expenditures	Other Expenditures
DSS	Acquired Brain Injury Waiver (ABI)	$39,421,217	NA	$39,421,217			
DSS	ABI II	$34,833,628	NA	$34,833,628			
DSS	Katie Beckett Model Waiver	$65,839	NA	$65,839			
DSS	Autism Waiver	$2,408,096	NA	$2,408,096			
DSS	Community First Choice	$230,356,513	NA	$230,356,513			
DSS	Money Follows the Person	$19,089,425	NA	$19,089,425			

State Agency	Long-Term Care Program	Total Expenditures SFY 2024	State Expenditures	Medicaid Expenditures	OAA Title III Expenditures	Other Federal Expenditures	Other Expenditures
DDS	Home and Community Based Services Waivers	$1,202,276,000		$1,202,276,000			
DDS	Intermediate Care Facility for Persons with Mental Retardation (ICF/MR)	$144,420,000		$144,420,000 Does not include private ICF/IDs which are funded by DSS			
DMHAS	Case Management	$50,518,201	$45,025,273	$164,085	$0	$4,189,698	$1,139,145
DMHAS	Assertive Community Treatment	$26,841,250	$26,067,903	$97,439	$0	$0	$675,908
DMHAS	Home and Community Based Services Waivers	$17,385,169	$0	$17,385,169	$0	$0	$0
DMHAS	MH Intensive Outpatient	$342,748	$43,382	$0	$0	$15,819	$283,547

State Agency	Long-Term Care Program	Total Expenditures SFY 2024	State Expenditures	Medicaid Expenditures	OAA Title III Expenditures	Other Federal Expenditures	Other Expenditures
DMHAS	MH Outpatient Therapy	$108,878,499	$82,093,382	$6,144,468	$0	$4,360,749	$16,279,901
DMHAS	MH Residential Group Home	$50,726,064	$42,445,834	$4,290,561	$0	$531,314	$3,458,356
DMHAS	MH Supervised Housing	$70,670,912	$67,660,785	$22,202	$0	$57,640	$2,930,286
DMHAS	MH Supported Housing	$26,529,582	$22,858,187	$12,017	$0	$3,053,979	$605,400
DMHAS	MH Psychosocial Rehabilitation	$20,604,515	$19,752,650	$0	$0	$293,595	$558,270
DMHAS	Crisis Stabilization	$12,137,825	$11,225,721	$0	$0	$589,545	$322,560
DMHAS	Mobile Crisis Services	$30,363,572	$20,174,258	$11,058	$0	$10,186,405	$(8,149)

State Agency	Long-Term Care Program	Total Expenditures SFY 2024	State Expenditures	Medicaid Expenditures	OAA Title III Expenditures	Other Federal Expenditures	Other Expenditures
DMHAS	Long Term Psychiatric Hospitalization	$209,216,102	$201,280,973	$0	$0	$7,935,129	$0
DMHAS	Substance Use Residential Long Term Care	$830,910	$614,352	$0	$0	$216,558	$1,534,086
DMHAS	Methadone Maintenance	$419,138	$68,933	$0	$0	$350,205	$0
DMHAS	Substance Use Residential Long Term Treatment	$13,596,005	$11,780,827	$0	$0	$1,815,178	$0
DMHAS	Substance Use Residential Transitional / Halfway House	$1,896,083	$1,772,505	$0	$0	$123,578	$0
DOH	Congregate Operating Subsidy Program	$11,837,690	$11,837,690				

State Agency	Long-Term Care Program	Total Expenditures SFY 2024	State Expenditures	Medicaid Expenditures	OAA Title III Expenditures	Other Federal Expenditures	Other Expenditures
DOH	Elderly Rental Registry and Counseling	$1,011,170	$1,011,170				
DOH	Elderly Rental Assistance Program	$2,011,839	$2,011,839				
DOH	811 PRA	$908,460	$0			$908,460	
DOT	Local Bus Services	$288,728,742 SFY 2023	$260,102,308 SFY 2023			$1,864,099 SFY 2023 Data	$7,724,396 (Fare Revenue) $3,779,067 (Other Revenue) $4,552,618 (Other Subsidies) $10,717,263 (Local) SFY 2023 Data
DOT	ADA Paratransit Services	$49,981,648 SFY 2023 Data	$46,956,971 SFY 2023 Data				$405,116 (Fare Revenue) $713,094 (Other Revenue)

State Agency	Long-Term Care Program	Total Expenditures SFY 2024	State Expenditures	Medicaid Expenditures	OAA Title III Expenditures	Other Federal Expenditures	Other Expenditures
							$1,956,221 (Local Subsidy) SFY 2023 Data
DOT	State Matching Grant Program	$7,742,213.16 SFY 2023 Data	$3,871,106.58 SFY 2023 Data				$3,871,106.58 (Local) SFY 2023 Data
DOT	Section5310 Program	$6,966,136 Data projections for FFY 2022 Award Cycle (most recent)	$1,547,735 Data projections for FFY 2022 Award Cycle (most recent)			$4,924,423 Data projections for FFY 2022 Award Cycle (most recent)	$493,979 Data projections for FFY 2022 Award Cycle (most recent)
DVA	Veterans' Health Care Services	$14,477,818	$11,525,967	$0	$0	$74,656	$2,877,195
DVA	Residential and Rehabilitative Services	$1,804,219	$1,143,509	$0	$0	$2,748	$657,962