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TO: The Honorable Beth Bye
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Members, Appropriations Committee

The Honorable Gayle S. Slossberg
The Honorable Catherine F. Abercrombie
Co-Chairs, Human Services Committee

Members, Human Services Committee

FROM: Roderick L. Bremby, Commissioner 

DATE: December 9, 2014

RE: Connecticut Home Care Program for Elders
Annual Report for SFY 2013

I am pleased to notify you of the availability of the SFY 2013 Annual Report for the Connecticut Home Care Program for Elders. The report may be accessed on the Department of Social Services web site at www.ct.gov/dss (click on Publications, then Reports). The Connecticut Home Care Program exemplifies the state's long-standing commitment to comprehensive community-based care for elders in need of long-term care. By enabling and providing supportive services at home, the state has helped to preserve the dignity and autonomy of older persons and has assisted families struggling to maintain older relatives at home.

In the interest of cost savings, we are not distributing hardcopies of the report but can do so upon request. The report includes comprehensive financial data, including service claims that can take up to a year to complete before they can be compiled and analyzed.

Development of home care options has helped to curb the spiraling costs of institutional care. However, its most important impact has been on the quality of life for Connecticut's older citizens. We thank you for your crucial support of these principles at the General Assembly over the years.

At the close of SFY 2013, slightly less than 16,000 Connecticut residents were being served by the Connecticut Home Care Program for Elders.

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The program combines federal and state funds to cost-effectively serve older adults according to their needs. Care plans are developed within the limits of 25%, 50% and 100% of the average nursing facility cost. The cost depends upon which Connecticut Home Care Program for Elders functional category corresponds to the individual's needs. This report describes the criteria for each category served by the program.

This report represents the third year of a five-year renewal for the Home- and Community-Based Services Waiver. The federal Centers for Medicare and Medicaid Services (CMS) has renewed the waiver for five years until June 30, 2015. As part of the renewal and approval process, the Department developed a set of performance measures to meet the assurances that states make to CMS when they are operating a waiver.

Continuing highlights of the program include:

DSS continues to work collaboratively with the Department of Community and Economic Development, the Connecticut Housing Finance Authority, the Department of Public Health and the Office of Policy and Management to implement the Assisted Living Demonstration Pilot Project. By offering assisted living services in the demonstration programs, residents are offered a viable choice that will allow them to maintain a degree of continued health, dignity and independence at significantly less cost than a nursing home. Four sites, The Retreat in Hartford, Herbert T. Clark in Glastonbury, Luther Ridge in Middletown and Smithfield Gardens in Seymour, are fully operational.

Starting July 1, 2013, the state entered into new contracts with Access Agencies based on a competitive procurement process. The result was the addition of a new Access Agency, the Western Connecticut Area Agency on Aging, to the existing agencies also awarded contracts. The request for proposal included transitioning the claims processing, provider enrollment and credentialing as well as collection of cost share and applied income payments to the Department's existing fiscal intermediary. This streamlined approach eliminated the duplicative processing of claims and streamlined the provider enrollment and credentialing process while bringing consistency to the process as well.

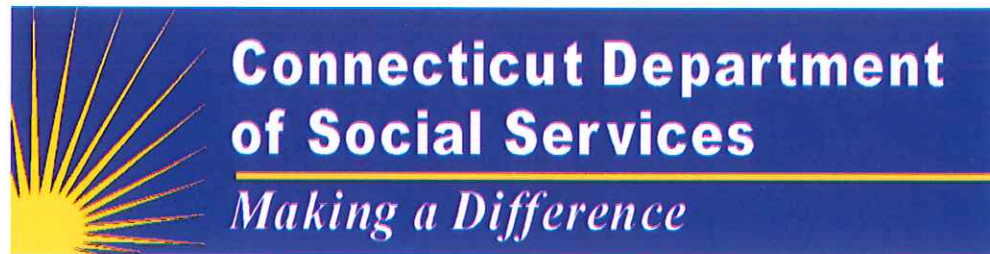
The Department's Alternate Care Unit, under PA 07-2, Section 29, continues to operate a pilot program implemented in October 2007 -- the Connecticut Home Care Program for Adults with Disabilities. The target population is individuals with degenerative, neurological conditions who are not Medicaid-eligible and who are in need of case management to develop, implement and monitor plans of care. This program was expanded effective July 1, 2014, to 100 slots, an increase from the original 50.

The Alternate Care unit submitted an application to the Centers for Medicare and Medicaid Services for a Home and Community-Based Services 1915i State Plan Option. This was approved by CMS with an effective date of February 2012. The population served under this state plan option is Home Care Program Category 1 clients who are also Medicaid recipients. This allows the state to claim 50% federal match for clients who were previously 100% state-funded. Over 550 persons are served under this state plan option.

As Commissioner of the Department of Social Services, I am proud to be part of the traditional pro-active role Connecticut has taken in developing innovative and effective policies and programs to address the needs of our elders and citizens with disabilities. On behalf of Governor Dannel P. Malloy, I thank you again for your continuing role in moving our state forward in this vital area.

c: Kathleen Brennan, Deputy Commissioner
Kate McEvoy, Director of Health Services

Making a Difference for Elders in the Community



**Connecticut Home Care
Program for Elders
Annual Report
To the Legislature
SFY 2013
July 2012 - June 2013**

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Connecticut Home Care Program for Elders at a Glance

- **18,670** elders were served on the State Funded, Medicaid Waiver, Adults with Disabilities and 1915i portions of the CT Home Care Program for SFY **2013**. Calculated with table data. See Page 24.
- **\$ 105,162,211** in savings were generated as a result of the reduced utilization of nursing facility beds due to the CT Home Care Program's Medicaid Waiver. See Page 8.
- The monthly average number of clients on the CT Home Care Program for SFY **2013** was **14,860**. See Page 22.
- The average monthly cost per client on the State Funded portion of the CT Home Care Program was **\$ 953** and the Medicaid Waiver portion of the CT Home Care Program was **\$ 1,919**. See Page 10.
- The program expenditures for the Medicaid Waiver and State Funded portion of the CT Home Care Program were **\$ 283,480,418**. See Page 27.
- The number of individuals screened for the CT Home Care Program who were referred for assessment and became clients was **4,193**. See Page 15.

Program Description and Organization

Through the CT Home Care Program for Elders, the State provides long term services and supports for older persons who continue to live at home. Options in the program such as personal care assistant services have increased consumer choice and expanded opportunities for consumers to direct the services which impact their lives. Commitments such as this, allow the State to provide long term services and supports in the least restrictive setting to Connecticut's growing population of older adults.

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

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

The program is organized under a tiered structure, which enables individuals to receive home care services in levels corresponding to their functional needs and financial eligibility. The first two categories are funded primarily through a State appropriation. Individuals in the third category qualify for reimbursement under the Medicaid waiver program therefore costs for these categories are equally distributed between Federal and State funds. Individuals in the fourth category receive services under the Pilot Program for Adults with Disabilities as specified in 17b-617 and is fully state funded. The fifth category of services is individuals receiving services under the 1915i state plan option for community based services. These individuals are Medicaid recipients who are less than nursing facility level of care. Their services plan costs are equally distributed between Federal and State funds.

Cost limits for each level of the program are established so that individual care plan expenditures can increase in response to individual needs. In practice, most actual care plan costs are well under the limits for each category. In Category 3, the category serving the neediest group of elders, the average cost of care is less than half of the cost limit.

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

Category 1: This category is targeted to individuals who are at risk of long term hospitalization or nursing facility placement if preventive home care services are not provided. Since these are not individuals who would immediately need nursing facility placement in the absence of the program, individual care plan limits are set at 25% of the weighted average Medicaid cost in a nursing facility.

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

Category 3: This category targets individuals who would otherwise require long term nursing facility care funded by Medicaid. In order to assure cost effectiveness, individual care plan costs cannot exceed 100% of the weighted average Medicaid cost in a nursing facility.

Category 4: This category of service also targets individuals who would otherwise require long term care in a nursing facility. Participants are under the age of 65 and their service plans are capped at 50% of the weighted Medicaid cost in a facility.

Category 5: These individuals are Medicaid recipients but whose care needs would put them at risk of institutionalization without services. This option became available in February of 2012 when the Centers for Medicare and Medicaid Services approved our state plan amendment to offer these services. As a result, over 550 who previously would have received services fully funded by state appropriations now receive services that are federally matched.

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

Assisted Living Services Component

Over the past several years, the State of Connecticut has developed alternatives to nursing facility care and assisted living has been a major focus of these efforts. Connecticut has introduced assisted living in state-funded congregate housing facilities, federally-funded HUD residences

and has developed four subsidized assisted living residences in Connecticut communities.

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

Private Assisted Living Pilot

Public Act 02-7 allowed the Department to establish the Private Assisted Living Pilot that became effective January 1, 2003. **As of July 1, 2012** the Pilot provides one hundred twenty five (125) clients with the opportunity to remain in their private assisted living facility after they have spent down their assets.

The Pilot grew out of recognition that some elders, after living in a Private Assisted Living Facility for a time, have spent down their assets and thus require help with their living expenses. In order to assist these individuals, the Pilot provides funding for their assisted living services. The Pilot does not pay for room and board; it is expected that such individuals will have family members who are willing and able to assist with some of those expenses. This Pilot is based on the premise that it will be cost effective for the State to provide for such individuals, for in doing so; they will not require admission to a nursing facility.

As of June 30, **2013**, the Private Assisted Living Pilot has served a total of **418** clients at a cost of **\$13,167,183**. This figure includes both core and assisted living service charges and covers a **ten** year period.

State Funded Congregate and HUD Facilities

Public Act 00-2 allowed the Department of Economic and Community Development (DECD) to offer assisted living services to residents in State Funded Congregate Housing and Federally Funded HUD Facilities. Through the collaborative effort of DECD, the Department of Public Health (DPH) and the Department of Social Services (DSS), the program became effective February 2001.

Public Act 00-2 also grants Managed Residential Community (MRC) status to approved State Funded Housing and Federally Funded HUD Facilities for the purpose of providing assisted living services and allows the Department of Public Health (DPH) to waive provisions of the assisted living services agency regulations on a case-by-case basis.

The assisted living services are funded through the State Department of Social Services (DSS) or the State Department of Economic and Community Development (DECD). The assisted living services are provided by an assisted living services agency (ALSA). The assisted living services

agency provides the personal care services, core services and supplemental services based on the care needs of the qualified residents.

Assisted Living Services provide a viable choice to the residents that will enhance and maintain a degree of continued health, dignity and independence at significantly less cost than nursing facility placement.

As of June 30, **2013**, **482** clients had received services in State funded congregate facilities at a cost of **\$12,978,565**. This figure includes both core and assisted living service charges and covers a **twelve** year period.

As of June 30, **2013**, **571** clients had received services in the HUD facilities participating in the assisted living pilot at a cost of **\$19,828,966**. This figure includes both core and assisted living service charges and covers a **twelve** year period.

Assisted Living Demonstration Project

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

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

As of June 30, **2013**, **757** clients had received services in the DEMO facilities participating in the assisted living pilot at a cost of **\$32,148,872**. This figure includes both core and assisted living service charges over a **nine** year period.

Care Management and Self Directed Care

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

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

As shown in the care continuum (Appendix E) some individuals, whether on their own, with family support, or with the assistance of a provider agency, are fully able to coordinate and monitor their own service providers, that is, to manage their own plan of care. These individuals are considered "self directed" in the Department's model and receive their services under the self directed care component of the program.

As of July **2012**, there were **231** active clients who were designated self-directed care, representing **1.6** % of the total caseload. By the end of June **2013**, there were **259** active self directed care clients representing **1.7** % of the total caseload.

Quality Enhancement System

The quality enhancement system in place for the CT Home Care Program for Elders is a system that monitors the unique needs and quality of services provided to our clients.

Our Quality Enhancement system has a Quality Assurance team to provide ongoing monitoring of program functions:

- The Quality Assurance Team conducts on-site administrative and chart audits of access agencies, assisted living service agency records, visits provider agencies and clients.
- The Quality Assurance Team reviews Access Agency Reports to identify any trends, issues and questions on the reported information. This team monitors the timeliness of information received and provides any necessary follow-up with the Access Agencies.
- The Quality Assurance Team has fully implemented a critical incident reporting system through a web based application that allows tracking and trending of data both client specific and system wide.
- The Quality Assurance Team has convened a statewide Quality Committee consisting of representatives from all of the contracted Access Agencies.

The Department of Social Services monitors provider compliance in conjunction with the Department of Public Health. The Community Nursing and Home Health Division within the Department of Public Health conduct annual licensure inspections of all licensed home health agencies. Serious issues of regulatory non-compliance by a licensed agency, which could jeopardize a client's health or safety, are brought to an expeditious hearing; any recommended action is immediately instituted.

Various QA activities are conducted to monitor provider compliance with CHCPE regulations and policies and to measure client satisfaction with services.

The QA team conducted a review of two Assisted Living facilities this year and chart reviews at each. Additionally, provider compliance was monitored by a record and administrative audit of five Access Agencies. Two Satisfaction Surveys were conducted with clients in two of the five state regions.

Goals for New Fiscal Year

- To conduct client satisfaction surveys, as our Home Care Program evolves to include choices such as Assisted Living and Personal Care Assistance Services, and to continue to obtain a measure of how our services impact the program participant.
- To meet or exceed performance measures specified in the 1915c waiver document and report finding to CMS.
- To implement systems for managing quality improvement activities to identify trends and areas needing remediation or improvement.

- Implement a CMS grant to test the new Participant Experience Survey to be utilized to develop performance measures
- Provide performance and quality based incentive payments to Access Agencies using quality indicators.
- Orient and train a new Access Agency as a result of the most recent competitive procurement
- Implement a fully electronic client record and work flow to improve efficiency and response time.

COST-EFFECTIVENESS OF THE WAIVER

Program Cost and Projected Savings

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

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

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

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

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

SAVINGS	—	COSTS	=	NET SAVINGS
\$ 237,537,078	—	\$ 132,374,867	=	\$ 105,162,211

This analysis is based on date-of-service data. It does not include bills that may have been paid after the end of SFY 2013.

The analysis of these factors reveals that the program costs are significantly less than the estimated savings in nursing facility expenditures. The amount of the difference represents the overall savings realized due to the Waiver home care program.

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

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

The Department's formula for estimating the net savings under the Waiver portion of the CT Home Care Program for Elders utilizes an analysis estimating savings by assuming that all Waiver clients would have entered a nursing facility in the absence of the program. In order to be conservative, the first three months stay on the program for new enrollees was not counted toward the savings on the assumption that individuals would try to delay the nursing facility admission as long as possible. Based on the longer length of stay prior to nursing facility admission, the Department has made an additional adjustment in the formula over past years. The Department has not projected savings for any newly enrolled individuals admitted within the fiscal year even though the costs for their services are still counted.

Since new enrollees receive services for an average of six months during the fiscal year of their enrollment, this adjustment has the effect of counting the home care costs but not counting savings for that period. To account for the fact that other Medicaid recipients might fill some of the beds that were left vacant by individuals who enroll in the CT Home Care Program for Elders, the analysis reduces the projected savings by 35% since 35% of nursing home admissions are for individuals on Medicaid.

SFY 2013
Connecticut Home Care Program for Elders
Average Monthly Cost / Case
Summary
Based on Date of Service

Statewide													
		Title XIX			State Funded			1915i			Total		
MAR	COS	Annual Recipients	Annual Expenditures	Cost / Service	Annual Recipients	Annual Expenditures	Cost / Service	Annual Recipients	Annual Expenditures	Cost / Service	Annual Recipients	Annual Expenditures	Cost / Service
Screening Services													
	611	3,096	\$ 863,000	\$ 278.75	3,751	\$ 1,022,152	\$ 272.50	157	\$ 43,668	\$ 278.14	7,004	\$ 1,928,820	\$ 1,935,824
	612	1,370	\$ 156,211	\$ 114.02	535	\$ 55,747	\$ 104.20	16	\$ 1,491	\$ 93.19	1,921	\$ 213,449	\$ 215,370
	613	113	\$ 33,109	\$ 293.00	128	\$ 22,463	\$ 175.49	36	\$ 13,825	\$ 384.04	277	\$ 69,397	\$ 69,674
		0	\$ -	\$ -	0	\$ -	\$ -	0	\$ -	\$ -	0	\$ -	\$ -
	Sub-Total		\$ 1,052,320			\$ 1,100,361			\$ 58,985			\$ 2,211,665	
		Total Unduplicated Recipients	Annual Expenditures	Avg. Mo. Cost / Recipient (b)	Total Unduplicated Recipients	Annual Expenditures	Avg. Mo. Cost / Recipient (b)	Total Unduplicated Recipients	Annual Expenditures	Avg. Mo. Cost / Recipient (b)	Total Unduplicated Recipients	Annual Expenditures	Avg. Mo. Cost / Recipient (b)
Waiver Services													
	601	12,692	\$ 17,974,529	\$ 118.02	5,344	\$ 4,868,007	\$ 75.91	578	\$ 1,181,740	\$ 170.38	18,614	\$ 24,024,275	\$ 24,042,889
	602	1,678	\$ 13,355,427	\$ 663.26	539	\$ 2,456,986	\$ 379.87	83	\$ 507,712	\$ 509.75	2,300	\$ 16,320,124	\$ 16,322,424
	603	569	\$ 407,571	\$ 59.69	145	\$ 72,604	\$ 41.73	23	\$ 9,656	\$ 34.98	737	\$ 489,831	\$ 490,568
	604	7,311	\$ 42,048,791	\$ 479.29	2,333	\$ 6,270,402	\$ 223.97	352	\$ 846,153	\$ 200.32	9,996	\$ 49,165,346	\$ 49,175,342
	605	0	\$ -	\$ -	0	\$ -	\$ -	0	\$ -	\$ -	0	\$ -	\$ -
	606	4,858	\$ 7,804,410	\$ 133.88	1,504	\$ 1,057,588	\$ 58.60	278	\$ 764,687	\$ 229.22	6,640	\$ 9,626,686	\$ 9,633,326
	607	9,121	\$ 38,029,971	\$ 347.46	3,718	\$ 7,244,933	\$ 162.38	497	\$ 1,921,113	\$ 322.12	13,336	\$ 47,196,017	\$ 47,209,353
	608	598	\$ 540,624	\$ 75.34	95	\$ 32,000	\$ 28.07	22	\$ 16,989	\$ 64.35	715	\$ 589,613	\$ 590,328
	609	8,560	\$ 3,696,252	\$ 35.98	3,355	\$ 996,284	\$ 24.75	281	\$ 145,013	\$ 43.00	12,196	\$ 4,837,548	\$ 4,849,744
	60A	44	\$ 77,829	\$ 147.40	20	\$ 33,871	\$ 141.13	0	\$ -	\$ -	64	\$ 111,700	\$ 111,764
	60B	184	\$ 26,683	\$ 12.08	71	\$ 27,320	\$ 32.07	3	\$ 2,771	\$ 76.98	258	\$ 56,774	\$ 57,032
	60C	278	\$ 4,579,815	\$ 1,372.85	468	\$ 5,622,188	\$ 1,001.10	12	\$ 240,526	\$ 1,670.32	758	\$ 10,442,529	\$ 10,443,287
	60D	2,004	\$ 45,371,891	\$ 1,886.72	535	\$ 4,724,399	\$ 735.89	4	\$ 11,814	\$ 246.13	2,543	\$ 50,108,103	\$ 50,110,646
	60E	57	\$ 252,051	\$ 368.50	4	\$ 9,305	\$ 193.85	0	\$ -	\$ -	61	\$ 261,356	\$ 261,417
	60F	88	\$ 51,711	\$ 48.97	15	\$ 8,353	\$ 46.40	0	\$ -	\$ -	103	\$ 60,064	\$ 60,167
	60G	409	\$ 10,718,382	\$ 2,183.86	111	\$ 1,325,726	\$ 995.29	0	\$ -	\$ -	520	\$ 12,044,108	\$ 12,044,628
	Sub - Total (c)	10,591	\$ 184,935,935	\$ 1,455.13	3,656	\$ 34,749,966	\$ 792.08	578	\$ 5,648,174	\$ 814.33	14,825	\$ 225,334,075	\$ 1,266.63
	Home Health Services (d)	10,591	\$ 57,841,973	\$ 455.12	3,656	\$ 5,952,544	\$ 135.68	578	\$ 666,790	\$ 96.13	14,825	\$ 63,794,517	\$ 358.60
	Total - Comm. Svcs.	10,591	\$ 243,830,228	\$ 1,918.53	3,656	\$ 41,802,871	\$ 952.84	578	\$ 6,373,948	\$ 918.97	14,825	\$ 291,340,257	\$ 1,637.66

(a) All Screening Services and Waiver Services expenditures and unduplicated recipients are from a Data Warehouse query."

(b) Avg. Monthly Cost per Recipient reflects the Annual Expenditures divided by the Total Unduplicated Count of Recipients.

(c) Subtotal figures under the Total Unduplicated Clients column are the Average Monthly Clients calculated for SFY13.

(d) Home Health Expenditures for Title XIX and 1915i Recipients are estimated, since these costs do not appear on the 613T-ACU

**SUMMARY OF PROGRAM COSTS AND SAVINGS (BY DATE OF SERVICE)
WAIVER CLIENTS
SFY 2013**

ASSESSMENTS

A	Assessments	3,096
B	Cost/Assessment	\$279
C	Annual Assessment Cost (AxB)	\$863,000

COMMUNITY & HOME HEALTH SERVICES

	Average Monthly Clients Served	10,591
	Monthly Community Services Cost	\$1,455
D	Annual Community Services Cost	\$184,935,935
	Monthly Home Health Cost	\$455
E	Annual Home Health Cost	\$57,841,973
	Annual Status Reviews	1,370
F	Annual Status Review Cost	\$156,211
G	Annual Services Cost (D+E+F)	\$242,934,119

AID TO THE AGED, BLIND, & DISABLED

	Average Monthly Clients Served	2,542
	Monthly OAA Cost	\$640
H	Annual OAA Cost	\$19,521,331

ADMINISTRATIVE EXPENSES

	Personal Services	\$842,629
	Fringe Benefits	\$588,655
	Other Expenses	\$0
I	Annual Administrative Cost*	\$1,431,284
J	Total Program Costs for SFY 2013 (C+G+H+I)	\$264,749,734
K	Adjustments	\$0
L	Adjusted Total Program Costs for SFY 2013 (J+K)	\$264,749,734
M	Federal Medicaid Reimbursement (50%xL)	(\$132,374,867)
N	Total State Program Costs After Federal Reimbursement (L+M)	\$132,374,867

NURSING HOME SAVINGS

O	Average Monthly Continuing Clients	10,399
P	Monthly NH Cost per Medicaid Client	\$5,857
	Nursing Home Savings Due to CHCP:	
Q	Total Client Months for Continuing Clients (Ox12)	124,788
R	Annual Nursing Home Savings Due to CHCP (PxQ)	\$730,883,316
S	Additional Costs for Medicaid Nursing Home Beds Filled Due to Diverted CHCP Clients (35%xR)	(\$255,809,161)
T	Total Nursing Home Savings for SFY 2013 (R+S)	\$475,074,155
U	Federal Medicaid Reimbursement (50%xT)	(\$237,537,078)
V	Total Nursing Home Savings After Federal Reimbursement (T+U)	\$237,537,078

NET FISCAL IMPACT

	Net State Savings for SFY 2013 (V-N)	\$105,162,211
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*Health Screens not included

**SFY 2013
CONNECTICUT HOME CARE PROGRAM FOR ELDER
PROGRAM COSTS BY DATE OF SERVICE**

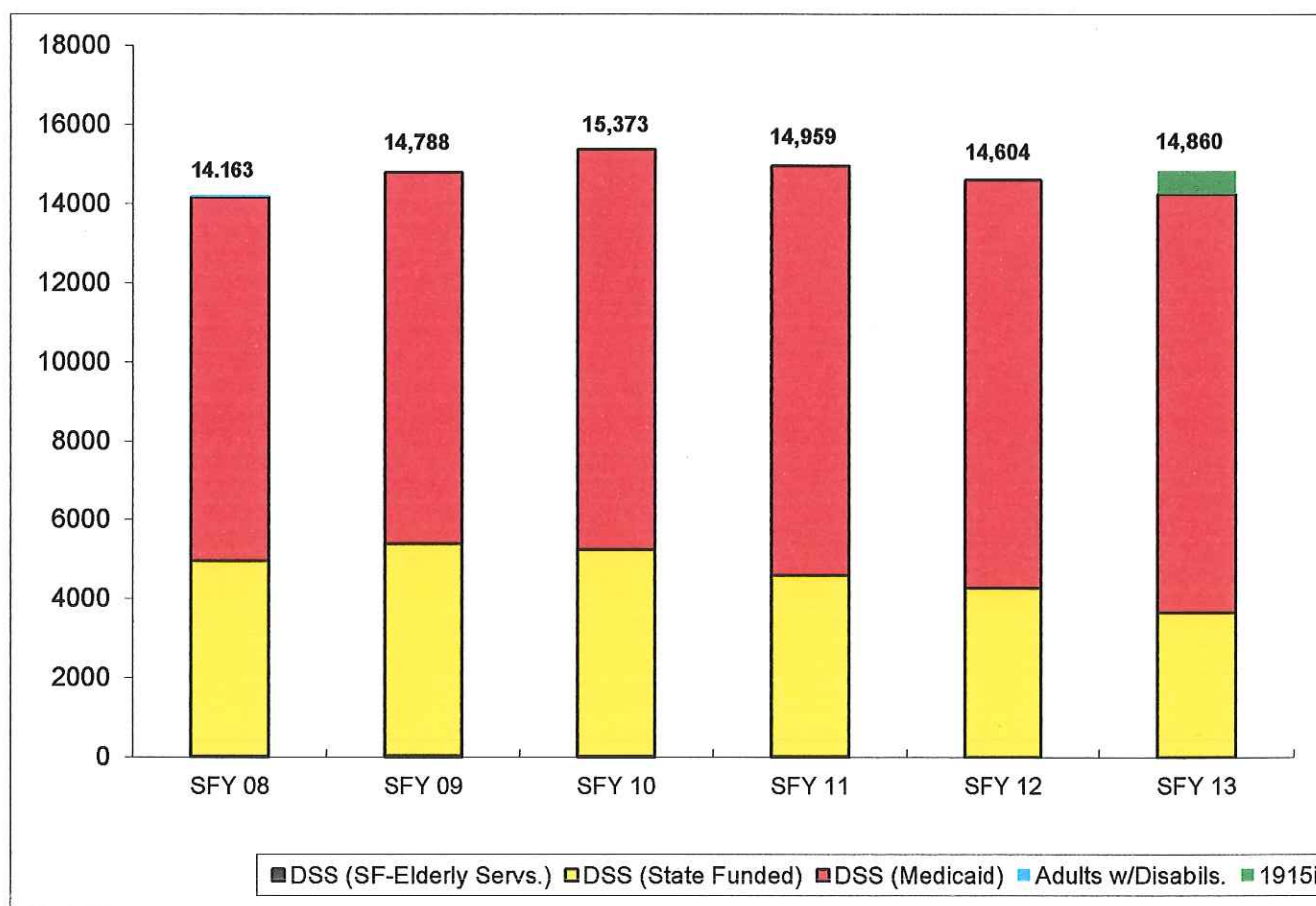
Program Expenses	Waiver	1915i	State Funded	Total
Assessments / Status Reviews	\$1,052,320	\$58,985	\$1,100,361	\$ 2,211,665
Home and Community Based Services	\$ 242,777,908	\$ 6,314,963	\$ 40,702,510	\$ 289,795,382
Total Expenses	\$243,830,228	\$6,373,948	\$41,802,871	\$ 292,007,047
Administrative Services	Waiver	1915i	State Funded	Total
Personal Services	\$842,629	\$47,472	\$296,700	\$1,186,801
Fringe Benefits	\$588,655	\$33,164	\$207,273	\$829,092
Other Expenses (Rent costs for allocated staff)				
Annual Administrative Costs	\$ 1,431,284	\$ 80,636	\$ 503,973	\$ 2,015,893
Net Costs	Waiver	1915i	State Funded	Total
Total Cost	\$ 245,261,512	\$ 6,454,584	\$ 42,306,844	\$ 294,022,940
Federal Reimbursement for Administrative Expenses	\$ (715,642)	\$ (40,318)	\$ -	\$ (755,960)
Federal Reimbursement for Program Expenses*	\$ (121,915,114)	\$ (3,186,974)	\$ -	\$ (125,102,088)
Net State Costs for SFY 2013	\$ 122,630,756	\$ 3,227,292	\$ 42,306,844	\$ 168,164,892

*Federal financial participation for Medicaid and 1915i expenditures estimated at 50%.

The following chart illustrates the overall trend in home care growth for elders within Connecticut.

ELDER HOME CARE CLIENTS AVERAGE MONTHLY CASELOADS

	<i>DSS State Funded (Elderly Services)</i>	<i>DSS State Funded</i>	<i>DSS Medicaid (Waiver)</i>	<i>DSS 1915i</i>	<i>DSS Adults with Disabilities</i>	<i>TOTAL</i>
<i>SFY 08</i>	24	4,923	9,216			14,163
<i>SFY 09</i>	31	5,357	9,400			14,788
<i>SFY 10</i>	22	5,224	10,127			15,373
<i>SFY 11</i>	21	4,580	10,358			14,959
<i>SFY 12</i>	3	4,264	10,337			14,604
<i>SFY 13</i>	-	3,656	10,591	568	45	14,860



CONNECTICUT HOME CARE PROGRAM OVERVIEW

Financial Eligibility – Medicaid Waiver

In order to qualify financially for the Waiver portion of the program, an elderly person (age 65 or older) must meet the income and asset rules applicable to an institutionalized Medicaid applicant. As specified in the Federal Waiver, this means that the gross income limit is 300% of the SSI payment, or **\$2,130**. The asset limit for an unmarried applicant is \$1,600, although a number of resources such as a residence, car, burial reserve and \$1,500 face value life insurance policy are exempt. There are special provisions in federal law regarding the treatment of assets for married couples when one spouse is considered “institutionalized” which allows for the protection of assets for the community spouse. As of January 2012, the law allowed a community spouse to protect assets from **\$23,184** up to **\$115,290** depending upon the couple’s original assets, in addition to the \$1,600 that the “institutionalized” person can keep. If both spouses require Waiver services, each can only have assets of \$1,600 after exemptions.

Financial Eligibility – State Funded

The State Funded portion of the program has no income limit. The financial eligibility difference between State Funded and Medicaid Waiver is related to asset limits. When the State Funded programs were consolidated in 1992, an asset limit was established to enable individuals with more assets than the Medicaid limit, but not unlimited assets, to qualify for State Funded home care. However, existing clients with assets higher than the new limit were allowed to continue receiving services. The asset limit for an individual in the State Funded portion of the program is 150% of the minimum amount that a community spouse could have under Medicaid; this figure was **\$34,776 as of January 2013**. A couple on the State Funded portion of the program can have 200% of that amount, or **\$46,368 as of January 2013**.

Financial Eligibility – 1915i

Participants in this category of service are Medicaid recipients whose income is at or below 150% of the federal poverty level.

Targeting the Frail Older Person

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

In SFY13, 7,897 individuals were referred for a full assessment of their needs to consider their potential for community placement. This is an increase of 2.0% over the previous year of 7,743.

Client Targeting

	New Program Referrals	New Clients
SFY 2008	7,936	3,798
SFY 2009	7,547	3,445
SFY 2010	6,891	4,306
SFY 2011	7,815	4,386
SFY 2012	7,743	3,895
SFY 2013	7,897	4,193

Assessment, Plan of Care Development, and Care Management

The care manager conducts a full assessment of the individual to determine service needs. Based on the results of the assessment, the care manager develops a written, individualized plan of community based social and medical services. The comprehensive plan of care specifies the type, frequency, duration and cost of all services needed for each client. The care manager is required to use the client's informal support system and pursue other funding sources before utilizing program funds. Direct client services other than care management are rendered by agencies which subcontract with the Access Agency and are registered with the Department.

Many individuals receiving home care services also receive the services of an independent care manager throughout their stay on the program. The care manager is a nurse or social worker who monitors the client's status monthly, reviews the care plan regularly and fully reassesses the client annually. Care management also includes ensuring that services are provided in accordance with the plan of care. As noted, care management is only provided when needed by the individual.

Application of Cost Limits

Once the plan of care is completed, the care manager must assure that the State's cost for the client's total plan of care, both medical and community based social services, does not exceed the average State cost of nursing facility care. This amount is calculated by deducting the average applied income contribution from the weighted average monthly Medicaid rate for nursing facility beds.

As of **January 1, 2013**, the limit on the total plan of care was **\$5,857** and remained the same through the end of **SFY 2013**. As noted above, the cost limits on the State Funded portion of the program are based on a percentage of this amount. There is also a specific requirement that the cost of social services under the Waiver cannot exceed 60% of the average nursing home rate. As of **January 1, 2013**, the limit on total plan of care for Medicaid Waiver Social Services costs was **\$4,173** and remained the same through the end of **SFY 2013**.

Client Fee

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

Acceptance of Services

The elderly individual is offered the choice of accepting a plan of home and community based care as an alternative to institutional care. This choice is required by federal law and must be documented in writing. In **SFY 2013**, **4,193** clients accepted plans of care for home and community based services in contrast to **3,895** in the prior year. This represents **53%** of the persons referred for assessment.

Client Characteristics

The following tables represent Demographic and Social Information, Health Status Information and additional characteristics of clients served by the CT Home Care Program for Elders.

CLIENT CHARACTERISTICS

SFY 2013

DEMOGRAPHIC AND SOCIAL INFORMATION

AGE	
UNDER 65*	0.2%
65-69	10.5%
70-74	15.1%
75-79	17.3%
80-84	19.3%
85-89	19.0%
90-94	13.3%
95-99	4.4%
OVER 99	0.9%

MARITAL STATUS	
WIDOWED	50.1%
MARRIED	16.8%
DIVORCED	18.4%
SEPARATED	3.1%
NEVER MARRIED	11.3%

RACE/ETHNICITY	
CAUCASIAN	65.9%
BLACK	13.3%
HISPANIC	17.7%
AM. INDIAN/ALASKAN NATIVE	0.2%
ASIAN/PACIFIC ISLANDER	1.0%

GENDER	
FEMALE	73.6%
MALE	26.4%

LIVING ARRANGEMENT	
ALONE	55.6%
WITH SPOUSE	13.3%
W/CHILDREN	20.4%
W/SPOUSE/CHILD.	2.4%
W/SIBLING/RELATIVES	3.5%
W/NON-RELATIVES	4.8%

HOUSING	
ELDERLY/OTHER SUBSIDIZED	35.7%
HOME OF CHILD/OTHER REL.	18.6%
APARTMENT/TRAILER	25.1%
OWN HOUSE/CONDO	15.3%
NURSING HOME/OTHER INSTIT.	1.6%
OTHER	3.8%

MEDICAID	
YES	72.4%
NO	27.6%

* Clients who are under the age of 65 and receiving CBS were grandparented in on the program from a pilot preadmission screening program.

In addition, State-funded CHCPDA clients, who are persons with disabilities ages 18-64, fall into this age group.

CLIENT CHARACTERISTICS

SFY 2013

HEALTH STATUS

SELF-PERCEIVED HEALTH	
GOOD	38.5%
FAIR	51.2%
POOR	9.1%
INFO INCOMPLETE	1.2%

ACTIVE MEDICAL PROBLEMS	
HEART DISEASE	29.6%
CVA/STROKE	13.1%
CANCER	12.3%
RESPIRATORY	14.1%
DIABETES	37.1%
ALZH/OTHER DEMENTIA	25.3%
BEHAVIORAL HLTH DIAG	27.5%

MUSCULOSKELETAL	
ARTHRITIS	57.0%
FRACTURES	8.4%
OSTEOPOROSIS	13.5%

CLIENT CHARACTERISTICS

SFY 2013

PHYSICAL FUNCTION

INDICATORS OF COGNITIVE FUNCTION

IADL DEPENDENCIES*	
SHOPPING	96.4%
TRAVEL/TRANSPORTATION	90.7%
HOUSEKEEPING	98.6%
LAUNDRY	92.7%
MEAL PREP	95.7%
MANAGING MEDICATIONS	80.4%
MANAGING FINANCES	73.8%
TELEPHONING	19.8%

COGNITIVE IMPAIRMENT (SCORES ON MSQ**)	
NONE OR MINIM. IMPAIRMENT(0-2 errors)	79.9%
MODERATE IMPAIRMENT(3-8 errors)	17.9%
SEVERE IMPAIRMENT(9-10 errors)	2.3%

ADL DEPENDENCIES***	
BATHING	87.5%
DRESSING	55.5%
TOILETING	20.6%
TRANSFERRING	20.5%
BLADDER CONTINENCE	30.5%
BOWEL CONTINENCE	14.7%
FEEDING(EATING)	13.6%

BEHAVIOR PATTERN	
WANDERING	2.7%
OTHER	2.9%
ABUSIVE	2.6%
UNSAFE	11.4%
REQUIRES SUPERVISION	57.8%

MOBILITY DEPENDENCY	
STAIRCLIMBING	62.2%
MOBILITY(OUTDOORS)	41.0%
WALKING(INDOORS)	21.5%
WHEELING	21.1%

* Instrumental Activities of Daily Living

** Mental Status Quotient

*** Activities of Daily Living

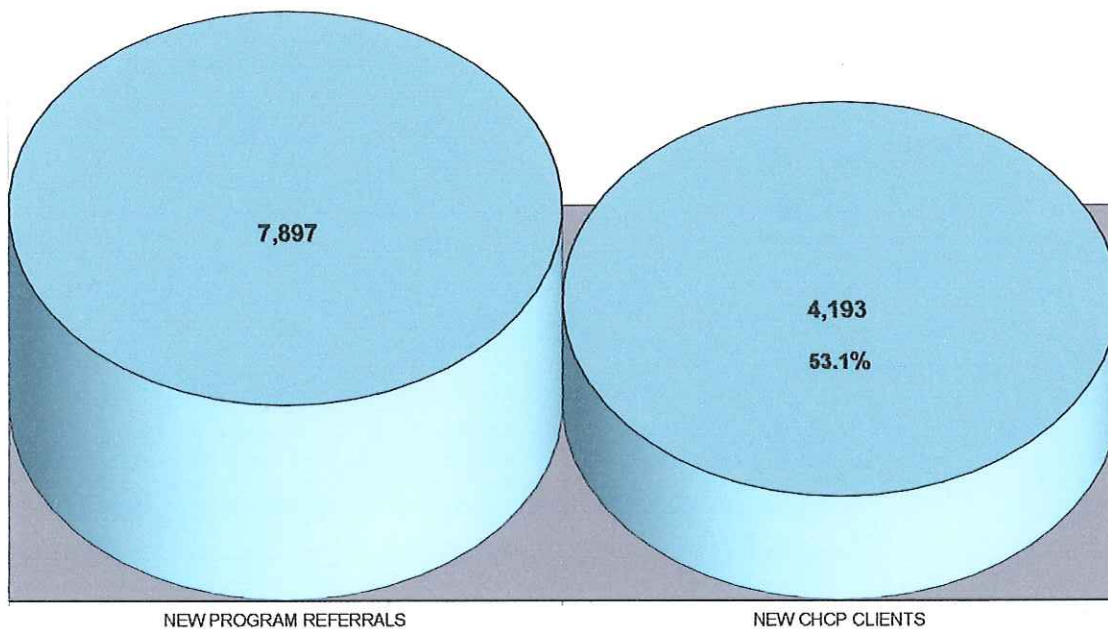
CASELOAD TRENDS 7/1/12 - 6/30/13

During the twenty sixth year of operations, July 1, 2012 through June 30, 2013, the combined Waiver and State Funded Program caseload decreased by 3%.

New Program Referrals and Placement Activity

The number of new clients placed on services during SFY 2013 was 4,193. An average of 349 new clients were placed on services each month and an average of 291 discharges occurred, resulting in an average net increase of 58 clients each month.

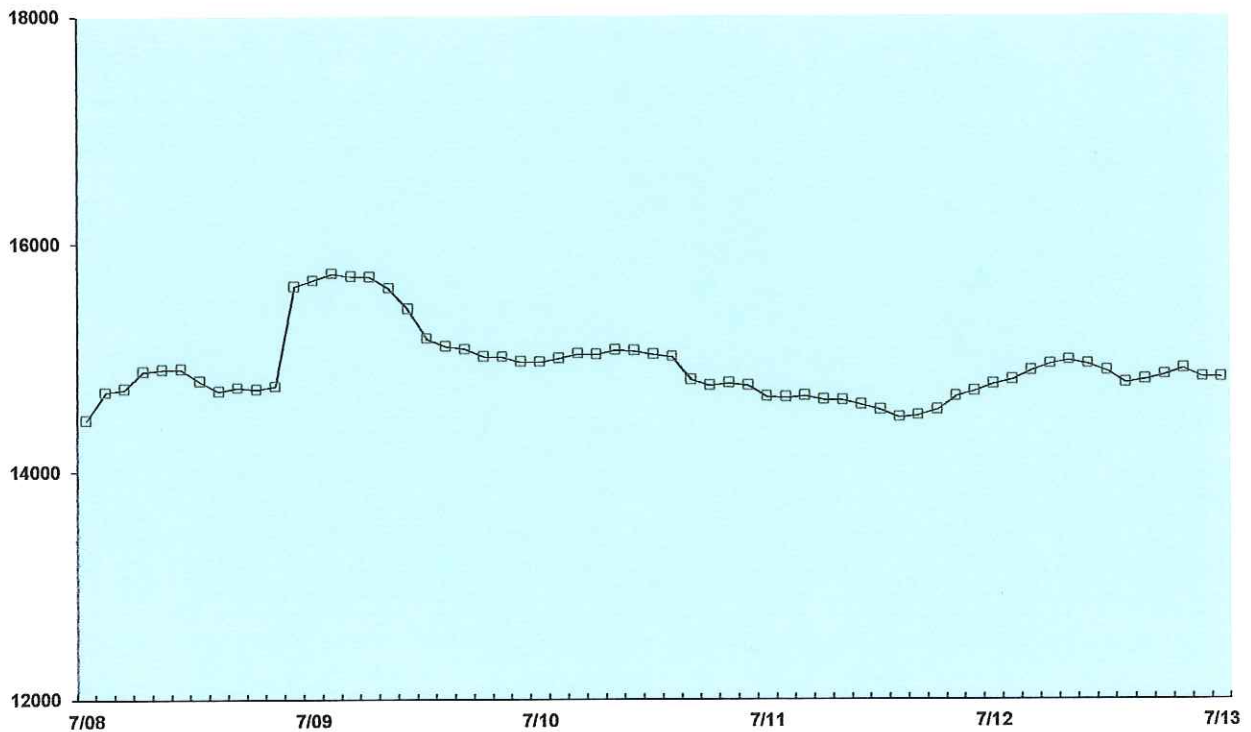
SFY13 PROGRAM ACTIVITY



Caseload

The following graph illustrates the Connecticut Home Care Program for Elders caseload since July 2008. As of June 30, 2013 there were 14,823 clients. This represents a .8% increase from the 14,703 active cases at the end of SFY 2012. The monthly average Connecticut Home Care Program for Elders caseload for SFY 2013 was 14,860.

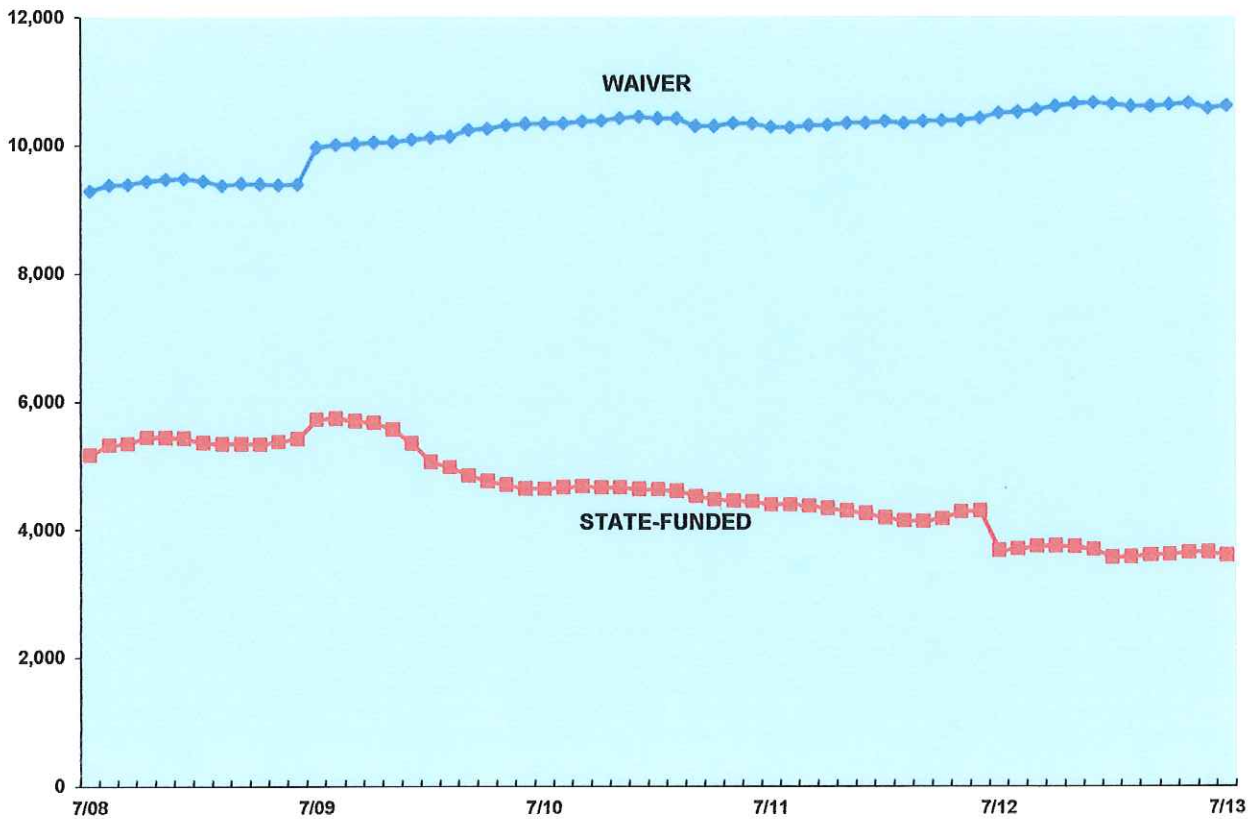
CONNECTICUT HOME CARE PROGRAM CASELOAD GROWTH



Caseload by Funding Source

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

The graph below illustrates the volume trends for State Funded and Waiver clients since the beginning of SFY 2009. As of June 30, 2013, approximately 71% of the persons receiving program services were Waiver clients.



Admissions and Discharges

Since July of 1990 the Department has monitored the volume of Waiver and State Funded clients.

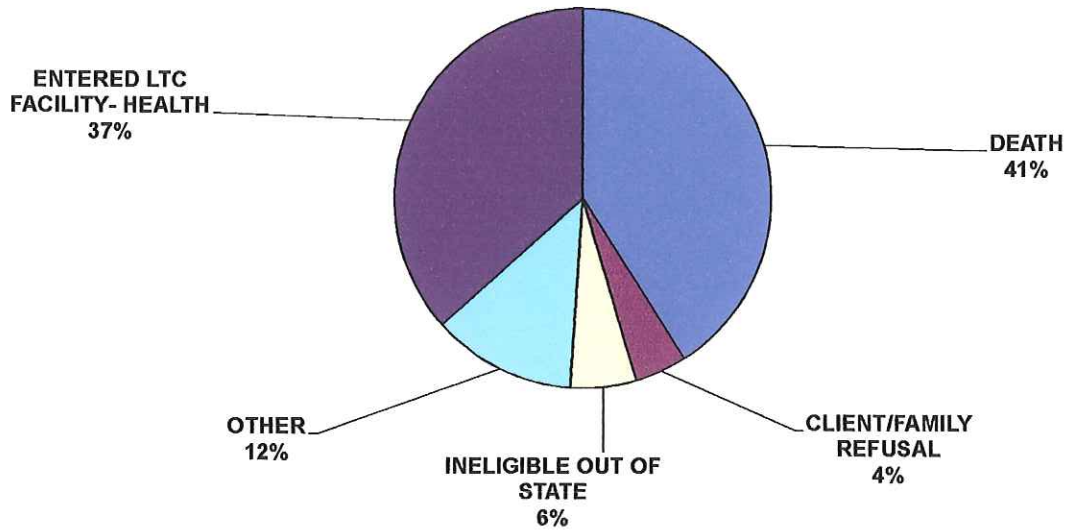
CT HOME CARE PROGRAM FOR ELDERS PROGRAM ACTIVITY

SFY 2013

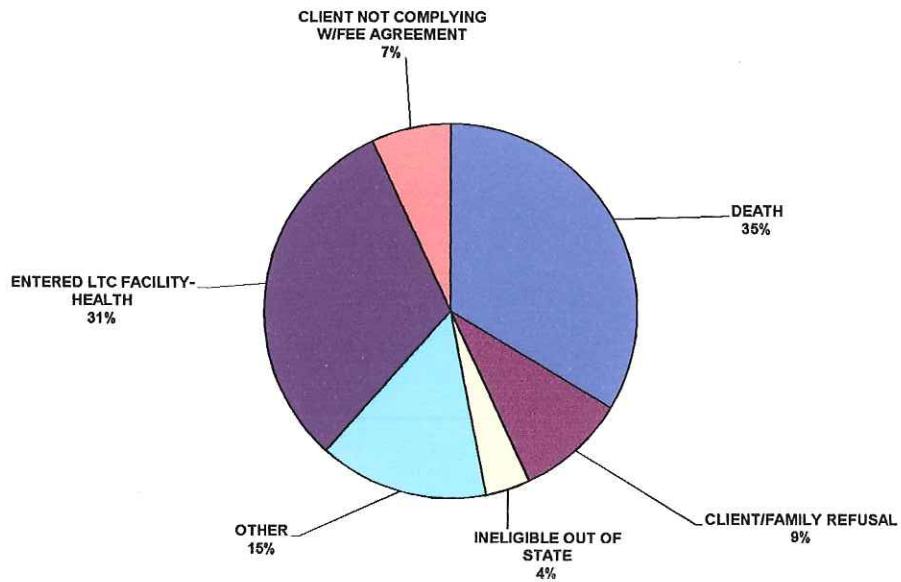
	CAT 1	CAT 2	CAT 3	CAT 4	CAT 5	TOTAL
	STATE FUNDED	STATE FUNDED	WAIVER	ADULTS WITH DISABILITIES	1915i	
CLIENTS BEGINNING OF YEAR	1,668	2,575	10,416	44	0	14,703
ADMISSIONS	470	1,144	2,309	4	40	3,967
DISCHARGES	(251)	(956)	(2,258)	(5)	(16)	(3,486)
ADJUSTMENTS	(804)	(206)	94	36	556	(361)
CLIENTS AT END OF YEAR	1,083	2,557	10,561	42	580	14,823

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

SFY 2013 WAIVER DISCHARGE REASONS



SFY 2013 STATE-FUNDED DISCHARGE REASONS



Transfers Within the Program

Since all home care services are now consolidated under the Department of Social Services, individuals do not need to transfer from one Department to another as their needs change. Most older persons who receive home care services from the Department are served under the Connecticut Home Care Program for Elders. However, some individuals who were "grandparented" into the former Essential Services Program, now the Department's Adult Services Division Community Based Services Program, continue to receive services through the Connecticut Home Care Program for Elders. These individuals do not necessarily qualify for the Medicaid Waiver; however, once qualified, these individuals are generally transferred to Medicaid to capture federal matching funds for their services.

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

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

PROGRAM EXPENDITURES AND COST SAVING PROGRAM ACTIVITIES

Program Expenditures 7/1/12 - 6/30/13

Actual program expenditures in SFY 2013 totaled \$289,795,382 before federal reimbursement. Actual expenditures after federal funds and reimbursement were \$164,693,294.

SFY 2013 Expenditures

	Waiver	State Funded	1915i	Total
Average Monthly Cost/Case	\$ 1,919	\$ 953	\$ 919	\$ 1,638
Total Cost	\$ 242,777,908	\$ 40,702,510	\$ 6,314,963	\$ 289,795,382
Federal Funds/Reimbursement	(\$ 121,915,114)	(\$ -0-)	(\$ 3,186,974)	(\$ 125,102,088)
Net State Cost	\$ 120,862,794	\$ 40,702,510	\$ 3,127,989	\$ 164,693,294

Mandatory Medicaid Applications

As noted above, all State Funded clients served by the Department are required to apply for Medicaid if their financial information indicates that they would qualify. This insures that the State receives the 50% match of federal funds wherever possible and lowers the percentage of clients whose services are purchased with 100% State funds. State Funded clients who appear to be eligible for Medicaid continue to be identified when their income and assets are reviewed during annual reassessments of functional status.

**For information regarding this report, please call:
Department of Social Services, Alternate Care Unit at
1-800-445-5394**

APPENDIX A -1

Brief History of the Connecticut Home Care Program for Elders

In the mid 1980's, the federal government offered states opportunities for expanding home care under special options called Medicaid "home and community-based services waivers." These options were called waivers because they allowed states to "waive" certain Medicaid rules including restrictive income limits and prohibitions against coverage for non-medical services. The rationale for creating the federal waivers rested in the belief that individuals, who would otherwise be institutionalized at the state's expense, could be diverted from this costly option if services were available to support them at home. In addition to home health services already covered by Medicaid (e.g. nursing, home health aide, physical therapy, speech therapy, occupational therapy and medical transportation), a wide array of home care services were considered necessary to adequately support a frail elder in the community. These services included: homemaker, home delivered meals, adult day care, chore help, non-medical transportation, companionship, emergency response systems, respite care, mental health counseling and care management. The federal waiver option thus allowed states to receive federal matching funds (50% match in Connecticut) for services which previously had been paid primarily with state funds.

In 1985, following a successful demonstration project, the Connecticut General Assembly voted to establish an expanded home care program taking advantage of the new waiver option. This legislation directed the Department of Income Maintenance (DIM) to apply for the federal waiver to maximize federal reimbursement but also required the program to serve individuals who would not qualify for the waiver and whose services would thus be fully state-funded. The program, then called the Long Term Care Pre-Admission Screening and Community-Based Services Program, (PAS/CBS) began statewide operation in 1987. It was targeted to very frail elders identified by hospital or nursing facility staff as likely to be admitted to a nursing facility within sixty days.

In 1990, the General Assembly began steps to consolidate home care services for elders. Public Act 90-182 ended admissions for elders in the Adult Services Program operated by the Department of Human Resources and in the state-funded portion of the PAS/CBS program operated by DIM. While existing clients were able to continue receiving services through their respective programs, new applicants in need of state-funded home care services were referred to the Promotion for Independent Living at the Department on Aging. Elders who were eligible for the Medicaid Waiver program could still apply to the Department of Income Maintenance.

The second phase of the consolidation came at the end of the SFY'92 Session. Through Public Act 92-16 of the May Session, the General Assembly merged three major programs: The Pre-admission Screening and Community Based Services, The Promotion of Independent Living and The Elder Services portion of the Adult Services Program and reinstated the state-funded portion of the home care program. The home care program was then renamed The Connecticut Home Care Program for Elders.

Under the umbrella of the Connecticut Home Care Program for Elders, the program continued to have two components, one fully state-funded; the other receiving matching funds under the federal waiver. The following year, the State reorganized several human services departments resulting in the consolidation of the three original departments under the new Department of Social Services.

Over the past years, new developments in the program increased consumer choices and expanded opportunities for consumers to influence the services that so directly affected their lives.

In February 1993, recognizing that many frail older persons were capable of working directly with their providers to assure that their service needs were met safely and efficiently, the Department began to implement a concept called "self directed care."

APPENDIX A -2

In SFY '95 with the enactment of P.A. 95-160 Subsection 7 of this act eliminated the licensing of Co-ordination, Assessment and Monitoring Agencies and substituted in their place a new entity called an "Access Agency." The Department consulted with the Home Care Advisory Committee over the following summer to develop standards for this new agency and issued regulations and a Request for Proposals the following November. New Department contracts to provide assessment and care management services were awarded in 1996 to three area Access Agencies.

The establishment of a waiting list for the Connecticut Home Care Program for Elders, in effect from SFY '96 through SFY '97, slowed the growth of the program. Intake for the home care program re-opened in August 1996, and by December 1997 all eligible individuals' applications from that waiting list were processed for program services.

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

DEPARTMENT OF SOCIAL SERVICES
CONNECTICUT HOME CARE PROGRAM & 1915(i) State Plan Option - FEE FOR SERVICE USE ONLY
Effective 1/1/2013

rev:12/12

APPENDIX B

<u>Category Type</u>	<u>Description</u>	<u>Functional Need</u>	<u>Financial Eligibility</u>	<u>Care Plan Limits</u>	<u>Funding Source</u>	<u>Intake Status</u>
Category 1 CHCPE	Limited home care for moderately frail elders	At risk of hospitalization or short term nursing home placement (1 or 2 critical needs)	Individual Income= No Limit* Assets: Individual = \$34,776.00 Couple= \$46,368.00	<25% NH Cost (\$1464.00 Monthly)	STATE	OPEN
Category 2 CHCPE	Intermediate home care for very frail elders with some assets above the Medicaid limits.	In need of short or long term nursing home care (3 critical needs)	Individual Income= No Limit* Assets: Individual = \$34,776.00 Couple= \$46,368.00	<50% NH cost (\$2928.00 Monthly)	STATE	OPEN
Category 3 CHCPE	Extensive home care for very frail elders who would otherwise be in a nursing home on Medicaid.	In need of long term nursing home care (3 critical needs)	Individual Income=\$2130.00/Mth Assets: Individual \$1,600.00 Couple: both as clients = \$1600.00 each one as client = \$24,784.00 (\$1600.00 + \$23,184.00 CSPA)**	100% NH Cost (\$5857.00 Monthly) Social Services Cap=\$4,173.00	MEDICAID WAIVER	OPEN
Category 4 CHCPD	Intermediate home care for individuals under age 65 with a degenerative neurological condition. ineligible for Medicaid	In need of short or long term nursing home care (3 critical needs)	Individual Income= No Limit* Assets: Individual = \$34,776.00 Couple= \$46,368.00	<50% NH cost (\$2928.00 Monthly)	STATE	CLOSED limited to 50 slots
Category 5 1915(i)	Same as category 1. Also active on categorically needy Medicaid S01, S02, S03, S04 Must be age 65 or older	At risk of hospitalization or short term nursing home placement (1 or 2 critical needs)	Individual Income - \$1,437 Assets: Individual \$1,600.00	50% Federal Reimbursement		OPEN

APPENDIX C-1

Sec. 17b-342. (Formerly Sec. 17-314b). Connecticut home-care program for the elderly.

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

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

APPENDIX C-2

contracts, the commissioner may use department staff to provide screening, coordination, assessment and monitoring functions for the program.

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

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

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

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

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

APPENDIX C-3

savings, and (6) a comparison between costs under the different contracts.

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

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

(2) Any person whose income exceeds two hundred per cent of the federal poverty level shall contribute to the cost of care in accordance with the methodology established for recipients of medical assistance pursuant to Sections 5035.20 and 5035.25 of the department's uniform policy manual.

(3) On and after June 30, 1992, the program shall serve persons receiving state-funded home and community-based services from the department, persons receiving services under the promotion of independent living for the elderly program operated by the Department of Social Services, regardless of age, and persons receiving services on June 19, 1992, under the home care demonstration project operated by the Department of Social Services. Such persons receiving state-funded services whose income and assets exceed the limits established pursuant to subdivision (1) of this subsection may continue to participate in the program, but shall be required to pay the total cost of care, including case management costs.

(4) Services shall not be increased for persons who received services under the promotion of independent living for the elderly program over the limits in effect under said program in the fiscal year ending June 30, 1992, unless a person's needs increase and the person is eligible for Medicaid.

(5) The annualized cost of services provided to an individual under the state-funded portion of the program shall not exceed fifty per cent of the weighted average cost of care in nursing homes in the state, except an individual who received services costing in excess of such amount under the Department of Social Services in the fiscal year ending

APPENDIX C-4

June 30, 1992, may continue to receive such services, provided the annualized cost of such services does not exceed eighty per cent of the weighted average cost of such nursing home care. The commissioner may allow the cost of services provided to an individual to exceed the maximum cost established pursuant to this subdivision in a case of extreme hardship, as determined by the commissioner, provided in no case shall such cost exceed that of the weighted cost of such nursing home care.

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

APPENDIX D

MEMBERS OF THE CT HOME CARE PROGRAM FOR ELDERS ADVISORY COMMITTEE

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Priscilla Russell/Linda Berneggar

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Maria Dexter

State of CT – DSS
Alternate Care Unit – 9th Fl.

Paul Chase

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Shirlee Stoute

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LeadingAge
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Kathy Bruni

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Alternate Care Unit – 9th Fl.

Margi Gerundo-Murkette

State of CT - DSS
Elderly Services Div. – 10th Fl.

Sheila Nolte

State of CT – DSS
Alternate Care Unit – 9th Fl.

Amy Dumont

State of CT - DSS
Alternate Care Unit – 9th Fl.

Maximum
Self
Direction

Minimum
Self
Direction

APPENDIX E

<p style="text-align: center;"><u>Client Managed</u></p> <p>Client or Family hires and trains workers independently or through a broker. (Personal Care Assistance Model available under CHCPE as a Pilot Program)</p>	<p style="text-align: center;"><u>Client Coordinated</u></p> <p>Client/Family purchases services through social service agencies and occasionally health agencies and is able to maintain maximum control of decision making. Scheduling and monitoring (third party may pay for the services purchased.)</p>	<p style="text-align: center;"><u>Provider Coordinated</u></p> <p>Client/Family receives services primarily through a health agencies; one agency takes the primary role in coordinating and monitoring health services, and possibly referring to other services, but the client/family assume responsibility for co-ordinating and monitoring the total plan of care</p>	<p style="text-align: center;"><u>Provider Managed</u></p> <p>Client/Family receives services primarily through a lead health agency which subcontracts with other agencies, as needed, to provide support services. The lead health agency assumes full responsibility for coordination and monitoring of plan of care with client/family input. (Lead Provider)</p>	<p style="text-align: center;"><u>Access Agency Coordinated</u></p> <p>Client/Family receives services which are arranged, coordinated and monitored by an access agency. Client is able to retain a high degree of control over decision making, scheduling and monitoring; therefore, care management by an access agency may not be intensive and may be short term</p>	<p style="text-align: center;"><u>Access Agency Managed</u></p> <p>Client/Family receives services which are arranged, coordinated and monitored by an access agency. Due to cognitive status of client and/or lack of family support, client control is limited and care management by an access agency is intensive</p>
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APPENDIX F-1

CT HOME CARE PROGRAM FOR ELDERS SOUTH CENTRAL REGION CLIENT SATISFACTION SURVEY REPORT MARCH 2013

1. SURVEY ADMINISTRATION AND POPULATION

The Alternate Care Unit conducted a client satisfaction survey for the Connecticut Home Care Program for Elders (CHCPE) care managed clients, residing in the program's South Central Region. A cover letter and a one page two sided survey were sent to one hundred and one (101) active CHCPE clients. This represents approximately three percent (3%) of the current total client population of 2956 clients, residing in the program's South Central Region.

The surveys were mailed on March 15, 2013. Clients were asked to return the survey by April 15, 2013. Active category one, two and three clients in the CHCPE program's South Central Region were selected randomly.

2. SURVEY RESULTS

Thirty-nine percent (39%) of surveyed clients responded to the survey. Eight (8%) of all surveys mailed were returned undeliverable because of incorrect address or client expiration.

The survey results are presented in six (6) defining categories: (A) respondent identifier; (B) CHCPE alternatives; (C) service satisfaction; (D) service dependability; (E) contact awareness; and (F) service utilization.

A. RESPONDENT IDENTIFIER

Sixty-nine percent (69%) of those completing the survey were program clients, twenty-six percent (26%) were family members, two percent (2%) were caregivers and the remaining three percent (3%) were completed by those identified as "other".

B. CHCPE ALTERNATIVES

Ninety percent (90%) of survey respondents indicated how they would manage without home care services. Thirty-four percent (34%) of these respondents reported they would enter a nursing home. Twenty-two percent (22%) said that they would do without home care services and thirty-five percent (35%) reported they would depend on family/friends for help. Nine percent (9%) of those responding said they would rely on some other home care alternative.

C. SERVICE SATISFACTION

Overall, CHCPE clients participating in the survey rated the services they received favorably.

D. SERVICE DEPENDABILITY

Eighty-seven percent (87%) of respondents reported that they received services when they were scheduled. Thirteen percent (13%) reported not being able to depend on receiving services as scheduled.

APPENDIX F-2

E. CONTACT AWARENESS

Eighty-two (82%) of clients reported they know to contact a care manager if they have a question about their services. Fifteen percent (15%) contact family and friends regarding services and three percent (3%) reported they would contact someone "other". Thirteen percent (13%) of survey respondents indicated they did not know who their care manager was.

F. CHCPE SERVICE UTILIZATION

Service utilization is assumed when a respondent rates a particular service on the survey. Conversely, services not rated by the respondent are considered services the client does not receive. The analysis of service utilization is limited to the number of clients reporting receiving the service, and does not include how often the services are received in a certain amount of time. Care management services are not included in the analysis since all survey participants receive care management services.

Sixty-five percent (65%) of survey respondents reported receiving Home Health Aide and seventy-eight percent (78%) Homemaker services; making them the most frequently reported services. The third and fourth most frequently reported services were Skilled Nursing at Sixty percent (60%) and Emergency Response System services which were reported by Fifty-five percent (55%), followed by Home Companion at forty-eight percent (48%), meals on wheels with twenty percent (20%), chore person at fifteen percent (15%), Adult Day Centers at fifteen percent (15%).

G. SUMMARY AND CONCLUSIONS

The Alternate Care Unit, Connecticut Department of Social Services, administered a client satisfaction survey for the CHCPE South Central Region in March 2013. One Hundred and one (101) clients in the CT Home Care Program's South Central Region were surveyed. Thirty-nine percent (39%) of surveyed clients responded to the survey. Program clients completed sixty-nine percent of the returned surveys. Family members were the second most frequent survey responders, accounting for about one fourth, followed by "others" and caregivers.

Many respondents, clients and family, expressed thanks and appreciation for the services provided and the support received from the staff employed in the South Central region.

Skilled Nursing Services, Home Health Aides and Emergency Response Systems had Good or Excellent ratings at ninety-six percent (96%). Companion Services ratings were at eighty-nine percent (89%).

The survey results also clearly indicated areas of focus where the South Central Region of the CHCPE has potential for improvement:

Meals on Wheels received an Excellent rating from twelve percent (12%) of respondents, a Good rating of fifty percent (50%) was received with thirteen percent (13%) of all respondents giving a rating of Fair and twenty-five percent (25%), one quarter of clients served, rating their service as poor.

APPENDIX F-3

Service dependability ratings at eight-seven percent (87%), Homemaker at eighty-four percent (84%) and Adult Day Services at eighty-three percent (83%), require increased monitoring.

Thirteen percent (13%) of clients responding to the survey indicated they did not know who their Care Manager was.

A new system for maintaining and updating client demographics at CT DSS should assist in decreasing the number of undeliverable or redirected surveys.

H. EXHIBITS

Cover Letter and Survey

Pie Charts reflecting the following:

- Survey Respondent
- Managing Without Services
- Skilled Nursing Services
- Home Health Aide
- Homemaker
- Companion
- Chore Person
- Meals On Wheels
- Adult Day Centers
- Emergency Response System

Bar Charts reflecting the following:

- Service Dependability
- Contact Awareness
- Client Satisfaction

Connecticut Home Care Program for Elders

Connecticut Home Care Program For Elders

Alternate Care Unit Mission

The mission of the Alternate Care Unit is to develop and offer cost-effective community-based and other long term care alternatives to individuals and families with continuing care needs and policies pertinent to long term care residents.

The activities of the Alternate Care Unit take place under the overall mission of the Connecticut Department of Social Services which is to serve families and individuals who need assistance in maintaining or achieving their full potential for self-direction, self reliance and independent living.



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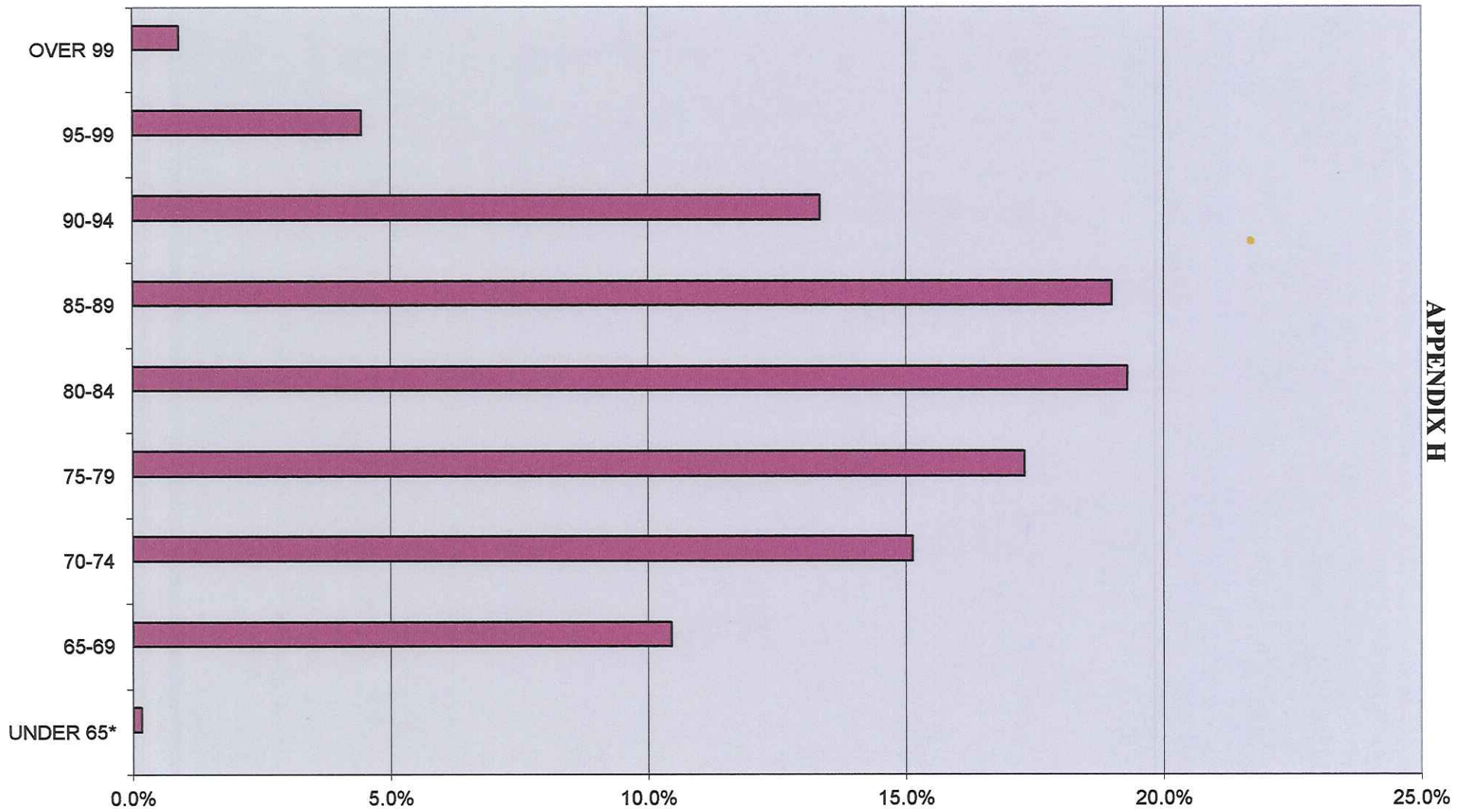
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- Skilled Nursing Services
- Home Health Aide
- Homemaker
- Companion
- Chore Person
- Meals On Wheels
- Adult Day Centers
- Emergency Response System

Bar Charts reflecting the following:

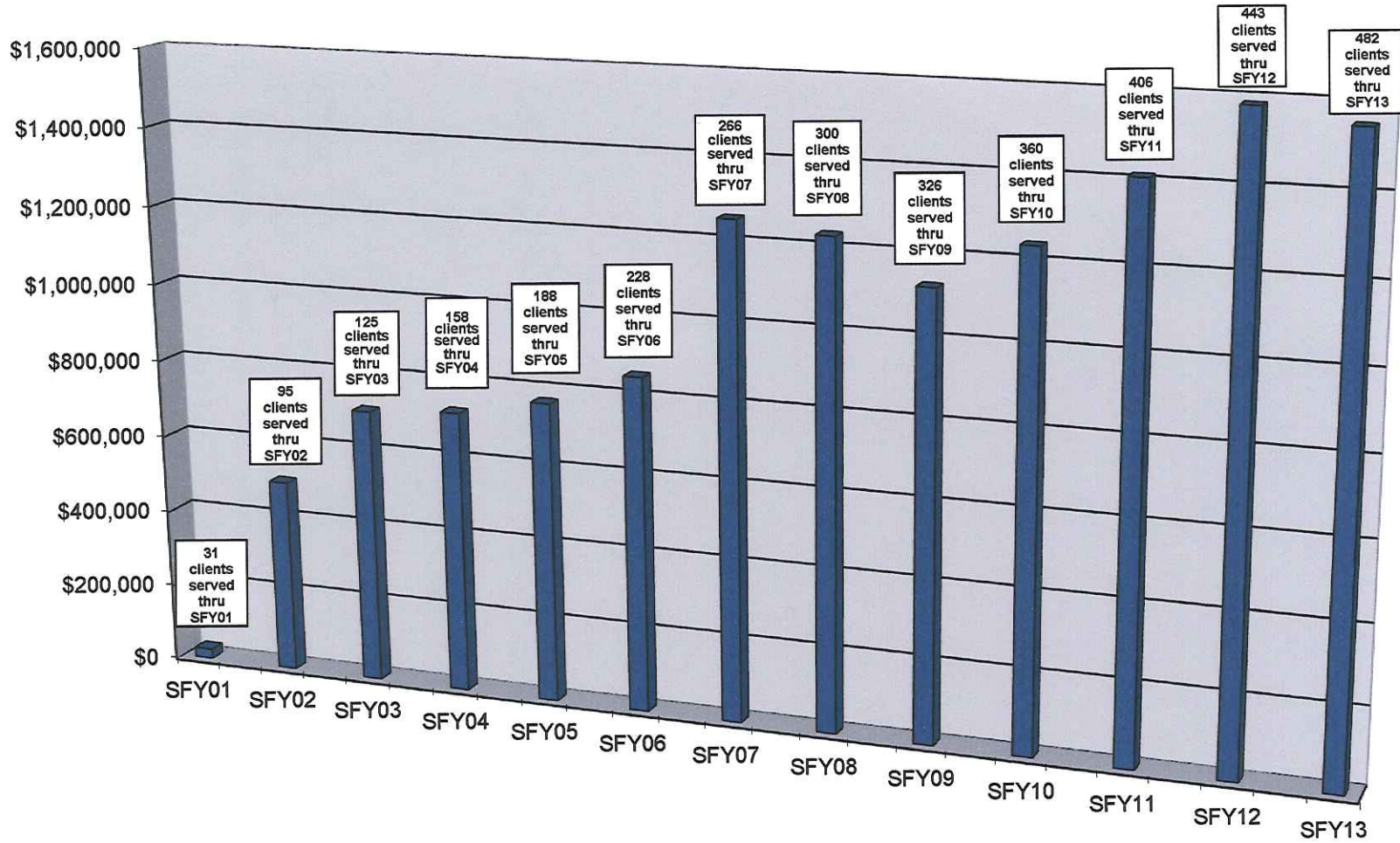
- Service Dependability
- Contact Awareness
- Client Satisfaction

SFY2013 CHCP AGE DISTRIBUTION



APPENDIX H

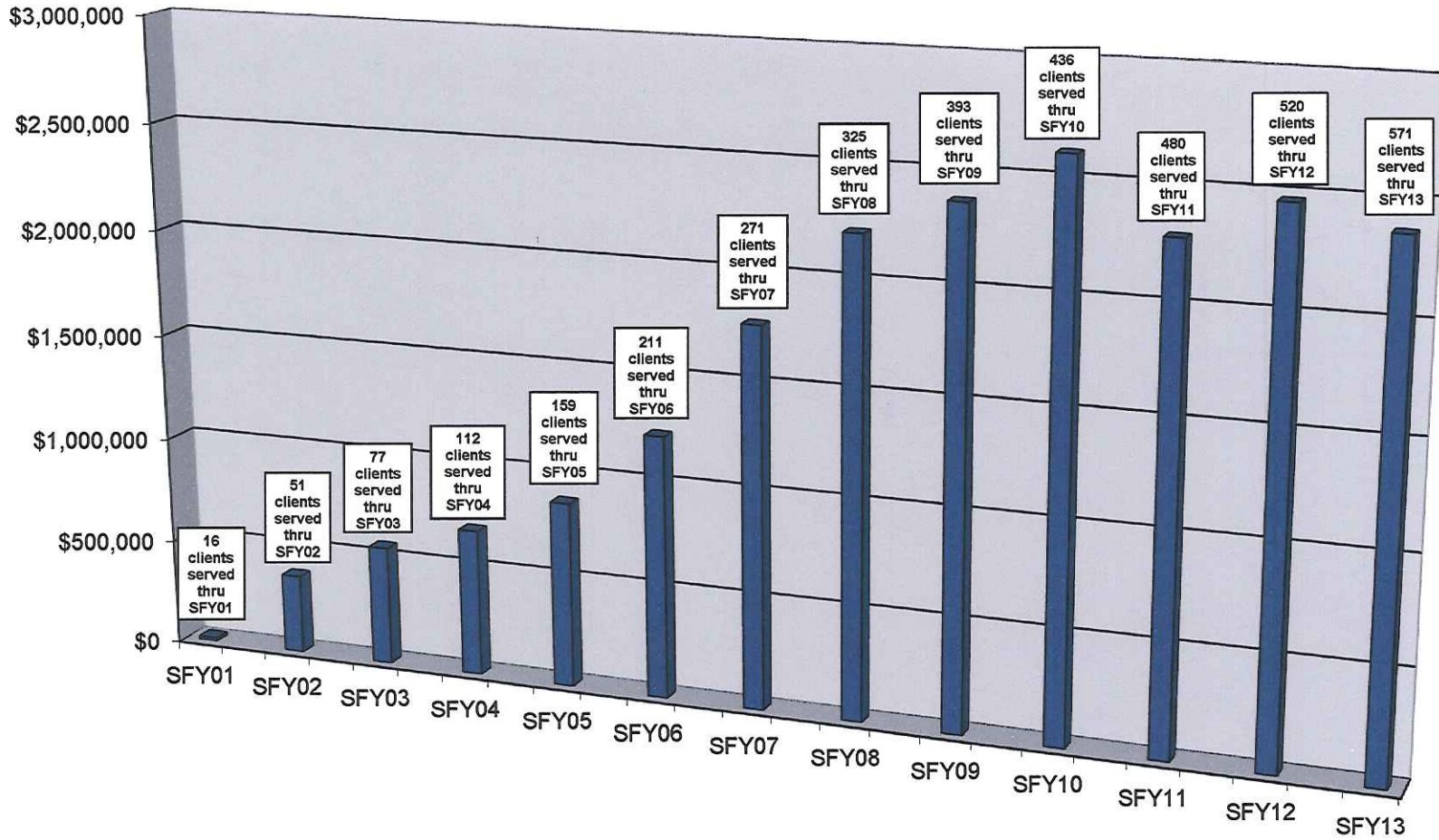
STATE FUNDED CONGREGATES GROWTH



APPENDIX I

The Connecticut Home Care Program for Elders began offering Assisted Living Services in State Funded Congregate housing facilities in March 2001.

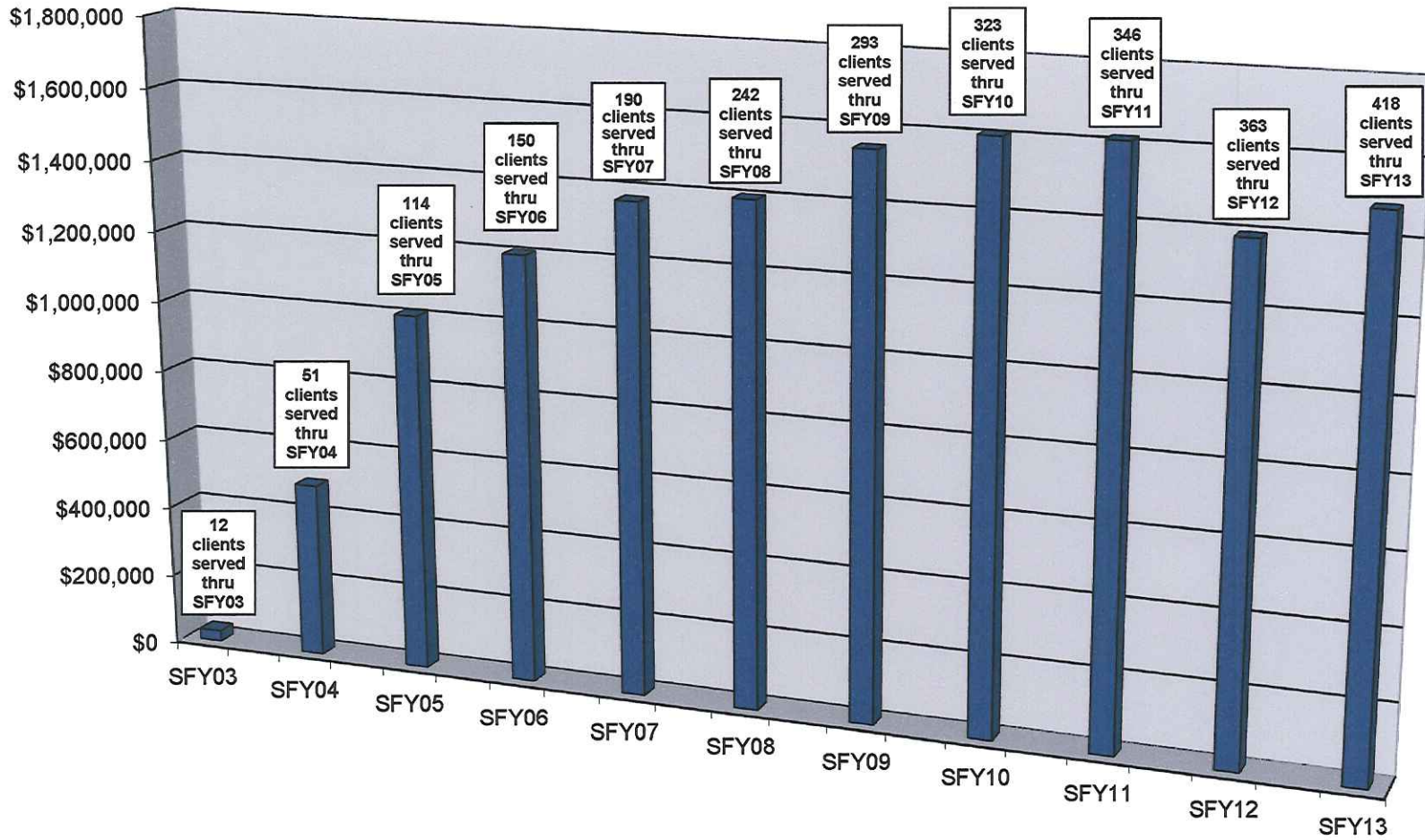
HUD FACILITIES GROWTH



APPENDIX J

The Connecticut Home Care Program for Elders began offering Assisted Living Services in federally funded HUD facilities in March 2001.

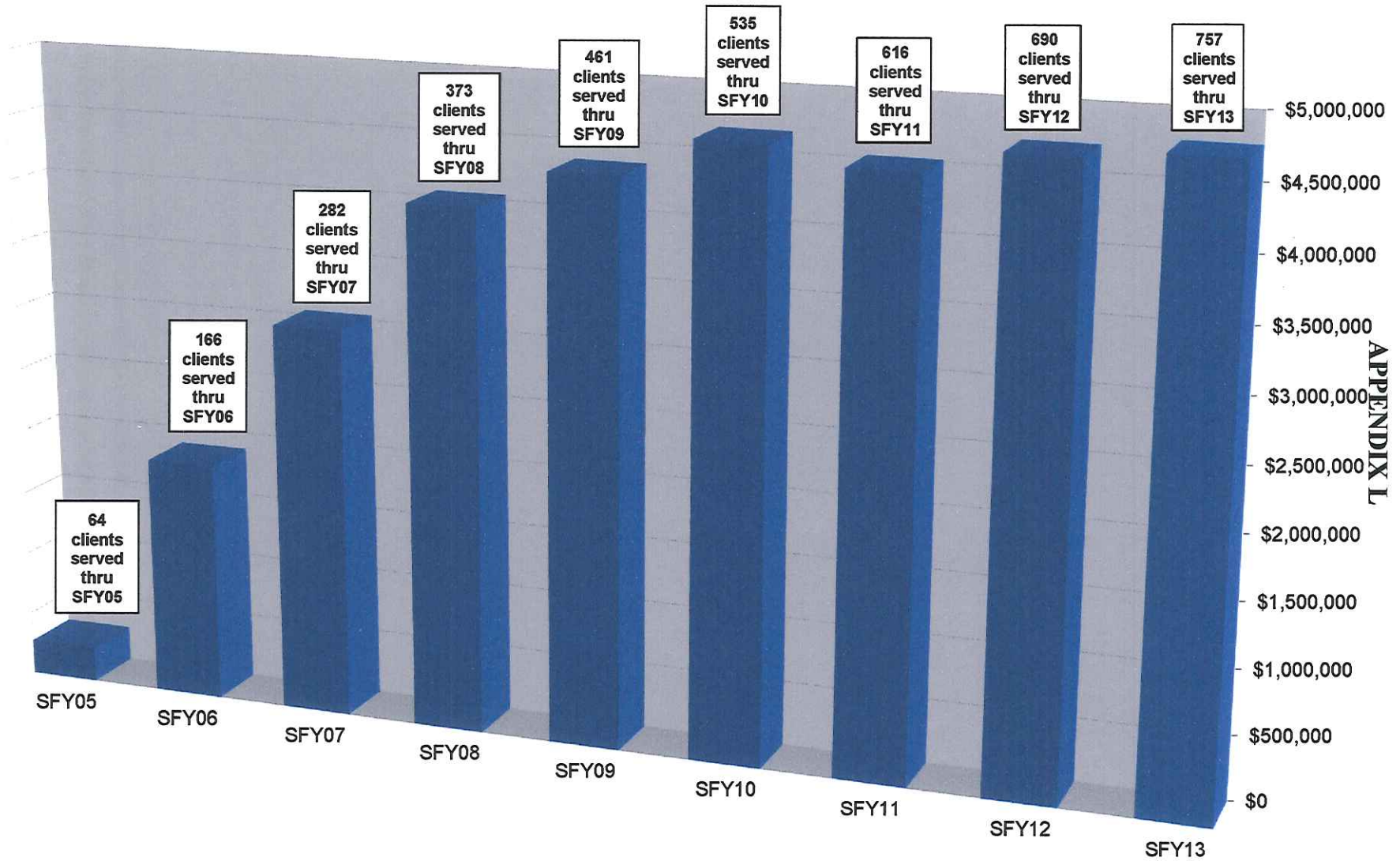
PRIVATE ASSISTED LIVING PILOT PROGRAM GROWTH



APPENDIX K

The Private Assisted Living Pilot began in March 2003.

ASSISTED LIVING DEMONSTRATION PROJECT GROWTH



The first units under the demonstration project became occupied in September 2004.

APPENDIX M CRITICAL INCIDENTS SFY13

