Connecticut Home Care

Home Care at a Glance

SFY 2009 Annual Report

To The Legislature

July 2008- June 2009

Connecticut Department of Social Services

Caring for Connecticut

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APPENDICES

Connecticut Home Care Program for Elders at a Glance

- 17,788 elders were served on the State Funded and Medicaid Waiver portions of the CT Home Care Program for SFY 2009. Calculated with table data. See Page 24.

- $ 99,231,258 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 2009 was 14,756. See Page 22.

- The average monthly cost per client on the State Funded portion of the CT Home Care Program was $ 981 and the Medicaid Waiver portion of the CT Home Care Program was $ 1,715. See Page 10.

- The program expenditures for the Medicaid Waiver and State Funded portion of the CT Home Care Program were $ 253,334,113. See Page 27.

- The number of individuals screened for the CT Home Care Program who were referred for assessment and became clients was 3,445. See Page 15.

- The average length of stay on the CT Home Care Program is 3.9 years. See Page 16.

Program Description and Organization

Through the CT Home Care Program for Elders, the State provides long term care services for older persons who continue to live at home**.** Options in the program such as the PCA Pilot 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 care 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 care 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 care 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 three-tiered structure, which enables individuals to receive home care services in levels corresponding to their functional needs and financial eligibility. The first two categories are funded primarily through a State appropriation. Individuals in the third category qualify for reimbursement under the Medicaid waiver program, therefore, costs for this category are equally distributed between Federal and State funds.

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 most needy group of elders, the average cost of care is less than half of the cost limit.

The following are descriptions of the three 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.

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. The Pilot provides seventy-five (75) 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, 2009, the Private Assisted Living Pilot has served a total of 293 clients at a cost of
$7,065,597. This figure includes both core and assisted living service charges and covers a six 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 will 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, 2009, 326 clients had received services in State funded congregate facilities at a cost of $7,193,990. This figure includes both core and assisted living service charges and covers an eight year period.

As of June 30, 2009, 393 clients had received services in the HUD facilities participating in the assisted living pilot at a cost of $10,090,103. This figure includes both core and assisted living service charges and covers an eight 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, 2009, 461 clients had received services in the DEMO facilities participating in the assisted living pilot at a cost of $ 13,543,431. This figure includes both core and assisted living service charges over a five year period.

Personal Care Assistance Pilot

The CT Home Care Program for Elders Personal Care Assistance Pilot was approved to serve up to 250 persons age 65 and older who meet all the technical, functional and financial eligibility requirements and for those clients that cannot access adequate home health services.

Persons under age 65 receiving services from the PCA Waiver for persons with disabilities become eligible for personal care assistance services under the CT Home Care Program for Elders when they turn age 65.

Legislation passed in 2006 allows participants on the PCA Waiver turning age 65 to choose between remaining on that program or receive services under the CT Home Care Program for Elders. Legislation passed in 2007 eliminated the 250 person cap but the program must operate within available appropriations.

As of June 30, 2009, 203 clients had been approved for services and 39 clients were pending.

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 2008, there were 192 active clients who were designated self directed care, representing 1.3 % of the total caseload. By the end of June 2009, there were 236 active self directed care clients representing 1.6 % of the total caseload.

The ACU clinical staff began to target those clients who, upon initial assessment into the program, appear to be candidates for self directed care after an initial six month period of care management services. These clients are reassessed for the self directed care option at the first six month interval rather than after one full year in the program.

The ACU staff began logging all self directed care referrals, their source, and disposition in an effort to spur Access Agency referrals and provide documentation of activity. On a scheduled basis, the Department evaluates all individuals in the program for self directed care to insure that only those clients who truly need care management are receiving that service.

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 caliber of services provided to our clients.

Our Quality Enhancement system has 2 teams to provide ongoing monitoring of program functions:

- The Quality Review Team conducts quarterly on-site/desk audits of access agencies and assisted living service agency records and visits provider agencies and clients;
- The Report 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 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. The Department of Social Services is informed and kept apprised of such actions.

Various QA activities are conducted to monitor provider compliance with CHCPE regulations and policies and to measure client satisfaction with services. Please refer to Appendix F for process and findings of the Access Agencies audits.

Onsite visits to providers are conducted including client record reviews and face to face interview. The QA team conducted a review at an Assisted Living Demonstration facility and chart reviews and client visits at four private assisted living facilities. Additionally, provider compliance was monitored by desk audits of a percentage of client records of three of the contracted access agencies.

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 affect the individual.
- To continue to expand the self directed care component of the Home Care Program by identifying appropriate clients.
- To improve the quality and accuracy of ad hoc program reports with the implementation of our Micro Systems Unit.
- To implement systems for managing quality improvement activities to identify trends and areas needing remediation or improvement

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
$ 205,613,554	__	$ **106,382,296**	=	$ **99,231,258**

This analysis is based on date-of-service data. It does not include bills that may have been paid after the end of SFY 2009.

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 2009

Connecticut Home Care Program for Elders

Average (Monthly) Cost / Case

Summary

Based on Date of Service

Statewide									
	State Funded			**Title XIX**			**Total**		
	Annual Services	Annual Expenditures	Cost / Service	Annual Services	Annual Expenditures	Cost / Service	Annual Services	Annual Expenditures	Cost / Service
Screening Services									
Assessments	3,911	$ 1,091,731	$ 279.14	1,999	$ 553,882	$ 277.08	5,910	$ 1,645,613	$ 278.45
Reviews	627	$ 56,969	$ 90.86	1,231	$ 109,642	$ 89.07	1,858	$ 166,611	$ 89.67
Health Screens	1,126	$ 33,725	$ 29.95	1,393	$ 41,831	$ 30.03	2,519	$ 75,556	$ 29.99
Misc. Adjustments	0	$ -	$ -	0	$ -	$ -	0	$ -	$ -
Sub-Total		**$ 1,182,425**	**$ 399.95**		**$ 705,355**	**$ 396.18**		**$ 1,887,780**	**$ 398.11**
	State Funded			**Title X1X**			**Total**		
	Total Un-duplicated Clients	Annual Expenditures	Avg. Mo. Cost / Client (a)	Total Un-duplicated Clients	Annual Expenditures	Avg. Mo. Cost / Client (a)	Total Un-duplicated Clients	Annual Expenditures	Avg. Mo. Cost / Client (a)
Waiver Services									
Respite Care	58	$ 107,952	$ 155.10	117	$ 161,420	$ 114.97	175	$ 269,372	$ 128.27
Non-Medical Transp.	163	$ 46,687	$ 23.87	285	$ 47,593	$ 13.92	448	$ 94,281	$ 17.54
Case Management	7,365	$ 8,532,654	$ 96.55	12,057	$ 16,259,797	$ 112.38	19,422	$ 24,792,452	$ 106.38
Adult Day Health	998	$ 4,478,785	$ 373.98	2,076	$ 12,052,614	$ 483.81	3,074	$ 16,531,399	$ 448.15
Chore	295	$ 208,991	$ 59.04	608	$ 419,890	$ 57.55	903	$ 628,881	$ 58.04
Companion	3,031	$ 7,258,997	$ 199.58	6,571	$ 32,342,836	$ 410.17	9,602	$ 39,601,833	$ 343.69
Meals	3,053	$ 3,857,354	$ 105.29	5,556	$ 8,779,312	$ 131.68	8,609	$ 12,636,666	$ 122.32
Homemaker	5,580	$ 15,278,495	$ 228.17	9,497	$ 44,020,397	$ 386.27	15,077	$ 59,298,892	$ 327.76
Mental Health Couns.	199	$ 150,019	$ 62.82	518	$ 461,411	$ 74.23	717	$ 611,430	$ 71.06
Personal Emerg. Resp.	4,881	$ 1,849,332	$ 31.57	8,964	$ 4,474,162	$ 41.59	13,845	$ 6,323,494	$ 38.06
Assisted Living	573	$ 6,291,399	$ 914.98	300	$ 3,624,945	$1,006.93	873	$ 9,916,344	$ 946.58
Sub - Total (c)	5,357	$ 48,060,667	$ 747.63	9,400	$ 122,644,376	$1,087.27	14,757	$170,705,043	$ 963.98
Home Health Svcs. (b)	5,357	$ 13,822,692	$ 215.03	9,400	$ 70,071,601	$ 621.20	14,757	$ 83,894,293	$ 473.75
Total - Comm. Svcs.	5,357	$ 63,065,785	$ 981.05	9,400	$ 193,421,332	$1,714.73	14,757	$256,487,116	$1,448.39

(a) Average Monthly Cost per Client reflects the Annual Expenditures divided by the Total Unduplicated Count of Clients divided by 12.

(b) Home Health Expenditures for Title XIX Clients are estimated, since these costs do not appear on the 613T-ACU.

(c) Subtotal clients figures are the Average Monthly Clients calculated for SFY09.

NOTE: All expenditures are from the MAR 915 Report except Home Health services expenditures which are from the Connecticut Home Care estimate.

SUMMARY OF PROGRAM COSTS AND SAVINGS (BY DATE OF SERVICE)
WAIVER CLIENTS
SFY 2009

	ASSESSMENTS	
A	Assessments	1,999
B	Cost/Assessment	$277
C	Annual Assessment Cost (AxB)	$553,882
	COMMUNITY & HOME HEALTH SERVICES	
	Average Monthly Clients Served	9,400
	Monthly Community Services Cost	$1,087
D	Annual Community Services Cost	$122,644,376
	Monthly Home Health Cost	$621
E	Annual Home Health Cost	$70,071,601
	Annual Status Reviews	1,231
F	Annual Status Review Cost	$109,642
G	Annual Services Cost (D+E+F)	$192,825,619
	AID TO THE AGED, BLIND, & DISABLED	
	Average Monthly Clients Served	2,256
	Monthly OAA Cost	$641
H	Annual OAA Cost	$17,353,152
	ADMINISTRATIVE EXPENSES	
	Personal Services	$1,312,450
	Fringe Benefits	$719,489
	Other Expenses	$0
I	Annual Administrative Cost*	$2,031,939
J	Total Program Costs for SFY 2009 (C+G+H+I)	$212,764,592
K	Adjustments	$0
L	Adjusted Total Program Costs for SFY 2009 (J+K)	$212,764,592
M	Federal Medicaid Reimbursement (50%xL)	($106,382,296)
N	Total State Program Costs After Federal Reimbursement (L+M)	$106,382,296
	NURSING HOME SAVINGS	
O	Average Monthly Continuing Clients	9,264
P	Monthly NH Cost per Medicaid Client	$5,691
Q	Nursing Home Savings Due to CHCP: Total Client Months for Continuing Clients (Ox12)	111,168
R	Annual Nursing Home Savings Due to CHCP (PxQ)	$632,657,088
S	Additional Costs for Medicaid Nursing Home Beds Filled Due to Diverted CHCP Clients (35%xR)	($221,429,981)
T	Total Nursing Home Savings for SFY 2009 (R+S)	$411,227,107
U	Federal Medicaid Reimbursement (50%xT)	($205,613,554)
V	Total Nursing Home Savings After Federal Reimbursement (T+U)	$205,613,554
	NET FISCAL IMPACT	
	Net State Savings for SFY 2009 (V-N)	$99,231,258

*Health Screens not included

SFY 2009
CONNECTICUT HOME CARE PROGRAM FOR ELDERS
PROGRAM COSTS BY DATE OF SERVICE

Program Expenses	State Funded	Waiver	Total
Assessments / Status Reviews	$ 1,182,425	$ 705,355	$ 1,887,780
Home and Community Based Services	$ 61,883,360	$ 191,450,753	$ 253,334,113
Sub - Total Expenses	$ 63,065,785	$ 192,156,109	$ 255,221,893

State-Funded PCA Pilot (Allied Community Resources)	$6,628,673	-	$6,628,673
Adjustments	$ -	$ -	$ -

Administrative Services	State Funded	Waiver	Total
Personal Services	$ 402,426	$ 1,312,450	$ 1,714,875
Fringe Benefits	$ 212,155	$ 719,489	$ 931,644
Other Expenses (Rent costs for allocated staff)	$ -	$ -	$ -
Annual Administrative Costs	$ 614,581	$ 2,031,938	$ 2,646,519

Net Costs	State Funded	Waiver	Total
Total Cost	$ 70,309,038	$ 194,188,047	$ 257,868,412
SSBG Funding - Program	$ -	$ -	$ -
SSBG Funding - Administrative	$ -	$ -	$ -
Federal Reimbursement - Medicaid *	$ -	$ (113,973,819)	$ (113,973,819)
Net State Costs for SFY 2009	$ 70,309,038	$ 80,214,227	$ 143,894,593

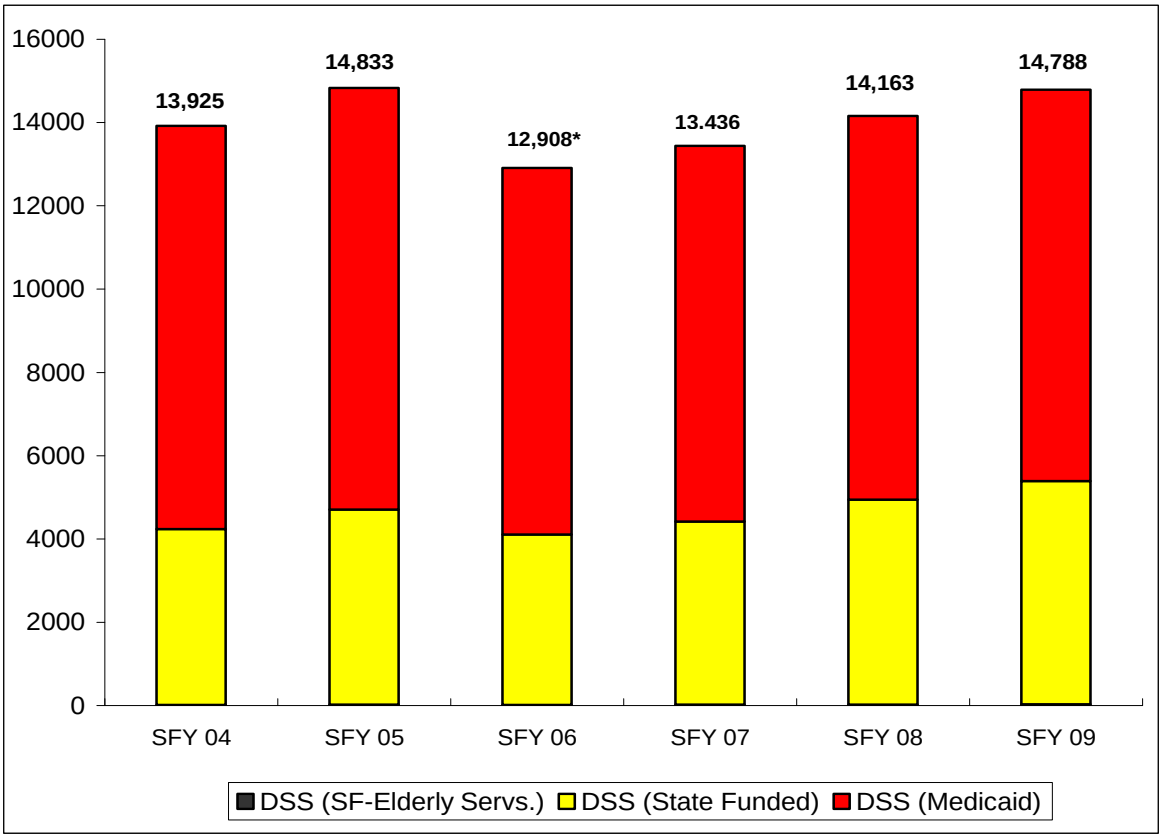
* Estimated based on one quarter at 50% federal financial participation and three quarters at 61.59%. This reflects the enhanced ARRA rate, which was implemented October 1, 2008.

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

ELDER HOME CARE CLIENTS

AVERAGE MONTHLY CASELOADS

	DSS State Funded (Elderly Services)	*DSS State Funded*	*DSS Medicaid (Waiver)*	*TOTAL*
SFY 04	*16*	*4,223*	*9,686*	*13,925*
SFY 05	*19*	*4,690*	*10,124*	*14,833*
SFY 06	*13*	*4,090*	*8,805*	*12,908**
SFY 07	*22*	*4,393*	*9,021*	*13,436*
SFY 08	*24*	*4,923*	*9,216*	*14,163*
SFY 09	*31*	*5,357*	*9,400*	*14,788*



* Reported numbers (SFY06 onward) reflect an accurate count of program participants based on a comprehensive review of several databases that provide client specific information. The review concluded that previously reported numbers were overestimated.

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 $2,022. 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 2009, the law allowed a community spouse to protect assets from $21,912 up to $109,560 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 $32,868 as of January 2009. A couple on the State Funded portion of the program can have 200% of that amount, or $43,824 as of January 2009.

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.

From July 1, 2008 through June 30, 2009, the Alternate Care Unit screened 15,242 elderly persons in contrast to 14,803 the previous year. This represents an increase of 3.0%. In SFY09, 7,547 individuals, approximately 50% of those screened, were referred for a full assessment of their needs to consider their potential for community placement. This is a decrease of 4.9% over the previous year of 7,936.

Client Targeting

	Persons Screened	Referred for Assessment	New Clients
SFY 2005	14,785	6,170 41.7%	4,361 29.5%
SFY 2006	14,875	6,605 44.4%	4,192 28.2%
SFY 2007	15,279	7,288 47.7%	4,021 26.3%
SFY 2008	14,803	7,936 53.6%	3,798 25.7%
SFY 2009	15,242	7,547 49.5%	3,445 22.6%

Note: Percentages are based on the number of persons screened

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, 2009, the limit on the total plan of care was $5,690.80 and remained the same through the end of SFY 2009. 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, 2009, the limit on total plan of care for Medicaid Waiver Social Services costs was $3,972.48 and remained the same through the end of SFY 2009.

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 2009, 3,445 clients accepted plans of care for home and community based services in contrast to 3,798 in the prior year. This represents 46% of the persons referred for assessment.

Length of Stay on the CT Home Care Program for Elders

Analysis of the data on all persons placed on services since SFY 1988, who have been discharged as of June 2009, indicates an average length of stay of 3.9 years.

Client Characteristics

The majority of the CT Home Care Program for Elders participants are Caucasian, female, widowed, live alone and are between the ages of 70 and 94. The following 3 pages present tables and additional demographic and social information of clients served by the CT Home Care Program for Elders.

CLIENT CHARACTERISTICS
SFY 2009

DEMOGRAPHIC AND SOCIAL INFORMATION

AGE	
UNDER 65*	0.3%
65-69	9.1%
70-74	14.8%
75-79	17.7%
80-84	20.9%
85-89	19.7%
90-94	12.9%
95-99	4.0%
OVER 99	0.7%

MARITAL STATUS	
WIDOWED	54.4%
MARRIED	18.7%
DIVORCED	14.8%
SEPARATED	3.1%
NEVER MARRIED	9.0%

RACE/ETHNICITY	
CAUCASIAN	70.6%
BLACK	12.7%
HISPANIC	14.2%
AM. INDIAN/ALASKAN NATIVE	0.1%
ASIAN/PACIFIC ISLANDER	0.8%

GENDER	
FEMALE	74.3%
MALE	25.7%

LIVING ARRANGEMENT	
ALONE	53.9%
WITH SPOUSE	14.5%
W/CHILDREN	21.7%
W/SPOUSE/CHILD.	2.6%
W/SIBLING/RELATIVES	3.7%
W/NON-RELATIVES	3.6%

HOUSING	
ELDERLY/OTHER SUBSIDIZED	38.2%
HOME OF CHILD/OTHER REL.	21.4%
APARTMENT/TRAILER	20.9%
OWN HOUSE/CONDO	14.0%
NURSING HOME/OTHER INSTIT.	1.5%
OTHER	3.8%

MEDICAID	
YES	65.7%
NO	34.3%

* 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 2009

HEALTH STATUS

SELF-PERCEIVED HEALTH	
GOOD	35.7%
FAIR	53.1%
POOR	9.6%
INFO INCOMPLETE	1.6%

ACTIVE MEDICAL PROBLEMS	
HEART DISEASE	30.6%
CVA/STROKE	12.9%
CANCER	12.6%
RESPIRATORY	13.9%
DIABETES	36.1%
ALZH/OTHER DEMENTIA	22.2%

MUSCULOSKELETAL	
ARTHRITIS	60.1%
FRACTURES	9.1%
OSTEOPOROSIS	14.7%

CLIENT CHARACTERISTICS
SFY 2009

PHYSICAL FUNCTION

IADL DEPENDENCIES*	
SHOPPING	96.0%
TRAVEL/TRANSPORTATION	88.7%
HOUSEKEEPING	98.0%
LAUNDRY	92.1%
MEAL PREP	93.5%
MANAGING MEDICATIONS	80.0%
MANAGING FINANCES	73.7%
TELEPHONING	18.3%

ADL DEPENDENCIES***	
BATHING	83.5%
DRESSING	48.0%
TOILETING	15.4%
TRANSFERRING	16.2%
BLADDER CONTINENCE	25.0%
BOWEL CONTINENCE	12.7%
FEEDING(EATING)	11.1%

MOBILITY DEPENDENCY	
STAIRCLIMBING	60.3%
MOBILITY(OUTDOORS)	40.6%
WALKING(INDOORS)	18.1%
WHEELING	20.3%

* Instrumental Activities of Daily Living

** Mental Status Quotient

*** Activities of Daily Living

INDICATORS OF COGNITIVE FUNCTION

COGNITIVE IMPAIRMENT (SCORES ON MSQ**)	
NONE OR MINIM. IMPAIRMENT(0-2 errors)	81.7%
MODERATE IMPAIRMENT(3-8 errors)	15.9%
SEVERE IMPAIRMENT(9-10 errors)	2.4%

BEHAVIOR PATTERN	
WANDERING	2.5%
OTHER	2.7%
ABUSIVE	2.2%
UNSAFE	5.2%
REQUIRES SUPERVISION	29.2%

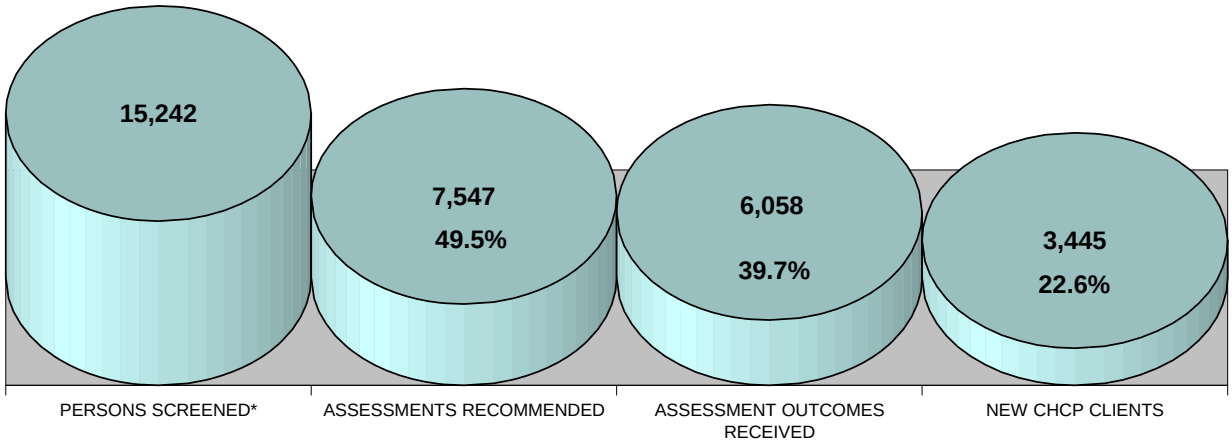
CASELOAD TRENDS
7/1/08 - 6/30/09

During the twenty second year of operations, July 1, 2008 through June 30, 2009, the combined Waiver and State Funded Program caseload increased by 3.2%.

Screening, Assessment and Placement Activity

The number of new clients placed on services during SFY 2008 was 3,445. An average of 287 new clients were placed on services each month and an average of 280 discharges occurred, resulting in an average net increase of 7 clients each month.

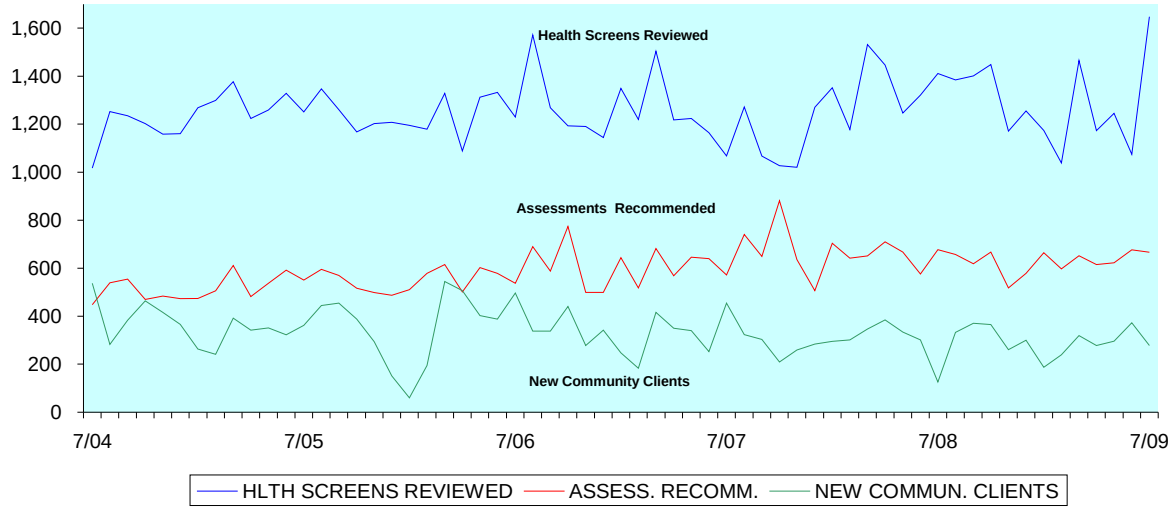
SFY09 PROGRAM ACTIVITY



***Includes people screened for OBRA and direct nursing home admissions**

Composite of Program Activity

The composite of program activity graph reflects the pattern of processing that has occurred since July 2004.



Caseload

The following graph illustrates the Connecticut Home Care Program for Elders caseload since July 2004. As of June 30, 2009 there were 14,800 clients. This represents a 3.2% increase from the 14,343 active cases at the end of SFY 2008. The monthly average Connecticut Home Care Program for Elders caseload for SFY 2009 was 14,756.

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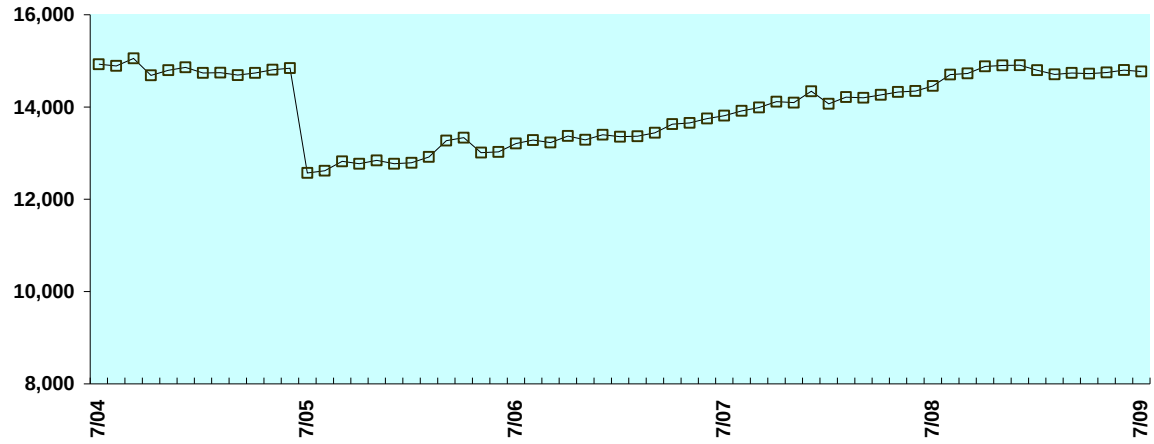
CONNECTICUT HOME CARE PROGRAM CASELOAD GROWTH

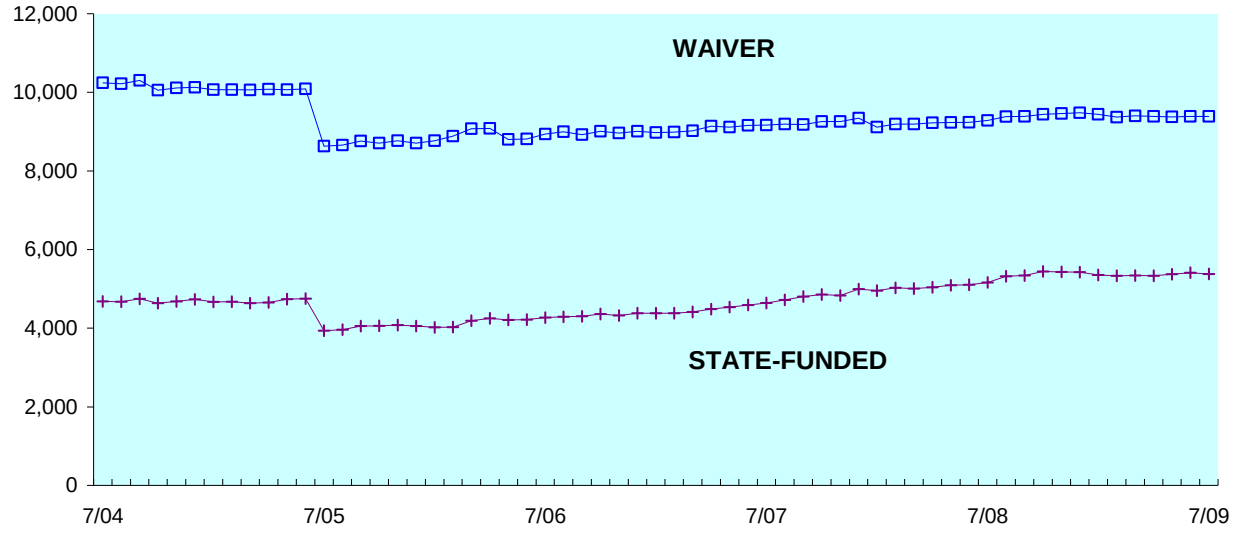


Note: Reported numbers (SFY06 onward) reflect an accurate count of program participants based on a comprehensive review of several databases that provide client specific information. The review concluded that previously reported numbers were overestimated.

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 2005. As of June 30, 2009, approximately 63% of the persons receiving program services were Waiver clients.



Note: Reported numbers (SFY06 onward) reflect an accurate count of program participants based on a comprehensive review of several databases that provide client specific information. The review concluded that previously reported numbers were overestimated.

Admissions and Discharges

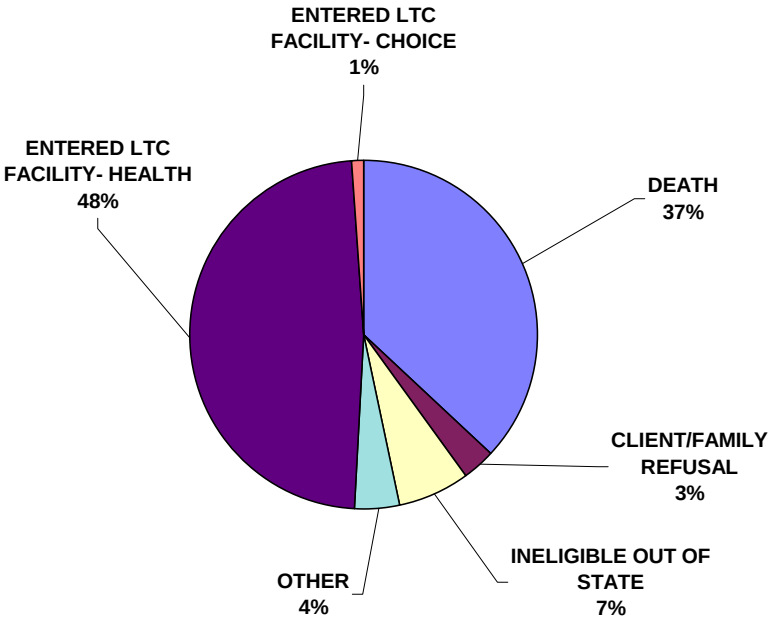
Since July of 1990 the Department has monitored the volume of Waiver and State Funded clients.

CT HOME CARE PROGRAM FOR ELDERS PROGRAM ACTIVITY

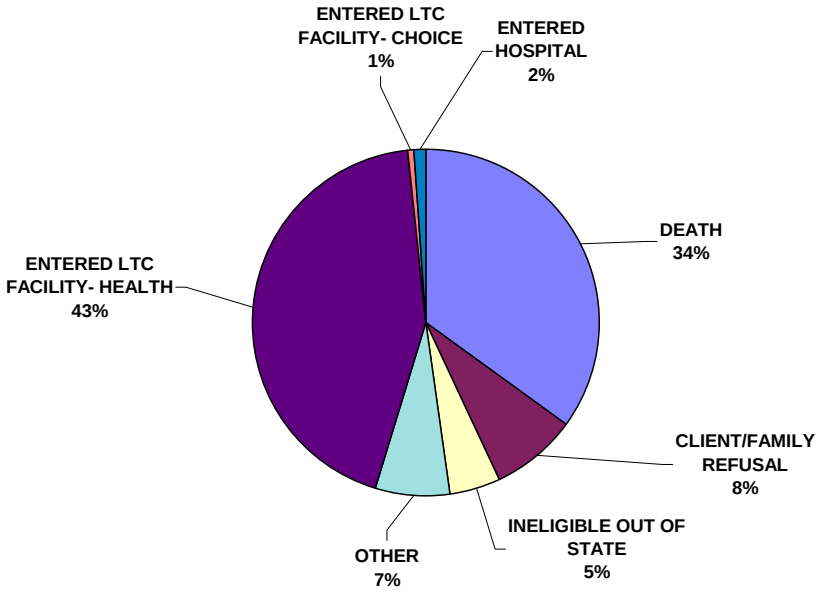
SFY 2009

	Waiver Clients (Level 3)	Funded State Clients (Level 2)	State Funded Clients (Level 1)	Total
Beginning Clients	**9,240**	**2,813**	**2,290**	**14,343**
Adjustments	**107**	**177**	**84**	**368**
Admissions	**1,633**	**1,114**	**698**	**3,445**
Discharges	**(2,080)**	**(949)**	**(327)**	**(3,356)**
Category Changes	**487**	**(100)**	**(387)**	**0**
Ending Clients	**9,387**	**3,055**	**2,358**	**14,800**

SFY 2009 WAIVER DISCHARGE REASONS



SFY 2009 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.

These changes have been made virtually seamless for the client. The following chart on category changes demonstrates the intra-program transfers that enable elders to increase services and enable the State to increase federal revenues as functional needs increase.

SFY 2009 CATEGORY CHANGES

FROM:	TO:	TOTAL TRANSFERS
CAT. 1	CAT. 2	**139**
CAT. 1	CAT. 3	**248**
TOTAL CAT. 1 TRANSFERS		**387**
CAT. 2	CAT. 3	**281**
CAT. 3	CAT. 2	**42**

PROGRAM EXPENDITURES AND COST SAVING PROGRAM ACTIVITIES

Program Expenditures 7/1/08 - 6/30/09

Actual program expenditures in SFY 2009 totaled $253,334,113 before federal reimbursement. Actual expenditures after federal funds and reimbursement were $139,360,294.

SFY 2009 Expenditures

	Waiver	State Funded	Total
Average Monthly Cost/Case	$ 1,715	$ 981	$ 1,448
Total Cost	$ 191,450,753	$ 61,883,360	$ 253,334,113
Federal Funds/ Reimbursement	($ 113,973,819)	($ -0-)	($ 113,973,819)
Net State Cost	$ 77,476,934	$ 61,883,360	$ 139,360,294

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-coordination, 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.

APPENDIX B

DEPARTMENT OF SOCIAL SERVICES

CONNECTICUT HOME CARE PROGRAM FOR ELDERS - FEE FOR SERVICE USE ONLY

rev:12/08 ***Effective 1/1/2009***

Category Type	Description	Functional Need	Financial Eligibility	Care Plan Limits	Funding Source	Intake Status
Category 1	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 = $ 32,868.00 Couple= $ 43,824.00	<25% NH Cost ($1420.00 Monthly)	STATE	OPEN
Category 2	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 = $ 32,868.00 Couple= $ 43,824.00	<50% NH cost ($2840.00 Monthly)	STATE	OPEN
Category 3	Extensive home care for very frail elders who would other-wise be in a nursing home on Medicaid.	In need of long term nursing home care (3 critical needs)	Individual Income2022.00/Mth Assets: Individual = $1,600.00 Couple: both as clients = $3,200 ($1600.00 x2) one as cli $23,512.00 ($1600.00 + $ 21,912.00	100% NH Cost ($5680.00 Monthly) Social Services) Cap=$3,972.48	MEDICAID WAIVER	OPEN

Notes:

1. ***Clients in the higher income range are required to contribute to the cost of their care.***
* 2. ***There is no income limit for the State Funded portion. The Medicaid Waiver income limit remains at 300% of SSI.***
3. ***Services available at all categories include the full range of home health and community based services.***
4. ***Care plan limits at all categories are based on the total cost of all state-administered services.***
5. ***Some individuals may be eligible for category 1 services but be financially eligible for Medicaid. In these cases, they will have their home health services covered by Medicaid with other community based services covered by state funds.***
6. ***Some indivduals under category 2 may become financially eligible for the Medicaid Waiver; In these cases, the client must apply for Medicaid and cooperate with the application process.***
** 7. ***Married couples who are over this asset limit for category 3 may be eligible based on the special spousal asset protection rule.***
8. ***Functional need is a clinical determination by the Department about the applicant's critical need for assistance in the following areas: Bathing, Dressing, Toileting, Transferring, Eating/Feeding, Meal Preparation and Medication Administration.***
9. ***Care Plan limits are for CHCP fee for service only***
10. ***For contracted Access Agencies use only.***

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

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

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

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 ADVISORY COMMITTEE

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10th Floor

Sheila Nolte
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11th Floor

CARE MANAGEMENT CONTINUUM

Maximum Self Direction

Minimum Self Direction

Client Managed	**Client Coordinated**	**Provider Coordinated**	**Provider Managed**	**Access Agency Coordinated**	**Access Agency Managed**
Client or Family hires and trains workers independently or through a broker. (Personal Care Assistance Model available under CHCPE as a Pilot Program)	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.)	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	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)	Client/Family receives services which are arranged, coodianted 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 a access agency may not be intensive and may be short term	Client/Family receives services which are arranged, coordianted 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

APPENDIX F – 1

CT HOME CARE PROGRAM FOR ELDERS
NORTH CENTRAL REGION
CLIENT SATISFACTION SURVEY REPORT
JULY 2009

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 North Central Region. A cover letter and two-sided one page survey were sent to one hundred and one (101) active CHCPE clients. This represents approximately two percent (2%) of the current total client population of 4, 816 clients, residing in the program's North Central Region.

The surveys were mailed on June 26, 2009. Clients were asked to return the survey by July 15, 2009. Active category two and three clients in the CHCPE program's North Central Region were selected randomly by computer.

2. SURVEY RESULTS

Thirty-three percent (33%) of surveyed clients responded to the survey. Four percent (4%) 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

Forty-nine percent (49%) of those completing the survey were program clients, thirty-two percent (32%) were family members, thirteen percent (13%) were caregivers and the remaining six percent (6%) were completed by those identified as "other".

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B. CHCPE ALTERNATIVES

Ninety-eight percent (98%) of survey respondents indicated how they would manage without home care services. Thirty-three percent (33%) of these respondents reported they would enter a nursing home. Thirty-seven percent (37%) said that they would do without home care services and twenty-seven percent (27%) reported they would depend on family/friends for help. Another three percent (3%) 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 very positively.

D. SERVICE DEPENDABILITY

Ninety-eight and one-half percent (98.5%) of respondents reported that they received services when they were scheduled. One and one-half percent (1.5%) reported not being able to depend on receiving services as scheduled.

E. CONTACT AWARENESS

Seventy-two percent (72%) of clients reported they know to contact a care manager if they have a question about their services. Twenty-two percent (22%) contact family and friends regarding services and six percent (6%) reported they would contact someone “other”.

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.

Eighty-three percent (83%) of survey respondents reported receiving skilled nursing services; making it the most frequently reported service. Homemaker services were the second most frequently reported service with eighty percent (80%). The third most frequently reported service was emergency response system services, which was reported by seventy-two percent (72%) of survey participants, followed by home health aide at sixty-eight percent (68%), meals on wheels with forty percent (40%), companion services at thirty-eight percent (38%), chore services at twenty percent (20%), and Adult Day Center at five percent (5%). Five percent (5%) of all respondents reported receiving a service not identified by the survey.

G. SUMMARY AND CONCLUSIONS

The Alternate Care Unit, Connecticut Department of Social Services, administered a client satisfaction survey for the CHCPE North Central Region in July 2009. One Hundred and one (101) clients in the CT Home Care Program's North Central Region were surveyed. Thirty-three percent (33%) of surveyed clients responded to the survey. Program clients completed nearly two thirds of the returned surveys. Family members were the second most frequent survey responders, accounting for slightly more than one fourth, followed by caregivers and "others".

The survey results showed Skilled Nursing services, Home Health Aide services, Adult Day Center services and Emergency Response System services with universally Good or Excellent ratings. This is an outstanding positive response.

The survey results also indicated two areas of focus where the North Central Region of the CHCPE has potential for improvement: First and foremost, an increase in client awareness of care management services. Less than three fourths (72%) of surveyed clients knew to contact their care managers with needs or concerns regarding their services. Secondly, Meals on Wheels received a rating of Excellent

from over one fourth of respondents, nearly one third responding Good, leaving forty percent (40%) responding fair or poor. Surveyed program clients reflect the need for an adequate and appealing provision of nutrition to sustain health.

H. EXHIBITS

Cover Letter and Survey
Response Data

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 Care
- Emergency Response System

Bar Charts reflecting the following:
- Service Dependability
- Contact Awareness
- Client Satisfaction

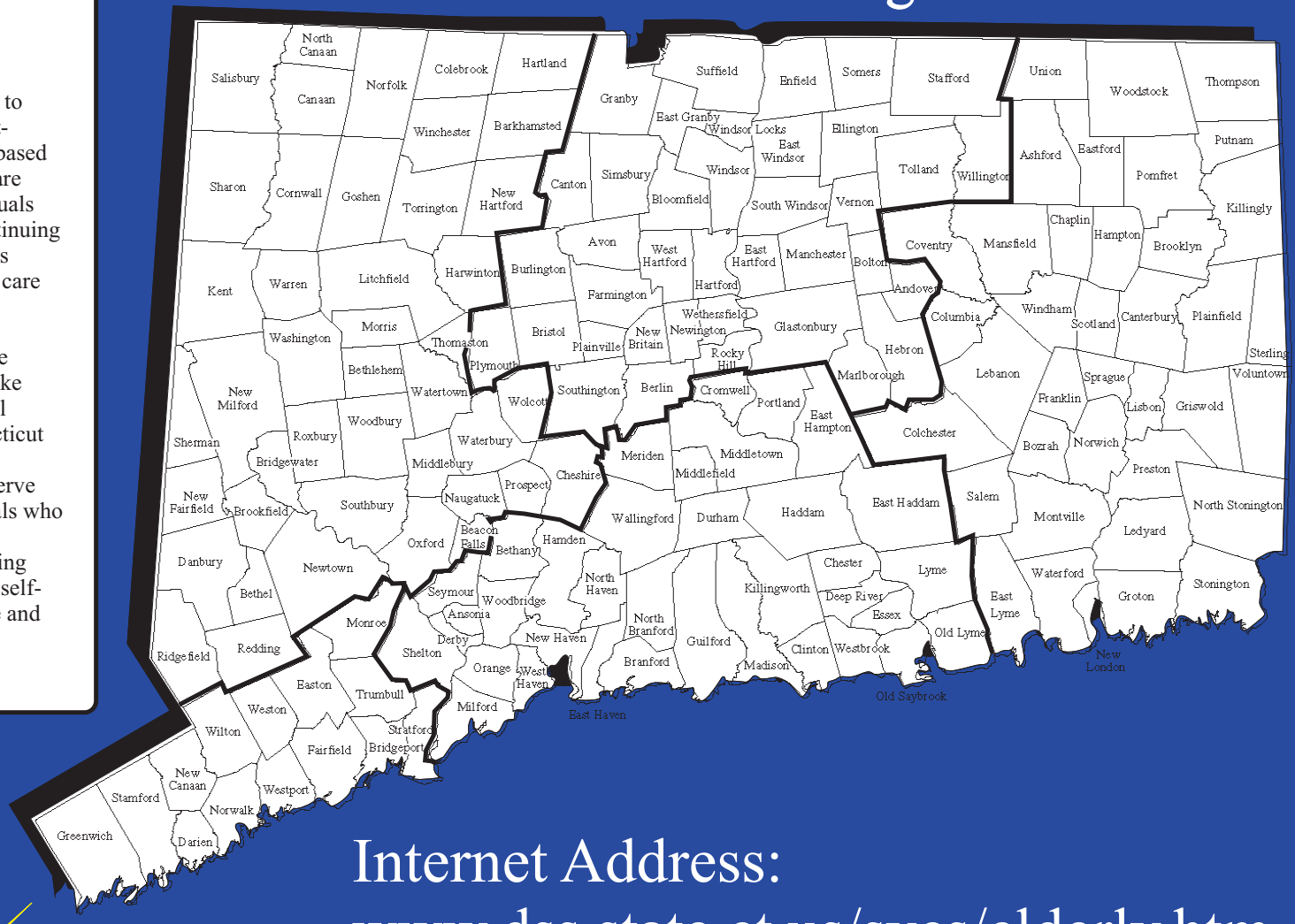
Appendix G

Connecticut Home Care Program For Elders

Alternate Care Unit Mission

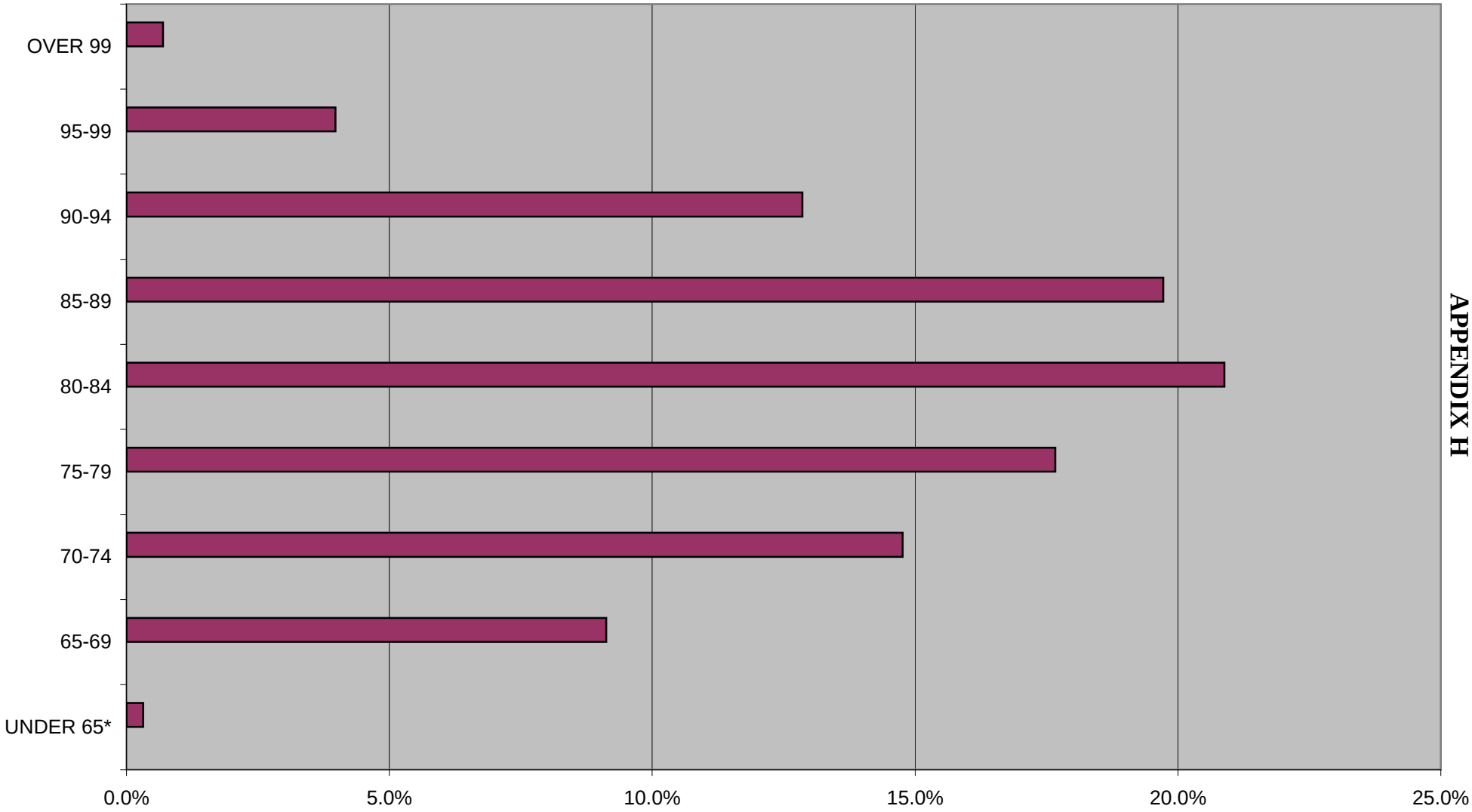
The mission of the Alternate Care Unit is to develop and offer cost-effective community-based and other long term care alternatives to individuals and families with continuing care needs and policies pertinent to long term care residents.

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.



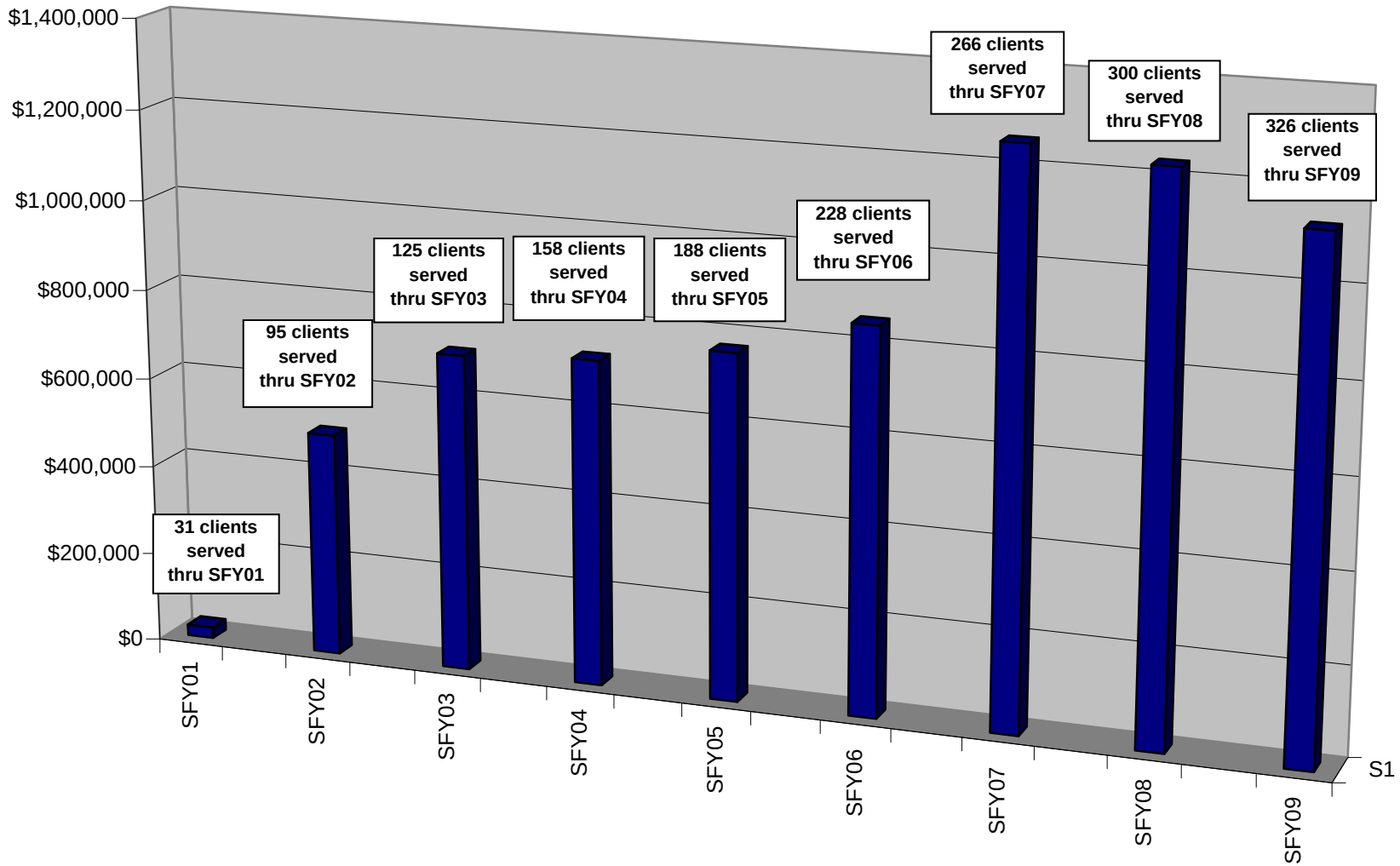
Internet Address:
www.dss.state.ct.us/svcs/elderly.htm

SFY2009 CHCP AGE DISTRIBUTION



APPENDIX H

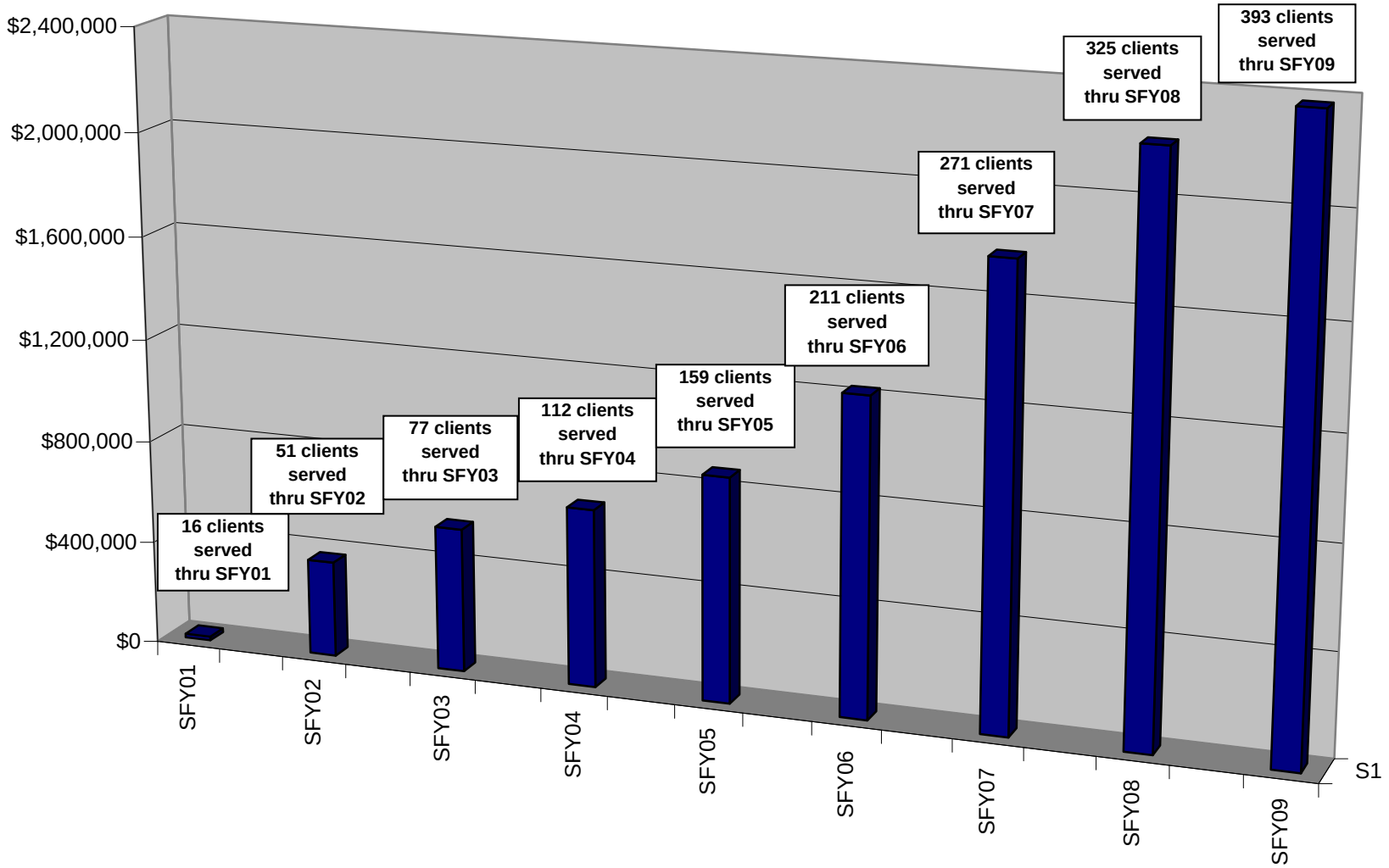
STATE FUNDED CONGREGATES GROWTH



APPENDIX I

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

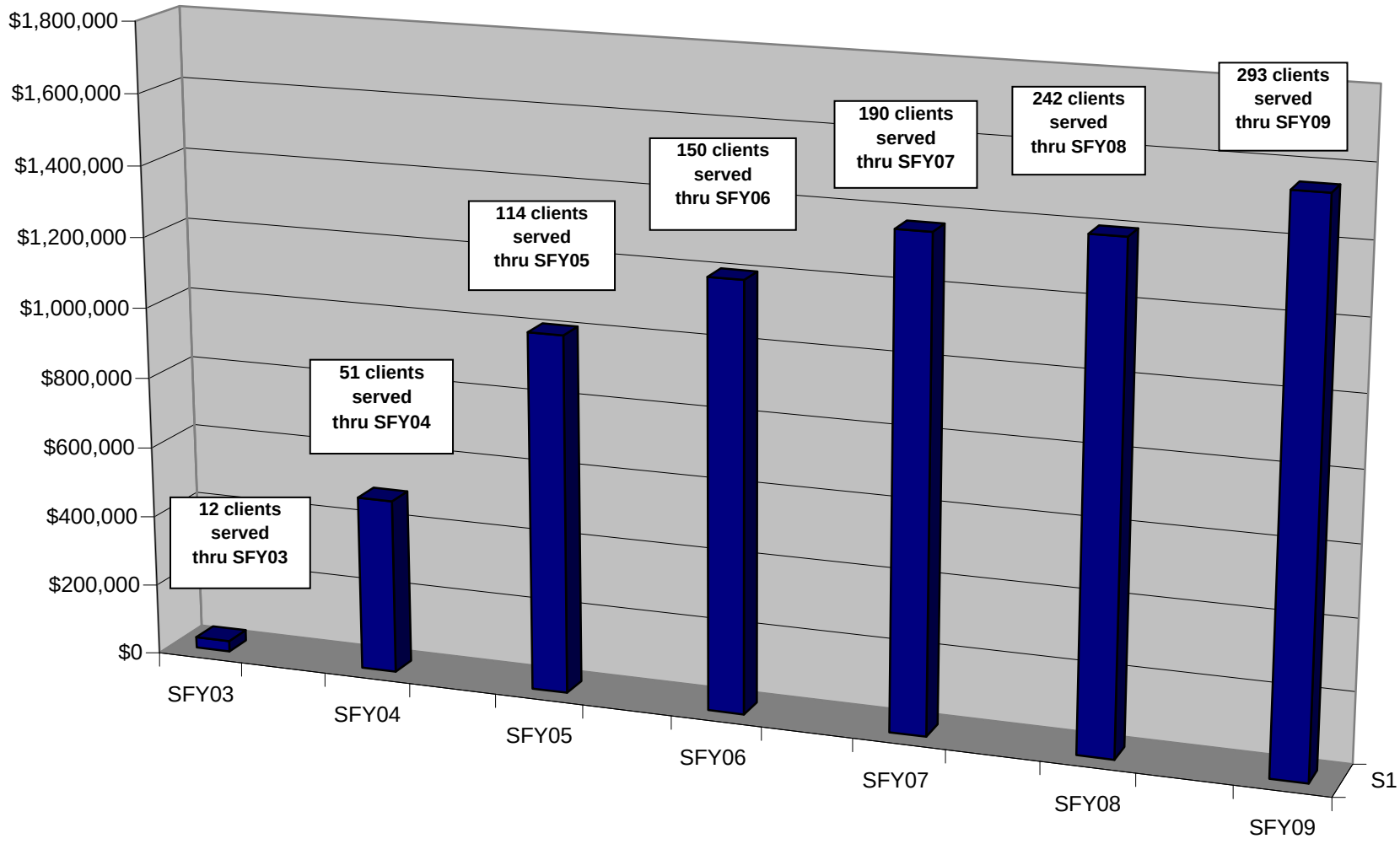
HUD FACILITIES GROWTH



APPENDIX J

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

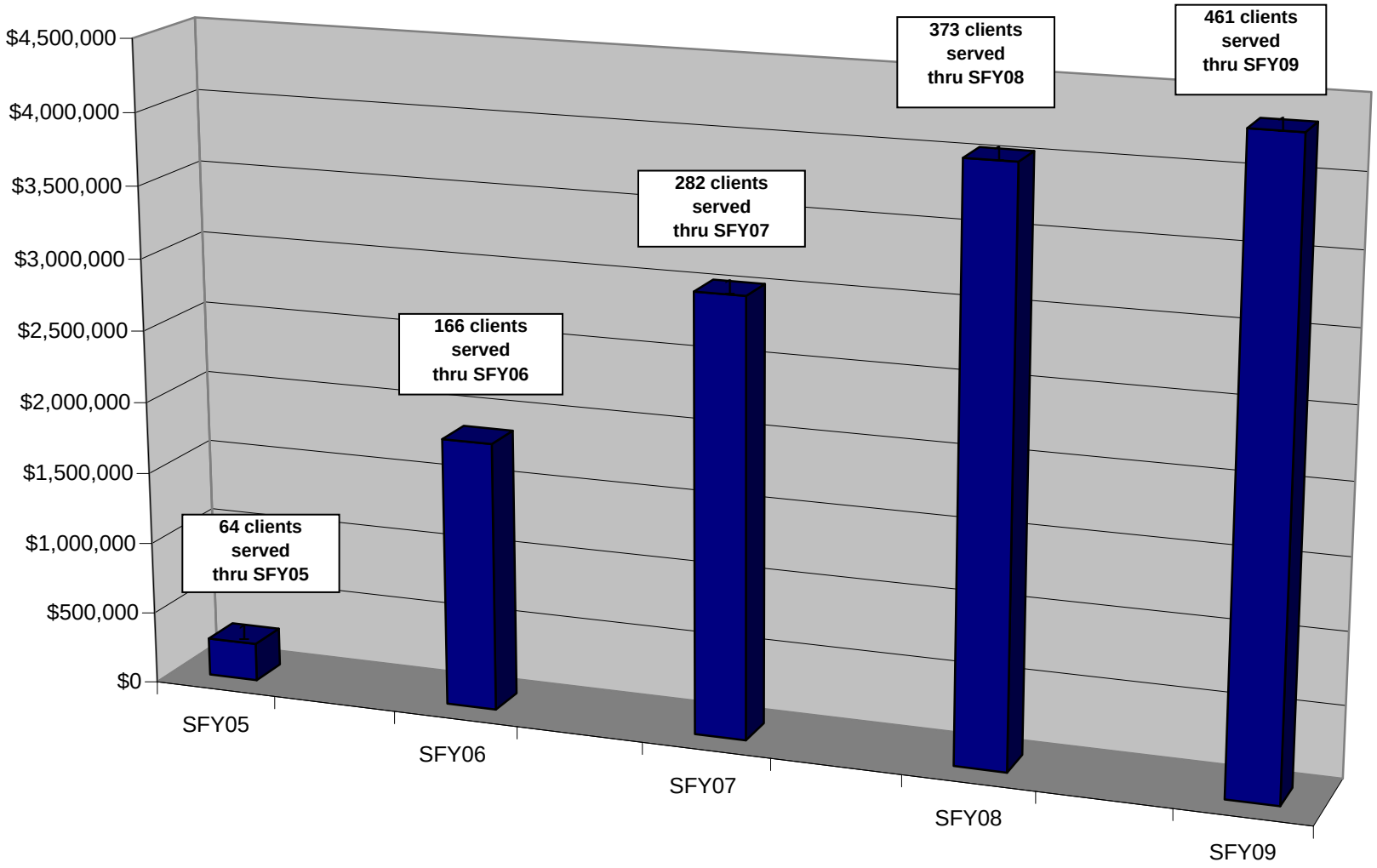
PRIVATE ASSISTED LIVING PILOT PROGRAM GROWTH



The Private Assisted Living Pilot began in March 2003.

APPENDIX K

ASSISTED LIVING DEMONSTRATION PROJECT GROWTH



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

APPENDIX L