Department of Aging & Disability Services
State Unit on Aging

Elderly Nutrition Services

Review of Funding Allocations | October 2023

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Reporting Requirements

CGS § 17a-851 requires the state's five area agencies on aging (AAAs) to assess the nutrition risk of older people in their service areas and report individual and average scores to the Department of Aging and Disability Services (ADS), which distributes both federal and state matching funds to the AAAs for elderly nutrition programs.

The law requires ADS to evaluate both federal and state funding allocations for elderly nutrition services based on factors including (1) elderly population data from the most recent U.S. census and (2) the average and individual assessment scores. The department must also solicit and consider information and recommendations from Elderly Nutrition Program providers.

The statute was amended last year to require ADS to report to the Aging, Appropriations, and Human Services committees by July 1, 2023:

1. the collected nutrition risk assessment data;
2. for each Meals on Wheels provider:
    a. reimbursement rates compared to the cost to provide these meals,
    b. administrative expenses,
    c. the number of providers that have reduced or eliminated deliveries based on inadequate state reimbursement; and
3. any recommended changes in how the funds are allocated.

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Executive Summary

Open to individuals age 60 or older, their spouses, and certain individuals under 60 years with a disability, the Elderly Nutrition Program reduces food insecurity and isolation through the provision of nutritionally balanced meals and socialization. By improving and maintaining the health and well-being of older adults, the program allows some of Connecticut's most vulnerable residents to remain in their homes or preferred community setting and avoid institutionalization.

Primarily funded by the Administration for Community Living (ACL), a division of the U.S. Department of Health and Human Services (HHS) and a partial matching state contribution, the program has two main components: congregate meals provided in community settings such as senior centers or senior housing buildings, and home delivered meals (commonly known as Meals on Wheels[1]) provided to individuals' homes by delivery drivers. Because it is not means-tested or an entitlement, services may be reduced or waiting lists established when the demand for services exceeds available funds. All providers have indicated that the need for services continually exceeds their available resources, and they have had to reduce meal services or establish a waiting list at some point as a result.

Home-delivered programs generally have lower reimbursement rates than congregate meal programs. Home-delivered rates for federal fiscal year (FFY) 2023 ranged from $5.36 to $9.96 per meal, with a weighted statewide average reimbursement of $6.90 per meal. Based on self-reported data submitted by each provider, two home delivery providers reported sufficient rates to cover their reported per-meal costs. Congregate reimbursement rates for FFY 2023 ranged from $6.80 to $13.60 per meal, with a weighted statewide average reimbursement of $10.46. Nine of the fifteen congregate program providers reported sufficient reimbursement to cover their reported per-meal costs.

Local providers are competitively selected for three-year periods and annually negotiate their contract and reimbursement within this time frame. As each local program is structured based on its unique service area population and geography, providers have different combinations of costs and may also account for them differently. This makes drawing cost comparisons between programs challenging.

Special Act 23-17 was enacted prior to the deadline for this report and establishes a task force to similarly study and make recommendations concerning the elderly nutrition program. ADS is represented on the task force, which began meeting in August 2023 and must submit its report by January 15, 2024. This report and its recommendations are not intended to supplant the charge of the current task force, but rather to be responsive to the original reporting requirements under Public Act 22-32, and to support the work of the task force. It is in that spirit that the following recommendations are proposed for its consideration.

Improve Data Standardization and Collection

Ultimately, the program's performance measures dictate what data is collected, but how that data is collected determines how accurately program performance can be assessed. The limitations of this report largely stemmed from the fact that ADS – State Unit on Aging does not regulate the

contractual relationship between the AAAs and their contracted local providers, nor has it typically collected contract budget information such as a provider's meal or administrative costs. Standardizing definitions and how data is collected from provider to provider (e.g., components of administrative costs) would allow for more consistency across performance measures and improved analysis, however, may not be possible due to the decentralized nature of the program.

For instance, inaccuracies may exist to the extent that an AAA or provider does not utilize or update fields when a participant is initially or annually assessed. Providers routinely raise participant cooperation issues about the large amount of data required during intake. Provider and AAA input could be used to identify such problems and brainstorm ways to mitigate them. Although the majority of this information is federally required and not easily revised, any potential streamlining would be welcome.

Administrative costs varied considerably from provider to provider. This is partially explained by the different ways in which administrative tasks are divided between the provider and their respective AAA. Streamlining administrative tasks wherever possible could potentially allow for more meals to be served within the same allotments, however, how administrative tasks are shared often is dictated by the specific contractual relationship.

Assess Equity of Intrastate Funding Formula

When allocating Title III funds through the Older Americans Act (OAA), the state must (1) determine its planning service areas (PSAs – see Glossary of Terms) and (2) create and utilize an Intrastate Funding Formula (IFF) by which funds are distributed to them. Connecticut's service areas were first determined as required by the OAA in 1973 and its map has generally been unchanged for nearly 50 years. The IFF must ensure equitable distribution of funding across the state to reflect the proportion of the program's target population living in each service area.

Currently under the IFF, half of allocated Title III funds for nutrition (of a total of $7,389,982 in FFY 22) and more than one-third of state funds are divided equally across the five service areas. This is done to ensure each region receives a minimum funding level. Whereas the five service areas may have originally had relatively equal proportions of the program's targeted population (i.e., older adults, with priority given to those who are minorities, low-income, disabled, or living in rural areas), that is no longer the case. On every demographic statistic, one service area has significantly higher proportions of these groups than the other four service areas.

As part of the process to develop the next State Plan on Aging, ADS will have the opportunity to explore ways to improve the distribution of funds under the IFF while ensuring that it remains equitable. This could include how the formula is structured, the data used within it, or the service area map to which it is applied. It is worth noting that changes to the IFF would affect all Title III OAA programs (e.g., supportive services such as case management, community services, in-

[1] Although home delivered meals are colloquially known as "Meals on Wheels," this name is also more broadly used by providers delivering meals who do not receive Title III funds. This report focuses only on providers receiving Title III funds. Other Meals on Wheels programs that do not receive Title III funds are not covered by this report.

home services, transportation, information and referral, and legal assistance) and not just the Elderly Nutrition Program. ADS encourages input on this process.

Utilize More Up-to-Date Demographic Data

The other half of Title III funds and more than one-third of state funds are allocated under the IFF according to weighted proportions of the program's target population living in each service area. The IFF pulls this demographic information from the U.S. decennial census. Connecticut's current State Plan on Aging covers the period from October 1, 2020, to September 30, 2023, and was extended to September 30, 2024, by the ACL. As ADS is still awaiting the release of the necessary 2020 decennial data sets from the Census Bureau, the IFF under the current plan is based on 2010 data.[2]

As part of the process to develop the next State Plan on Aging, ADS will have the opportunity to update demographic data as part of its IFF. ADS encourages input on this process.

Improve Target Population Participation

In addition to Title III funding, ADS receives a (1) federal performance-based Nutrition Services Incentive Program (NSIP) grant and (2) Social Services Block Grant (SSBG) allocated from the Connecticut Department of Social Services. NSIP (totaling $1,384,193 in FFY 22) is allocated to the state's five area agencies on aging (AAAs) based on the number of meals served in their region in the prior FFY as compared to the state as a whole. States have broad discretion over the use of SSBG funds (totaling $823,601 in FFY 22), which must be legislatively approved (CGS § 4-28b). SSBG funds have been distributed in the same manner as NSIP funds, but SSBG funds could be distributed differently.

In FFY 2022, 49% of all participants in the home delivered meal were considered at high nutrition risk or risk of malnutrition, however the rate at which this target population was served varied by service area, with 41% in the South Central and Western service areas to a high of 59% in the Eastern service area. In the same time period, 18% of participants in the congregate meal program were considered at high risk, ranging from a low of 11% in the Western service area to a high of 25% in the South Central service area.

The participation rates of minority older adults varied significantly across service areas in both programs. In the home-delivery program, rates ranged from a low of 8% in the Eastern and Western regions to a high of 30% in the Southwest region. In the congregate program, rates ranged from a low of 5% in the Eastern region to a high of 30% in the South Central region. At a minimum, service rates of target groups should be representative of their proportion in the service area itself. For instance, if 10% of a service area's older adults are minorities, then providers in that area should strive to have at least 10% of their participants, if not more, in this demographic.

In addition, it is recommended that strategies being used by service areas more successful in serving target populations be shared and employed statewide to enable service areas below the

[2] The 2020 datasets are expected before the next state plan must be submitted.

state averages to improve their targeting and outreach to these older adults, which should in turn improve service levels of this metrics. If programs need to institute wait lists or reduce services, it should be done in a planful manner, and with a view towards preserving services for the program's intended target participants.

Assess Alternative Options for Allocating Discretionary Funding

The remaining 40% of non-matching state funds are allocated at the discretion of the ADS Commissioner, in consultation with the AAAs, based on their need for them. ADS has been allocating these funds using a blend of the IFF and NSIP percentages.

The task force may wish to explore other alternative options for allocating this discretionary funding to better meet service area needs.

Assess Payment Timing and Options to Improve Provider Cash Flow

At the start of nearly every federal fiscal year in October, there is rarely an approved federal budget. Continuing Resolutions provide some program funding to bridge the gap between the beginning of the FFY and a budget being enacted, however, every state begins the new FFY without knowing what the specific funding for the year will be, or when they will ultimately receive it. This is a constant concern raised by local providers and their AAAs, who do not have reserves available. Potential solutions that could be explored by the task force may include adjustment of how the state's share of the program's funding is scheduled for allocation.

Providers have also expressed frustration with the timeliness of receiving payment after they have submitted their costs to their AAA for reimbursement. Lags in reimbursement have a trickle-down effect on the suppliers who providers rely upon, and in some instances, program participants. For example, unpaid bills have occasionally resulted in supply disruptions, such as a lack of milk with meals.

Assess Options for Leveraging Additional Funding

All providers have indicated that the need for services continually exceeds their available resources, and, in some instances, providers have had to reduce the number of meals provided or have established waiting lists for services. One solution may include leveraging other federally supported programs, particularly those which older adults may already be eligible for but not accessing, like the Supplemental Nutrition Assistance Program (SNAP).

According to the Food Research and Action Center, nationwide only 42% of eligible older adults are enrolled in SNAP compared to 83% of all eligible people that participate in this program. Many older adults who are homebound are likely eligible for SNAP but may not have the ability to use these benefits due to their lack of mobility. States including Minnesota and Wyoming allow SNAP benefits to be used for Meals on Wheels programs, however.

As SNAP benefits are federally funded with only the administrative costs split with the state, it is worth exploring ways to maximize SNAP participation, including an exploration of the Restaurant Meals Program option.

Address Complexities in Program Administrative Processes

There are several components to the Elderly Nutrition Program for which it could be appropriate to explore streamlining of processes across the state. Recently, local providers and AAAs across the state have started to work in a consortium to create the required yearly Nutrition Education Plans, which may represent time and cost savings for programs in comparison to each provider or AAA creating their own separate plans. It is worth noting that many of the administrative pieces of the program are dictated by individual contracts between the ADS – State Unit on Aging and the AAAs, and in turn, the AAAs and the local providers. However, there may be other areas where the state's providers can work together to reduce some of the administrative burdens or leverage the wider network for time and cost savings, such as in menu creation and approval.

In addition, the Task Force may want to look at the existing state regulations to explore if any should be updated to reflect the changing landscape of the program.

Nutrition Risk Factors

Each Elderly Nutrition Program participant is required to go through the intake and assessment process with a program staff member utilizing the Consumer Registration Form (Form 5). This form collects information on the participant's demographics (§§ I, II, and IV), functional status (§ V), nutrition risk information (§ VI), and need for assistance with activities of daily living (§ VII). The Nutrition Risk section (see excerpt below) utilizes the ACL's recommended DETERMINE checklist which is based on the following warning signs for poor nutrition:

Disease
Eating Habits
Tooth Loss/Mouth Pain
Economic Hardship
Reduced Social Contact
Medications
Involuntary Weight Loss/Gain
Needs Assistance in Self-Care
Elder Years Above Age 80

These risk factors are assessed using the following Yes or No questions. Each "yes" answer has a specified score associated with it. A participant who does not provide an answer to each question is deemed to have answered "no," which has a risk score of zero.[3] A total score of six or higher is considered high nutrition risk.

Form 5 § VI – Nutrition Risk Assessment

VI. Assessment Form - Nutrition				
	Yes	No	Unknown	
a.) Nutritional Risk:	❍	❍	❍	I have an illness or condition that made me change the kind or amount of food I eat. (2)
	❍	❍	❍	I eat fewer than 2 meals per day. (3)
	❍	❍	❍	I eat few fruits and vegetables or milk products. (2)
	❍	❍	❍	I have problems chewing/swallowing that make it hard for me to eat. (2)
	❍	❍	❍	I do not always have enough money or food stamps to buy the food I need. (4)
	❍	❍	❍	I take 3 or more different prescription or over-the-counter drugs each day. (1)
	❍	❍	❍	I eat alone most of the time. (1)
	❍	❍	❍	I have 3 or more drinks of beer, liquor or wine almost every day. (2)
	❍	❍	❍	Without wanting to, I have lost or gained 10 pounds in the last 6 months. (2)
	❍	❍	❍	I am not always physically able to shop, cook or feed myself. (2)

[3] Although Form 5 indicates an "unknown" answer option, this field is not actually usable in the data system. As a result, a non-answer is typically scored as a "no."

Total Nutrition Score

0-2 = No/Low risk
3-5 = Moderate risk
6 or more = High risk

Regional Nutrition Risk

In FFY 2022, 49% of participants in the home delivered meal program were considered at high nutrition risk or risk of malnutrition. The table below provides this information by service area, with nutrition risk ranging from a low of 41% in the South Central and Western service areas to a high of 59% in the Eastern service area. These risk groups could be underrepresented to the extent that at-risk participants who do not provide an answer are deemed to be at lower risk.

FFY 2022 Home Delivered Meal Participants at High Nutrition Risk by Service Area

Service Area	Total Participants Served	# At High Risk	% At High Risk
Eastern	2,593	1,530	59%
North Central	1,578	836	53%
South Central	1,778	729	41%
Southwestern	1,355	745	55%
Western	3,031	1,243	41%
Total	**10,335**	**5,083**	**49%**

Note: Participation totals include all who were served home-delivered meals, including those who may also participate in the congregate meal program. This likely reflects the different ways hybrid meals (“grab & go”) are categorized and accounted for.

In the same period, 18% of participants in the congregate meal program were considered at high risk. The table below provides this information by service area, with nutrition risk ranging from a low of 11% in the Western service area to a high of 25% in the South Central service area.

While a lower risk profile for congregate meal participants is expected, as these individuals typically have greater mobility than home-delivered participants, these at-risk groups could still be underrepresented to the extent that at-risk participants who do not

provide an answer are deemed to be at lower risk. Risk groups could also be overrepresented to the extent that higher-risk home-delivered meal participants are also counted when they receive meals in the congregate meal program. This program "crossover" varies according to service area, and likely has a negligible impact in the Southwest (1.3% crossover) and North Central (4.5%) areas, with the greatest impact in Western (16.2%), followed by South Central (14.7%), and Eastern (8.6%) areas.

FFY 2022 Congregate Meal Participants at High Nutrition Risk by Service Area

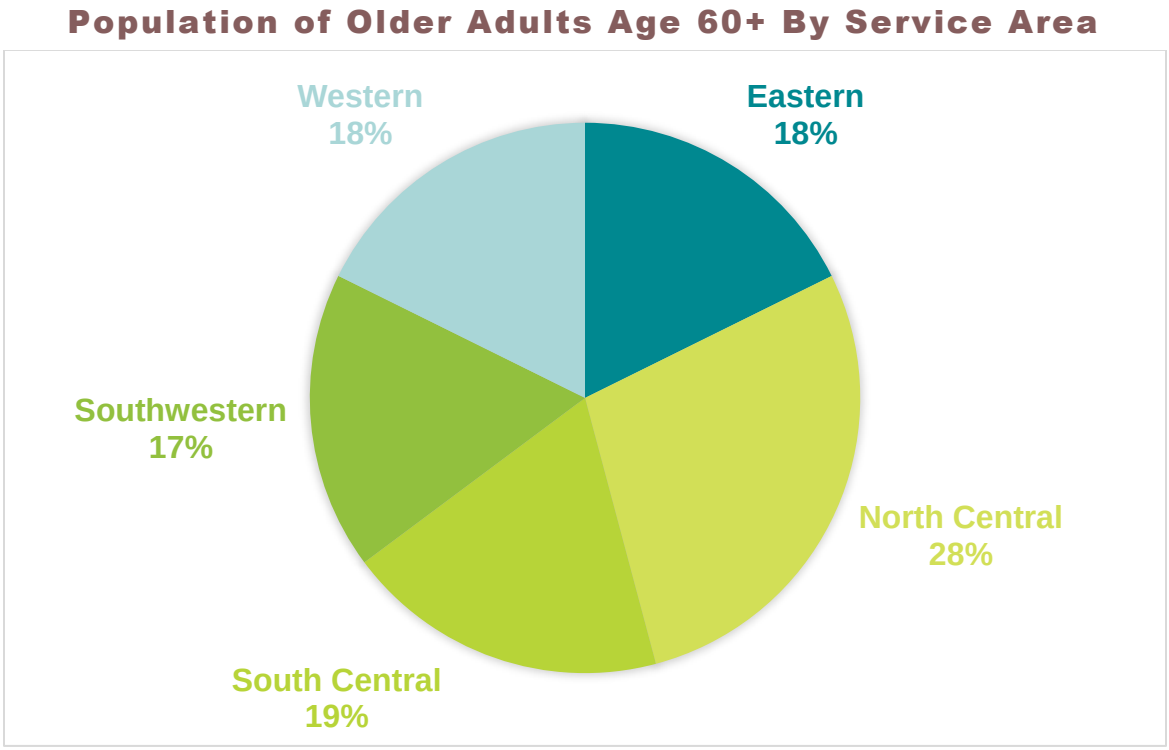
Service Area	Total Participants Served	# At High Risk	% At High Risk
Eastern	2,395	503	21%
North Central	2,279	433	19%
South Central	1,153	288	25%
Southwestern	1,603	224	14%
Western	1,825	201	11%
Total	**9,255**	**1,649**	**18%**

Note: Participation totals include all who were served congregate meals, including those who may also participate in the home delivered meal program. This likely reflects the different ways hybrid meals (e.g., "grab & go") are categorized and accounted for.

Under Connecticut's program guidelines, a participant with a high nutrition risk score should be referred to a registered dietitian or nutritionist by their elderly nutrition provider to receive one-on-one nutrition counseling to address these risks and create strategies to lower them. All participants should be reassessed each year and continue to receive supports to address nutrition risk, if any. ADS' State Unit on Aging works with the AAAs and local providers to create and utilize prioritization guidelines to ensure that the participants with the greatest need or at the highest risk are prioritized for service. ADS annually reports this nutrition risk to the ACL as part of its State Performance Report.

Regional Aging Population

Based on 2020 decennial census data, the pie chart below depicts each service area's share of the state's older adult population, defined as age 60 and older. The North Central service area has a significantly larger share of Elderly Nutrition Program's target population – 28% – compared to the state's other four regions where this population appears to be more evenly distributed between 17% to 19%.



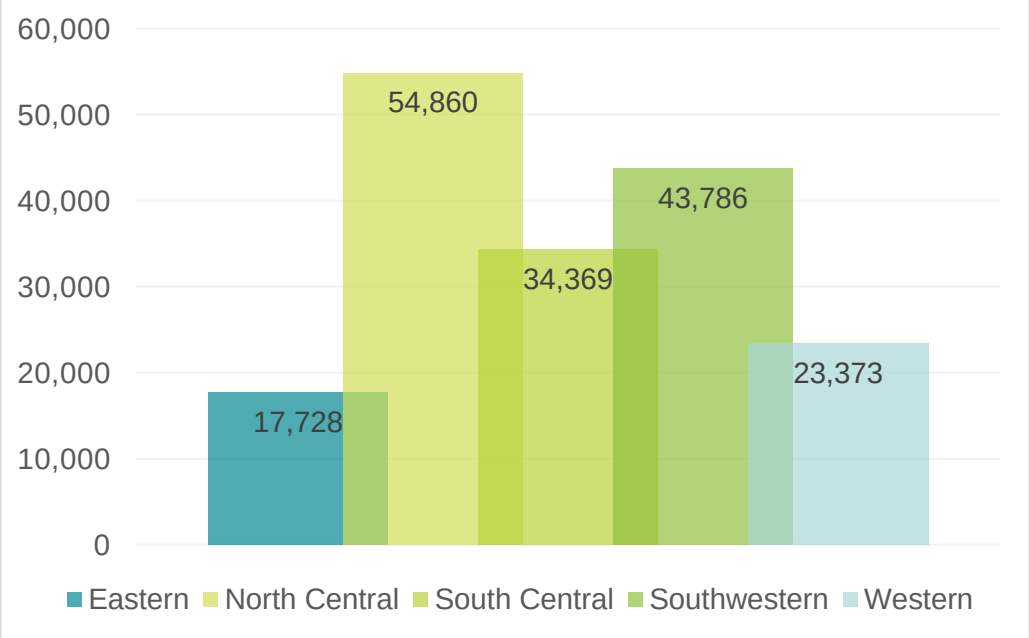
Source: U.S. Census Bureau, 2020 decennial census data

Regional Racial and Ethnic Diversity

Service Area Demographics

Based on 2020 decennial census data, there are 174,116 older adults (age 60+) who also identify as being a member of a racial or ethnic minority. The chart below depicts each service area's share of this older adult minority population. The regional share of this priority target population shows significant variation – ranging from a high of nearly 32% in the North Central service area to a low of 10% in the Eastern service area.

Population of Minority Older Adults Age 60+ by Service Area



Source: U.S. Census Bureau, 2020 decennial census data

Minority Participants Served

The participation rates of minority older adults varied significantly across service areas in both programs. In the home-delivery program, rates ranged from a low of 8% in the Eastern and Western regions to a high of 30% in the Southwest region. In the Congregate Program, rates ranged from a low of 5% in the Eastern region to a high of 30% in the South Central region.

Minority Older Adults Served by Area

	Home-Delivery Minority Participants	*Congregate Minority Participants*
Eastern	8%	5%
North Central	22%	22%
South Central	23%	30%
Southwest	30%	18%
Western	8%	7%

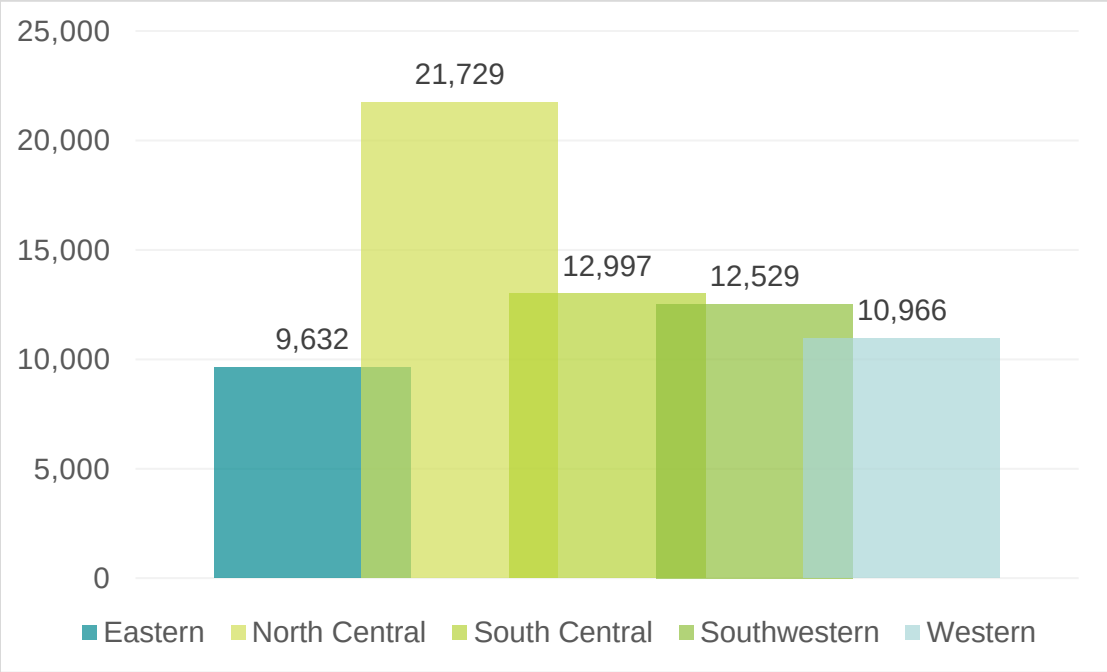
Source: Local service provider data

Regional Poverty

Service Area Demographics

Based on 2021 American Community Survey data, which covers the period January 1, 2016 to December 31, 2020, the chart below depicts how poverty is distributed within Connecticut's older adult population (age 60+). Significant variation ranges from a high of 32% in the North Central service area and a low of 14% in the Eastern service area.

Population of Older Adults Age 60+ Living in Poverty by Service Area



Source: 2021 American Community Survey data

Low Income Participants Served

The participation rates of older adults at or below the poverty level varied significantly across service areas in both programs. In the home-delivery program, rates ranged from a low of 18% in the North Central region to nearly double that amount – 32% – in the Southwest region. In the congregate program, rates ranged from a low of 8% in the Western region to a high of 28% in the South Central region.

Low-Income Older Adults Served by Area

	Home-Delivery Participants in Poverty	*Congregate Participants in Poverty*
Eastern	19%	14%
North Central	18%	13%
South Central	22%	28%
Southwest	32%	16%

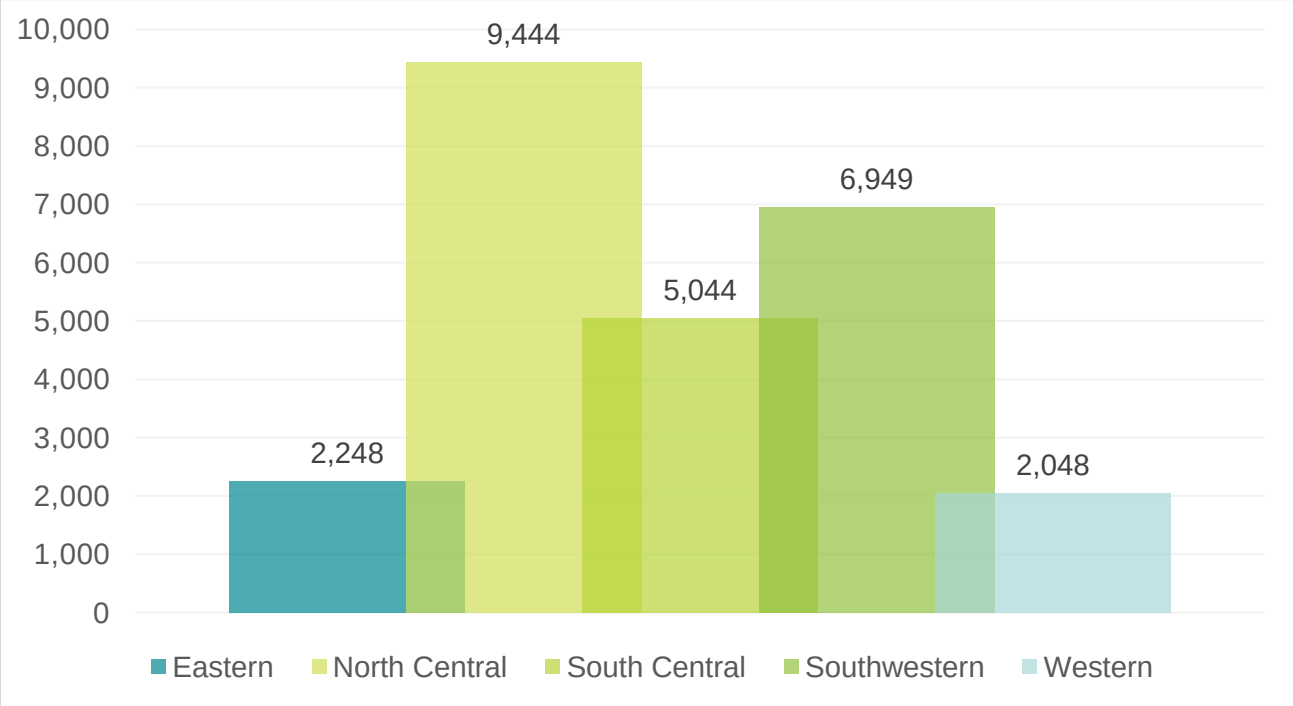
Western	21%	8%

Source: Local service provider data

Regional Minority Poverty

Based on 2021 American Community Survey data covering the period January 1, 2016, to December 31, 2020, the chart below depicts how poverty is distributed within Connecticut's older adult (age 60+) minority population. Of a total population of 25,733, 37% reside in the North Central service area while less than 10% reside in either the Eastern or Western service areas.

Minority Population of Older Adults Age 60+ Living in Poverty by Service Area



Source: 2021 American Community Survey

Rural Regions

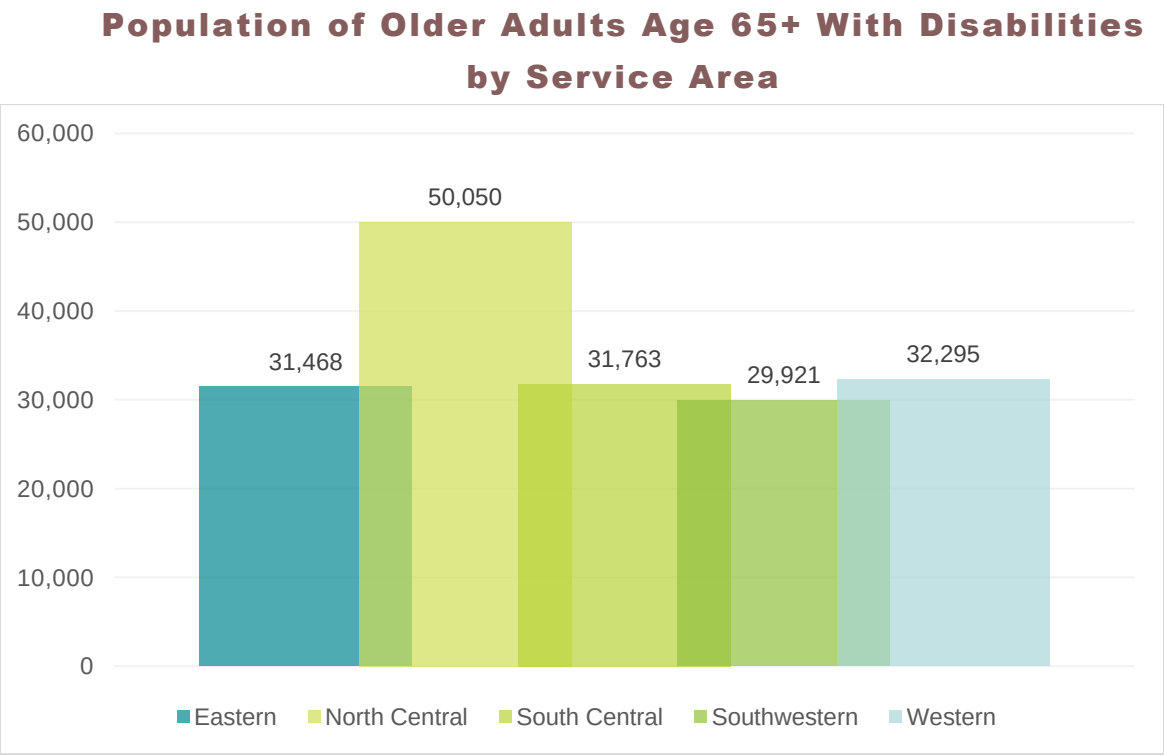
The rural-urban commuting area (RUCA) codes classify U.S. census tracts using measures of population density, urbanization, and daily commuting. According to this USDA designation, only one of Connecticut's service areas – Western – qualifies as such, while in prior years, under a different ACL "rural" definition, Eastern also had

qualifying towns. Of Western's 159,407 older adults identified in the 2020 decennial census data, nearly 18% are considered to live in a rural-urban community area.

Regional Disability Prevalence

Estimates of disability prevalence within a region can vary based on how disability is defined, the context in which it is referenced, or the way it is measured. According to 2021 American Community Survey (ACS) one-year estimates, approximately 13% of the total U.S. civilian noninstitutionalized population has a disability. In comparison, an estimated 12% of Connecticut's civilian noninstitutionalized population has a disability.[4]

The chart below depicts the prevalence of older adults (defined as 65+) with disabilities by service area. The North Central service area has a significantly larger share of this program target population as compared to the state's other four regions, where this population appears to be more evenly distributed.



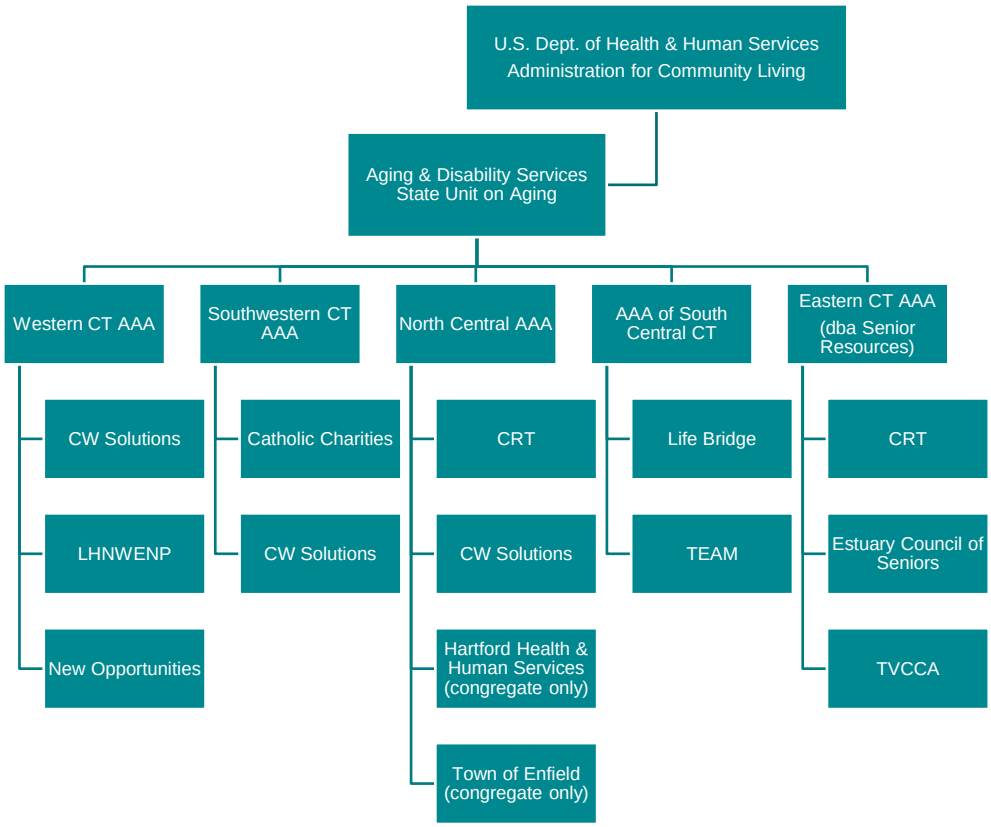
Source: 2021 American Community Survey data covering January 1, 2016, to December 31, 2020; 60+ dataset not available

[4] U.S. Census Bureau, 2021: ACS 1-Year Estimates Subject Tables, s1810 – Disability Characteristics https://data.census.gov/table?q=s1810&y=2021

Evaluating Federal Allocations

The Elderly Nutrition Program is primarily funded by the Administration for Community Living (ACL), a division of the U.S. Department of Health and Human Services (HHS). These funds come through the Older Americans Act (OAA) and a partial matching state contribution. ADS also receives from the ACL a performance-based Nutrition Services Incentive Program (NSIP) grant and a Social Services Block Grant allocated from the Connecticut Department of Social Services. ADS then distributes both the federal and state funds to the AAAs based on an Intrastate Funding Formula (IFF) required under OAA, as well as NSIP and state funding formulas. In addition to state and federal funds, the program is supported by local funds and voluntary participant contributions.[5]

Elderly Nutrition Program Organization[6]



[5] Local providers may request a participant pay a voluntary fee for meals furnished, except that an eligible person cannot be denied a meal due to an inability to pay this fee (CGS § 17a-851(d)).
[6] Chart reflects current providers as of the reporting date. New provider contracts will be effective on October 1, 2023, and may result in changes.

Connecticut is allocated federal funds based on an OAA statutory funding formula that looks at all U.S. states and territories, the demographics of their older adults, and their utilization of OAA funding.

Funding Sources for Elderly Nutrition Program in FFY 2022 and SFY 2022

	FFY 22 (*10/1/21 – 9/30/22*)	SFY 22 (*7/1/21 – 6/30/22*)
Federal Funds		
USDA NSIP Grant	$1,384,193	
Title III C1 & C2	7,389,982	
Social Services Block Grant	689,134	
State Funds		
Elderly Nutrition		$2,969,528
Subtotal	$9,463,309	$2,969,528
Grand Total Federal & State Funds	**$12,432,837**	

OAA Allocation – Intrastate Funding Formula

Each year the ACL allocates a set amount of OAA funding to each state and defines how the funding is proportioned for each Title III line item. Because the program is not means-tested or an entitlement, services may be reduced or waiting lists established when the demand for services exceeds these available funds.

When allocating the overall award, the OAA requires the state to:

1. determine its Planning and Service Areas (PSAs – see Glossary of Terms) and
2. create and utilize an Intrastate Funding Formula (IFF) by which funds are distributed to these service areas.

Connecticut submits information about how its IFF is calculated, and the resulting proportions of allocations, in each State Plan on Aging.[7] The demographic data used as the basis for the IFF comes from the most recent decennial census data sets available. Unfortunately, ADS is still awaiting the release of the necessary 2020 decennial data sets from the Census Bureau and therefore the IFF is still based on 2010 data.

The IFF must ensure equitable distribution of funding across the state, to reflect the proportion of the program's target population living in each service area. The IFF starts by looking at the proportion of adults aged 60 and older in the state and in each region

[7] State plans are revised every three to four years. ADS will be submitting its next state plan for FFY 24.

(base population). Each region's base population is then weighted based on the proportion with the following social and demographic characteristics:

1. who are members of a racial and ethnic minority;
2. with incomes at or below the federal poverty level (FPL);
3. unable to perform basic activities without assistance;
4. living in rural communities; and
5. who are both members of racial or ethnic minorities *and* have incomes below the FPL.

The service area's weighted population is then added to their base population and compared to the state's overall population of older adults as outlined in the table below.

Formula for Distributing Title III Funds vs. Weighted Populations - 2010 Census

	Eastern	North Central	South Central	South-western	Western	Total
Total 60+	120,637	202,766	136,641	127,954	121,856	709,854
Minority 60+	8,481	31,392	19,595	26,270	11,261	96,999
Low Income 60+	5,305	13,243	7,880	7,950	7,135	41,513
Disabled 60+	2,154	3,934	2,691	2,404	2,291	13,474
Rural 60+	31,561	6,194	3,736	1,600	21,922	65,013
Low Income Minority 60+	715	4,939	2,540	3,660	1,789	13,643
Total Weighted Population	168,853	262,468	173,083	169,838	166,254	940,496
Percent Weighted Population	17.95%	27.91%	18.40%	18.06%	17.68%	100.00%
Share of Funds Under IFF	**18.97%**	**23.96%**	**19.20%**	**19.03%**	**18.84%**	**100.00%**

Half of allocated Title III funds are divided equally across service areas to ensure adequate minimum proportions are met, with one-fifth allocated to each AAA. The other half of Title III funds are allocated according to the above weighted percentages. The resulting percentage (above in bold) represents the area's overall share of funds distributed under the Intrastate Funding Formula (IFF).

Fund Transfers

To ensure funds are directed to where they are most needed according to the needs of the state and regions, up to 40% of funds can be transferred between Title III C-1 congregate meal funding and Title III C-2 home delivered meal funding. Transfers may be requested once per federal fiscal year and must be approved by the ACL.

USDA Performance-Based Allocation

The U.S. Department of Agriculture's performance-based Nutrition Services Incentive Program (NSIP) grant is authorized by Section 311 of the Older Americans Act. NSIP is allocated to the AAAs based on the number of meals served in their region in the prior federal fiscal year (FFY) as compared to the state as a whole and is outlined in the table below. In this way, regions that served the greatest number of meals were rewarded with a higher allocation of funds to incentivize them to serve more meals.

Formula for Distributing NSIP Funds vs. Weighted Populations - 2010 Census

	Eastern	North Central	South Central	South-western	Western	Total
Percent Weighted Population	17.95%	27.91%	18.40%	18.06%	17.68%	100.00%
Share of Funds Distributed Under NSIP	**21.69%**	**17.21%**	**16.71%**	**19.33%**	**25.07%**	**100.00%**

NSIP allocations may only be used to purchase domestically produced food (e.g., milk, fruit, vegetables, protein products) that are used in a meal or portion of a meal, but not for bags of groceries. The funds may not be used to pay for administration or other nutrition services such as education or counseling.

Fund Transfers

Unlike Title III funds, NSIP allocations may not be transferred.

Social Services Block Grant

Social Services Block Grant (SSBG) funds are a flexible source of funds administered by HHS and used by states to support social services activities that meet program goals. There are no federal eligibility criteria for SSBG participants and states have broad discretion over the use of funds.[8]

SSBG funds are received by the Department of Social Services (DSS), which allocates them to ADS to provide home delivered meals. Prior to FFY 2022, participants receiving meals paid for using SSBG funds were those who were at or below 150% FPL, a requirement which has since been suspended. The funds are intended to augment elderly nutrition providers' available funding to provide additional meals.

[8] Federal provisions on SSBG are found at 42 U.S.C. 1397 et seq.

By law, SSBG allocation plans must be legislatively approved (CGS § 4-28b). Under the 2023 allocation plan, the FFY 2023 proposed allocation of $982,601 includes a temporary increase of $150,000 over the FFY 2022 allocation of $832,601. This increase was intended to offset the increased cost of food due to inflation. SSBG Funds have been distributed in the same manner as NSIP funds, as outlined in the table below.

Formula for Distributing SSBG Funds vs. Weighted Populations - 2010 Census

	Eastern	North Central	South Central	South-western	Western	Total
Percent Weighted Population	17.95%	27.91%	18.40%	18.06%	17.68%	100.00%
Share of Funds Distributed Under SSBG	**21.69%**	**17.21%**	**16.71%**	**19.33%**	**25.07%**	**100.00%**

Temporary Pandemic Relief Funds

Since the onset of the COVID-19 pandemic, Connecticut has received several rounds of emergency funding, as outlined in the table below. These funds were distributed according to the IFF, as described above. Due to the permissibility of carryover, funds may have been expended in a different federal fiscal year than they were received.

Federal Grant Awards for Elderly Nutrition During COVID-19 Emergency

	FFY 20	FFY 21
Families First Coronavirus Response Act (FFCRA)	$2,440,854	-
Coronavirus Aid, Relief and Economic Security Act (CARES)	$4,694,125	-
Consolidated Appropriations Act (CAA)	-	$1,616,400
American Rescue Plan Act (ARPA)	-	$7,063,766
FFY Total	$7,134,979	$8,680,166
Total Federal Emergency Funds	**$15,815,145**	

Notes: FFCRA, CARES, CAA and ARPA figures are exclusive of transfers.

In addition, $3 million in ARPA funds was distributed directly to local providers (i.e., without distributing through the AAAs) in state fiscal year (SFY) 2022, to cover pandemic-related economic losses or capitol expenses. Distribution was based on a provider's prior year performance (i.e., share of number of meals served), in the same manner as NSIP funds, as described above. Most recently, PA 23-204 provides $2.25 million in SFY 2024 from ARPA funds for the program.

While these allocations were vital to helping the state and local providers navigate the pandemic and continue to serve as many people as possible, the intent of these funds was temporary relief. As Connecticut moves into a post-COVID reality, funding levels are anticipated to return to pre-COVID levels, and providers must adjust their service levels accordingly.

Evaluating State Allocations

State Allocation

The Elderly Nutrition Program also receives an allocation of state funds each year to partially match federal funding. State Nutrition funds are allocated in one amount (in contrast to separate earmarked federal allocations for congregate and home delivered meals) in accordance with CGS § 17a-851(b), which requires:

- 60% of state funds appropriated to the AAAs for elderly nutrition and social services be allocated in the same proportion as allocations made pursuant to CGS § 17a-851(a), by which:
    - ADS must equitably allocate, in accordance with federal law, federal funds received under Title III-B and III-C of the OAA to the five AAAs
        - ADS allocates these funds using the IFF percentages
- 40% of state funds appropriated to the AAAs for elderly nutrition and social services used for purposes other than the required non-federal matching funds be allocated at the discretion of the ADS Commissioner, in consultation with the AAAs, based on their need for these funds
        - ADS allocates these funds using a blend of the IFF and NSIP percentages
- Any state funds appropriated to the AAAs for administrative expenses must be allocated equally

Most recently, PA 23-204 provides an additional $1.5 million for the program in SFY 2025.

Regional Allocations

Each service area has sub-regions, determined by the AAA, and each of those sub-regions is covered by a provider which contracts with the AAA. These contracts are procured through a competitive Request for Proposals (RFP) bid process every three to six years. The newest RFP was released by the AAAs in January 2023, and it is expected that the new provider contracts will be effective on October 1, 2023.

The AAAs then allocate funding to their contracted providers based on their allocation methodology. These providers, in consultation with their AAAs, are then responsible to provide services within their budget constraints, and with a mandate to target OAA priority populations.

Provider Costs

Broadly speaking, costs for the Elderly Nutrition Program include administrative and meal production costs. Home-Delivered meal programs also incur delivery costs, whereas congregate meal programs have site management costs. It is worth noting that each local provider is a separate entity, many under the umbrella of larger organizations, with distinct needs and operating guidelines. As each program is structured based on its unique service area population and geography, providers have different combinations of costs and may also account for them differently. This makes drawing cost comparisons between programs challenging.

Local providers are competitively selected for three-year periods and annually submit their proposed budget for approval by the AAA. As these providers are subcontractors of the AAAs, ADS does not collect or retain cost data in the regular course of the program. Provider meal costs included in this report are self-reported by each local provider and should be considered and interpreted accordingly. Please also note providers submitted to ADS their average meal costs which included both their program's home-delivered and congregate meals rather than separate average costs.

Administrative Costs

Administrative costs vary from program to program based on how administrative tasks are divided between the AAA and their local service providers. These tasks include 1) intake assessments and annual reassessments, 2) nutrition counseling, 3) data entry and reporting, and 4) nutrition education.

Intake Assessment and Reassessment

Depending on how services are contracted, either an AAA or local service provider staff member completes an intake and assessment for each participant. Participants rated with a high nutrition risk score are referred to a registered dietitian or nutritionist to receive one-on-one nutrition counseling to address these risks and create strategies to lower them. Participants are reassessed each year and continue to receive supports to address any nutrition risks.

Nutrition Counseling

Nutrition Counseling provides individualized guidance to participants who are at nutrition risk because of their health or nutrition history, dietary intake, chronic illness, or medication use, or to the participants' caregivers. Counseling is done one-on-one and involves an assessment of the participant's needs, and a plan with the measures required to overcome any identified deficiencies.

Data Entry and Reporting

All required participant information is entered into the program's data management system and reported to ADS' State Unit on Aging, which must in turn annually report it to the ACL. The responsibility of data entry varies from contract to contract, with some AAAs handling data management centrally, others delegating this task to local service providers, and some local providers delegating this to a subcontracted caterer.

Nutrition Education

Nutrition Education is provided to all participants and consists of generalized educational modules and materials on important healthy aging subjects including bone health, oral health, sodium intake, balanced diets, physical activity, diabetes, and heart disease.

Meal Production Costs

Menu Creation & Analysis

Under both federal and state law (CGS § 17a-852), Elderly Nutrition programs must provide one meal per day, five days per week to program participants. However, some providers may opt to provide as much as two meals per day for up to seven days per week. These meals are required to meet one-third of the recommended Dietary Reference Intake or Daily Guidelines for Americans and are designed to be low-sodium and low-sugar to meet the variety of dietary needs of older adults (e.g., diabetes, heart disease, hypertension, and osteoporosis). Although technically not a requirement, providers are encouraged to also offer culturally appropriate meals where possible for those who, for example, observe a Kosher diet. To accomplish this, providers may handle meal planning and nutritional analysis in-house or outsource this task to a caterer.

Meal Production

Home-delivered meal production costs are generally lower than congregate meal costs due to economies of scale and differences in their preparation and holding requirements. Significantly more home-delivered meals are produced than congregate meals and can be made in-advance by flash freezing them, whereas congregate meals are prepared on the day they are served and must be properly hot-held. Like menu planning, providers can contract to produce meals in their own commissary or subcontract with a caterer. Which production method achieves greater cost control depends on factors such as program size and organizational capacity.

Home Delivery Costs

The costs associated with home delivery of meals include the cost of drivers as well as the delivery vehicles used, their maintenance, and fuel costs. Whereas some programs employ only paid drivers, other programs may fully or partially utilize volunteers to deliver meals. The geography of the provider's service area is another cost factor. In general, programs operating in rural areas have longer travel times between each stop, while more urban programs have more efficient delivery routes in a neighborhood or cluster of building complexes. As both federal and state regulations restrict use of funding for capital expenditures, providers must fundraise to replace delivery vehicles.

Congregate Site Management Costs

Like delivery cost factors, the use of paid versus volunteer site management staff can vary from program-to-program, resulting in significant cost differentials. There are also greater supply costs for serving these meals, such as paper goods and flatware. Most of the programs utilizing caterers have them deliver the congregate meals to the sites utilizing catering staff and vehicles, which also increases costs.

COVID Impact

When COVID started, programs had to change congregate meal distribution and home delivery guidelines, for instance, establishing "grab and go" meals, and purchase personal protective equipment for staff and drivers. These costs are included in a provider's meal costs and factored into reimbursement rates.

Grab & Go Meals

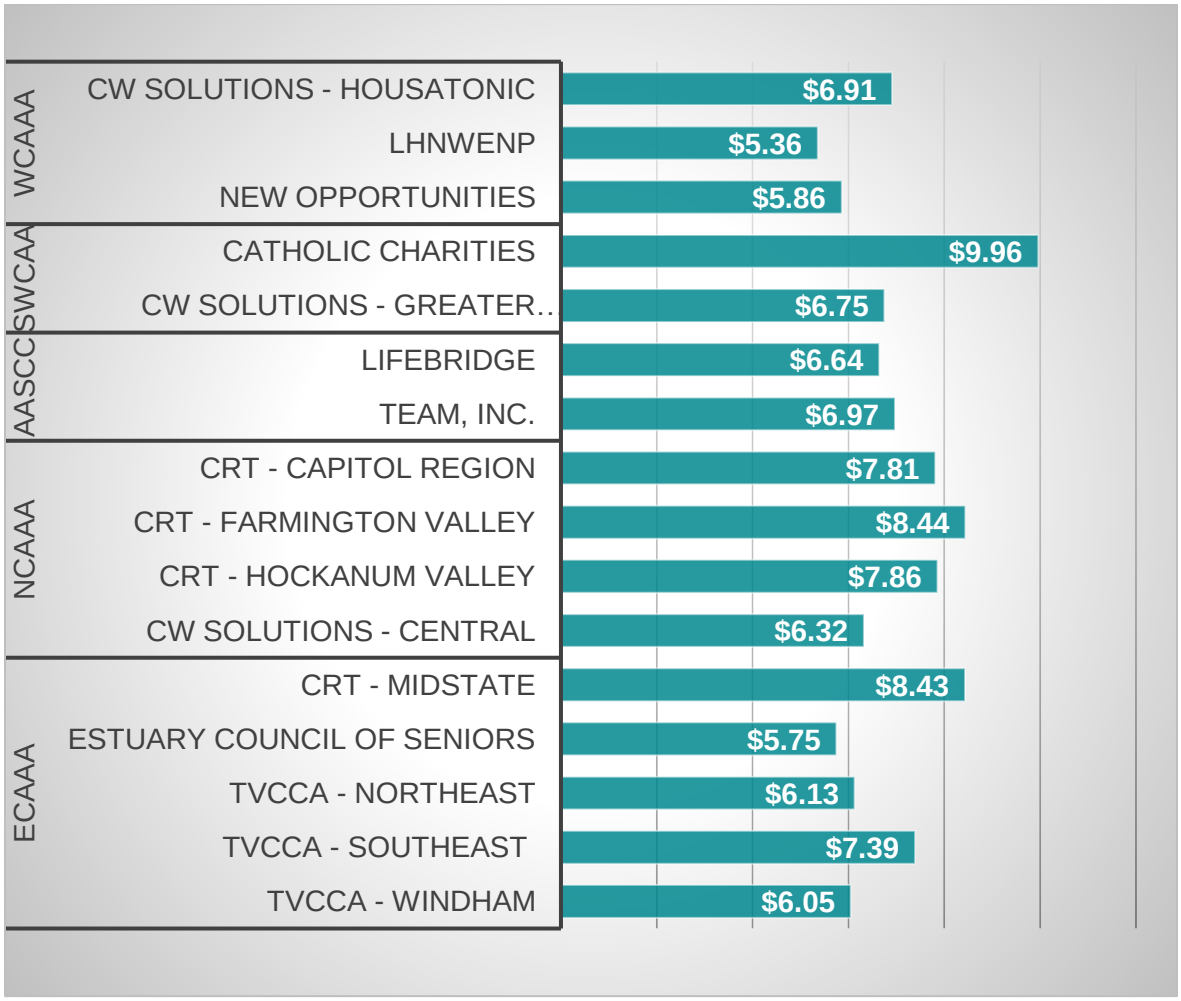
Classifying a service as congregate or home-delivered impacts reporting and data collection and determines funding streams. Grab & Go meals are ready-to-eat packaged meals that are picked up by participants and taken away from the site for consumption. Per ACL guidelines, Grab & Go meals consumed at home without congregating are deemed home-delivered meals, whereas meals consumed with others at the pick-up site or "at home while congregating" (including socializing with others outside of the home over a virtual platform organized by a provider) are deemed congregate meals.

Reimbursement Rates

Statewide Home-Delivery Program

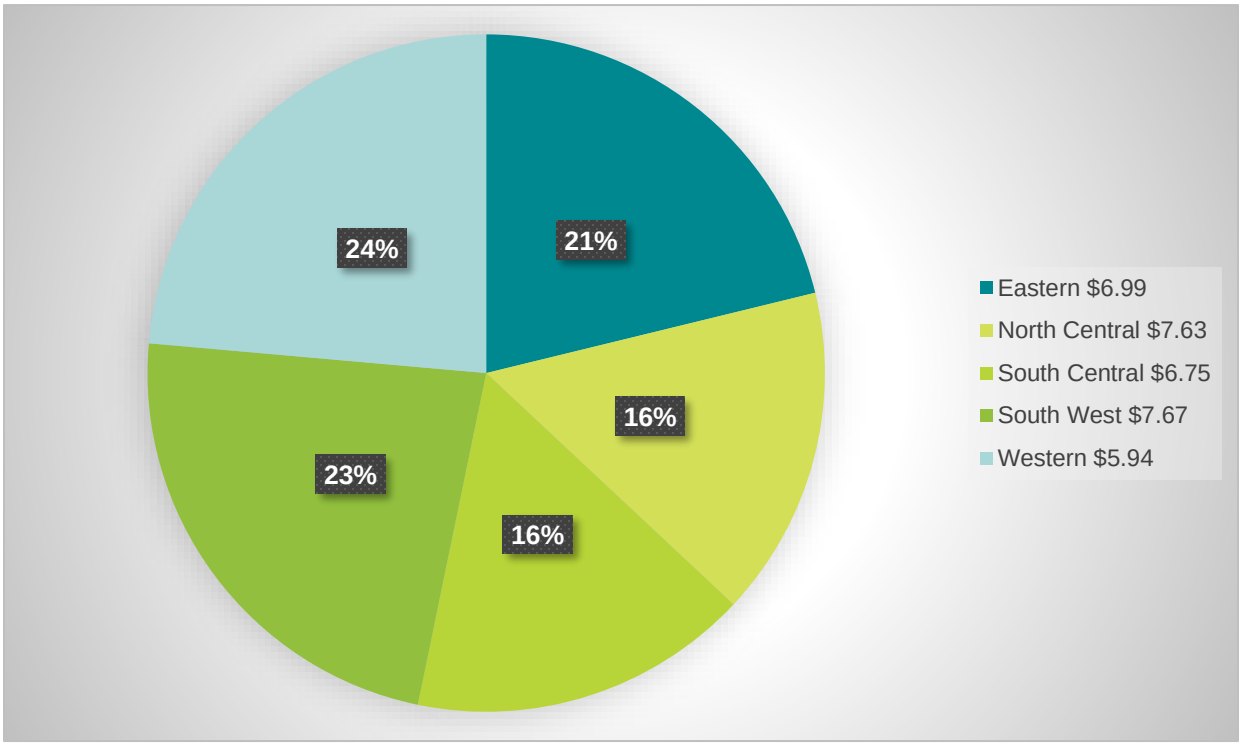
Local providers are competitively selected for three-year periods and annually negotiate their contract and reimbursement within this time frame. Each year, providers submit their proposed budget for approval by the AAA. The AAA negotiates each provider's contracted rates based on the amount of federal and state funding the AAA anticipates receiving, and how it must be distributed across the service area. Once finalized, programs are tasked with serving as many participants as possible while operating within their approved budget or raising additional local funding to enable them to serve more. Home-delivered rates for FFY 2023 shown below range from $5.36 to $9.96 per meal.

FFY 2023 Home-Delivered Per-Meal Reimbursement by Provider



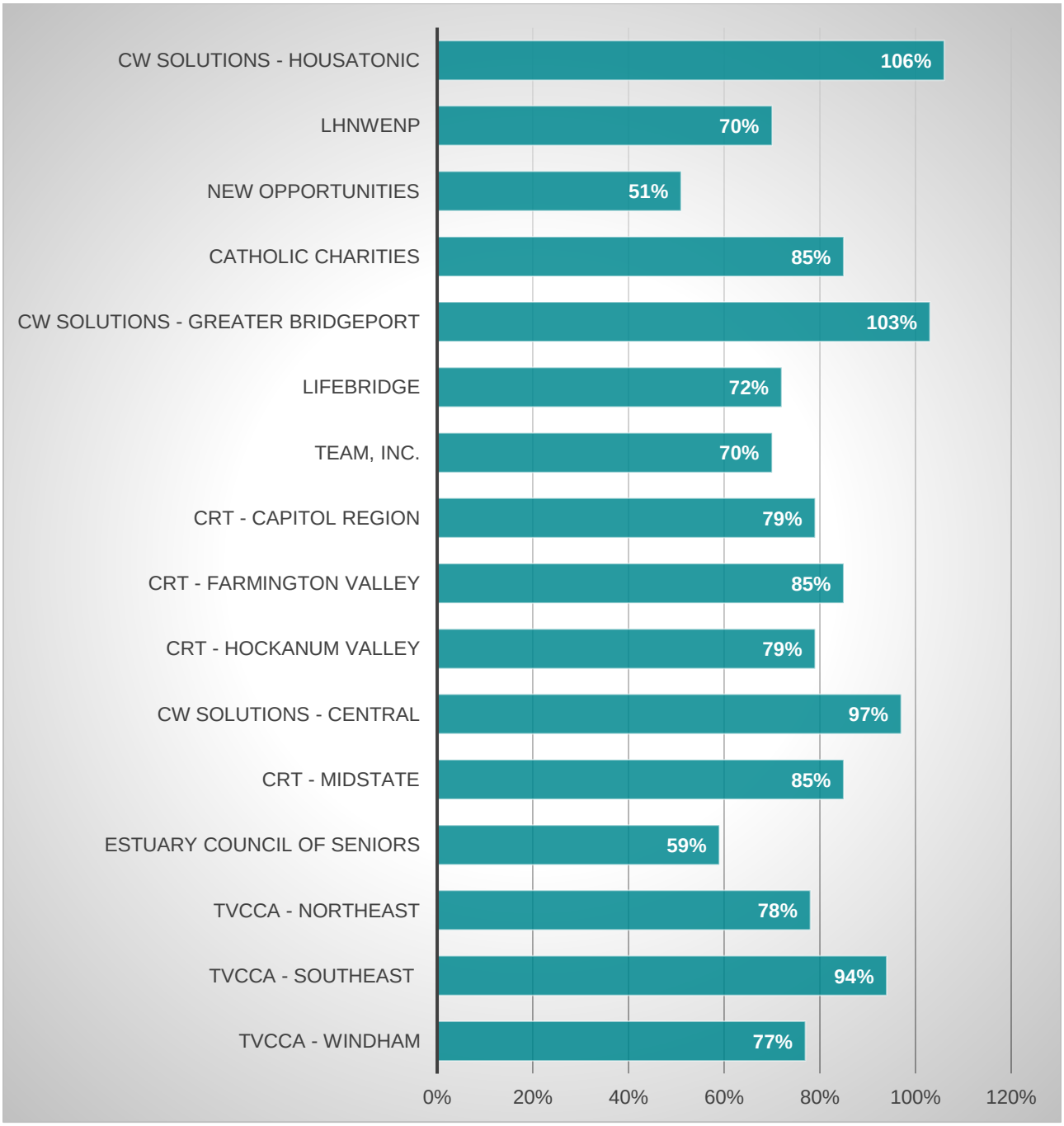
The chart below depicts the percentage of home-delivered meals served by each service area and their respective average reimbursement rates. Based on these service levels, the weighted average reimbursement rate for home-delivered meals statewide was $6.90.

FFY 2023 Average Home-Delivered Meal Reimbursement and Percentage of Meals Served by Area



The graph below indicates each provider's per-meal reimbursement rate compared to their self-reported meal costs. Please note providers submitted to ADS their average meal costs, which included both their program's home-delivered and congregate meals rather than separate average costs.

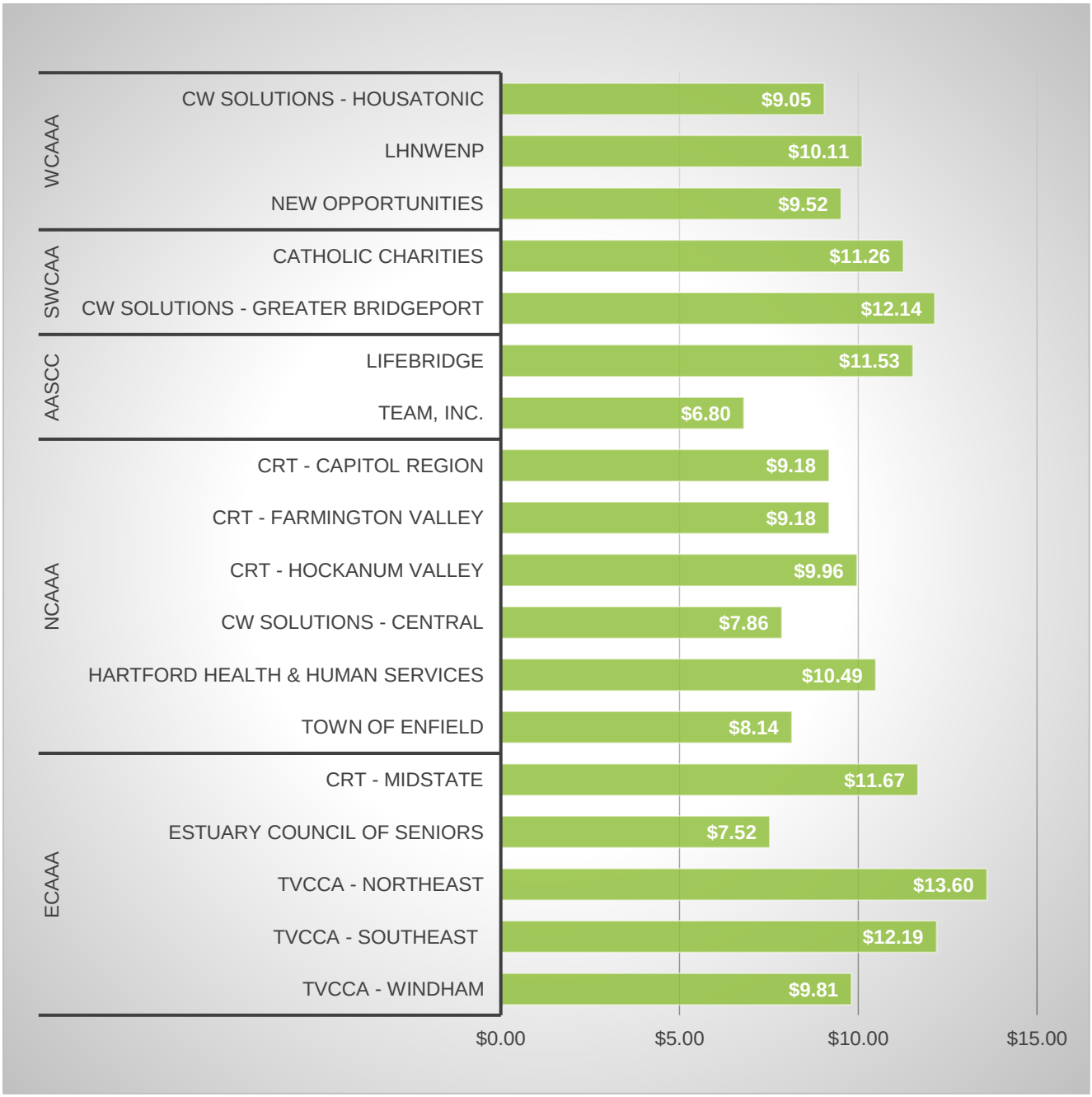
FFY 2033 Home-Delivered Meal Costs Reimbursed



Statewide Congregate Meal Program

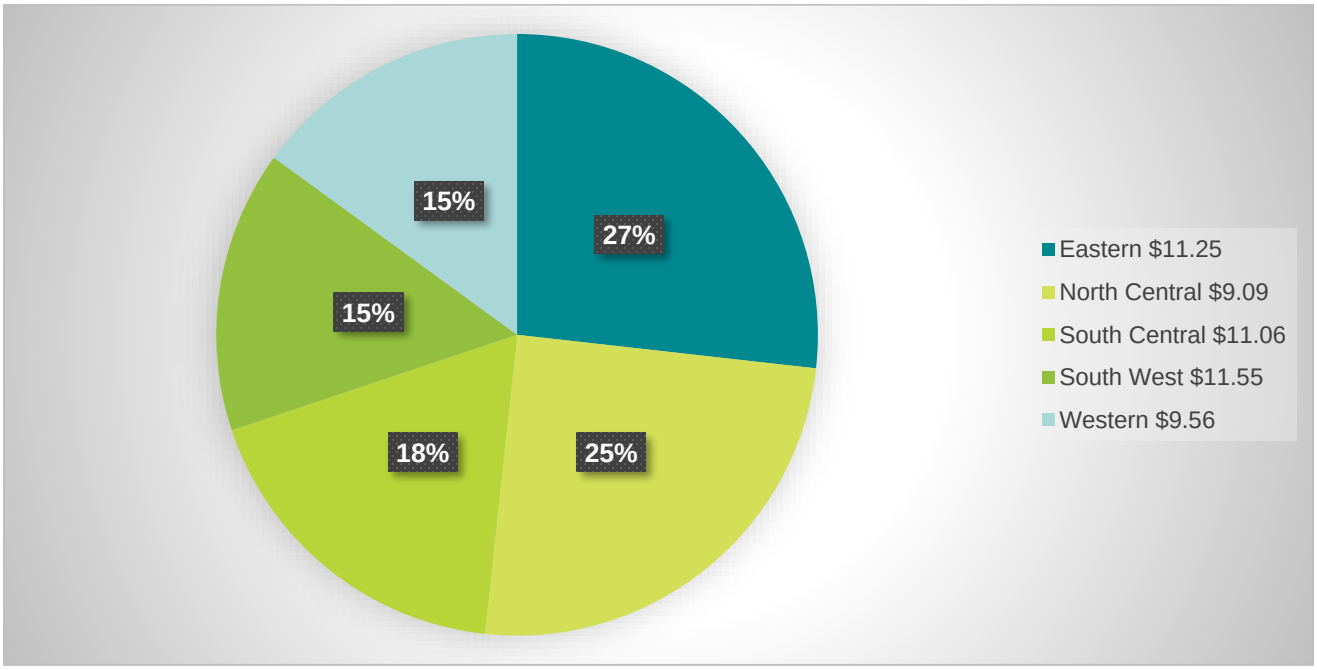
As with home-delivered rates, local providers are selected for three-year periods and annually negotiate their contract and reimbursement within this time frame. Congregate rates for FFY 2023 shown below range from $6.80 to $13.60 per meal.

FFY 2023 Congregate Per-Meal Reimbursement by Provider



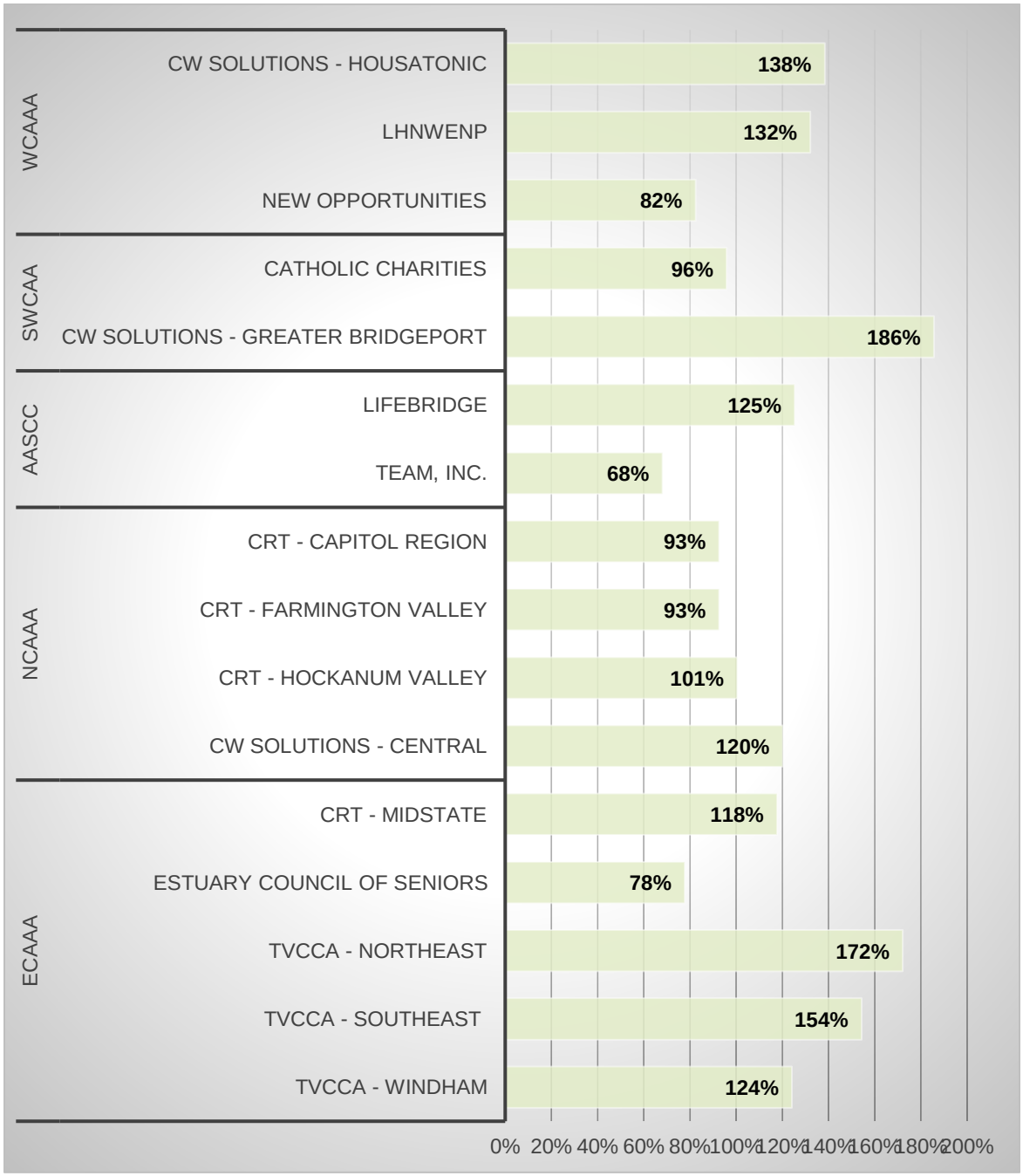
The chart below depicts the percentage of congregate meals served by each service area and their respective average reimbursement rates. Average reimbursement rates ranged from a low of $9.37 to a high of $11.55. Based on reported meal service levels, the weighted average reimbursement rate for congregate meals statewide was $10.46.

FFY 2023 Average Congregate Meal Reimbursement and Percentage of Meals Served by AAA



As the graph below indicates, nine providers reported sufficient contracted reimbursement rates to cover their reported per-meal costs in the congregate program. However, six providers reported costs exceeded their contracted reimbursement rates. Please note providers submitted to ADS their average meal costs which included both their program's home-delivered and congregate meals rather than separate average costs.

FFY 2023 Congregate Meal Costs Reimbursed



Eastern Area Agency on Aging

Home-Delivered Meals

In the Eastern service area, home-delivered program administration is split between the AAA, known as Senior Resources, and its five contracted providers. The AAA is responsible for providing all nutrition counseling and education. Local service providers handle initial intake and assessments, however for most contracts, annual reassessments are completed by Senior Resources. Local providers are also responsible for menu creation and analysis, meal production, and delivery.

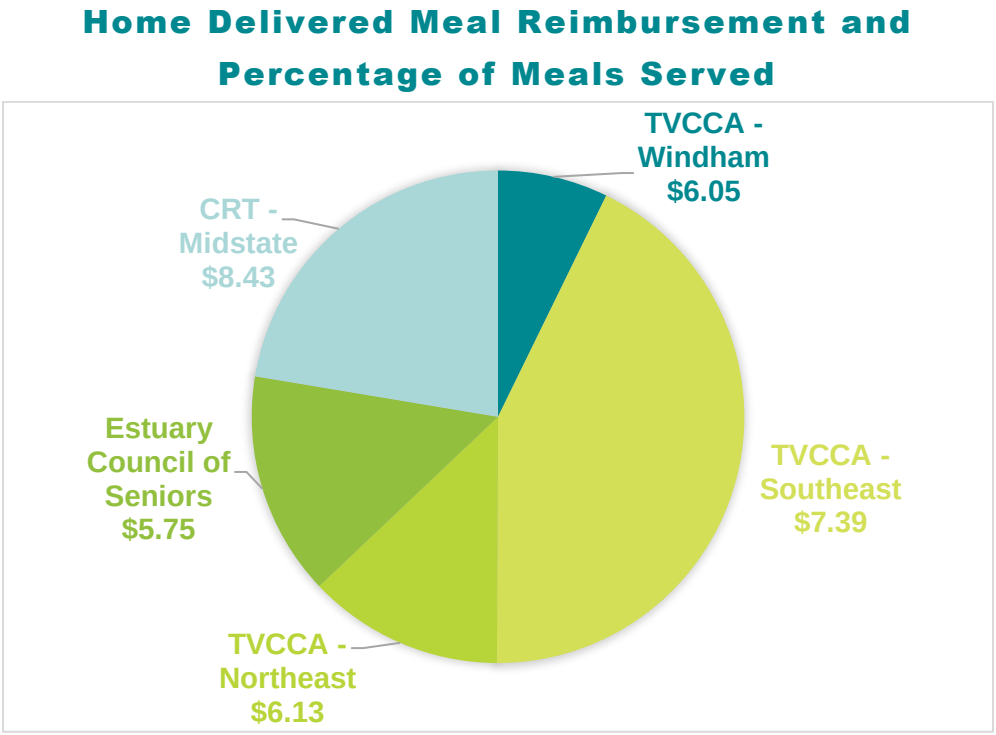
Cost Components and Reimbursement for Eastern Home-Delivered Meal Program

Home-Delivered Meals	*CRT - Midstate*	*Estuary Council of Seniors*	*TVCCA - Northeast*	*TVCCA - Southeast*	*TVCCA - Windham*
Meal Production	In-House	In-House	In-House	In-House	In-House
In-House Commissary Staff	**	5	6	6	6
Drivers - Paid vs. Volunteer	Paid	Both	Both	Both	Both
Drivers (# Paid/Volunteer)	**	50	3 Paid; 3 Vol	11 Paid; 35 Vol	1 Paid; 7 Vol
Per-Meal Reimbursement Rate	$8.43	$5.75	$6.13	$7.39	$6.05
*Average Meal Cost**	$9.91	$9.67	$7.90	$7.90	$7.90
Average Per-Meal Profit/Loss	-$1.48	-$3.92	-$1.77	-$0.51	-$1.85

*Includes administrative costs per Nutrition Cost Calculation Workbook

**Requested information was not provided or was only provided in aggregate across contracted regions.

The chart below depicts the percentage of home-delivered meals served by each provider and their respective reimbursement rates, with the most meals served by TVCCA – Southeast, and least by TVCCA – Windham. Based on these service levels, the weighted average reimbursement rate for Eastern service area home-delivered meals was $6.99. As the table above indicates in red, all providers have reported per-meal costs that exceed their contracted reimbursement rate in the home-delivered program.



Congregate Meals

Except for MIS data entry, all program administration for the Eastern congregate program is handled by local service providers. These providers produce their meals in-house, and generally utilize paid staff for site management, although CRT-Midstate utilizes both paid staff and volunteers.

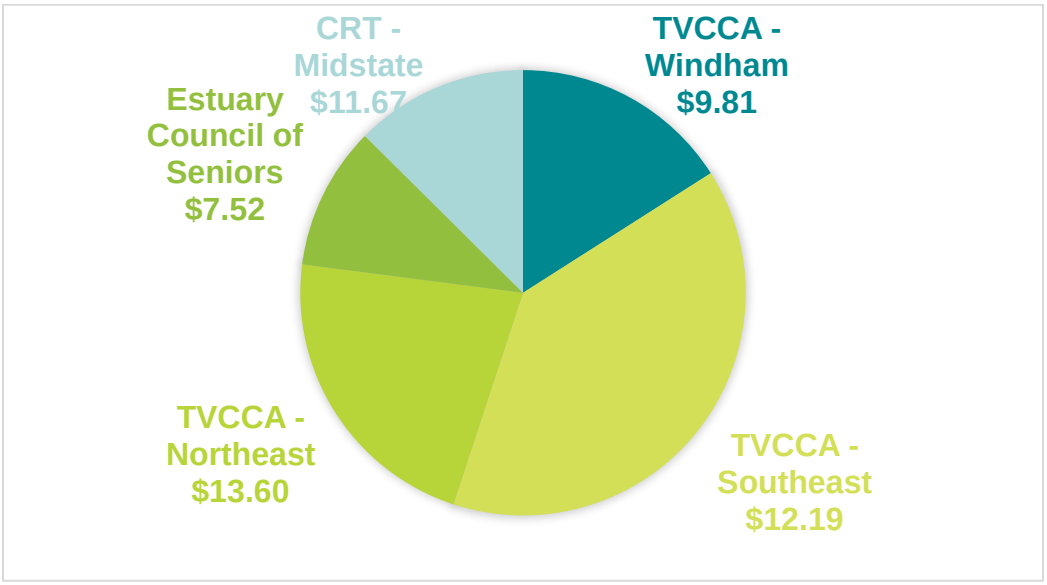
Cost Components and Reimbursement for Eastern Congregate Meal Program

Congregate Meals	*CRT - Midstate*	*Estuary Council of Seniors*	*TVCCA - Northeast*	*TVCCA - Southeast*	*TVCCA - Windham*
Meal Production	In-House	In-House	In-House	In-House	In-House
In-House Commissary Staff	--	5	6	6	6
Site Managers - Paid vs. Volunteer	Both	Paid	Paid	Paid	Paid
Site Managers (# Paid/Volunteer)	--	4	8	14	6
Restaurant Sites	--	0	0	1	0
Per-Meal Reimbursement Rate	$11.67	$7.52	$13.60	$12.19	$9.81
*Average Meal Cost**	$9.91	$9.67	$7.90	$7.90	$7.90
Average Per-Meal Profit/Loss	$1.76	-$2.15	$5.70	$4.29	$1.91

*Includes administrative costs per Nutrition Cost Calculation Workbook

The chart below depicts the percentage of congregate meals served by each provider and their respective reimbursement rates, with the most meals served by TVCCA – Southeast, and the least by Estuary Council of Seniors. Reimbursement rates ranged from a low of $7.52 to a high of $13.60. Based on reported meal service levels, the weighted average reimbursement rate for Eastern service area congregate meals was $11.22. As the table above indicates, all but one provider (Estuary) has reported sufficient contracted reimbursement rates to cover their reported per-meal costs in the congregate program.

Congregate Meal Reimbursement and Percentage of Meals Served



North Central Area Agency on Aging

Home-Delivered Meals

Except for AAA data entry, it appears that all program administration for the North Central AAA (NCAAA) home-delivered program is handled by local service providers.[9] These providers produce their meals in-house, and generally utilize paid drivers for deliveries, although CW Solutions - Central utilizes both paid staff and volunteers.

Cost Components and Reimbursement for North Central Home-Delivered Meal Program

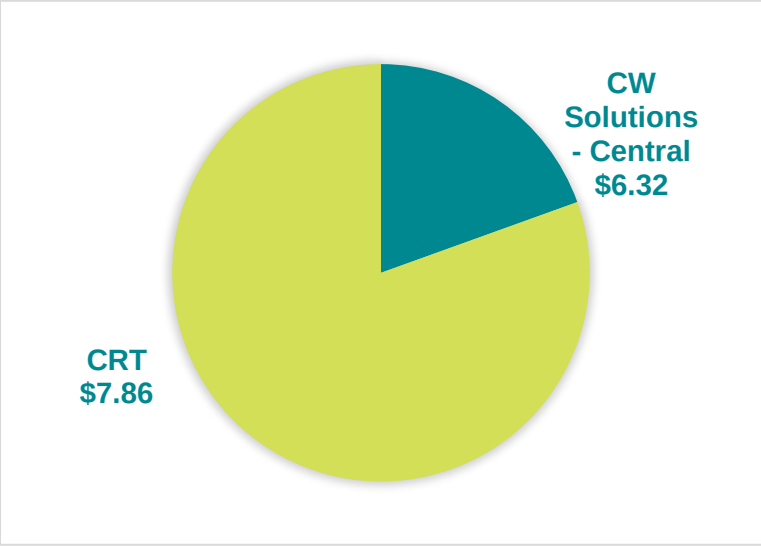
	CRT - Capitol Region	***CRT - Farmington Valley***	***CRT - Hockanum Valley***	***CW Solutions - Central***
Meal Production	In-House	In-House	In-House	In-House
In-House Commissary Staff	--	--	--	20
Drivers - Paid vs. Volunteer	Paid	Paid	Paid	Both
Drivers (# Paid/Volunteer)	--	--	--	5 Paid; 25 Vol
Per-Meal Reimbursement Rate	$7.81	$8.44	$7.86	$6.32
*Average Meal Cost**	$9.91			$6.54
Average Per-Meal Profit/Loss	-$2.10	-$1.47	-$2.05	-$0.22

*Includes administrative costs per Nutrition Cost Calculation Workbook

The chart below depicts the percentage of home-delivered meals served by each provider and their respective reimbursement rates, with the most meals served by CRT's three combined branches and the least by CW Solutions.[10] Based on these service levels, the weighted average reimbursement rate for North Central home-delivered meals was $7.63. As the table above indicates in red, all providers have reported per-meal costs that exceed their contracted reimbursement rate in the home-delivered program.

[9] CRT did not provide responses to some cost component questions.
[10] CRT provided aggregate service totals and costs rather than by its three separate contracts as requested.

Home Delivered Meal Reimbursement and Percentage of Meals Served



Congregate Meals

Except for AAA data entry, all program administration for the North Central congregate programs is handled by local service providers. These providers produce their meals in-house, and generally utilize paid staff for site management, although CRT utilizes both paid staff and volunteers. The Town of Enfield's program does not provide nutrition counseling or site management, as this is a weekend-only program located at a housing site with housing site staff distributing meals and the work-week provider handling nutrition counseling.

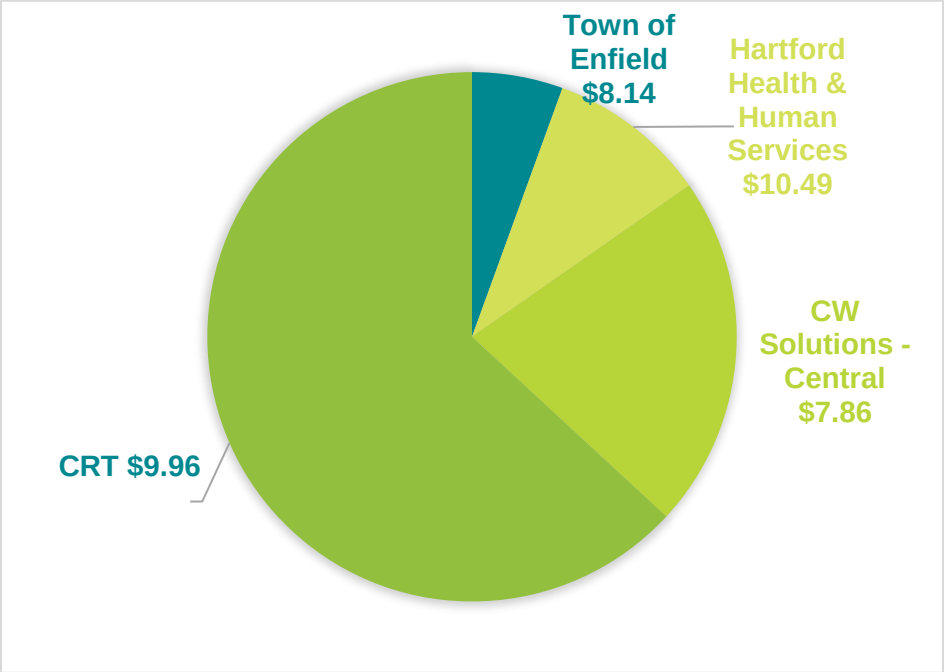
Cost Components and Reimbursement for North Central Congregate Meal Program

	CRT - Capitol Region	***CRT - Farmington Valley***	***CRT - Hockanum Valley***	***CW Solutions - Central***	***Hartford Health & Human Services***	***Town of Enfield***
Meal Production	In-House	In-House	In-House	In-House	In-House	In-House
In-House Commissary Staff	--	--	--	20	2 F/T 1 P/T	2
Site Managers - Paid vs. Volunteer	Both	Both	Both	Paid	Paid	N/A
Site Managers (# Paid/Volunteer)	--	--	--	6	2	N/A
Restaurant Sites	--	--	--	0	N/A	N/A
Per-Meal Reimbursement Rate	$9.18	$9.18	$9.96	$7.86	$10.49	$8.14
*Average Meal Cost**	$9.91	$9.91	$9.91	$6.54	$8.77	$10.36
Average Per-Meal Profit/Loss	-$0.73	-$0.73	$0.05	$1.32	$1.72	-$2.22

*Includes administrative costs per Nutrition Cost Calculation Workbook

The chart below depicts the percentage of congregate meals served by each provider and their respective reimbursement rates, with the most meals served by the combined CRT branches, and the least by the Town of Enfield. Per-meal reimbursement rates varied significantly, ranging from a low of $7.86 to a high of $10.49. Based on reported meal service levels, the weighted average reimbursement rate for North Central service area congregate meals was $9.09. As the table above indicates, half of the providers reported insufficient contracted reimbursement rates to cover their reported per-meal costs in the congregate program.

Congregate Meal Reimbursement and Percentage of Meals Served



South Central Area Agency on Aging

Home-Delivered Meals

In the South Central service area, home-delivered program administration is split between the AAA, known as the Area Agency of South Central Connecticut (AASCC), and its two contracted providers. Local providers handle initial intake and assessments and program data entry; however, the AAA completes the annual reassessments. The AAA is responsible for providing all nutrition education, while providers handle nutrition counseling. Both work with their caterers for menu creation and analysis and meal production as well as utilizing their own paid delivery drivers.

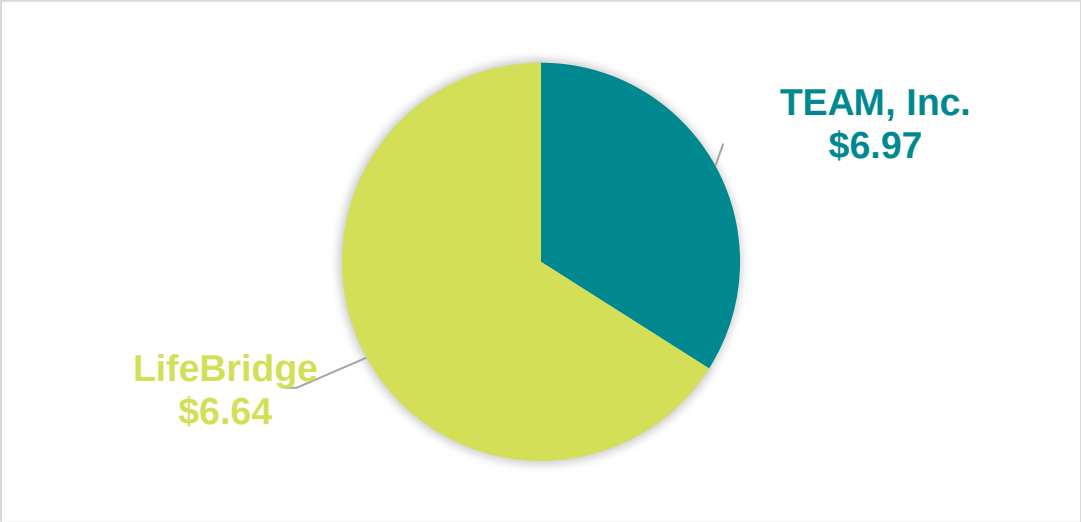
Cost Components and Reimbursement for South Central Home-Delivered Meal Program

Home-Delivered Meals	*LifeBridge*	*TEAM, Inc.*
Meal Production	Caterer	Caterer
In-House Commissary Staff	N/A	N/A
Drivers	Paid	Paid
Drivers (# Paid/Volunteer)	11	5
Per-Meal Reimbursement Rate	$6.64	$6.97
*Average Meal Cost**	$9.20	$9.99
Average Per-Meal Profit/Loss	-$2.56	-$3.02

*Includes administrative costs per Nutrition Cost Calculation Workbook

The chart below depicts the percentage of home-delivered meals served by each provider and their respective reimbursement rates, with the majority of meals served by LifeBridge. Based on these service levels, the weighted average reimbursement rate for South Central home-delivered meals was $6.75. As the table above indicates in red, both providers have reported per-meal costs that exceed their contracted reimbursement rate in the home-delivered program by approximately 30%.

Home Delivered Meal Reimbursement and Percentage of Area Meals Served



Congregate Meals

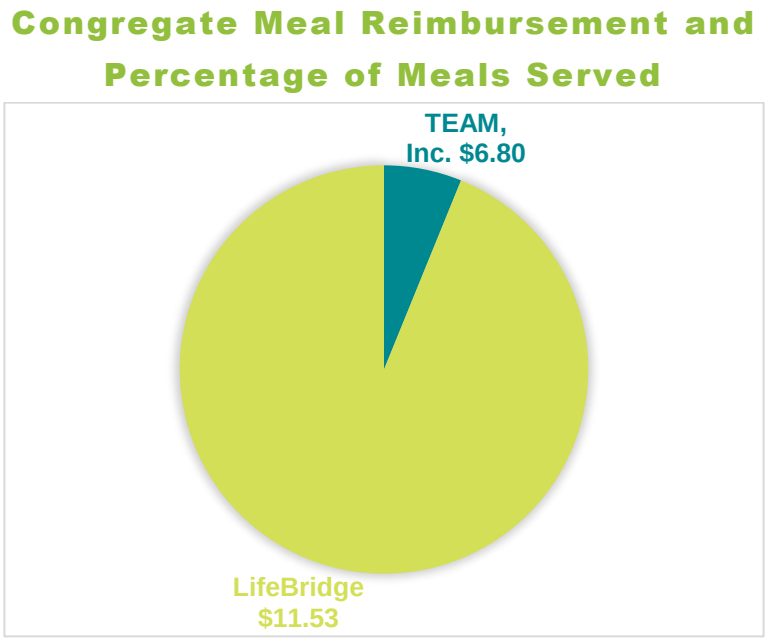
All program administration for the South Central congregate programs is handled by local service providers, including data entry. Like the home-delivered program, these providers utilize caterers for menu creation, analysis, and meal production and paid staff for site management.

Cost Components and Reimbursement for South Central Congregate Meal Program

Congregate Meals	*LifeBridge*	*TEAM, Inc.*
Meal Production	Caterer	Caterer
In-House Commissary Staff	N/A	N/A
Site Managers (# Paid/Volunteer)	15	4**
Site Managers Paid vs. Volunteer	Paid	Paid
Restaurant Sites	0	1
Per-Meal Reimbursement Rate	$11.53	$6.80
*Average Meal Cost**	$9.20	$9.99
Average Per-Meal Profit/Loss	$2.33	-$3.19

*Includes administrative costs per Nutrition Cost Calculation Workbook
**Paid for by host site centers.

The chart below depicts the percentage of congregate meals served by each provider and their respective reimbursement rates, with a significantly higher reimbursement provided to LifeBridge, which serves the majority of the area's meals. Based on reported service levels, the weighted average reimbursement rate for South Central service area congregate meals was $11.06. As the table above indicates, TEAM, Inc. reported insufficient contracted reimbursement rates to cover their reported per-meal costs in the congregate program.



Southwest Area Agency on Aging

Home-Delivered Meals

In the Southwest service area, home-delivered program administration is split between the AAA, known as Southwestern CT Agency on Aging (SWCAA), and its two contracted providers. Local providers handle initial intake and assessments and program data entry; however, the AAA completes the annual reassessments for CW Solutions of Greater Bridgeport. The AAA is responsible for providing all nutrition education, while providers handle nutrition counseling. Whereas Catholic Charities outsources their menu creation and analysis and meal production to caterers and only uses paid delivery drivers, CW Solutions handles menu and meal production in-house and utilizes both paid and volunteer drivers.

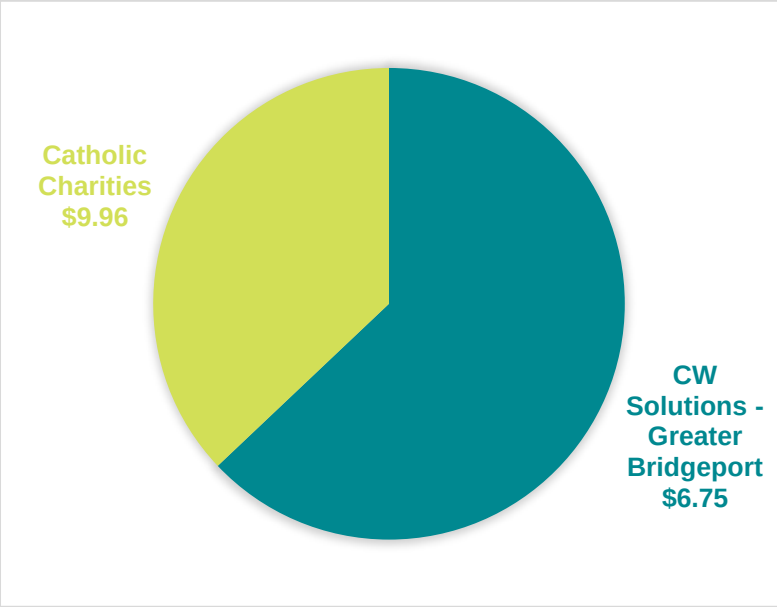
Cost Components and Reimbursement for Southwest Home-Delivered Meal Program

Home-Delivered Meals	***Catholic Charities***	***CW Solutions - Greater Bridgeport***
Meal Production	Caterer	In-House
In-House Commissary	N/A	20
Drivers - Paid vs. Volunteer	Paid	Both
Drivers (# Paid/Volunteer)	10	9 Paid 16 Volunteer
Per-Meal Reimbursement Rate	$9.96	$6.75
*Average Meal Cost**	$11.74	$6.54
Average Per-Meal Profit/Loss	-$1.78	$0.21

*Includes administrative costs per Nutrition Cost Calculation Workbook

The chart below depicts the percentage of home-delivered meals served by each provider and their respective reimbursement rates with a significantly higher reimbursement for CW Solutions, which provides the majority of meals served. Based on these service levels, the weighted average reimbursement rate for Southwest home-delivered meals was $7.67. As the table above indicates, Catholic Charities reported per-meal costs that exceed their contracted reimbursement rate.

Home Delivered Meal Reimbursement and Percentage of Meals Served



Congregate Meals

Except for AAA data entry, all program administration for the Southwest congregate programs is handled by its two local service providers. These providers utilize paid staff for site management but differ in their approach to menu planning and meal production, with Catholic Charities outsourcing these tasks to a caterer and CW Solutions handling these tasks in-house.

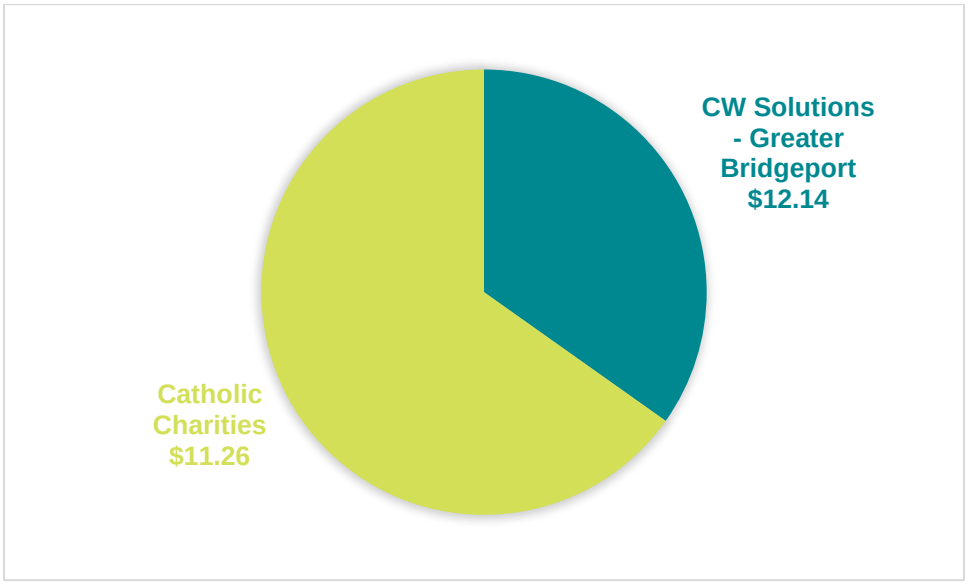
Cost Components and Reimbursement for Southwestern Meal Program

Congregate Meals	***Catholic Charities***	***CW Solutions - Greater Bridgeport***
Meal Production	Caterer	In-House
Site Managers - Paid vs. Volunteer	Paid	Paid
Site Managers (# Paid/Volunteer)	6	7
Restaurant Sites	0	1
In-House Commissary	N/A	20
Per-Meal Reimbursement Rate	$11.26	$12.14
*Average Meal Cost**	$11.74	$6.54
Average Per-Meal Profit/Loss	-$0.48	$5.60

*Includes administrative costs per Nutrition Cost Calculation Workbook

The chart below depicts the percentage of congregate meals served by each provider and their respective reimbursement rates, with Catholic Charities receiving a lower reimbursement rate and serving the majority of the area's meals. Based on reported service levels, the weighted average reimbursement rate for Southwest service area congregate meals was $11.55. As the table above indicates, Catholic Charities reported insufficient contracted reimbursement rates to cover their reported per-meal costs in the congregate program. In contrast, CW Solutions reported a significant per-meal profit margin.

Congregate Meal Reimbursement & Percentage of Meals Served



Western Area Agency on Aging

Home-Delivered Meals

In the Western service area, how the home-delivered program administration is split between the AAA, known as Western Connecticut Area Agency on Aging (WCAAA), and its three contracted providers depends on the contract. The AAA is responsible for providing all initial intake and assessments as well as annual reassessments and nutrition counseling and MIS data entry. For its contract with New Opportunities, WCAAA also provides nutrition education. The AAA provides data entry for LHNWENP as well. Local providers are also responsible for menu creation and analysis and meal production, with two contracting with caterers and one – CW Solutions – Housatonic – handling these tasks in-house. Two providers use both paid and volunteer delivery drivers, but one – LHNWENP –- only uses paid staff.

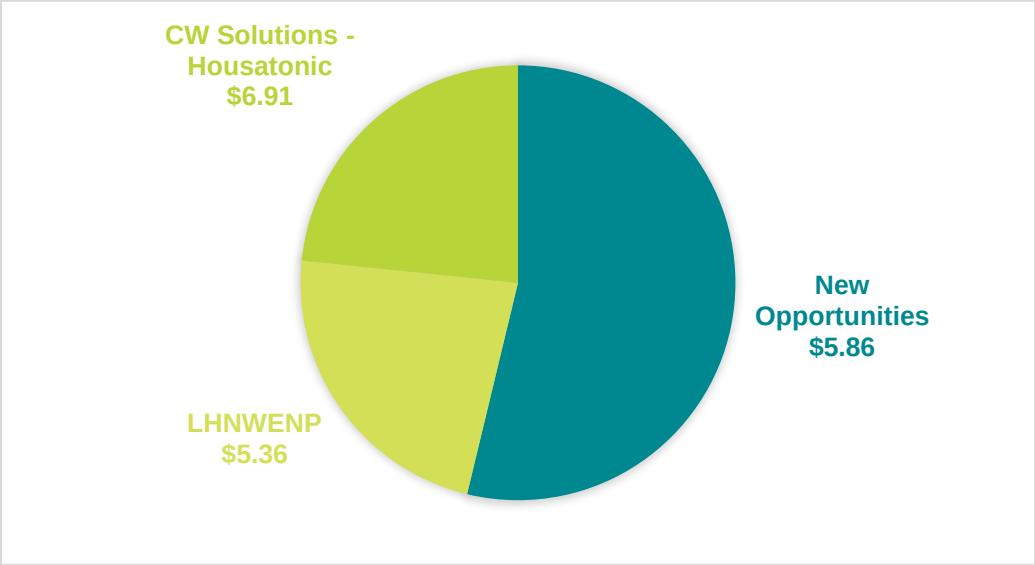
Cost Components and Reimbursement for Western Home-Delivered Meal Program

Home-Delivered Meals	***CW Solutions - Housatonic***	***LHNWENP***	***New Opportunities***
Meal Production	In-House	Caterer	Caterer
Drivers - Paid vs. Volunteer	Both	Paid	Both
Drivers (# Paid/Volunteer)	5 Paid 4 Volunteer	14	23 Paid 15 Volunteer
In-House Commissary Staff	20	N/A	N/A
Per-Meal Reimbursement Rate	$6.91	$5.36	$5.86
*Average Meal Cost**	$6.54	$7.65	$11.55
Average Per-Meal Profit/Loss	$0.37	-$2.29	-$5.69

*Includes administrative costs per Nutrition Cost Calculation Workbook

The chart below depicts the percentage of home-delivered meals served by each provider and their respective reimbursement rates, with New Opportunities providing just over half of the meals served. Based on these service levels, the weighted average reimbursement rate for Western home-delivered meals was $5.94. As the table above indicates, CW Solutions reported sufficient reimbursement to cover their per-meal costs, while the other two providers reported costs that exceeded their contracted reimbursement rates.

Home Delivered Meal Reimbursement and Percentage of Meals Served



Congregate Meals

With a few exceptions, program administration for the Western congregate programs is generally handled by its three local service providers. For its contracts with New Opportunities and LHNWENP, the AAA provides nutrition education. The AAA also provides nutrition counseling for LHNWENP as well. The providers utilize paid staff for site management but differ in their use of paid and unpaid staff as well as in their approach to menu planning and meal production. LWNWENP and New Opportunities use paid site managers and caterers, and CW Solutions handles these tasks in-house.

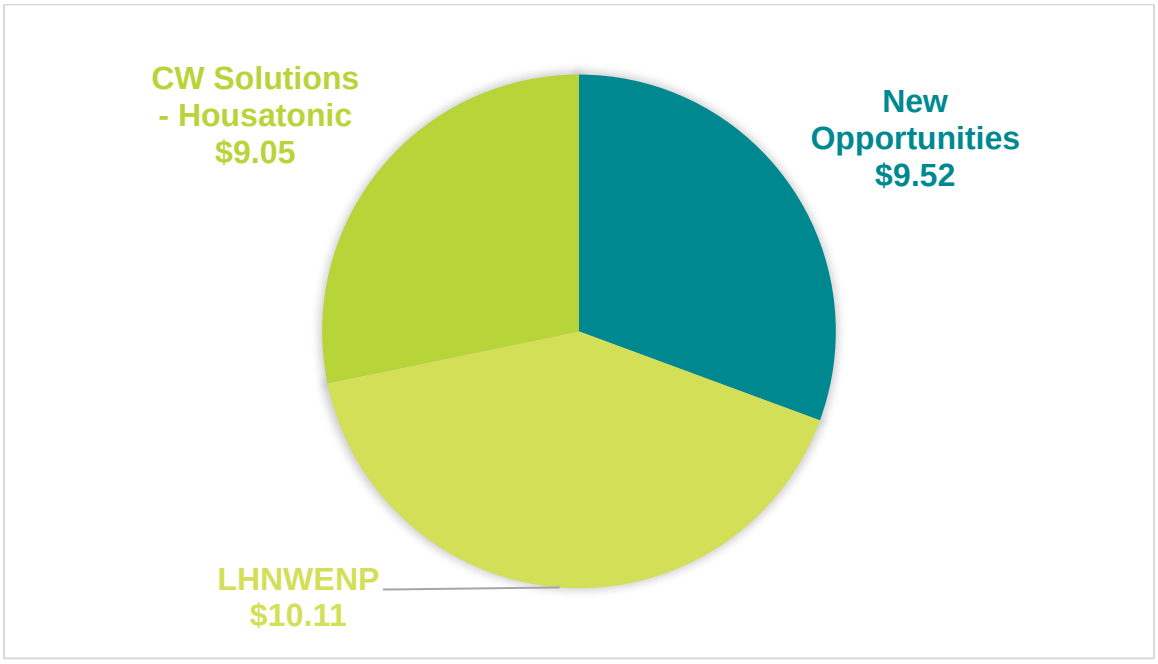
Cost Components and Reimbursement for Western Congregate Meal Program

Congregate Meals	*CW Solutions - Housatonic*	*LHNWENP*	*New Opportunities*
Meal Production	In-House	Caterer	Caterer
In-House Commissary Staff	20	N/A	N/A
Site Managers - Paid vs. Volunteer	Both	Paid	Paid
Site Managers (# Paid/Volunteer)	4 Paid 2 Volunteer	4	6
Restaurant Sites	1	0	10
Per-Meal Reimbursement Rate	$9.05	$10.11	$9.52
Average Meal Cost	$6.54	$7.65	$11.55
Average Per-Meal Profit/Loss	$2.51	$2.46	-$2.03

*Includes administrative costs per Nutrition Cost Calculation Workbook

The chart below depicts the percentage of congregate meals served by each provider and their respective reimbursement rates, with each provider serving similar shares of the area's meals. Based on reported service levels, the weighted average reimbursement rate for Western service area congregate meals was $9.61. As the table above indicates, New Opportunities reported an insufficient contracted reimbursement rate to cover their reported per-meal costs in the congregate program. In contrast, the other two providers reported per-meal profits.

Congregate Meal Reimbursement and Percentage of Meals Served



Recommended Changes in Fund Allocations

Special Act 23-17 was enacted prior to the deadline for this report. The act establishes a task force to similarly study and make recommendations concerning the elderly nutrition program including a review of the (1) eligibility requirements, (2) types of meals provided, (3) costs of the meal preparation and delivery, (4) number of participants in the program compared to the estimated number of persons in need of nutrition services, (5) adequacy of funding levels, and (6) process for contracting with providers of elderly nutrition services. ADS is represented on the task force, which began meeting in August 2023 and must submit its report by January 15, 2024.

This report and its recommendations are not intended to supplant the charge of the current task force, but rather to be responsive to the original reporting requirements under Public Act 22-32, and to support the work of the task force as a source of information. In that spirit, the following recommendations are proposed for consideration.

Improve Data Standardization and Collection

Ultimately, the program's performance measures dictate what data is collected, but how that data is collected determines how accurately program performance can be assessed. The limitations of this report largely stemmed from the fact that ADS – State Unit on Aging does not regulate the contractual relationship between the AAAs and their contracted local providers, nor has it typically collected contract budget information such as a provider's meal or administrative costs. Standardizing definitions and how data is collected from provider to provider (e.g., components of administrative costs) would allow for more consistency across performance measures and improved analysis, however, may not be possible due to the decentralized nature of the program.

For instance, inaccuracies may exist to the extent that an AAA or provider does not utilize or update fields when a participant is initially or annually assessed. Providers routinely raise participant cooperation issues about the large amount of data required during intake. Provider and AAA input could be used to identify such problems and brainstorm ways to mitigate them. Although the majority of this information is federally required and not easily revised, any potential streamlining would be welcome.

Administrative costs varied considerably from provider to provider. This is partially explained by the different ways in which administrative tasks are divided between the provider and their respective AAA. Streamlining administrative tasks wherever possible could potentially allow for more meals to be served within the same allotments, however, how administrative tasks are shared often is dictated by the specific contractual relationship.

Assess Equity of Intrastate Funding Formula

When allocating Title III funds, the OAA requires the state to (1) determine its planning service areas (PSAs – see Glossary of Terms) and (2) create and utilize an Intrastate Funding Formula (IFF) by which funds are distributed to them. Connecticut's service areas were first determined as required by the OAA in 1973 and its map has generally been unchanged for nearly 50 years. The IFF must ensure equitable distribution of funding across the state to reflect the proportion of the program's target population living in each service area.

Currently under the IFF, half of allocated Title III funds for nutrition (of a total of $7,389,982 in FFY 22) and more than one-third of state funds are divided equally across the five service areas, with one-fifth allocated to each AAA. This is done to ensure each region receives a minimum funding level. Whereas the five service areas may have originally had relatively equal proportions of the program's targeted population (i.e., older adults, with priority given to those who are minorities, low-income, disabled, or living in rural areas), that is no longer the case. On every demographic statistic, one service area has significantly higher proportions of these target groups than the other four service areas.

As part of the process to develop the next State Plan on Aging, ADS will have the opportunity to explore ways to improve the distribution of funds under the IFF while ensuring that it remains equitable. This could include how the formula is structured, the data used within it, or the service area map to which it is applied. It is worth noting that changes to the IFF would affect all Title III OAA programs (e.g., supportive services, such as case management, community services, in-home services, transportation, information and referral, and legal assistance) and not just the Elderly Nutrition Program. ADS encourages input on this process.

Utilize More Up-to-Date Demographic Data

Half of Title III funds and more than one-third of state funds are allocated under the IFF according to weighted proportions of the program's target population living in each service area. This should be equitable because it is directly linked to a service area's actual demographic composition. However, the IFF pulls this demographic information from the U.S. decennial census, which is only updated once a decade. Connecticut's current State Plan on Aging covers the period from October 1, 2020**,** to September 30, 2023**.** As ADS is still awaiting the release of the necessary 2020 decennial data sets from the Census Bureau, the IFF under the current plan is based on 2010 data.[11]

As part of the process to develop the next State Plan on Aging, ADS will have the opportunity to update demographic data as part of its IFF. ADS encourages input on this process.

Improve Target Population Participation

In addition to Title III funding, ADS receives a (1) federal performance-based Nutrition Services Incentive Program (NSIP) grant and (2) Social Services Block Grant (SSBG) allocated from the Connecticut Department of Social Services. NSIP (totaling $1,384,193 in FFY 22) must be allocated to the AAAs based on the number of meals served in their region in the prior FFY as compared to the state as a whole. States have broad discretion over the use of SSBG funds (totaling $823,601 in FFY 22), which must be legislatively approved (CGS § 4-28b). SSBG funds have been distributed in the same manner as NSIP funds but could be distributed differently.

In FFY 2022, 49% of participants in the home delivered meal were considered at high nutrition risk or risk of malnutrition, however, the rate at which this target population was served varied by service area, with 41% in the South Central and Western service areas to a high of 59% in the Eastern service area. In the same time period, 18% of participants in the congregate meal program were considered at high risk, ranging from a low of 11% in the Western service area to a high of 25% in the South Central service area.

The participation rates of minority older adults varied significantly across service areas in both programs. In the home-delivery program, rates ranged from a low of 8% in the Eastern and Western regions to a high of 30% in the Southwest region. In the

[11] The 2020 datasets are expected before the next state plan must be submitted.

congregate program, rates ranged from a low of 5% in the Eastern region to a high of 30% in the South Central region. At a minimum, service rates of target groups should be representative of their proportion in the service area itself. For instance, if 10% of a service area's older adults are minorities, then providers in that area should strive to have at least 10% of their participants, if not more, in this demographic.

In addition, it is recommended that strategies being used by service areas more successful in serving target populations be shared and employed statewide to enable service areas below the state averages to improve their targeting and outreach to these older adults. This should in turn improve service levels of this metrics. If programs need to institute wait lists or reduce services, it should be done in a planful manner, and with a view towards preserving services for the program's intended target participants.

Assess Alternative Options for Allocating Discretionary Funding

The remaining 40% of non-matching state funds are allocated at the discretion of the ADS Commissioner, in consultation with the AAAs, based on their need for them. ADS has been allocating these funds using a blend of the IFF and NSIP percentages.

The task force may wish to explore other alternative options for allocating this discretionary funding to better meet service area needs.

Assess Payment Timing and Options to Improve Provider Cash Flow

At the start of nearly every federal fiscal year in October, there is rarely an approved federal budget. Continuing Resolutions provide some program funding to bridge the gap between the beginning of the FFY and a budget being enacted, however, every state begins the new FFY without knowing what the specific funding for the year will be, or when they will ultimately receive it. This is a constant concern raised by local providers and their AAAs, who do not have reserves available. Potential solutions that could be explored by the task force may include adjustment of how the state's share of the program's funding is scheduled for allocation.

Providers have also expressed frustration with the timeliness of receiving payment after they have submitted their costs to their AAA for reimbursement. Lags in reimbursement have a trickle-down effect on the suppliers who providers rely upon, and in some instances, program participants. For example, unpaid bills have occasionally resulted in supply disruptions, such as a lack of milk with meals.

Assess Options for Leveraging Additional Funding

All providers have indicated that the need for services continually exceeds their available resources, and, in some instances, providers have had to reduce the number of meals provided or have established waiting lists for services. One solution may include leveraging other federally supported programs, particularly those which older adults may already be eligible for but not accessing, like the Supplemental Nutrition Assistance Program (SNAP).

According to the Food Research and Action Center, nationwide, only 42% of eligible older adults are enrolled in SNAP compared to 83% of all eligible people that participate in this program. Many older adults who are homebound are likely eligible for SNAP but may not have the ability to use these benefits due to their lack of mobility. However, states including Minnesota and Wyoming allow SNAP benefits to be used for Meals on Wheels programs. As SNAP benefits are federally funded, with only the administrative costs split with the state, it might be worth exploring ways to maximize SNAP participation, including an exploration of the Restaurant Meals Program option.

Address Complexities in Program Administrative Processes

There are several components to the Elderly Nutrition Program for which it could be appropriate to explore streamlining of processes across the state. Recently, local providers and AAAs across the state have started to work in a consortium to create the required yearly Nutrition Education Plans, which may represent time and cost savings for programs in comparison to each provider or AAA creating their own separate plans. It is worth noting that many of the administrative pieces of the program are dictated by individual contracts between the ADS – State Unit on Aging and the AAAs, and in turn, the AAAs and the local providers. However, there may be other areas where the state's

providers can work together to reduce some of the administrative burdens or leverage the wider network for time and cost savings, such as in menu creation and approval.

In addition, the Task Force may want to look at the existing state regulations to explore if any should be updated to reflect the changing landscape of the program.

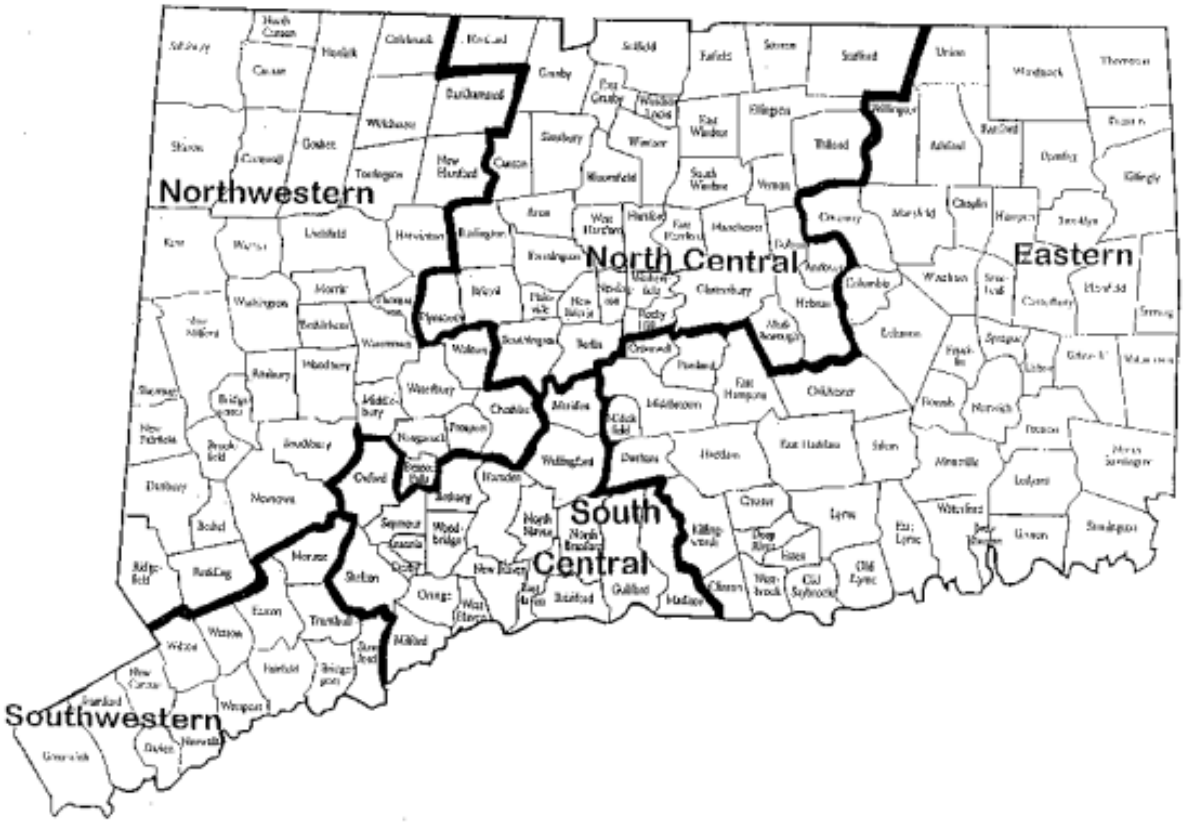
Glossary of Terms

Area Agencies on Aging (AAAs)

The state's five AAAs are private, nonprofit planning and service agencies for older adults that receive state and federal funds to carry out the federal Older Americans Act's (i.e., Title III) requirements. Generally, they plan, coordinate, evaluate, and act as brokers for older adult services. They award funds to local agencies, which in turn provide meals and related social services at local sites.

Planning and Service Areas (PSAs)

Connecticut's PSAs were first determined as required by the Older Americans Act in 1973. As part of 1976's State Plan on Aging, the PSAs were redetermined and brought into alignment with the Health Service Areas created in response to Federal Public Act 93-641, the National Health Planning and Resources Act. When this redetermination was complete, there was a large shift of 17 towns between the South Central and Eastern regions, with a few other towns shifted between regions to conform with the Health Service Areas. Those PSAs have remained the same since 1976 with the exception of two towns that have been shifted to a different PSA in the interim.



There are five PSAs in Connecticut, as shown in the above map:

- Western region: Western Connecticut Area Agency on Aging (Waterbury)
- North Central region: North Central Area Agency on Aging (Hartford)
- Eastern region: Senior Resources (Eastern Connecticut Area Agency on Aging) (Norwich)
- Southwestern region: Southwestern Connecticut Agency on Aging (Bridgeport)
- South Central region: Agency on Aging of South Central Connecticut (North Haven)