Connecticut Long-Term Care Planning Committee

Balancing the System:

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

A Report to the General Assembly

January 2016

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I. EXECUTIVE SUMMARY

A. Balancing the System

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

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

This Long-Term Services and Supports Plan (Plan) addresses the needs for LTSS of the citizens of Connecticut. Developed by the Long-Term Care Planning Committee in collaboration with the Long-Term Care Advisory Council, this Plan was produced to educate and provide recommendations to policymakers regarding what steps Connecticut should initiate and continue to take in order to achieve a balanced and person-centered LTSS system over time through 2025.

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

As in the 2013 Plan, the 2016 Plan is committed to balancing the LTSS system in terms of the ratio of home and community-based and institutional care and the ratio of public and private resources. By balancing the ratio of community-based and institutional services, what is meant is not a system with an equal split between community and institutional services. Instead, a more balanced system in Connecticut would meet the 2025 goal of 75 percent of individuals receiving Medicaid LTSS in the community and 25 percent receiving LTSS in institutions. Central to achieving this balance is a commitment to independence and choice for all individuals seeking services and supports. Towards this end, this new Plan continues to address the development and maintenance of a person-centered system of LTSS across the lifespan and across all disabilities with the focus on informed choice, least restrictive and most enhancing setting, and community inclusion.

Three years have passed since the last Plan and much has changed to improve Connecticut's LTSS system, yet there is more to be done. Changes in policy and funding on the federal and state level have fostered progress in creating a balanced LTSS system in Connecticut. Despite this progress and the many highlights which are described later in this Executive Summary, Connecticut's LTSS system still faces many of the same rules, barriers and challenges that were in place three years ago.

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

1. Long-Term Services and Supports Affects Everyone

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

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

Therefore, all of the recommendations and action steps put forward in this Plan apply to individuals of all ages and disabilities, unless specifically noted. While we recognize that certain populations have not received the equal footing they deserve in terms of attention and resources in LTSS planning and program development, we have deliberately been inclusive in our recommendations and have not segmented out certain groups of individuals or disabilities. This strategy is designed to break down some of the barriers experienced by individuals with certain disabilities and promote a philosophy that is person-centered and focused on the needs of individuals and their families.

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

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

- *Long-term services and supports (LTSS)* refer to a broad range of paid and unpaid services for persons who need assistance due to a physical, cognitive or mental disability or condition. LTSS consist largely of personal assistance with the routine tasks of life as well as additional activities necessary for living independently at home, at work, at school and at recreational activities. Unlike medical care where the goal is to cure or control an illness, the goal of LTSS is to allow an individual to

attain and maintain the highest reasonable level of functioning in the course of everyday activities and to contribute to independent living.

- *Home and community-based care* encompasses home care, adult day care, respite, community housing options, transportation, personal assistants, assistive technology and employment services.
- *Institutional care* includes nursing facilities, intermediate care facilities for people with mental retardation (ICF/MRs), psychiatric hospitals, and chronic disease hospitals.

2. The Current System Is Out of Balance

Connecticut's LTSS system has many positive elements and great strides have been made in providing real choices and options for older adults and individuals with disabilities. Despite these gains, the system is still fundamentally out of balance in two important areas.

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

In order to provide real choices to individuals and families there needs to be equal access to community and institutional care, regardless of age and disability. While there are several sources of payment for LTSS, Medicaid is by far the largest payer and therefore is the focus of this discussion. Traditionally, in Connecticut and nationwide, Medicaid has made access to institutional care easier than home and community-based care. Largely, this is a result of federal Medicaid rules and regulations. Consequently, the ratio between care and supports provided in the home and community and those provided in institutions has consistently been out of balance and skewed towards institutional care.

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

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

In addition, the LTSS system must provide support to the network of informal caregivers and ensure the recruitment and retention of formal caregivers, whose respective roles are essential, complementary and form the backbone of the LTSS system. This will become increasingly critical as the number of individuals receiving home and community-based care increases over the next several decades.

Balancing the Ratio of Public and Private Resources

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

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

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

B. Facts and Trends

- People of all ages and from all socio-economic, racial and ethnic backgrounds need LTSS.
- Disabilities affect 10.7 percent of all Connecticut residents – 378,244 individuals in 2013. (See page 25)
- It is estimated that 69 percent of 65 year olds will need LTSS as they age: 79 percent for women and 58 percent for men. On average, they will need three years of LTSS. (See page 25)
- Home and community-based services (HCBS) help people with LTSS needs stay in their homes and communities while reducing LTSS spending. States that have expanded their Medicaid home and community-based services programs require

increases in short term spending, followed by a reduction in institutional spending and long-term cost savings. (See page 41)

- Medicaid pays the majority of LTSS expenses. In Connecticut, in state fiscal year (SFY) 2015, Medicaid LTSS expenses accounted for 15 percent of the state budget and 40 percent of the Medicaid budget. (See page 40)

C. What's New in Connecticut

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

Progress in Meeting the Balancing Goals

This Plan advocates that by providing more choices for those with LTSS needs and assuring access to needed services, by 2025 the Connecticut Medicaid program should be serving 75 percent of LTSS clients in home and community-based settings[1], with only 25 percent choosing institutional care[2]. The proportion of Medicaid LTSS clients receiving services in the community has increased from 56 percent in SFY 2012 to 59 percent in SFY 2015. Slowly, but surely, the Connecticut Medicaid program is moving in the right direction and meeting the Long-Term Services and Supports Plan's target of a one percent increase a year.

With regard to public spending on LTSS, between SFY 2003 and SFY 2015 the proportion of Medicaid LTSS expenditures for home and community-based services increased by 14 percent, rising from 31 percent to 45 percent of all Medicaid LTSS expenditures – an average increase of one percent per year. Likewise, there was a 14 percent decrease in the proportion of expenditures for LTSS provided in institutional settings. Overall, total Medicaid LTSS expenditures increased by approximately 51 percent between SFY 2003 and SFY 2015 ($1.914 billion to $2.889 billion).

Long-Term Services and Supports Scorecard for Connecticut

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

[1] The Medicaid long-term care community services include home health services, hospice, home and community-based waiver programs, and targeted case management for mental health and developmental disabilities.

[2] The Medicaid long-term care institutional services include nursing facilities, hospice, intermediate care facilities for persons with developmental disabilities (ICF/MRs), and chronic disease hospitals.

population using LTSS) was published by AARP in 2014[3]. Connecticut received an overall ranking of 12 among all the 50 states in the country. The score card looks at four areas of measurement, with each number ranking the state among all 50 states:

1) Affordability and access (CT = 4);

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

3) Quality of life and quality of care (CT = 6); and

4) Support for family caregivers (CT = 30).

Money Follows the Person Rebalancing Demonstration

The Money Follows the Person (MFP) Rebalancing Demonstration, which began operation in December 2008, has been a leading force in Connecticut's efforts to rebalance the system of LTSS to reflect consumer needs and choice. The program, located within the Department of Social Services (DSS), serves Medicaid eligible individuals across the age span with physical disabilities, mental illness and intellectual and cognitive disabilities. Under MFP, as of October 30, 2015, over 3,000 individuals have been transitioned from a nursing facility to community living. Connecticut has established five rebalancing benchmarks under MFP that are aligned with the goals of the Long-Term Services and Supports Plan:

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

Progress in meeting these benchmarks is monitored through ongoing evaluations by the University of Connecticut Center on Aging at http://www.uconn-aging.uchc.edu/money_follows_the_person_demonstation_evaluation_reports.html.

In April 2015, DSS submitted a five-year MFP Sustainability Plan to the Centers for Medicare and Medicaid Services (CMS) outlining the state's strategy to continue program efforts through 2020. Over the next five years MFP will continue the provision of (1) addiction services and supports; (2) informal caregiver supports; (3) peer supports; and (4) Transitional Recovery Assistance services and implement new rebalancing strategies focusing on community collaboration, social determinant interventions and collaboration with no-wrong door initiatives. DSS will administer the

[3] *Raising Expectations: A State Scorecard on Long-Term Services and Supports for Older Adults, People with Physical Disabilities, and Family Caregivers*; AARP Policy Institute, 2014

transitional program until 2018 when the last nursing home transition will be made as part of the MFP demonstration. CMS awarded DSS $236 million dollars through 2020 to implement the sustainability plan.

Long-Term Services and Supports Rightsizing Initiative

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

- ***Public Act 11-242, Sections 83 & 84***

This Public Act mandated DSS to develop a strategic plan, consistent with the State's long-term care plan, to rebalance the Medicaid LTSS system. In developing the plan, DSS included providers representing in-home, institutional, and community settings and contracted with nursing facilities and home and community-based providers to implement the Plan. The law permits DSS to waive the Department of Public Health (DPH) codes regulating nursing facilities, residential care homes, and assisted living service agencies if (1) a regulated provider requires such a waiver to carry out the strategic plan and (2) the DSS Commissioner determines that the waiver will not endanger the health or safety of the provider's residents or clients. The law exempts from the general Certificate of Need moratorium on new nursing facility beds those beds relocated to a new facility to meet priority needs identified in the strategic plan.

- ***Rightsizing Strategic Plan***

The Rightsizing Plan, *Rebalancing Long-Term Services and Supports*, *2013-2015*, was released by Governor Malloy and DSS in January 2013. It is the result of a multi-month process of stakeholder briefings, engagement, and data and systems analysis. It also meets the requirements of Public Act 11-242, which requires DSS to develop a strategic plan, consistent with this LTSS Plan, to rebalance the Medicaid LTSS system. The plan can be viewed at http://www.ct.gov/dss/cwp/view.asp?Q=517822&A=4125.

According to the 2013-2015 Rightsizing Plan:

- By 2025, more than 48,600 individuals in Connecticut are expected to need Medicaid LTSS – an increase of more than 9,800 individuals over current levels.
- The ratio of clients receiving Medicaid home and community-based and institutional services is expected to shift from 60%/40% respectively in SFY 2015 to 76%/24% by 2025.
- Currently, the key initiative driving these results is the Money Follows the Person Rebalancing Initiative.

- ***Rightsizing Grants***

DSS, in partnership with the Department of Economic and Community Development (DECD), developed a request for proposals for the planning and implementation of LTSS rightsizing initiatives for which nursing facilities, in conjunction with community partners, may apply. $40 million in grant and bond funds through SFY 2017 have

been authorized to fund nursing facilities that are interested in diversifying their business practice to include the provision of home and community-based services. Governor Malloy awarded $9 million to 7 facilities in early 2014, and over $3 million to 4 additional facilities in May 2015. A third round of funds is expected to be awarded in late 2015/early 2016 bringing the total dollar amount awarded for nursing home diversification to $25 million.

Aging in Place

As mandated by Special Act 12-6, a task force was established in August 2012 to study how the state can encourage "aging in place." This study examined (1) infrastructure and transportation improvements, (2) zoning changes to facilitate home care, (3) enhanced nutrition programs and delivery options, (4) improved fraud and abuse protections, (5) expansion of home health care options, (6) tax incentives, and (7) incentives for private insurance. Final passage of several bills resulted due to the findings and recommendations presented to the legislature December 28, 2012 including (A) PA 13-109: An Act Concerning Livable Communities charged the Commission on Aging with the development of a Livable Communities Initiative; (B) PA 13-250 requires a coordinated outreach system to increase the use of supplemental nutrition assistance program; (C) PA 14-73 requires the State Department on Aging and the Department of Social Services hold quarterly meetings with nutrition service stakeholders to (1) develop recommendations to address complexities in the administrative processes of nutrition services, (2) establish quality control benchmarks, and (3) help move toward greater quality, efficiency and transparency in the elderly nutrition program; and (D) PA 15-40 requires the stakeholders required by 17a-302a to study alternative sources for nutrition services and submit a report of its findings, including any recommendations they may have regarding nutrition services to the Aging Committee by July 1, 2016.The full report of the Task Force to Study Aging in Place can be accessed online at: http://coa.cga.ct.gov/pdfs/AginginPlaceTF/Aging%20In%20Place%20Task%20Force%20FINAL%20report.pdf.

Livable Communities

Public Act 13-109: *An Act Concerning Livable Communities* charged the Commission on Aging with the development of a Livable Communities Initiative. The Act required the Commission on Aging to establish and facilitate partnerships with (1) municipal leaders, (2) representatives of municipal senior and social services offices, (3) community stakeholders, (4) planning and zoning boards and commissions, (5) representatives of philanthropic organizations, and (6) representatives of social services and health organizations to (A) plan informational forums on livable communities, (B) investigate innovative approaches to livable communities nationwide, and (C) identify various public, private and philanthropic funding sources to design such communities. Public Act 13-109 also requires the Commission on Aging to report annually on Connecticut's Liveable Communities Initiative to the Connecticut General Assembly's Committees on

Aging, Housing, Human Services and Transportation. Reports can be accessed at http://coa.cga.ct.gov/index.php/reports.

Public Act 14-73: *An Act Concerning Livable Communities and Elderly Nutrition* offers opportunities for municipalities to be recognized as a "Livable Community" by meeting certain requirements through Connecticut's Commission on Aging's Livable Communities Initiative.

Private Financing of Long Term Services and Supports

Special Act 14-6: *An Act Concerning a Study of Funding and Support for Home and Community-Based Care for Elderly Persons and Persons with Alzheimer's Disease*, charged the Commission on Aging with studying: (1) private sources of funding available to elderly persons and persons with Alzheimer's disease in need of home and community-based care; (2) the availability of programs funded by the state that provide home or community-based care to elderly persons or persons with Alzheimer's disease in need of home and community-based care; (3) the cost effectiveness of such programs funded by the state; and (4) recommendations on which state programs should be expanded. The completed study was submitted to the Connecticut General Assembly's, Aging Committee on January 1, 2015 and can be found at http://coa.cga.ct.gov/index.php/additional-mandates-by-ct-general-assembly.

On March 24, 2015, Connecticut's Legislative Regulation Review Committee approved changes to the Connecticut Partnership for Long-Term Care regulations to allow for more affordable Connecticut Partnership policies and provide greater protections for Connecticut Partnership policyholders. The change to the Partnership regulation: (1) Reduces the minimum inflation protection requirement for Connecticut Partnership policies from 5% compounded to 3 ½% compounded; (2) Reduces the increase in the minimum daily benefit from 5% each year to 3 ½%; and (3) Allows policyholders who experience a lifetime cumulative rate increase of 50% or more to reduce their benefits below the Partnership inflation protection and minimum daily benefit requirements without having their policy lose its Partnership status. This means a Connecticut Partnership policyholder in this situation can reduce their daily benefit to any level offered by the insurer. They can also lower their inflation protection to any level, as long as they maintain some level of automatic inflation protection.

Home and Community-Based Services Programs

- **Acquired Brain Injury Waiver II (ABI II)**

Effective December 1, 2014, DSS implemented the ABI Waiver II in order to increase the number of available waiver slots for individuals ages 18-64 with disability due to an Acquired Brain Injury. ABI Waiver II varies from ABI Waiver I in the following ways (1) offers a lower cost cap, at 150% of the cost of institutional care vs. 200% of the cost of

institutional care for ABI Waiver I; (2) does not cover Transitional Living Services due to underutilization of the services in ABI Waiver I; and (3) includes five additional services: adult day health, ABI Recovery Assistant, ABI Recovery Assistant II, consultation services and agency-based personal care.

- **Aging and Disability Resource Center Grant (ADRC)**

In 2012 Connecticut was one of eight states awarded Enhanced Options Counseling grant funds from the federal Administration for Community Living (ACL). Connecticut received $2,277,438 over three years to collaborate with ACL on the development of national standards for "No-Wrong Door" systems, person-centered training programs and the continued provision of one-on-one in-person and telephonic counseling and person-centered planning services to anyone seeking information and assistance regarding long-term services and supports. Connecticut was awarded an additional $135,000 in September 2015 to continue their partnership with ACL through the development and testing of a web-based "No-Wrong Door" governance tool and piloting a national person-centered planning training curriculum.

- **Community First Choice (CFC)**

On July 1, 2015, DSS launched a new Medicaid State Plan service pursuant to 1915(k) of the Social Security Act. This new option, made possible by the Affordable Care Act, will enable Medicaid beneficiaries who require nursing facility or other institutional level of care to self-direct community-based services utilizing individual budgets, with the support of a fiscal intermediary. Services include transitional supports when moving from institutions to the community as well as services that increase independence or substitute for human assistance such as, personal care assistants, support and planning coaches, nurse coaches, home delivered meals, environmental accessibility modifications, Personal Emergency Response System, and assistive technology.[4] As a parallel component to CFC implementation, all Medicaid Waivers offering self-directed services, including Personal Care Attendant and Acquired Brain Injury, were revised to remove personal care attendant services. Effective July 1, 2015, self-directed services for individuals on the affected Waivers are provided as a Medicaid State Plan service through CFC.

- **Expansion of Katie Beckett Waiver**

Effective January 1, 2015, 100 new slots were added to the Katie Beckett Waiver providing additional children up to age 22 with physical disabilities the opportunity to remain at home or in the community through access to home and community-based services.

- **State Balancing Incentive Payments Program (BIP)**

[4] Department of Social Services Annual Report, State Fiscal Year 2015; http://www.ct.gov/dss/lib/dss/pdfs/reports/dss_annualreport2015.pdf

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

- **Behavioral Health Homes (BHHs)**

Made possible by the Affordable Care Act, the Department of Mental Health and Addiction Services (DHMAS), in partnership with DSS and the Department of Children and Families (DCF), have initiated the process to amend the state's Medicaid State Plan to implement Behavioral Health Homes utilizing the existing infrastructure of Connecticut's private/non-profit and state Local Mental Health Authorities (LMHAs) and some of their affiliates effective October 1, 2015. BHH services are targeted to individuals with severe and persistent mental illness who are eligible for Medicaid with annual claims of at least $10,000 per year and connects them to an array of services designed to improve experience in care, improve overall health, and reduce per capita costs of health care. The services available through BHHs include: (1) comprehensive care management; (2) care coordination; (3) health promotion; (4) transitional care; (5) patient and family support and (6) referral to community support services. As of October 30, 2015, BHH Designated Provider Agencies are providing outreach and engagement to consumers with the goal of enrolling an initial 6,000-7,000 individuals and up to 10,000 statewide at full capacity.

- **Testing Experience and Functional Tools (TEFT)**

In 2014, Connecticut received funding of $5 million over 5 years to implement the TEFT grant consisting of 4 components: (1) Consumer experience of care survey: this is a voluntary survey of participants who receive home and community-based services through Medicaid. The survey examines consumer experience on various components of Medicaid LTSS. The goal of the survey is to improve Medicaid funded care received in the community. The UConn Center on Aging is administering the survey for Connecticut; (2) Pilot a functional assessment tool for the Centers for Medicare and Medicaid Services (CMS): Connecticut is field testing functional assessment measures for CMS using a CMS dictated tool. Testing is being conducted by the UConn Center on Aging. Connecticut will not be using this tool in practice because the state is implementing the Universal Assessment. However, to be good partners with CMS, Connecticut has agreed to pilot the tool on specific Medicaid populations; (3) Demonstrate use of Personal Health Records (PHR): Connecticut will be testing the use of PHRs with Medicaid consumers under the leadership of the UConn School of Nursing. Connecticut issued a request for proposals seeking PHR vendors in September, 2015 and UConn has been conducting town hall style meetings around the state to obtain consumer and provider thoughts and concerns regarding the use of PHRs. The PHRs will only contain

information that the consumer enters and will only be shared with those that the consumer grants permission; and (4) Develop and test standards for electronic long term services and support systems (e-LTSS): This portion of TEFT is being conducted by the UConn School of Nursing. The UConn School of Nursing is working with other TEFT grantees and CMS to "identify, evaluate and harmonize an electronic Long Term Services and Supports standards in conjunction with the Office of National Coordinator's Standards and Interoperability Framework."[5]

Nursing Facilities

- ***Moratorium***

The moratorium on new nursing facility beds was extended indefinitely during the 2015 legislative session.[6] DSS continues to analyze and monitor the need for beds. Several methods are used to reduce unneeded capacity such as de-licensing or reclassifying beds.

- ***Nursing Facility Closures***

According to the Connecticut Annual Nursing Facility Census Survey, there were a total of three nursing facilities in the state that closed since the last LTSS Plan (2013 – 2015)[7]. As of September 30, 2015, there were 230 licensed nursing facilities in the State.

Workforce

- The Governor's LTSS Rebalancing Strategic Plan includes workforce development activities to support expansion of 13,700 additional community home health, personal care attendants and nurse LTSS workers by 2022 and to retrain an additional 3,000 institutional LTSS workers for work in the community. $550,000 per year is available to fund the workforce development initiatives. A partnership has been established with the Workforce Investment Boards.

Transportation

- In accordance with Section 13a-153f (a) (d) of the Connecticut General Statutes, the CT Department of Transportation (DOT) issued a policy statement addressing the Department's policy regarding the concept of Complete Streets. The policy statement defines complete streets as, "a means to provide safe access for all users by providing a comprehensive, integrated, connected multi-modal network of transportation options." In the Policy Statement the DOT affirms its commitment to

[5] Connecticut's TEFT Grant Factsheet; DSS and the University of Connecticut Center for Quantitative Medicine.
[6] Section 391, Public Act 15-5
[7] State of Connecticut Annual Nursing Facility Census, Office of Policy and Management, Policy Development and Planning Division, 2015

considering the needs of users of all ages and abilities when designing and constructing Connecticut's transportation network.[8]

State Government

- A Department on Aging was established on January 1, 2013. In 2005, the legislature reestablished the department effective January 1, 2007, but implementation was delayed until 2013.

- A Department of Housing (DOH) was fully implemented on July 1, 2013 in an effort to consolidate housing related programs implemented across various state agencies. As the lead agency, DOH oversees all housing- related matters across the state.

Federal Government

- In 2014, the federal Administration for Community Living (ACL) was reorganized to include oversight of (1) the State Health Insurance Assistance Program and Senior Medicare Patrol Program (known as CHOICES in Connecticut) historically administered by the Centers for Medicare and Medicaid Services; and (2) the Centers for Independent Living, previously administered by the Department of Education and moved as a result of the federal 2014 Workforce Innovation and Opportunity Act.
  http://www.acl.gov/NewsRoom/NewsInfo/2014/2014_10_20.aspx

Other State Plans Addressing Long-Term Services and Supports

- ***State Plan on Aging: October 1, 2014 – September 30, 2017***
  http://www.ct.gov/agingservices/lib/agingservices/pdf/2015-2017finaldraftstateplanonaging.pdf

- ***2015-19 Consolidated Plan for Housing and Community Development*** -
  http://www.ct.gov/doh/lib/doh/conplan_with_ap_for_pub.pdf

- ***2015-2016 Action Plan for Housing and Community Development, July, 2015*** -
  http://www.ct.gov/doh/lib/doh/2015-16_ap_w_att.pdf

D. Goals, Recommendations and Action Steps

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

[8] Connecticut Department of Transportation Policy Statement, Policy No, EX.0.-31; October 23, 2014. http://www.bikewalkct.org/uploads/1/1/8/5/11852691/ex_o_-31_complete_streets_-_oct2014.pdf

In addition to two rebalancing goals, this Plan provides a set of long-term and short-term recommendations. The long-term recommendations provide a high level view of the essential components of a well-balanced and person-centered system of LTSS. These recommendations are reflective of a system of services and supports, and as such, must be viewed as both interrelated and interdependent. The short-term recommendations reflect strategic priorities identified for action over the next three years (2016-2018).

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

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

Goals

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

Develop a system that provides for more choice and opportunities for community integration as alternatives to all institutional settings, and increases the proportion of individuals receiving Medicaid long-term home and community-based care from 60 percent in 2015 to 75 percent by 2025, requiring approximately a 1.5 percent increase in the proportion of individuals receiving Medicaid long-term services and supports in the community every year.

2. Balance the ratio of public and private resources:

Increase the proportion of costs for long-term services and supports covered by private insurance and other dedicated sources of private funds to 25 percent by 2025. Such an increase in private insurance and other sources of private funding would reduce the burden both on Medicaid and on individuals' out-of-pocket expenses. Nationally, private insurance (long-term care and other health insurance) represented 11.9 percent of spending for long-term services and supports in 2012.[9]

[9] "Other dedicated sources of private funds" means private long-term care insurance, other types of private insurance and other private spending for nursing facilities and home health services. It does not include "out-of-pocket" spending or informal care. Source: National Health Policy Forum; *The Basics: National Spending for Long-Term Services and Supports;* George Washington University; March 27, 2014.

Long-Term Recommendations

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

- Provide true individual choice and self-direction to all users of long-term services and supports, regardless of funding source.

- Promote efforts to enhance quality of life in various long-term services and supports settings.

- Ensure the availability of a wide array of support services for those living in the community. Ensure quality of long-term services and supports in the context of a flexible and person-centered service delivery system that acknowledges the dignity of risk.

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

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

- Encourage communities to take an active role in planning and supporting long-term services and supports for their residents.

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

- Address the anticipated long-term services and supports workforce shortage.

- Provide support to informal caregivers.

- Preserve and expand affordable and accessible housing for older adults and individuals with disabilities, including assisted living, residential care homes, and other supportive housing and emergency housing options for older adults.

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

- Expand and improve employment opportunities and vocational rehabilitation for persons with disabilities and older adults.

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

- Improve quality of life and reduce utilization of long-term services and supports and health care services by focusing on health promotion and disease prevention.

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

Short-Term Recommendations

These short-term recommendations provide an action agenda for improving the system of long-term services and supports in Connecticut in the three years spanning 2016 through 2018. Criteria for proposing these targeted priority recommendations are that they will help to ensure the success of the system of long-term services and supports and can be acted upon in the next three years.

Programs and Services

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

- Ensure access to all levels of the State-funded Connecticut Home Care Program for Elders.

- In the State-funded tiers of the Connecticut Home Care Program for Elders, eliminate or reduce the required co-payment.

- Support the continued implementation of the 1915(k) state plan option, Community First Choice.

- Identify skills needed for residents of institutions who desire to transition back to the community and provide appropriate skill training and resources.

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

- Support family caregivers with training, respite care, mental health services and counseling, financial assistance, workplace flexibility and opportunities for workplace benefits.

- Measure the effectiveness of the new Adult Family Living model to determine future resource allocation, policy and programmatic enhancements and potential growth.

- Address isolation of all older adults and individuals with disabilities living in the community. Cultivate an atmosphere in communities of diversity and inclusiveness Also, address the impact of isolation on quality of life, abuse, neglect and exploitation.

- Strengthen the No Wrong Door system and connection between State and local services by exploring reimbursement options for assistance through the CHOICES network, developing ongoing person-centered and options counseling training to senior centers, municipal government offices, resident service coordinators and other community agencies.

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

- Promote coordination and service integration between physical and behavioral health providers and support the utilization of evidence based practices for providing care across the lifespan.

- Develop a pilot project focused on improving person-centered care across settings when an individual is transferred from one care setting to another.

- Address the education and training of direct care workers to include skills and competencies related to the physical, cultural, cognitive and behavioral health care needs of consumers of long-term services and supports.

- Adequately support Protective Services for the Elderly, the Office of Protection and Advocacy, the Office of the Chief State's Attorney, and other relevant agencies to

identify, investigate and prosecute cases of abuse, neglect and exploitation. Support the development of multi-disciplinary teams to enhance response to abuse.

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

- Provide advocacy and financial support for increased use of assistive technology to meet the needs of individuals within their homes and avoid or defer the need for institutionalization.

- Provide nutritional counseling and elimination of food insecurity.

Infrastructure

- Coordinate efforts among various entities impacting No Wrong Door development and monitor progress on the state's No Wrong Door endeavors.

- Continue the Balancing Incentive Program (BIP), to create infrastructure investments of a consumer friendly statewide No Wrong Door system, a conflict free case management, and a uniform assessment tool.

- With a focus upon hospital admission and discharge, use best efforts to divert individuals to an appropriate care setting of their choice.

- Address the historical fragmentation of the Medicaid home and community-based waivers, which are associated with specific age and diagnostic eligibility criteria.

- Provide timely eligibility decisions regarding eligibility in all government sponsored long-term services and supports programs. Consider development and use of a presumptive eligibility model.

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

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

- Achieve greater integration of employment of persons with disabilities into the Money Follows the Person Rebalancing Initiative and home and community-based services.

- Support improved coordination, communication and guidance among the medical care, behavioral health and long-term services and supports systems.

    - Ensure that current and future initiatives affecting the long-term services and supports system are well coordinated and complementary.

    - Support the development of electronic health records by providers of long-term services and supports and exchange of electronic health records among providers across the Connecticut health care system to streamline care transitions, coordinate care delivery and improve quality and outcomes.

    - Support a learning collaborative approach to bring together providers across disciplines and perspectives, and to learn from older adults and individuals with disabilities.

- Develop or enhance mobility management programs to help consumers learn how to access and navigate transportation options.

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

Financing

- Achieve adequate and sustainable provider reimbursement levels that support the cost of long-term services and supports and quality requirements for all segments of the long-term services and supports continuum in order to ensure capacity to meet the evolving needs and demographics of Connecticut residents.

- Provide greater flexibility in the budgeting and use of Medicaid funds for long-term services and supports.

- Capture and reinvest cost savings across the long-term services and supports continuum.

    - Reinvest savings resulting from Money Follows the Person, the Balancing Incentive Program and other emerging Medicaid long-term services and supports programs to enhance the availability and capacity of home and community based services.

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

- Explore various methods to increase the private sector's greater involvement as a payer of long-term services and supports.

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

- Work with the Federal government to preserve and reauthorize the Older Americans Act and preserve Social Security Act provisions for Supplemental Security Income, Social Security and Social Security Disability benefits funding, which are currently at risk.

Quality

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

- The Departments of Public Health and Social Services should work together to ensure consistency among their respective regulations and oversight activities.

- Review licensing certification requirements and Probate Court protocols (currently there is no licensing for conservators or guardians) for training of community-based formal caregivers, conservators and guardians to assure that the specialized needs of the individual are met and provide training where there are gaps.

- Expand the scope of the Long-Term Care Ombudsman program to provide Ombudsman support to consumers receiving long-term services and supports regardless of setting in order to align the program with Medicaid LTSS rebalancing efforts. Additional appropriations to the Long-Term Care Ombudsman program would be necessary to expand beyond their current jurisdiction.

- Support an integrated approach to CT's response to abuse, neglect and exploitation.

- Establish “learning collaboratives” where health care professionals come together on a regular basis for education and discussion on evidenced-based and emerging best practices in LTSS across the lifespan, in areas of both physical and behavioral health.

Housing

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

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

- Adopt policies that encourage incorporation of accessible housing features into new construction so that new housing can support its residents throughout the lifespan.

- Continue and expand State investment in the development of housing that is affordable and accessible for older adults and persons with disabilities.

- Encourage the growth and development of community- based service models that bring long- term services and supports to housing residents. Work with the federal government to secure at-risk housing subsidy, preservation, and development funds.

Workforce

- Develop a comprehensive and safe direct care workforce-consumer on-line matching system.

- Promote model re-training programs that allow the existing pool of institutionally-based paid direct care workers to be trained to provide services and supports in the community

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

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

E. Development and Implementation of the Plan

Development

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

In 2015, the Long-Term Care Planning Committee embarked on the development of its seventh long-term care plan in partnership with the Advisory Council. The Advisory Council worked with the Planning Committee in four essential areas: providing data, identifying areas of need, developing recommendations, and obtaining public input.

The Advisory Council assisted the Planning Committee with gathering broad public input on the draft Plan from diverse organizations and individuals throughout Connecticut with an interest in LTSS. Public comment was solicited twice: on the draft recommendation in July and September of 2015 and the full Plan in October and December of 2015. (*See Appendix D – Sources of Public Comment).*

Implementation

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

For those aspects of the Plan that do not require legislative changes or allocation, or reallocation, of resources, the State agencies represented on the Planning Committee, in collaboration with the Long-Term Care Advisory Council, will work together to address these items and periodically review their progress. In addition, annually, from 2016 through 2018, the Long-Term Care Planning Committee will choose to focus on several strategic priorities among the short term recommendations based on: 1) timeliness; 2) readiness for implementation or change; 3) availability of funding; and 4) need for coordination with other entities or programs.

II. VISION, MISSION AND GOVERNING PRINCIPLES

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

A. Vision

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

B. Mission

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

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

The system must:

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

III. LONG-TERM SERVICES AND SUPPORTS IN CONNECTICUT

A. The People

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

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

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

A Word about the Data

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

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

Much of the data on disability in Connecticut used in this Plan is drawn from the U.S. Census Bureau 2013 American Community Survey (ACS). In this survey, disability is defined as "the product of interactions among individuals' bodies; their physical, emotional, and mental health; and the physical and social environment in which they live, work, or play. Disability exists where this interaction results in limitations of

activities and restrictions to full participation at school, at work, at home, or in the community." The ACS uses six disability items to determine an individual's disability status: 1) hearing difficulty, 2) vision difficulty, 3) cognitive difficulty, 4) ambulatory difficulty, 5) self care difficulty, and 6) independent living difficulty.[10]

Who Needs Long-Term Services and Supports?

National Perspective

Approximately 12 million people, or about 4 percent of the total U.S. population, are in need of some level of LTSS. In the community, about 10 to 11 million people, or 4 percent, need help with one or more ADLs or IADLs; roughly 4.7 million, or almost 2 percent, need help with ADLs; and about 3.2 million need help with two or more ADLs. Although older adults are proportionally much more likely than younger people to need long-term services and supports, approximately half of the individuals living in the community needing help with one or more ADLs or IADLs are non elderly.[11]

Among older adults, it is estimated that 69 percent of 65 year olds will need LTSS as they age: 79 percent for women and 58 percent for men. On average, they will need three years of LTSS. Although over 30 percent of people age 65 will not need LTSS, 17 percent will need up to one year; 12 percent will need from one to two years; 20 percent will need from two to five years; and 20 percent will need 5 years or more.[12]

Connecticut

Disabilities affect 10.7 percent of Connecticut residents, lower

TABLE 1

Number of Persons with Disabilities in Connecticut by Age, 2013

Age	Total Population	Persons with a Disability	Percentage
<5	190,738	1,637	0.9%
5 to 17	593,421	27,737	4.7%
18 to 34	767,690	38,665	5.0%
35 to 64	1,468,005	142,755	9.7%
65 to 74	288,151	55,057	19.1%
75+	233,404	112,393	48.2%
Total	3,541,409	378,244	10.7%

Source: U.S. Census Bureau, 2013 American Community Survey, One Year Estimates, Connecticut, Custom Table from B18101

[10] U.S. Census Bureau, American Community Survey, 2013 Subject Definitions, pages 58-61. http://www2.census.gov/programs-surveys/acs/tech_docs/subject_definitions/2013_ACSSubjectDefinitions.pdf

[11] H. Stephen Kay, Charlene Harrington, and Mitchell P. LaPlante; *Long-Term Care: Who Gets It, Who Providers It, Who Pays, and How Much?*; Health Affairs, Vol. 29:1; January 2010; pages 11-21.

[12] Peter Kemper et al, "Long-Term Care Over an Uncertain Future: What Can Current Retirees Expect?, *Inquiry* 42, no. 2 (Winter 2005/2006): 335-350.

FIGURE 1a
Percentage of Persons with a Disability in Connecticut by Age, 2013

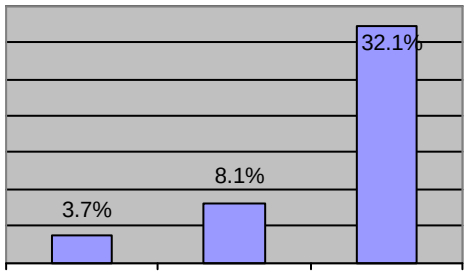


FIGURE 1b
Number of Persons with a Disability in Connecticut by Age, 2013

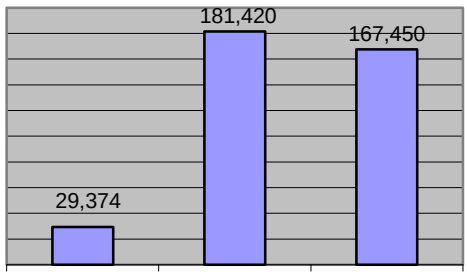


FIGURE 2
Distribution of Persons with Disabilities in Connecticut by Age, 2013

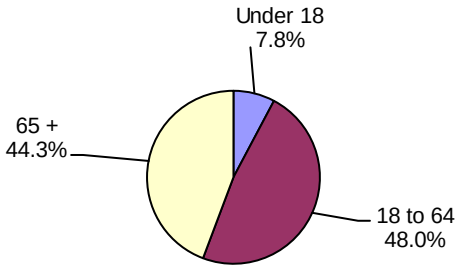
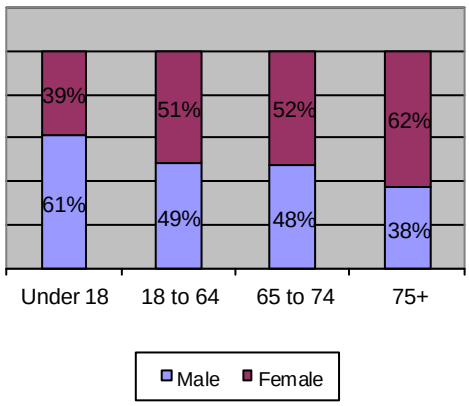


FIGURE 3
Proportion of Individuals with Disabilities by Age and Gender, 2013



Source: U.S. Census Bureau, American Community Survey, Connecticut, 2013

than the national average of 12.6 percent.[13] In 2013, there were 378,244 individuals living in Connecticut with some type of long-lasting condition or disability (Table 1). Disability rates rise with age, with 3.7 percent of children and youth under age 18

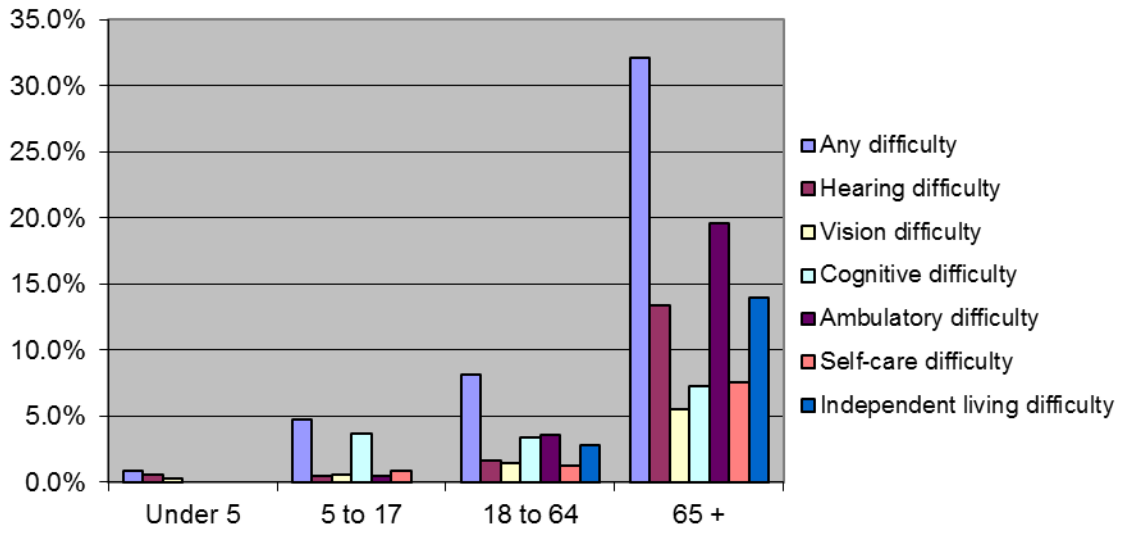
[13] U.S. Census Bureau, 2013 American Community Survey, Selected Social Characteristics (U.S. DP02 and Connecticut B18101). Data includes individuals living in households and group quarters and exclude the population living in institutions. The American Community Survey, which samples housing units and their occupants, provides Census data every year instead of once in ten years.

reporting a disability, 8.1 percent of adults age 18 to 64, and 32.1 percent of older adults age 65 and over (Figure 1a).

Although the largest proportion of the Connecticut population with a disability is found among those ages 65 and over (Figure 1a), 48 percent of the total numbers of persons with a disability are adults between the ages of 18 and 64 (Figures 1b and 2).

Among individuals with disabilities, the ratio of males to females shifts as the population ages, as is the case in the general population. Among children and youth with disabilities, 61 percent are males. By the senior years, this proportion is reversed, with females comprising 62 percent of those with disabilities age 75 and older (Figure 3).

Figure 4
Percent Distribution of Types of Disabilities in CT by Age, 2013



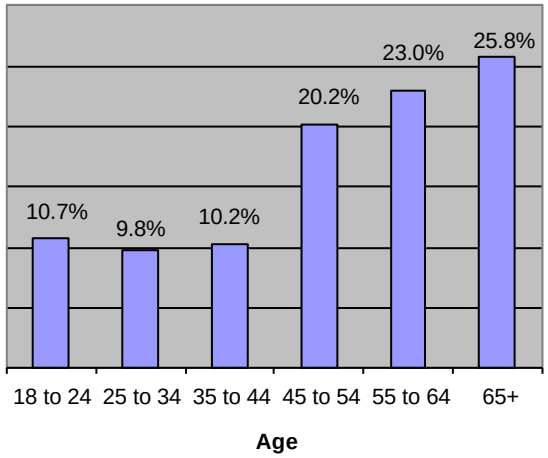
Source: U.S. Census, 2013 American Community Survey, Connecticut, Table S1810: Disability Characteristics

The distribution of types of disabilities in the population varies considerably by age (Figure 4). The proportion of individuals with disabilities increases with age, affecting less than one percent of children under age five and steadily rising to 32 percent of adults age 65 and older. Among individuals in the 5 to 17 year old group, the greatest reported difficulty is cognitive (3.7 percent). Among adults age 18 to 64, the greatest difficulty is ambulatory (4.0 percent) followed by cognitive (3.4 percent). Among individuals age 65 and older, ambulatory difficulties are most prevalent (19.6 percent) followed by independent living difficulties (14.0 percent). Cognitive difficulties were experienced by the same proportion of individuals in the 5 to 17 and the 18 to 64 age

groups (3.7 and 3.4 percent, respectively) and doubled in the over 65 age group (7.3 percent). The 2013 American Community Survey determined those with cognitive difficulty by asking individuals if due to a physical, mental or emotional condition, they had "serious difficulty concentrating, remembering or making decisions." [14] [15]

Another picture of individuals with disabilities is provided by the Connecticut Behavioral Risk Factor Surveillance System (BRFSS), which surveys adults age 18 and over living in the community (Figure 5). Overall, in 2013, 17.5 percent of Connecticut adults answered yes when asked if they are "limited in any way in any activities because of physical, mental or emotional problems." [16] This translates into approximately 482,519 Connecticut adults age 18 and older living in the community with some degree of activity limitation. This compares to the 2013 Connecticut Census estimate of 348,870 individuals with disabilities age 18 and over.

FIGURE 5
Connecticut Residents Limited Due to a Physical, Mental or Emotional Problems by Age, 2013



Source: Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System Survey, 2013. Percentages weighted to population characteristics

B. Long-Term Services and Supports

Home and community-based services

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

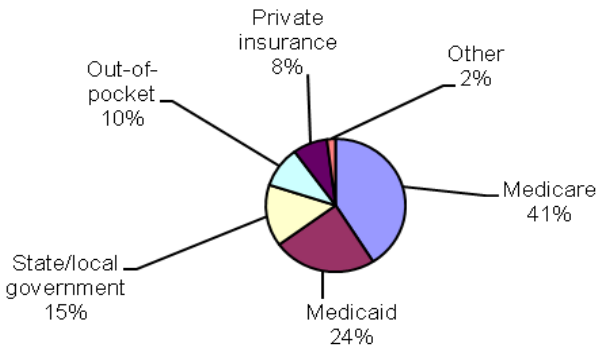
[14] U.S. Census Bureau, 2013 American Community Survey, uses six items to determine an individual's disability status: 1) hearing difficulty, 2) vision difficulty, 3) cognitive difficulty, 4) ambulatory difficulty, 5) self-care difficulty, and 6) independent living difficulty. Source: U.S. Census Bureau, American Community Survey, 2013 Subject Definitions, page 58 to 61. http://www2.census.gov/programs-surveys/acs/tech_docs/subject_definitions/2013_ACSSubjectDefinitions.pdf

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

[16] Centers for Disease Control and Prevention (CDC). Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, , 2013. http://www.cdc.gov/brfss/brfssprevalence/index.html.

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

FIGURE 6
Sources of Payment for Home Health Care in the U.S., 2009



Source: National Assoc. for Home Care and Hospice, Basic Statistics about Home Care, Updated 2010, Appendix A, Fig. 2.

Home Care Services

In the U.S., approximately 33,000 home care providers delivered care to an estimated 12 million individuals who required services due to acute illness, long-term health conditions, permanent disability, or terminal illness. Of these agencies, 10,580 were Medicare certified in 2009.[17]

Nationally, 80 percent of home health care costs incurred in 2009 were covered by government payers (federal, state and local). Medicare paid the largest share of skilled home care costs, covering 41 percent of the total payments. Private sources, including private insurance and out-of-pocket payment, represented 20 percent of payments (Figure 6). It is important to note that home health care represents only a portion of home care services and generally addresses more medically oriented needs.

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

- *Home health care agencies*, which are licensed by DPH, provide care in the home that is typically prescribed by an individual's physician as part of a written plan of care. These agencies offer skilled nursing, home health aide services, physical therapy, occupational therapy, speech therapy, and hospice services. Non-medical services include helping individuals with activities of daily living such as bathing, dressing and eating; assistance with cooking, cleaning, and other housekeeping jobs; and managing medications. Although home health care may include some non-

[17] National Association for Home Care and Hospice, *Basic Statistics About Home Care*, Updated 2010.

medical home care services such as homemakers and companions, home health care is more medically oriented, helping individuals recover from an illness or injury. Home health care agencies, unlike homemaker-home health aide agencies and homemaker-companion agencies, may be eligible for Medicare reimbursement. As of June 30, 2015, there were 104 agencies licensed by DPH to provide home health care services in Connecticut.[18]

- *Homemaker-home health aide agencies*, which are licensed by DPH, are similar to homemaker-companion agencies in that they provide non-medical assistance to individuals. In addition, they have the authority to provide training programs and competency evaluations for home health aides. As of June 30, 2015, there were 3 licensed agencies in Connecticut.[19]

- *Homemaker-companion agencies* provide non-medical assistance to persons with disabilities and older adults and must be registered with the Department of Consumer Protection. Tasks generally include grocery shopping, meal preparation, laundry, light housekeeping and transportation to appointments. As of June 30, 2015, there were 528 registered homemaker-companion agencies active in Connecticut.[20]

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

Adult Day Care

Adult day services are an option for frail older adults who want to remain in their homes. They provide respite to family caregivers as well as therapeutic care for cognitive and physically impaired older adults. Health, personal care and social services are provided to adults who do not need the continuous services of a nursing facility or institutional setting and are able to leave their homes. Individuals receive professional services ranging from social activities and therapeutic recreation to nursing care and rehabilitation services, representing a blend of traditional health and social services.[21]

Adult day care centers are not regulated by DPH. Instead, the Connecticut Association of Adult Day Centers (CAADC) is authorized by DSS to provide a program of peer review and certification, which is required in order for an adult day center to receive State

[18] Connecticut Department of Public Health, 2015.
[19] Connecticut Department of Public Health, 2015.
[20] Connecticut Department of Consumer Protection, 2015.
[21] The Connecticut Association of Adult Day Centers, https://canpa.memberclicks.net/adult-day-services , November, 2015.

funds. As of November 2015, there were 48 adult day centers certified by CAADC serving people who receive State assistance.[22]

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

An array of Medicaid and State-funded programs has been developed in Connecticut to address the need for LTSS for those living at home or in other community settings. Medicaid, through its home and community-based waiver programs, is the major public financing mechanism for providing LTSS in community settings. Under both Medicaid and State-funded programs, individuals who would otherwise require the level of care provided in an institutional setting are served in the community. Most people express a strong preference for home and community-based services over institutional care since it allows them to live in their own homes, participate in community life and exert more control over their own affairs.[23]

- **For Ages 65 and Older**

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

1. *Medicaid Elder Waiver*: constitutes the Medicaid portion of the CHCPE. As of June 30, 2015, it provided community-based services to 11,331 older adults age 65 and older, who would otherwise be institutionalized. Available services include adult day care, homemaker, companion, chore, home delivered meals, emergency response systems, care management, home health, skilled nursing, respite, assisted living and minor home modifications. The monthly average number of participants for SFY 2015 was 12,303.

2. *State-Funded CHCPE*: constitutes the State-funded portion of the CHCPE and provides the same services as the Medicaid Elder Waiver except that plans of care are capped at lower levels. The program serves adults age 65 and older with higher income and asset levels than permitted under the Waiver portion. The program will also cover individuals with fewer needs than under the Medicaid Elder Waiver. On June 30, 2015 there were 3,622 people enrolled.

- **For Ages 18 to 64**

[22] The Connecticut Association of Adult Day Centers, http://canpa.memberclicks.net/adult-day-centers, November 2015.
[23] Teresa A. Keenan, Ph.D., *Home and Community Preferences of the 45+ Population*, *AARP*, 2010

Connecticut Home Care Program for Disabled Adults (CHCPDA): is a state-funded pilot program that provides services based upon the CHCPE model. The program serves up to 50 individuals age 18 to 64 with degenerative, neurological conditions who are not eligible for other programs and who need case management and other supportive services. On June 30, 2015, there were 100 people enrolled.

Medicaid Acquired Brain Injury Waiver: provides 23 specific behavioral and support services to persons between the ages of 18 and 64 with acquired brain injury. The monthly average number of participants during SFY 2015 was 384.

Medicaid Personal Care Assistance Services (PCA) Waiver: provides personal care services to persons with physical disabilities who are age 18 to 64 years of age. In this person-directed program, participants hire and direct their own care. The monthly average number of participants during SFY 2015 was 782.

- **For All Ages**

DDS Individual and Family Support (IFS) Waiver: provides in-home, day, vocational and family supports services for people who live in their own or family home. In SFY 2015, the monthly average number of participants was 3,934.

DDS Comprehensive Supports Waiver: provides for the vocational and in-home services needed for people who need a more intensive level of support to remain in their own family home. These services are delivered in licensed settings (community living arrangements, community companion homes and assisted living) and include residential and family support services, vocational and day services and specialized and support services. In SFY 2015, the monthly average number of participants was 4,976.

DDS Employment and Day Supports (EDS) Waiver: provides support to individuals who live with family or in their own homes and have a strong natural support system. This includes children under the age of 21 with complex medical needs who would otherwise require institutional placement and individuals over the age of 18 who require career development, supported employment or community-based day supports, respite, and/or behavioral supports to remain in their own or their family home. In SFY 2015, the monthly average number of participants was 637.

Mental Health Waiver: administered by the Department of Mental Health and Addiction Services, this program diverts people with serious mental illness from nursing facilities and works to discharge those who no longer need to live in a nursing facility. The program began on April 1, 2009. As of June 30, 2015, there were 400 individuals enrolled and using waiver services.

- **For Children**

Medicaid Katie Beckett Waiver: offers case management and home health services primarily to children with disabilities who would normally only qualify for Medicaid in an institution. The waiver itself offers only case management services, but the families have access to full Medicaid benefits, including home health and physical therapy. The program operates within available appropriations. The number of participants as of June 30, 2015 was 291.

State Long-Term Care Programs

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

Municipal, Non-Profit, Private Sector and Volunteer Services

In addition to the State programs, a wide array of statewide, regional and local long-term services and supports exist throughout Connecticut that are administered by government agencies, non-profit and for-profit organizations, as well as volunteer groups. Each city and town provides services and accommodations to address the needs of older adults and persons with disabilities. Connecticut has five regional Centers for Independent Living, five Area Agencies on Aging, and a number of statewide and local mental health councils and advisory councils for persons with disabilities. There is also the Corporation for Independent Living, which is a non-profit partner focused on new housing initiatives for persons with disabilities. Also indispensable to the system of care are the myriad of volunteer organizations that address the needs of individuals with specific chronic illnesses and conditions, providing support and companionship that foster "sustainable" independent living.

Community Housing Options

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

In fostering choice, self-determination, independence and community integration, it is important to assure that residential housing is community-based and not institutional. In distinguishing between residential and institutional settings, five aspects can be considered: 1) residential scale and characteristics; 2) privacy; 3) autonomy, choice and control within the residential settings; 4) integration with the greater community; and 5) resident control over moving to, remaining in, or leaving the setting.[24]

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

TABLE 2
Community Housing Options in Connecticut, June 30, 2015

	# Facilities	# Units/ Beds/ Residents	Age
State Funded Congregate Housing	24	985 residents	62 and older
Managed Residential Communities (Assisted Living)	119	N/A	Adults and older adults
Residential Care Homes	101	2,894 beds	Adults and older adults
Continuing Care Retirement Communities	19	N/A	Older adults
Nursing Facilities	231	27,510beds (as of 9/30/14)	All ages

Source: Office of Policy and Management, 2015

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

Congregate Housing

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

As of June 30, 2015, 985 people age 62 and over lived in 24 State-funded congregate housing facilities in Connecticut. Residents were all low-income and had a minimum of one ADL limitation. Beginning in 2001, DOH (formerly DECD) and DSS introduced assisted living services within State-funded congregate housing facilities. Twelve of the

24 congregate facilities are participating in this service expansion. As of June 30, 2015, 114 congregate housing residents were actively enrolled in the assisted living program. Throughout the year, 158 residents were served under this program. [25]

Assisted Living Services/ Managed Residential Communities

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

As of June 30, 2015, there were 90 ALSAs licensed in Connecticut providing services in 119 managed residential facilities.[26]

Since the cost of living in a MRC and the assisted living services purchased are virtually all paid out of pocket, these community living arrangements are available to individuals who can afford the cost of both room and board and services. Through a collaborative effort of DECD, DPH, OPM and DSS, Connecticut has made assisted living services available to lower-income individuals through the Assisted Living Demonstration Project, State-funded congregate housing, HUD complexes and the Private Pay Assisted Living Pilot.

Residential Care Homes

Residential care homes are facilities that provide a room, meals and supervision, but no nursing services, for individuals whose limitations prevent them from living alone. Services vary from facility to facility but may include dietary and housekeeping services, monitoring of prescription medication, social and recreational opportunities, and assistance with activities of daily living. Residential care homes in Connecticut are licensed by DPH. As of June 30, 2015, there were 101 residential care homes in Connecticut with a total of 2,894 beds.[27]

Continuing Care Retirement Communities

Continuing Care Retirement Communities (CCRCs) provide residents, through contractual agreements, lifetime shelter and access to a wide variety of services,

[25] Connecticut Department of Housing, 2015.
[26] Connecticut Department of Public Health, 2015.
[27] Connecticut Department of Public Health, 2015.

including long-term health services. Each resident pays a substantial entrance fee and monthly fees in exchange for a living unit and access to services. Various levels of care such as independent living, assistance with daily activities and nursing facility care are typically provided on CCRC campuses. As their needs change, residents are usually able to move from one level of care to another without leaving the community. If a CCRC does not have a nursing facility on campus, it often has an arrangement with a nearby nursing facility to admit its residents on a priority basis. Each CCRC is mandated to register with DSS by filing an annual disclosure statement. Although CCRCs are not licensed by the state, various components of their LTSS packages, such as residential care beds, assisted living services, and nursing facility care are licensed by DPH. As of June 30, 2015 there were 22 CCRCs operating in Connecticut, and two "CCRC at Home" providers. [28]

Supportive Housing

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

Residential Settings for Individuals with Intellectual Disabilities

DDS administers or contracts for residential services from independent living, individualized home supports, continuous residential supports, community living arrangements, community companion homes, and residential center settings.[29]

- *Individualized Home Supports* -- Some people need minimal hours of staff support to live in their own place or family home. This staff support may be in the form of assistance with budgets, shopping and/or leisure activities. People receiving Individualized Home Supports get staff support from a few hours a day to only a few hours a month, depending on the needs of the person. On June 30, 2015, 2,823 individuals received Individualized Home Supports.

- *Community Companion Homes* -- People with an intellectual disability live in a family setting that is not within their own family. People in these settings live with a family that has received training and licensing from DDS. On June 30, 2015, 376 individuals lived in Community Companion Homes.

- *Continuous Residential Supports*-- People who need overnight support and live with three or fewer people share an apartment or house and have staff from an agency

[28] Connecticut Department of Social Services, 2015
[29] Connecticut Department of Developmental Services, 2015

or hired privately. On June 30, 2015, 723 individuals lived in Continuous Residential Supports.

- *Community Living Arrangements* -- People who need 24 hour support are provided with staff in group home settings. Usually, two to six people share an apartment or house and have staff available to them 24 hours a day. On June 30, 2015, 3,738 individuals lived in Community Living Arrangements.

Residential Settings for Individuals with Psychiatric or Addiction Disorders

DMHAS funds several types of residential settings for individuals age 18 and older with psychiatric or addiction disorders. In SFY 2015, a total of 56,912 individuals received mental health services in the community and 1,533 received services in inpatient settings. Also in SFY 2015, a total of 56,368 individuals received substance abuse services in the community and 2,691 received inpatient services.[30]

Psychiatric disorders

- *Group Homes* – A community-based residence with on-site staffing 24 hours per day, seven days a week. In SFY 2015, 246 individuals lived in these group home settings.

- *Supervised Housing* – Services are provided in intensively managed housing where individuals live in private or shared apartments with staff co-located 24 hours per day, seven days a week. In SFY 2015, 844 individuals lived in supervised housing.

Addiction disorders

- *Long-Term Care* – A 24 hour per day, seven days a week staffed residence with a structured recovery environment providing substance abuse intermediate and long-term residential treatment or care. In SFY 2015, 1,523 individuals participated in this program.

Institutional Care Settings

Nursing Facilities

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

[30] Connecticut Department of Mental Health and Addiction Services, 2015

facilities (skilled nursing facilities) and rest homes with nursing supervision (intermediate care facilities).

TABLE 3

Percent Distribution of Residents in Connecticut Nursing Facilities by Payment Source on September 30, 1995 and 2014

Payment Source	1995	2014
Medicaid	68	70
Medicare	11	16
Private Pay	20	9
Insurance	2	1
Other	< 1	2

Source: State of Connecticut Nursing Facility Registry and Connecticut Annual Nursing Facility Census, Office of Policy and Management, Policy Development and Planning Division.

On September 30, 2014, there were 24,341 individuals residing in Connecticut nursing facilities. The majority of residents were white (84 percent), female (68 percent), and without a spouse (81 percent), a profile that has remained consistent over the years. Thirteen percent of the residents were under age 65, 39 percent were between age 65 and 84 and 48 percent were age 85 or older.[31]

Connecticut had a total of 27,510 licensed nursing facility beds as of September 30, 2014. Since 1991, efforts have been made to reduce the number of residents in Connecticut's nursing facilities by placing a moratorium on additional beds. Despite the moratorium, from 1991 to 1994, the total number of licensed beds increased from 29,391 to 32,149. This was due to the addition of beds that had been approved before the moratorium went into effect. From 1994 to 2014, the total number of licensed beds decreased by 4,639, or 14 percent.[32]

In 2014, the average daily cost to a nursing facility resident paying privately in Connecticut was $400 a day for a semi-private room, or over $146,000 a year. Medicaid was the primary source of payment for 70 percent of nursing facility residents in

[31] State of Connecticut Annual Nursing Facility Census, Office of Policy and Management, Policy Development and Planning Division, 2014.
[32] State of Connecticut Nursing Facility Registry and Connecticut Annual Nursing Facility Census, Office of Policy and Management, Policy Development and Planning Division, 2014.

Connecticut as of September 30, 2014, with Medicare covering 16 percent and private pay covering 9 percent.[33] (Table 3)

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

On June 30, 2015, a total of 832 people over the age of 18 in Connecticut resided in either a DDS or private provider operated ICF/MR. Of these individuals, 468 people resided in an ICF/MR operated by DDS in one of six locations throughout the state. Another 364 individuals resided in group homes operated at an ICF/MR level of care by private agencies. Of all of the people living in an ICF/MR, 404 (49 percent) were between the age of 18 and 54, 209 (21 percent) were between the ages of 55 and 64, and 211 (21 percent) were age 65 and over. At this level of care, individuals received residential and day habilitation services, prevocational services and supported employment services. All services are financed through the State Medicaid Program.[34]

Chronic Disease Hospitals

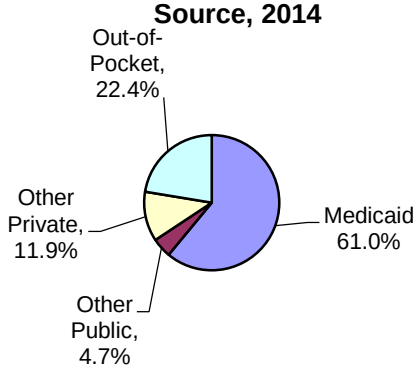
On June 30, 2015, there were six chronic disease hospitals in Connecticut with a total of 832 beds.[35] These long-term hospitals provide diagnosis, care and treatment of a wide range of chronic diseases.

C. Financing

In the U.S., $219.9 billion was spent on LTSS in 2012, representing 9.3 percent of all personal health care spending. Medicaid is the dominant source of payment for LTSS (61%), followed by out-of-pocket payments by individuals and families (22.4%). Other private and public sources cover the balance of expenditures (16.6%). Medicare plays no role in financing LTSS, since the purpose is to cover acute and post-acute medical care for people age 65 and older and for younger individuals who qualify for Social Security because of disability (Figure 7).[36] In addition to these expenditures is the unpaid care provided by family members and other informal caregivers.

Nationally, most LTSS spending goes to the relatively small minority of individuals in nursing facilities. In contrast, the vast majority of community residents needing LTSS receive only unpaid assistance. Furthermore, although about half of all individuals receiving LTSS are under age 65,

FIGURE 7
National Spending for LTSS, by Source, 2014



[33] State of Connecticut Annual Nursing Facility Census Development and Planning Division, 2014.
[34] Connecticut Department of Developmental Services,
[35] Connecticut Department of Public Health, 2015.
[36] National Health Policy Forum; *The Basics: National* George Washington University; March 27, 2014.

four-fifths of LTSS spending is for elderly individuals.[37]

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

Medicare may pay for individuals who are eligible and require skilled or recuperative care for a short time, but do not cover individuals with stable chronic conditions. The Older Americans Act is another Federal program that helps pay for LTSS services. As financial circumstances and the need for care changes, a variety of payment sources may be used.[38]

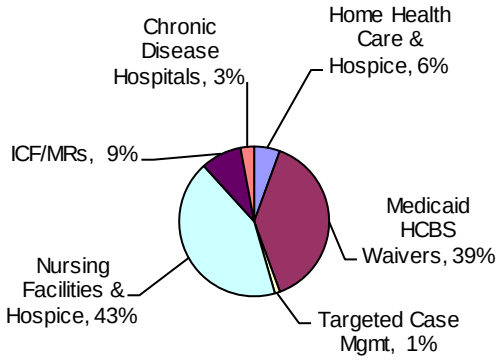
Medicaid

The Medicaid program, jointly funded by the state and federal government, is the primary payer for LTSS in the U.S. and the major public program providing coverage for nursing facility care, accounting for 61 percent of all LTSS spending in 2014 (Figure 7). Medicaid provides coverage for people who are poor and disabled. It also provides LTSS for individuals who qualify for Medicaid because they have 'spent down' their assets due to the high costs of such care and have become nearly impoverished. For example, many older adults become eligible for Medicaid as a result of depleting their assets to pay for nursing facility care that Medicare does not cover.

In SFY 2015, the Connecticut Medicaid program spent $2.889 billion on LTSS. These Medicaid LTSS expenses account for 40 percent of all Medicaid spending and 15% percent of total expenditures for the State of Connecticut.[39]

Looking at Connecticut's expenses for Medicaid LTSS in more detail, 45 percent was spent on home and community-based services and 55 percent

FIGURE 8
Proportion of CT Medicaid LTC Expenditures, SFY 2015



Source: Office of Policy and Management, 2015
Does not total 100% due to rounding

[37] H. Stephen Kay, Charlene Harrington, and Mitchell P. LaPlante; *Long-Term Care: Who Gets It, Who Provides It, Who Pays, and How Much?*; Health Affairs, Vol. 29:1; January 2010; page 11.
[38] U.S. Department of Health and Human Services, National Clearinghouse for Long-Term Care Information, Who Pays for Long-Term Care?
http://www.longtermcare.gov/LTC/Main_Site/Paying/Public_Programs/Index.aspx
[39] Office of Policy and Management, Policy Development and Planning Division, 2015

on institutional care (Figure 8). Breaking down Medicaid home and community-based waiver services further, we see that services for individuals with developmental disabilities account for 26 percent of long-term care expenses, in contrast to thirteen percent for the Elder, Personal Care Assistance, Katie Beckett, Acquired Brain Injury, and Mental Health waivers combined. Over time, the proportion of Medicaid LTSS expenses for home and community-based services has increased from 23 percent in SFY 1996 to 45 percent in SFY 2015.

A consistent conclusion from research on Medicaid home and community-based services waivers is that these services provide savings over care in institutional settings over the long term.[40] In addition, experience from other states has shown that home and community-based services help people with disabilities stay in their homes while reducing LTSS spending. Researchers at the Institute for Health and Aging at the University of California, San Francisco, found that the growth in spending was greater for states offering limited community-based services than for states with large, well-established home and community-based programs. They conclude that while expansion of home and community-based services requires a short-term increase in spending, it is followed by a reduction in institutional spending and long-term cost savings.[41]

Medicare

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

Out-Of-Pocket Spending / Private Pay

Nationally in 2012, approximately 22.4 percent of spending for LTSS was paid directly by individuals (about $49.3 billion), rendering out-of-pocket payments as the second largest source of long-term care financing (Figure 7). This includes direct payment of services as well as deductibles and co-payments for services primarily paid by another source, but does not include the uncompensated costs of informal caregivers.

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

[41] H. Stephen Kaye et al, *Do Noninstitutional Long-Term Care Services Reduce Medicaid Spending?* Health Affairs, Vol. 28, No. 1, January/February, 2009, pgs 262-272.

Private Insurance Spending

In 2012, coverage from private insurance and other private spending for nursing facilities and home health services represented 11.9 percent of LTSS expenditures in the U.S. (Figure 7). Sources of private insurance include supplemental Medicare coverage (Medigap), traditional health insurance, and private long-term care insurance.

Private Long-Term Care Insurance

Long-term care insurance covers services needed by people who cannot perform every day activities on their own due to a chronic condition, limited ability to function or deterioration in mental capacity. It covers a wide range of services that include bathing, dressing, eating, using the toilet, continence, and transferring from a bed to a chair. Since individuals in need of LTSS do not usually require skilled help, the services are not generally covered by private health insurance or Medicare. Depending upon the policy, care can be provided in a variety of places, including: a person's home, a nursing facility, through community-based services (i.e., adult day care) and in a variety of assisted living settings (i.e., continuing care retirement communities, residential care homes, assisted living facilities).[42]

In Connecticut, the number of individuals who purchased long-term care insurance in 2014 was 2,933. As of December 31, 2014, there were 106,484 Connecticut residents with a private long-term care insurance policy in force.[43]

Connecticut Partnership for Long-Term Care[44]

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

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

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

[42] Connecticut Partnership for Long-Term Care, *Frequently Asked Questions*, April 2015
[43] Office of Policy and Management, Policy Development and Planning Division, 2015
[44] Connecticut Partnership for Long-Term Care, 2015

As of June 30, 2015, there were over 58,000 Partnership policies sold in Connecticut. Purchasers of Partnership policies range in age from 20 to 88 years old, with the average age at purchase being 57 years old. Over 2,600 Partnership policyholders have utilized benefits under their policies, with over $219 million in benefits paid. Only 169 Partnership policyholders have accessed Medicaid utilizing the Asset Protection earned under their policies. This has helped the Partnership save the State over $22.2 million in Medicaid long-term care funds with larger savings projected for the future.

Connecticut was the first state to implement a Partnership. From 1992, when the Partnership was first launched, through 2006, New York, Indiana and California developed similar Partnership programs. Due to changes in federal law (Deficit Reduction Act of 2005) making it easier for states to establish Partnership programs, 38 new states have developed Partnership programs. Connecticut currently has reciprocity with all the Partnership states, except California, for the granting of Medicaid Asset Protection under the program.

Older Americans Act

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

The federal Administration for Community Living provided $18.2 million in FFY 2015 to the State Department on Aging (SDA). Of these funds, $14.1 million of Older Americans Act Title III dollars were distributed by formula to the Area Agencies on Aging who in turn contract with community-based organizations to provide social and nutritional services. The remaining $4.1 million of these funds were special grants received by SDA, including State Health Insurance Program, Senior Medicare Patrol, Aging and Disability Resource Centers, Chronic Disease Self-Management Education, and Elder Abuse Prevention. Both federal and State funds for SDA provided a multitude of services to 75,144 seniors.

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

The State Supplement Program provides a monthly cash benefit for basic living expenses to low-income individuals who are age 65 and over, individuals who are disabled and between the ages of 18 and 64, or individuals who are blind. Benefit amounts vary based on an individual's needs and expenses. Those eligible for State Supplement benefits are also eligible for Medicaid. Those receiving a State Supplement benefit live

in a variety of settings, including their own apartments, housing for older adults or persons with disabilities, or residential care homes.

Rental Subsidies

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

Veterans Affairs

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

IV. FUTURE DEMAND FOR LONG-TERM SERVICES AND SUPPORTS

A. Population and Disability Trends

Although long-term services and supports (LTSS) are needed by people of all ages and may be required as a result of a diverse array of disabilities or chronic illnesses, it is important to recognize the significant impact the aging of our society will have on the future demand for LTSS. In 1900, adults age 65 and older accounted for a little over four percent of the total U.S. population. A century later, the proportion of older adults in the U.S. population had grown to over 12 percent or 35 million. By 2030, the older adult population is expected to have grown to over 19 percent of the U.S. population, or 72 million.[45]

In Connecticut over between2013 and 2025, the total population is projected to grow by 250,953, an increase of seven percent. When looked at by age group, a different picture emerges. The percentage of individuals under age 18 will decrease by seven percent and the percent of adults between the ages of 18 and 64 will only increase by two percent. In contrast, the percent of individuals age 65 and over will increase substantially, by 51 percent, due to the aging of the Baby Boom generation (Table 4).

TABLE 4
Connecticut Population Projections: 2013 - 2025

Age Group	2013	2015	2020	2025	Pop. Growth 2013-2025	Percent Change: 2013 - 2025
<18	784,159	771,901	740,586	725,931	-58,228	-7%
18 to 64	2,235,695	2,299,631	2,313,213	2,278,484	42,789	2%
65+	521,555	583,490	673,979	787,947	266,392	51%
Total	3,541,409	3,655,022	3,727,778	3,792,362	250,953	7%

Source: Office of Policy and Management calculation based on: 1) U.S. Census 2013 American Community Survey, DPO2 and 2) Population Projections for the State of Connecticut: Statewide 2015 - 2025, developed by CT State Data Center on 11/1/2012 and custom tabulated on 7/20/15.

According to U.S. Census projections, a significant growth in the proportion of older adults in the population will occur after 2011, the year the oldest of the Baby Boom generation (those born between 1946 and 1964) turn 65. In Connecticut, between 2013 and 2025, the proportion of older adults in the population is expected to grow from 15 percent in 2013 to 18 percent in 2020, and then to 21 percent in 2025 (Table 5).

[45] U.S. Bureau of the Census; Older Population by Age Group: 1900-2050.

TABLE 5
Connecticut Population Projections,
Percent Distribution of Population by Age: 2013 – 2025

Age	2013	2015	2020	2025
Under 18	22%	21%	20%	19%
18 to 64	63%	63%	62%	60%
65+	16%	16%	18%	21%

Source: Office of Policy and Management calculation based on: 1) U.S. Census 2013 American Community Survey, DPO2 and 2) Population Projections for the State of Connecticut: Statewide 2015 - 2025, developed by CT State Data Center on 11/1/2012 and custom tabulated on 7/20/15.

In 2013, the U.S. Census estimated that there were 378,244 individuals in Connecticut with one or more disabilities (excluding individuals living in institutions). Between 2013 and 2025, this number is expected to grow by 23 percent, or 86,104 people, to an estimated 464,348.[46] However, when broken down by age, dramatically different trends appear that parallel the general population trends. The number of individuals with disabilities under age 18 is projected to decrease by almost 9 percent (-2,515) over 12 years and the number of individuals with disabilities age 18 to 64 is projected to increase by almost two percent (3,137). In contrast, the population with disabilities age 65 and older is expected to significantly increase by 85,481 or 51 percent (Table 6).

TABLE 6
Projection of Non-Institutionalized Persons with Disabilities in Connecticut by Age: 2013 – 2025

	2013	2025	2013 / 2025 Increase	Percent Increase
Under 18	29,374	26,859	-2,515	-8.6%
18 to 64	181,420	184,557	3,137	1.7%
65+	167,450	252,931	85,481	51.0%
Total	378,244	464,348*	86,104	22.8%

*Note: May not total due to rounding

Source: Office of Policy and Management based on Sources: 1) U.S. Census Bureau, 2013 American Community Survey DP02, 2) CT Population Projections for the State of Connecticut: Statewide 2015 - 2025, developed by Connecticut State Data Center on 11/1/2012 and custom tabulated on 7/20/15.

[46] These projections are based on the 2013 Census disability data applied to State Population Projections through 2025. The Census does not tabulate disability status for individuals in institutions. Disability projections assume a constant rate of disability over time.

B. Demand for Long-Term Services and Supports

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

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

TABLE 7
Connecticut Medicaid Long-Term Care Clients and Expenditures: SFY 2015

	SFY 2015 Medicaid LTC Clients, Monthly Average	SFY 2015 Medicaid LTC Expenditures
Community-based Care	27,341	$1.311 billion
Institutional Care	18,516	$1.643 billion
Total	45,857	$2.954 billion

Source: Office of Policy and Management, 2015.
Does not total due to rounding

As discussed in Section III, Medicaid is the largest and most significant payer of LTSS at both the state and national level. Of the 45,857 Medicaid clients who received LTSS in Connecticut each month in SFY 2015, 60 percent received services in the community and 40 percent received care in an institutional setting (Table 7). If these ratios remain steady over the next decade and disability rates do not vary, U.S. Census Bureau disability data and population projections for Connecticut suggest that in the year 2025 there will be a 23 percent increase in individuals receiving Medicaid LTSS: an additional 6,288 Medicaid clients receiving LTSS in the community and an additional 4,259 receiving care in institutions (Table 8). To meet this additional demand for LTSS, Medicaid expenditures are expected to grow from $2.954 billion in SFY 2015 to $6.610 billion in 2025, assuming current ratios of institutional and community care and a five percent annual inflation rate (Table 9).

TABLE 8
Projections of Connecticut Medicaid Long-Term Care Clients by Current and Optimal Ratios of Community and Institutional Care SFY 2015 and SFY 2025

	2015 Client Ratio	2025 clients/ monthly average	Change from 2012 to 2025	Optimal Client Ratio	2025 Optimal clients/ monthly Average	Change from 2012 to 2025
Community-based Care	**60%**	33,629	6,288	**75%**	42,303	14,962
Institutional Care	**40%**	22,775	4,259	**25%**	14,101	-4,415
Total		56,404	10,547		56,404	10,547

Source: Office of Policy and Management, Policy and Planning Division, 2015 based on: (1) Department of Social Services Medicaid data for SFY 2015; (2) U.S. Census Bureau, 2013 American Community Survey DP02, 2) Connecticut Population Projections: Statewide 2015 - 2025, developed by Connecticut State Data Center on 11/1/2012 and provided to OPM on 7/20/2015.

TABLE 9
Projections of Connecticut Medicaid Long-Term Care Expenditures by Current and Optimal Client Ratios of Community and Institutional Care SFY 2015 and SFY 2025 in Billions

	Current Client Ratio	2025 Expenditures with Current Client Ratio	Change from 2012 to 2025	Optimal Client Ratio	2025 Expenditures with Optimal Client Ratio	Change from 2012 to 2025
Community-based Care	**60%**	$2.896	$1.585	**75%**	$3.643	$2.332
Institutional Care	**40%**	$3.714	$2.072	**25%**	$2.311	$.668
Total		$6.610	$3.657		$5.954	$3.000

Note: Expenditure projections include a 5 percent annual compound rate increase. Numbers do not total due to rounding.
Source: Office of Policy and Management, Policy and Planning Division, 2015 based on: (1) Department of Social Services Medicaid data for SFY 2013; (2) U.S. Census Bureau, 2013 American Community Survey DP02, 2) Connecticut Population Projections: Statewide 2015 - 2025, developed by Connecticut State Data Center 11/1/2012 and provided to OPM on 7/20/2015..

If current ratios of Medicaid community and institutional LTSS were to evolve over time to reflect the greater emphasis on home and community-based services achieved in other states, Connecticut could develop a LTSS system that provides community-based care to 75 percent instead of 60 percent of its Medicaid long-term care clients. If the

number of Medicaid clients receiving LTSS in 2025 reflected this optimal ratio, Connecticut could expect an additional 14,962 clients receiving community-based services and supports, and a decrease of 4,415 individuals receiving care in institutions when compared to actual 2015 levels (Table 8). By holding the number of individuals served in 2025 constant, and increasing the proportion of individuals receiving community-based care to 75 percent, Medicaid LTSS expenditures are projected to be $5.954 billion, instead of $6.610 billion; $657 million less than the State might otherwise have spent (Table 9).

Total Medicaid LTSS expenditures in 2025 are projected to be lower under the optimal ratios because in general, although the same numbers of people are served, the cost of serving people at home and in the community, on average,[47] is significantly lower than serving them in institutions.

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

By way of comparison, in the U.S., Medicaid spending for community-based LTSS amounted to 34.1 percent of all expenditures for Medicaid LTSS. A comparison of states provided in Table 10 shows Oregon to have the highest proportion of Medicaid long-term spending for home and community-based services (78.3 percent) and New Jersey to be the lowest (27.4 percent). Among the states, Connecticut ranks 36th, with 43.4 percent of Medicaid LTSS expenditures for home and community-based services. [48, 49]

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

[48] Due to different methodology, this analysis calculated that the Connecticut Medicaid program spent 43.4 percent for community-based long-term services and supports in 2012, in contrast to the analysis by the CT Office of Policy and Management, which calculated a percentage of 41 percent in 2012 and 44 percent in 2015.

[49] In this analysis by Truven Health Analytics, community-based services include waivers authorized under Section 1915(c) of the Social Security Act; personal care; home health; HCBS authorized under Section 1115 or Section 1915(a) of the Social Security Act; Program of All-Inclusive Care for the Elderly (PACE); rehabilitative services; private duty nursing; state plan HCBS authorized under Section 1915(i) of the Social Security Act; self-directed personal assistance services authorized under Section 1915(j) and Section 1915 (k) of the Social Security Act. Institutional services include nursing homes; intermediate care facilities for people with mental retardation (ICF/MR); mental health facilities – regular payments; mental health facilities – disproportionate share payments.

Although no one other state's model can be totally replicated in Connecticut, spending patterns in other states illustrate that greater ratios of home and community-based care are achievable. If Connecticut is to reach a ratio of 75 percent for community-based care sooner than 2025, balancing efforts will need to be more aggressive.

TABLE 10
Percent of Medicaid Long-Term Care Spending for Home and Community-Based Services, FY 2012*

State	Percent	U.S. Rank
Oregon	78.3	1
Minnesota	72.6	2
Alaska	68.7	3
Vermont	67.5	4
Massachusetts	57.8	11
Rhode Island	57.0	12
Maine	55.0	15
New Hampshire	50.3	22
Connecticut	43.4	36
U.S.	49.5	N/A
New Jersey	27.4	51

* New Mexico & Hawaii were not part of the analysis due to lack of available data.
Source: Steve Eiken, Kate Sredl, Brian Burwell, and Lisa Gold Jessica Kasten, Brian Burwell, Paul Saucier; Medicaid Expenditures for Long-Term Services and Supports: 2012 Update; Truven Health Analytics; April 28, 2014

C. Caregiver Supply and Demand

Informal Caregivers

Relatives, friends and other unpaid caregivers account for the vast majority of individuals providing LTSS to individuals across the lifespan. Looking at this another way, only 13 percent of people needing any type of LTSS use paid helpers in either a primary or secondary role.[50] In 2013, there were 40 million family caregivers in the U.S providing care to an adult with limitations in daily activities at any one time. Over this time, the estimated economic value of unpaid contributions from informal caregivers was approximately $470 billion, up from an estimated $450 billion in 2009. In fact, the

[50] H. Stephen Kay, Charlene Harrington, and Mitchell P. LaPlante; *Long-Term Care: Who Gets It, Who Providers It, Who Pays, and How Much?*; Health Affairs, Vol. 29:1; January 2010; page 15.

economic value of caregiving exceeded total Medical spending in the U.S. for both medical and LTSS. In Connecticut, in 2013, there were an estimated 459,000 caregivers at any given time, accounting for an estimated $5.9 billion in unpaid contributions.[51]

Paid Direct Caregivers

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

Table 11
Connecticut 2010 and Projected 2020 Occupations

Occupational Title	Employment		Change	
	2010	2020	Number	Percent
Personal Care Aides	15,794	24,162	8,368	53.0%
Home Health Aides	10,533	14,343	3,810	36.2%
Registered Nurses	37,404	44,550	7,146	19.1%
Nursing Aides, Orderlies, and Attendants	13,304	25,848	2,544	10.9%
Occupational Therapists	1,967	2,342	375	19.1%
Occupational Therapist Assistants	616	813	197	32.0%
Physical Therapists	3,748	4,538	790	21.1%
Physical Therapist Aides	555	703	148	26.7%
Physical Therapist Assistants	436	562	126	28.9%
Respiratory Therapists	1,360	1,678	318	23.4%
Speech-Language Pathologists	1,736	1,999	263	15.1%

Source: Office of Policy and Management, from Connecticut Department of Labor, *Connecticut Statewide Forecast: 2010 –2020*, http://www1.ctdol.state.ct.us/lmi/ctoccgroups.asp

Paid direct caregivers go by a number of titles, include nurse's aides, personal care assistants and home health aides. In 2012, there were an estimated 50,000 direct-care workers in Connecticut providing daily services and supports to older adults and individual with disabilities who needed assistance with personal care and other daily

[51]Susan C. Reinhard et al, *Valuing the Invaluable: 2015 Update; Undeniable Progress, but Big Gaps Remain*, AARP Public Policy Institute 2015..

activities of living.[52] Between 2012 and 2022, the demand for paid direct care workers nationally is expected to grow by 37 percent, with an increasing number, an estimated 67% in 2022, employed in community-based settings.[53]

Current efforts to balance the institutional bias of the current long-term services and supports system are leading to a greater percentage of people receiving long-term services and supports at home. As a result, LTSS occupations in Connecticut will see double-digit figure growth between 2010 and 2020. The impact of this shift on the paid caregiver workforce in Connecticut is reflected in a predicted 53 percent rise in personal and home care aide positions and a 36.2 percent increase in home health aide positions (Table 11).

[52] CT Commission on Aging; *Direct Care Workforce Development Strategic Plan Updated*; December, 2012; http://coa.cga.ct.gov/pdfs/publications/2012/workforce%20plan%2012.13.12.pdf
[53] PHI National; *Occupational Projections for Direct-Care Workers 2012-2022*; December, 2014; http://phinational.org/sites/phinational.org/files/phi-factsheet14update-12052014.pdf

V. GOALS and RECOMMENDATIONS

A. Introduction

The goals and recommendations provided in this Plan are put forward to improve the balance of the system of long-term services and supports (LTSS) in Connecticut for individuals of all ages and across all types of disabilities and their families. In addition to two rebalancing goals, this Plan provides a set of long-term and short-term recommendations. The long-term recommendations provide a high level view of the essential components of a well balanced and person centered system of LTSS. These recommendations are reflective of a system of services and supports, and as such, must be viewed as both interrelated and interdependent. The short-term recommendations reflect strategic priorities identified for action over the next three years (2016-2018).

In 2005, a broad philosophical statement was enacted in Connecticut statute to guide policy and budget decisions. It states that *"Connecticut's long-term care plan and policy must provide that individuals with long-term care needs have the option to choose and receive long-term care and support in the least restrictive, appropriate setting*." This simple statement provides a larger framework for Connecticut to make the necessary changes to the laws and regulations that govern the State's system of LTSS to make real choices for people a reality.

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

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

B. Goals

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

> ***GOAL #1:*** *Develop a system that provides for more choice and opportunities for community integration as alternatives to all institutional settings, and increases the proportion of individuals receiving Medicaid long-term home and community-based care from 60 percent in 2015 to 75 percent by 2025, requiring approximately a 1.5 percent increase in the proportion of individuals receiving Medicaid long-term services and supports in the community every year.*

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

In the 13 years since the establishment of the Plan's goal of improving the balance between home and community-based services and institutional care (SFY 2003 – 2015), this goal has been met, with a steady increase in the proportion of Medicaid long-term care clients served in the community of one percent a year, from 46 percent to 60 percent (Table 12). However, to meet the goal of 75 percent of Medicaid clients receiving LTSS in the community by 2025, this pace must accelerate to 1.5 percent a year.

With regard to expenditures, between SFY 2003 and SFY 2015, the proportion of Medicaid dollars for LTSS spent on services received in the community increased by one percent a year (Table 13).

TABLE 12
Proportion of Connecticut Medicaid LTSS Clients over Time

SFY	Home & Community Care	Institutional Care	Total Monthly Average LTSS Medicaid Clients
2002-2003	46%	54%	37,969
2003-2004	49%	51%	39,305
2004-2005	50%	50%	40,417
2005-2006	51%	49%	41,773
2006-2007	52%	48%	41,335
2007-2008	52%	48%	40,057
2008-2009	53%	47%	40,097
2009-2010	54%	46%	40,442
2010-2011	55%	45%	41,402
2011-2012	56%	44%	41,725
2012-2013	58%	42%	42,577
2013-2014	59%	41%	44,712
2014-2015	60%	40%	45,876

Source: Office of Policy and Management, Policy Development and Planning Division, 2015

TABLE 13
Proportion of Connecticut Medicaid LTSS Expenditures over Time

SFY	Home & Community Care	Institutional Care	Total LTSS Medicaid Expenses in billions
2002-2003	31%	69%	$1.914
2003-2004	33%	67%	$1.955
2004-2005	35%	65%	$1.977
2005-2006	32%	68%	$2.227
2006-2007	33%	67%	$2.299
2007-2008	33%	67%	$2.404
2008-2009	35%	65%	$2.498
2009-2010	38%	62%	$2.587
2010-2011	40%	60%	$2.695
2011-2012	41%	59%	$2.770
2012-2013	43%	57%	$2.894
2013-2014	45%	55%	$2.877
2014-2015	45%	55%	$2.889

Source: Office of Policy and Management, Policy Development and Planning Division, 2015

If Connecticut is able to meet the goal of serving three out of every four Medicaid LTSS clients in the community, the impact on future LTSS expenditures will be significant. Additionally, Connecticut would be offering more choice to its residents. Based on U.S. Census Bureau disability data and population projections, and assuming the proportion of individuals with disabilities remains the same, it is estimated that by 2025 the number of persons with disabilities in Connecticut will grow by 86,104 or 23 percent. However, this increase is concentrated among older adults, with a 51 percent increase among individuals age 65 and older. For individuals with disabilities under age 18, an estimated 8.6 percent decrease is projected between 2013 and 2025 and for those ages 18 to 64, the number is expected to increase by only 1.7 percent. (Table 9) Assuming current ratios of community-based to institutional care, a five percent per year inflation rate and a 23 percent increase in the number of individuals with disabilities, Medicaid expenditures for LTSS are anticipated to grow from $2.954 billion in SFY 2015 to $6.610 billion by SFY 2025 to meet the expected increase in demand for long-term care. (Tables 7 and 9)

However, if 75 percent of Medicaid clients receive community care in 2025, these LTSS expenditures are only expected to be $5.954 billion, which is $657 million less than the State might otherwise have spent that year. This cost avoidance over time not only allows Connecticut to provide relief to the Medicaid budget but also allows Connecticut to meet the needs of a larger group of individuals.

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

2. Balancing the ratio of public and private resources

> ***GOAL #2:*** *Increase the proportion of costs for long-term services and supports covered by private insurance and other dedicated sources of private funds to 25 percent by 2025. Such an increase in private insurance and other sources of private funding would reduce the burden both on Medicaid and on individuals' out-of-pocket expenses. Nationally, private insurance (long-term care and other health insurance) represented 11.9 percent of spending for long-term services and supports in 2012.*[54]

[54] "Other dedicated sources of private funds" means private long-term care insurance, other types of private insurance and other private spending for nursing homes and home health services. It does not include "out-of-pocket" spending or informal care. Source: National Health Policy Forum; *The Basics: National Spending for Long-Term Services and Supports, 2012;* George Washington University; March 27, 2014.

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

The lack of Medicare and health insurance coverage for LTSS, combined with the lack of planning, has created a LTSS financing system that is overly reliant on the Medicaid program. Medicaid, by default, has become the primary public program for LTSS. However, in order to access Medicaid, individuals must first impoverish themselves. Therefore, we have a system that requires individuals to spend all their savings first in order to receive government support for their ongoing needs.

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

If enough individuals would plan for their LTSS needs through long-term care insurance or dedicated savings, there would be more Medicaid funding for community-based care and people would not have to deplete their assets if they required prolonged LTSS. For example, the burden for paying for LTSS on both the state Medicaid program (61 percent) and individuals paying out-of-pocket (22.4 percent) would be significantly reduced if the proportion of LTSS costs covered by private insurance (long-term care and other health insurance - 11.9 percent) successfully reached 25 percent (See Figure 7 on page 39). If these reductions in expenses were evenly divided between Medicaid and out-of-pocket costs for individuals, then Medicaid's share of the costs could be reduced by 11 percent. Using today's dollars, and a Medicaid LTSS budget of approximately $2.956 billion, that would equate to $325 million in annual savings. These savings could be partially allocated to the General Fund and partially used to help fund enhancements to the LTSS system, such as infrastructure and service improvements, leading to more choices for individuals and their families.

Private long-term care insurance has emerged to specifically cover the personal and custodial care services and supports that comprise most of what is referred to as LTSS, including both home-based and institutional services. However, private long-term care insurance (LTCI) has its limitations. The premium for LTCI is priced based on the purchaser's age. The older someone is the more expensive the policy. Therefore, for

many individuals who wait too long to plan for their LTSS, LTCI may not be affordable. Also, there will always be a portion of the population where LTCI is not affordable at any age.

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

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

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

C. Long-Term Recommendations

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

- Provide true individual choice and self-direction to all users of long-term services and supports, regardless of funding source.
- Promote efforts to enhance quality of life in various long-term services and supports settings.
- Ensure the availability of a wide array of support services for those living in the community. Ensure quality of long-term services and supports in the context of a flexible and person-centered service delivery system that acknowledges the dignity of risk.

- Provide individuals, caregivers and persons on nursing home waitlists options counseling and decision support to encourage advanced person-centered planning for long-term services and supports to prevent institutionalization and to extend the availability of private funds for care.
- Achieve greater integration and uniformity of administration of State long-term services and supports serving both older adults and people with disabilities and their families, and emphasize policies related to function as opposed to age or diagnosis.
- Encourage communities to take an active role in planning and supporting long-term services and supports for their residents.
- Address the long-term services and supports education and information needs of the Connecticut public, including specialized educational efforts to specific groups, such as baby boomers and employers.
- Address the anticipated long-term services and supports workforce shortage.
- Provide support to informal caregivers.
- Preserve and expand affordable and accessible housing for older adults and individuals with disabilities, including assisted living, residential care homes, and other supportive housing and emergency housing options for older adults.
- Encourage and enable the provider community to transform and develop services and supports that will help to achieve the goals of this Plan.
- Expand and improve employment opportunities and vocational rehabilitation for persons with disabilities and older adults.
- Support state and local efforts to improve and expand accessible, affordable, and inclusive transportation that accommodates the needs of residents, family and direct care worker companions.
- Improve quality of life and reduce utilization of long-term services and supports and health care services by focusing on health promotion and disease prevention.
- Address emergency preparedness/disaster planning for older adults and persons with disabilities.

D. Short-Term Recommendations

These short-term recommendations provide an action agenda for improving the system of long-term services and supports in Connecticut in the three years spanning 2016 through 2018. Criteria for proposing these targeted priority recommendations are that they will help to ensure the success of the system of long-term services and supports and can be acted upon in the next three years.

Programs and Services

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

- Ensure access to all levels of the State-funded Connecticut Home Care Program for Elders.

- In the State-funded tiers of the Connecticut Home Care Program for Elders, eliminate or reduce the required co-payment.

- Support the continued implementation of the 1915(k) state plan option, Community First Choice.

- Identify skills needed for residents of institutions who desire to transition back to the community and provide appropriate skill training and resources.

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

- Support family caregivers with training, respite care, mental health services and counseling, financial assistance, workplace flexibility and opportunities for workplace benefits.

- Measure the effectiveness of the new Adult Family Living model to determine future resource allocation, policy and programmatic enhancements and potential growth

- Address isolation of all older adults and individuals with disabilities living in the community. Cultivate an atmosphere in communities of diversity and inclusiveness Also, address the impact of isolation on quality of life, abuse, neglect and exploitation.

- Strengthen the No Wrong Door system and connection between State and local services by exploring reimbursement options for assistance through the CHOICES

network, developing ongoing person-centered and options counseling training to senior centers, municipal government offices, resident service coordinators and other community agencies.

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

- Promote coordination and service integration between physical and behavioral health providers and support the utilization of evidence based practices for providing care across the lifespan.

- Develop a pilot project focused on improving person-centered care across settings when an individual is transferred from one care setting to another.

- Address the education and training of direct care workers to include skills and competencies related to the physical, cultural, cognitive and behavioral health care needs of consumers of long-term services and supports.

- Adequately support Protective Services for the Elderly, the Office of Protection and Advocacy, the Office of the Chief State's Attorney, and other relevant agencies to identify, investigate and prosecute cases of abuse, neglect and exploitation. Support the development of multi-disciplinary teams to enhance response to abuse.

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

- Provide advocacy and financial support for increased use of assistive technology to meet the needs of individuals within their homes and avoid or defer the need for institutionalization.
- Provide nutritional counseling and elimination of food insecurity.

Infrastructure

- Continue efforts towards greater integration of and uniformity of administration of State long-term services and supports serving both older adults and people with disabilities and their families, and emphasize policies related to function as opposed to age or diagnosis.

- Coordinate efforts among various entities impacting No Wrong Door development and monitor progress on the state's No Wrong Door endeavors.

- Continue the Balancing Incentive Program (BIP), to create infrastructure investments of a consumer friendly statewide No Wrong Door system, a conflict free case management, and a uniform assessment tool.

- With a focus upon hospital admission and discharge, use best efforts to divert individuals to an appropriate care setting of their choice.

- Address the historical fragmentation of the Medicaid home and community-based waivers, which are associated with specific age and diagnostic eligibility criteria.

- Provide timely eligibility decisions regarding eligibility in all government sponsored long-term services and supports programs. Consider development and use of a presumptive eligibility model.

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

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

- Achieve greater integration of employment of persons with disabilities into the Money Follows the Person Rebalancing Initiative and home and community-based services.

- Support improved coordination, communication and guidance among the medical care, behavioral health and long-term services and supports systems.

    - Ensure that current and future initiatives affecting the long-term services and supports system are well coordinated and complementary.

    - Support the development of electronic health records by providers of long-term services and supports and exchange of electronic health records among providers across the Connecticut health care system to streamline care transitions, coordinate care delivery and improve quality and outcomes.

    - Support a learning collaborative approach to bring together providers across disciplines and perspectives, and to learn from older adults and individuals with disabilities.

- Develop or enhance mobility management programs to help consumers learn how to access and navigate transportation options.

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

Financing

- Achieve adequate and sustainable provider reimbursement levels that support the cost of long-term services and supports and quality requirements for all segments of the long-term services and supports continuum in order to ensure capacity to meet the evolving needs and demographics of Connecticut residents.

- Provide greater flexibility in the budgeting and use of Medicaid funds for long-term services and supports.

- Capture and reinvest cost savings across the long-term services and supports continuum.

    - Reinvest savings resulting from Money Follows the Person, the Balancing Incentive Program and other emerging Medicaid long-term services and supports programs to enhance the availability and capacity of home and community based services.

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

- Explore various methods to increase the private sector's greater involvement as a payer of long-term services and supports.

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

- Work with the Federal government to preserve and reauthorize the Older Americans Act and preserve Social Security Act provisions for Supplemental Security Income, Social Security and Social Security Disability benefits funding, which are currently at risk.

Quality

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

- The Departments of Public Health and Social Services should work together to ensure consistency among their respective regulations and oversight activities.

- Review licensing certification requirements and Probate Court protocols (currently there is no licensing for conservators or guardians) for training of community-based formal caregivers, conservators and guardians to assure that the specialized needs of the individual are met and provide training where there are gaps.

- Expand the scope of the Long-Term Care Ombudsman program to provide Ombudsman support to consumers receiving long-term services and supports regardless of setting in order to align the program with Medicaid LTSS rebalancing efforts. Additional appropriations to the Long-Term Care Ombudsman program would be necessary to expand beyond their current jurisdiction.

- Support an integrated approach to CT's response to abuse, neglect and exploitation.

- Establish "learning collaboratives" where health care professionals come together on a regular basis for education and discussion on evidenced-based and emerging best practices in LTSS across the lifespan, in areas of both physical and behavioral health.

Housing

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

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

- Adopt policies that encourage incorporation of accessible housing features into new construction so that new housing can support its residents throughout the lifespan.

- Continue and expand State investment in the development of housing that is affordable and accessible for older adults and persons with disabilities.

- Encourage the growth and development of community- based service models that bring long- term services and supports to housing residents. Work with the federal government to secure at-risk housing subsidy, preservation, and development funds.

Workforce

- Develop a comprehensive and safe direct care workforce-consumer on-line matching system.

- Promote model re-training programs that allow the existing pool of institutionally-based paid direct care workers to be trained to provide services and supports in the community.

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

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

VI. CONCLUSIONS

Over the next 10 years Connecticut will be challenged to develop a long-term services and supports (LTSS) system that is person focused and directed and provides real choices for individuals with disabilities and their families. Many uncertainties could affect the level of demand for LTSS in Connecticut. Disability rates may decline, medical technologies may reduce the incidence of certain chronic diseases, or new conditions may arise that increase the demand for LTSS. There are no guarantees. However, we do know that Connecticut residents want a system that maximizes the opportunity for all persons, regardless of age or disability, to live in the community as independently as possible. We also know that current levels of Medicaid LTSS expenditures for institutional care and the significant reliance on public funds for LTSS will not allow Connecticut to reach its goal of real LTSS choices and to adequately meet a possibly growing demand for services and supports. The time to take steps to balance the system is now. As outlined in this Plan, the shifting of the ratio of home and community-based and institutional care, coupled with a larger role for private funds in the system, will position Connecticut to be responsive to the potential LTSS needs of our citizens in the short and long-term and will help realize its goal of a system driven by choice and consumer control.

Balancing the System:

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

A Report to the General Assembly
January 2016

APPENDICES

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APPENDIX A.

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

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

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

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

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

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

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

(e) Any state agency, when developing or modifying any program that, in whole or in part, provides assistance or support to persons with long-term care needs, shall, to the maximum extent feasible, include provisions that support care-giving provided by family members and other informal caregivers and promote consumer-directed care.

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

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

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

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

APPENDIX B.

Long Term Care Planning Committee Members (April 2015)

Legislators

Senator Mae Flexer, Co-Chair, Aging Committee
Representative Joseph C. Serra, Co-Chair, Aging Committee
Senator Kevin C. Kelly, Ranking Member, Aging Committee
Representative Mitch Bolinsky, Ranking Member, Aging Committee
Senator Theresa B. Gerratana, Co-Chair, Public Health Committee
Representative Matthew Ritter, Co-Chair, Public Health Committee
Senator Joe Markley, Ranking Member, Public Health Committee
Representative Prasad Srinivasan, Ranking Member, Public Health Committee
Marilyn Moore, Co-Chair, Human Services Committee
Representative Catherine F. Abercrombie, Co-Chair, Human Services Committee
Senator Joe Markley, Ranking Member, Human Services Committee
Representative Terrie Wood, Ranking Member, Human Services Committee

State Agencies Representatives

David Guttchen, Office of Policy and Management (Chair of Planning Committee)
Kathy Bruni, Department of Social Services
Margy Gerundo-Murkette, Department on Aging
Jennifer Glick, Department of Mental Health and Addiction Services
Beth Leslie, Office of Protection and Advocacy for Persons with Disabilities
Laura McMenamin, Department of Housing
Bob Smith, Department of Developmental Services
Donna Ortelle, Department of Public Health
Amy Porter, Department of Rehabilitation Services
Lisa Rivers, Department of Transportation
Michael Santoro, Department of Housing
Kim Somaroo-Rodriguez, Department of Children and Families
Michael Sanders, Department of Transportation

Staff

Melissa Morton, Office of Policy and Management

APPENDIX C.

Long-Term Care Advisory Council Membership

Organization	Representative
CT Commission on Aging	Julia Evans Starr (Co-Chair)
CT Association of Residential Care Homes	Sonja Zandri
Personal Care Attendant	
CT Association of Area Agencies on Aging	Marie Allen
CT Council for Persons with Disabilities	Gary Waterhouse
CT Association of Health Care Facilities	Matthew Barrett
CT Assisted Living Association	Christopher Carter
CT Association of Adult Day Care	Andrei Brel
Bargaining Unit for Heath Care Employees/ 1199 AFL-CIO	Deborah Chernoff
CT Family Support Council	Moira O'Neil
Consumer	Michelle Duprey
AARP – CT	Nora Duncan
CT Association of Home Care, Inc.	Debra Hoyt
LTC Ombudsman's Office	Nancy Shaffer
Legal Assistance Resource Center	Joelen Gates
CT Community Care, Inc.	Molly Rees Gavin
CT Hospital Association	Jennifer Jackson
CRT/CT Assoc. of Community Action Agencies	
CT Alzheimer's Association	Mary Tibbals
LeadingAge CT	Margaret Morelli
Family Caregiver	Susan Raimondo
CT Coalition of Presidents of Resident Councils	Brian Capshaw
American College of Health Care Administrators	Richard Brown
Consumer	
Consumer	Nonunion Home Health Aide

Friends of the Advisory Council

Bill Eddy, CT Commission on Aging, Member
Quincy Abbot, ARC/CT
Claudio Gualtieri, AARP-CT
Cathy Ludlum
Melinda Montovani, Brain Injury Alliance of Connecticut
Representative Jonathan Steinberg

APPENDIX D.

Sources of Public Comment

With the assistance of the Long-Term Care Advisory Council, a draft of the Plan recommendations was distributed widely in October 2015 to diverse organizations and individuals throughout Connecticut with an interest in long-term services and supports. A draft of the full Plan and appendices was distributed for comment in November 2015. In total, public comments were received from 10 organizations.

Organizations

- Long-Term Care Advisory Council Workgroup: Julie Evans Starr, CT's Legislative Commission on Aging; Quincy Abbot, ARC-CT; Marie Allen; CT Area Agencies on Aging Association; Chris Carter, Connecticut Assisted Living Association; Deborah Chernoff, SEIU-1199; Michelle Duprey, City of New Haven Disability Services; Bill Eddy, CT's Legislative Commission on Aging; Jolene Gates, Legal Assistance Resource Center; Molly Rees Gavin, Connecticut Community Care, Inc.; Claudio Gualtieri, AARP-CT; Deb Migneault, CT's Legislative Commission on Aging; Melinda Montovani, Brain Injury Alliance of Connecticut; Susan Raimondo, Multiple Sclerosis Society, CT Chapter; Nancy Shaffer, Long-Term Care Ombudsman; Mary Tibbals, Alzheimer's Association CT Chapter
- Alzheimer's Association - Connecticut Chapter: Eleanora Tornatore-Mikesh and Mary Tibbals
- CT's Legislative Commission on Aging: Julie Evans Starr, Deborah Migneault, Bill Eddy
- CT Association of Area Agencies on Aging: Maureen McIntyre, Marie Allen, Ted Surh, Joan Wessell, Christina Fishbein
- CT Association of Health Care Facilities: Matthew Barrett
- CT Association for Healthcare at Home: Deborah R. Hoyt, President and CEO and Tracy Wodatch
- The Arc Connecticut: Quincy Abbot and Leslie Simoes, Executive Director
- Brain Injury Alliance of Connecticut: Melinda Montivani
- Connecticut Legal Services: Jolene Gates
- Leading Age CT: Margaret Morelli

APPENDIX E.

A. Long-Term Care Planning Committee History

Establishment of the Long-Term Care Planning Committee

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

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

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

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

Long-Term Care Planning Committee Products

Preliminary Long-Term Care Plan – 1999

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

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

Home Care Report – 2000

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

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

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

Long-Term Care Plan - 2001

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

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

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

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

Long-Term Care Plan – 2004

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

2004 Long-Term Care Plan Status Reports

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

Long-Term Care Website

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

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

Policy Statement Formalized into Law

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

Long-Term Care Needs Assessment

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

Long-Term Care Plan – 2007

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

2007 Long-Term Care Plan Status Reports

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

Long-Term Care Plan – 2010

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

2010 Long-Term Care Plan Status Reports

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

Long-Term Care Plan – 2013

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

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

B. Olmstead Planning Efforts

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

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

In 2000, the Department of Social Services began developing an Olmstead Plan and the Long-Term Care Planning Committee provided oversight and leadership for the process. In order to assure that individuals with disabilities and family members of persons with disabilities were active participants in the development of the Olmstead Plan, a Community Options Task Force was created to take the lead in the development of the Plan. The men and women of this advisory group, made up of adults of all ages with various disabilities, family members of persons with disabilities, and representatives from the elder community, worked hard on Connecticut's Community Options Plan, entitled "Choices are for Everyone," for two years.

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

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

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

Systems Change Grants

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

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

Connecticut Behavioral Health Partnership

Operation of the Connecticut Behavioral Health Partnership program began on January 1, 2006, serving children and families enrolled in the state HUSKY A and B programs and DCF involved children with special behavioral health needs. DCF and DSS have formed the Behavioral Health Partnership to oversee an integrated public behavioral health service system for children and families. The primary goal is to provide enhanced access to and coordination of a more complete and effective system of community-based behavioral health services and supports and to improve member outcomes. Secondary goals include better management of state resources and increased federal financial participation in the funding of behavioral health services.

Money Follows the Person Rebalancing Demonstration

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

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

5. Increase the percentage of LTSS participants living in the community compared to the institution.

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

State Balancing Incentive Payments Program (BIP)

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

Community First Choice (CFC)

On July 1, 2015, DSS launched a new Medicaid State Plan service pursuant to 1915(k) of the Social Security Act. This new option, made possible by the Affordable Care Act, will enable Medicaid beneficiaries who require nursing facility or other institutional level of care to self-direct community-based services utilizing individual budgets, with the support of a fiscal intermediary. Services include transitional supports when moving from institutions to the community as well as services that increase independence or substitute for human assistance such as, personal care assistants, support and planning coaches, nurse coaches, home delivered meals, environmental accessibility modifications, Personal Emergency Response System, and assistive technology. As a parallel component to CFC implementation, all Medicaid Waivers offering self-directed services, including Personal Care Attendant and Acquired Brain Injury, were revised to remove personal care attendant services. Effective July 1, 2015, self-directed services for individuals on the affected Waivers are provided as a Medicaid State Plan service through CFC.

APPENDIX F.

LONG-TERM SERVICES AND SUPPORTS PLANNING EFFORTS

Status Report:

2013 Long-Term Care Plan for Connecticut

June 2015

Status Report

2013 LONG-TERM CARE PLAN FOR CONNECTICUT

Connecticut Long-Term Care Planning Committee

JUNE 2015

Status Report – June 2015
2013 LONG-TERM SERVICES AND SUPPORTS PLAN FOR CONNECTICUT

Introduction

This Status Report is the third annual update on the status of the 2013 Long-Term Care Plan recommendations. It provides information on actions of the State agencies to address the Plan recommendations as well as on relevant legislation passed by the General Assembly and signed by the Governor.

Acronyms Used in this Status Report

AAA - Area Agency on Aging
ADA – Americans with Disabilities Act
ADRC – Aging and Disability Resource Centers
CMS – Center for Medicare and Medicaid Services
CT – Connecticut
CHCPE - Connecticut Home Care Program for Elders
DDS – Department of Developmental Services
DMHAS – Department of Mental Health and Addiction Services
DPH – Department of Public Health
DORS – Department of Rehabilitation Services
DOT – Connecticut Department of Transportation
DSS – Department of Social Services
DOH – Department of Housing
DECD – Department of Economic and Community Development
HUD - Department of Housing and Urban Development (HUD), Department of Economic and Community Development
LTC - Long-Term Care
LTSS – Long-Term Services and Supports
MFP – Money Follows the Person
OPM – Office of Policy and Management
PASRR - Pre-Admission Screening Resident Review
PCA – Personal Care Assistant
SDA – State Department of Aging
SFY – State Fiscal Year
VA – Veteran's Administration

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2013 LONG-TERM SERVICES AND SUPPORTS PLAN FOR CONNECTICUT

RECOMMENDATIONS	ADMINISTRATIVE AND OTHER ACTIONS	LEGISLATIVE ACTIONS AND NEW FUNDING
GOAL 1. Balancing the ratio of home and community-based and institutional care		
Develop a system that provides for more choice and opportunities for community integration as alternatives to all institutional settings, and increase the proportion of individuals receiving Medicaid long-term home and community-based care from 56 percent in 2012 to 75 percent by 2025, requiring approximately a 1.4 percent increase in the proportion of individuals receiving Medicaid long-term services and supports in the community every year.	On January 29, 2013, Governor Malloy announced the Strategic Rebalancing Plan. The plan established strategies, tactics and requested funding through SFY 2015. The plan which was funded by the legislature aims to rebalance the ratio of home and community based and institutional care by focusing on 5 key areas: workforce; service delivery and gaps; housing and transportation; nursing facility diversification; and hospital/nursing home discharges. In April 2015, Governor Malloy's Strategic Rebalancing Plan was reviewed and revised for FY2016-2018. The plan continues to aim to rebalance the ratio of home and community based and institutional care by focusing on 5 key areas: workforce; service delivery and gaps; housing and transportation; nursing facility diversification; and hospital/nursing home discharges.	Senate Bill 1502, Sec. 394: This section does three main things 1) indefinitely extends the moratorium on nursing home beds; 2) revises language regarding restriction exceptions for requesting additional nursing home bed approval deleting "AIDS and TBI" and adding the more general guideline of "patients requiring neurological rehabilitation"; and 3) adds language clarifying parameters for relocating Medicaid beds between licensed facilities.

RECOMMENDATIONS	ADMINISTRATIVE AND OTHER ACTIONS	LEGISLATIVE ACTIONS AND NEW FUNDING
GOAL 2. Balancing the ratio of public and private resources		
Increase the proportion of costs for long-term services and supports covered by private insurance and other dedicated sources of private funds to 25 percent by 2025. Such an increase in private insurance and other sources of private funding would reduce the burden both on Medicaid and on individuals' out-of-pocket expenses. Nationally, private insurance (long-term care and other health insurance) represented 11.6 percent of spending for long-term services and supports in 2010.	Between 7/1/14 and 6/30/15, the CT Partnership for LTC held five (5) public forums on Partnership LTC insurance and the importance of planning ahead for future LTC needs. The Partnership, in addition to the public forums, held over 35 presentations and trainings between 7/1/14 and 6/30/15. Additionally, between 7/1/14 and 5/31/15, over 75 information packets were disseminated and over 200 consumers received counseling and assistance via telephone.	Public Act 14-8: Expands disclosure requirements for individual and group long-term care insurance policies. It also extends existing and new disclosure requirements to group policies delivered or issued for delivery (1) to one or more employers or labor organizations or a trust established by any of them or the fund's trustees and (2) for employees or former employees, members or former members, or the labor organizations. Public Act 14-10: Requires long-term care (LTC) insurance policy issuers (carriers) to spread premium rate increases of 20% or more over at least three years. It also requires LTC carriers to notify individual policyholders and group certificate holders of (1) a premium rate increase and (2) the option of reducing benefits to reduce the premium rate. Public Act 15-80 establishes the Achieving a Better Life Experience Act (ABLE Act) allowing families to establish a trust for individuals who developed blindness or a disability

RECOMMENDATIONS	ADMINISTRATIVE AND OTHER ACTIONS	LEGISLATIVE ACTIONS AND NEW FUNDING
		before age 26. The trust may be used to cover qualifying expenses and the funds in the trust or contributed to the trust must be disregarded by the State when determining eligibility for federally funded assistance or benefit programs. Total amount in the trust cannot exceed the amount allowable for CT 529 accounts.
LONG TERM RECOMMENDATIONS		
Provide true individual choice and self-direction to all users of long-term services and supports.	The SDA in cooperation with the Agency on Aging of South Central CT, Southwestern CT Agency on Aging and the VA CT Health Care System developed and implementing a Veteran's Directed Home and Community Based Services Program (VDHCBS) in the south central region and southwestern region of CT. The program went statewide March of 2014. VDHCBS provides veterans of all ages the opportunity to self-direct their home and community based services, manage individual budgets and hire PCAs of their choice. DPH is working with CMS on Advancing Excellence in America's Nursing Homes. This is an ongoing, coalition-based campaign concerned with how to care for	Special Act 13-22: Requires that by July 1, 2014, DSS (1) conduct a cost benefit analysis of providing home care versus institutional care for Medicaid and HUSKY Plan Part B recipients age eighteen years of age and under, and (2) make recommendations to the joint standing committee of the General Assembly having cognizance of matters relating to human services on other Medicaid waiver programs or state plan options the state may apply for or utilize in order to provide home care services to Medicaid recipients age eighteen years of age and under.

RECOMMENDATIONS	ADMINISTRATIVE AND OTHER ACTIONS	LEGISLATIVE ACTIONS AND NEW FUNDING
	the elderly, chronically ill and disabled as well as those recuperating in a nursing facility environment. The campaign builds on the success of other quality initiatives like Quality First, the Nursing Home Quality Initiative, and the culture change movement. Campaign goals include creating a culture of person-centered, individualized care and an empowered workforce in nursing facilities. In partnership with United Way and town level entities, DSS has funding for both SFY16 and 17 to build a No Wrong Door (NWD) library and call-in center. Development continues of the NWD system. The automated solution will coordinate financial and functional aspects of LTSS applications and assist applicants with navigation from application to services. Coordination is ongoing with DSS, DMHAS, DDS, DORS and SDA. Initiate Community First Choice Option targeted for July 1, 2015. DSS initiated development of the No Wrong Door coordinated with ConneCT and Access Health. The automated solution will coordinate financial and	

RECOMMENDATIONS	ADMINISTRATIVE AND OTHER ACTIONS	LEGISLATIVE ACTIONS AND NEW FUNDING
	functional aspects of LTSS applications and assist applicants with navigation from application to services. Coordination is ongoing with DMHAS, DDS, DORs and SDA.	
Promote efforts to enhance quality of life in various long-term services and supports settings.	DPH is working with CMS who has developed a national partnership to improve the quality of care provided to individuals with dementia living in nursing facilities. This partnership is focused on delivering health care that is person-centered, comprehensive and interdisciplinary. By improving dementia care through the use of individualized, person-centered care approaches, CMS hopes to reduce the use of unnecessary antipsychotic medications in nursing homes and eventually other care settings as well. The partnership promotes a systematic process to evaluate each person and identify approaches that are most likely to benefit that individual. Nursing homes are exploring best practices to reduce or eliminate alarm use in CT facilities. Alarms used in nursing homes are alerting devices designed to emit a warning signal when a resident moves in a way perceived to put them at risk, usually for falls. As nursing homes have decreased the use of physical restraints, the use of	Public Act 14-194: Mandates certain training for all nursing home staff related to caring for individuals with dementia. Public Act 14-231, Section 14: Requires chronic and convalescent nursing homes and rest homes with nursing supervision to complete a comprehensive medical history and examination for each patient upon admission, and annually after that. It requires the DPH commissioner to prescribe the medical examination requirements in regulations, including tests and procedures to be performed. Public Act 15-50: Entitles patients of nursing homes, residential care homes, and chronic disease hospitals, or their designated representatives, to receive a copy of any Medicare or Medicaid application completed by such a facility on the patient's behalf. The bill adds this requirement to the nursing home patients' bill of rights. Public Act 15-115: Establishes a bill of rights for residents of Continuing Care Retirement

RECOMMENDATIONS	ADMINISTRATIVE AND OTHER ACTIONS	LEGISLATIVE ACTIONS AND NEW FUNDING
	alarms has increased. There are several nursing homes that are participating in the Music and Memory project which brings personalized music into the lives of the elderly or infirm through digital music technology, vastly improving quality of life in dementia patients. Nursing home staff and other elder care professionals are taught how to create and provide personalized playlists using iPods and related digital audio systems that enable those struggling with Alzheimer's disease, dementia and other cognitive and physical challenges to reconnect with the world through music-triggered memories. In March, 2014, CMS awarded DSS a $500,000 TEFT planning grant to test quality measurement tools and demonstrate e-health in Medicaid community-based LTSS. The grant program is designed to field test an experience survey and a set of functional assessment items, demonstrate personal health records, and create a standard electronic	Communities, requires CCRCs to provide DSS and residents certain disclosures and extends penalties for providers that violate the bill of rights. Public Act 15-236: This bill makes a number of changes regarding elder abuse. Among other things, it: 1) makes certain emergency medical service providers mandated reporters of elderly abuse and expands training requirements for employees of certain entities who care for someone age 60 or older; 2) gives abused, neglected, exploited, or abandoned elderly people a civil cause of action against perpetrators; 3) requires the Commission on Aging to (a) study best practices for reporting and identifying elderly abuse, neglect, exploitation, and abandonment and (b) create a portal of training resources for financial institutions and agents; 4) requires certain financial agents to receive training on elderly fraud, exploitation, and financial abuse; and 5) makes changes in definitions of elderly neglect and necessary services. Public Act 15-130: Extends to residential care homes (RCHs) statutory requirements for nursing homes regarding the management of residents' personal funds. It establishes (1) notification and account management

RECOMMENDATIONS	ADMINISTRATIVE AND OTHER ACTIONS	LEGISLATIVE ACTIONS AND NEW FUNDING
	LTSS record. The Participant Experience Survey will be the cornerstone of DSS' quality management activities for the waiver programs. In partnership with the University of Connecticut Center on Aging, DSS will study the relationship of social determinants on the factors that lead to institutionalization. From those findings, interventions will be created to address those determinants. DDS held two trainings on Alzheimer' disease and dementia Issues concerning the people DDS serves. 175 staff of Public and Private Providers attended these first two sessions. Additional sessions will be offered in each region and a video of the training has been posted on the DDS website.	procedures and (2) penalties for failure to comply.
Ensure the availability of a wide array of support services for those living in the community, including meals and adult day care.	The DSS Strategic Rebalancing Plan includes funding to support growth in capacity of community LTSS. The plan includes funding for nursing facilities interested in diversifying their business model to increase the availability of community LTSS. On May 29, 2015, Governor Malloy announced funding for the second round of nursing facility grants.	Special Act 14-6: The Commission on Aging must study (1) private sources of funding available to elderly persons and persons with Alzheimer's disease in need of home or community-based care, (2) the availability of programs funded by the state that provide home or community-based care to elderly persons and persons with Alzheimer's disease in need of home or community-based care,

RECOMMENDATIONS	ADMINISTRATIVE AND OTHER ACTIONS	LEGISLATIVE ACTIONS AND NEW FUNDING
	The proposals included opportunities to house offices for support organizations serving residents and a community case management program with an integrated adult day health center. MFP Demonstration Services – substance abuse supports, informal caregiver supports, and peer supports – continue to be offered to MFP participants through their Demonstration year. The LTSS Strategic Plan funds an impact analysis of a 1915(i) amendment to fund supports such as substance abuse intervention, peer support, and supported employment for Supportive Housing and for qualifying rest homes. Effective January 1, 2014, the DMHAS HCBS Mental Health Waiver was amended to include Adult Day Care and Home Delivered Meals**.** The amended waiver increased capacity to 811. Effective 12/1/14 Adult Day Health was added as a service to the ABI 2 Waiver. The SDA convened the first nutrition quarterly meeting in September 2014. DSS and the other stakeholders participated.	and (3) the cost effectiveness of such programs funded by the state. Not later than January 1, 2015, the commission must submit a report on the study, including recommendations on which state programs should be expanded, to the joint standing committee of the General Assembly having cognizance of matters relating to aging. Public Act 14-73: An Act Concerning Livable Communities and Elderly Nutrition. Not later than January 1, 2015, the Commission on Aging, as part of the livable community initiative established pursuant to this section, shall recognize communities that have implemented livable community initiatives allowing individuals to age in place and to remain in the home setting of their choice. Such initiatives shall include, but not be limited to: (1) Affordable and accessible housing, (2) community and social services, (3) planning and zoning regulations, (4) walkability, and (5) transportation-related infrastructure The Department on Aging and the Department of Social Services shall hold quarterly meetings with nutrition service stakeholders to (1) develop recommendations to address complexities in the administrative processes of nutrition services, (2) establishes quality

RECOMMENDATIONS	ADMINISTRATIVE AND OTHER ACTIONS	LEGISLATIVE ACTIONS AND NEW FUNDING
	Regular quarterly meetings continue to be convened by SDA with the elderly nutrition stakeholders in accordance with Public Act 14-73. The SDA ADRC grant is assisting the state Older Adult Behavioral Health workgroup in an asset exercise designed to measure and analyze, at a regional and statewide level, the availability of behavioral health services for older adults age 55 or older. The UCONN Health Evaluation Team is conducting 10 focus groups and 5 community forums throughout the state as well as a survey of over 900 aging, medical & behavioral health professionals and is preparing a report summarizing the findings.	control benchmarks, and (3) help move toward greater quality, efficiency and transparency in the elderly nutrition program. Stakeholders shall , but not be limited to, area agencies on aging, access agencies, the Commission on Aging, nutrition providers, representatives of food security programs and contractors, nutrition host site representatives and consumers. Public Act 15-40: This bill requires SDA and DSS, together with certain nutrition stakeholders, to study alternative sources of funding for nutrition services programs and report their findings and recommendations to the Aging Committee by July 1, 2016. The bill also amends existing law to specify the number of nutrition stakeholders that must be at the meetings Senate Bill 1502, Sec. 358: Establishes a grant program within the Department of Mental Health and Addiction Services (DMHAS) to provide community-based behavioral health services, including (1) care coordination services, and (2) access to information and referral services for available health care and social service programs. The services shall be provided by organizations that provide acute care and emergency behavioral health services. The DMHAS Commissioner shall

RECOMMENDATIONS	ADMINISTRATIVE AND OTHER ACTIONS	LEGISLATIVE ACTIONS AND NEW FUNDING
		establish eligibility criteria and the application process for the grant program. Senate Bill 1502, Sec. 359: Establishes a study on the current adequacy of psychiatric services to be led by the DMHAS Commissioner who shall consult with the DCF and DSS Commissioners and providers of behavioral health services, including, but not limited to, hospitals and advocacy agencies.
Ensure quality of long-term services and supports in the context of a flexible and person-centered service delivery system that acknowledges the dignity of risk.	The State Unit on Aging in cooperation with the 5 Area Agencies on Aging and the VA CT Health Care System developed and is implementing a Veteran's Directed Home and Community Based Services Program (VDHCBS) statewide. This 100% consumer directed program is currently serving 32 clients. It expanded statewide in March 2014. Under VDHCBS veterans serve as employer of the PCA of their choice and manage a self-directed, individualized budget. They are informed of risk but allowed to assume risk if that is the best choice for them and sign a risk assessment form. ADRC services are available statewide and Operating Protocols are utilized to ensure quality of program service delivery.	Senate Bill 1502, Sec. 413(e): Adds requirement that nursing facilities inform both the nursing home resident and/or the resident's representative and DSS when the facility has reason to believe the resident will qualify for Medicaid within 180 days. DSS may use the notification from the facility as a trigger to contact the resident to assess whether or not the resident would like to and is able to move back into the community and receive home and community-based services and then develop a care plan to aid in the transition.

RECOMMENDATIONS	ADMINISTRATIVE AND OTHER ACTIONS	LEGISLATIVE ACTIONS AND NEW FUNDING
	DPH has approved certain medication administration by specially trained and qualified home health aides in the home health setting. Home health aides will be required to obtain certification for the administration of medication in accordance with DPH approved curriculum. The LTSS Strategic Plan includes the funds to develop various workforce training programs acknowledging a person-centered delivery system. These programs include a model re-training program which allows for the existing pool of institutionally-based paid direct care workers to be trained to provide LTSS in the community; and the collaboration with the community college system to design direct-service curricula using the foundation of person-centered care. In partnership with the University of Connecticut Center on Aging, DSS will study health outcomes and quality of life associated with MFP participant's assumption of risk following informed choice. The LTSS Strategic Plan funds the development of a nurse leadership institute for the sharing of best practices in	

RECOMMENDATIONS	ADMINISTRATIVE AND OTHER ACTIONS	LEGISLATIVE ACTIONS AND NEW FUNDING
	person-centered care and nurse delegation. DDS is actively working on numerous initiatives regarding person centered thinking, healthy relationship training for individuals, and a mentor project working with providers to shift to more individualized supports in services that lead to many discussions to dignity of risk and risk mitigation. DDS is using materials developed by MFP to begin the discussions with providers. DDS Self Advocate Coordinators have implemented a program called IP (individual Plan) Buddies in which a Self-Advocate Coordinator will assist a person and help advocate for them during the planning process at their request. They are also running a campaign for Respectful Language among DDS providers and the communities in the state. The campaign and video are on the DDS website. The Mental Health Waiver program for individuals with serious mental illness encompasses the recovery orientation adopted by the Department of Mental Health and Addiction Services (DMHAS), but also signals new directions in the community treatment of people with serious psychiatric disabilities. Each person	

RECOMMENDATIONS	ADMINISTRATIVE AND OTHER ACTIONS	LEGISLATIVE ACTIONS AND NEW FUNDING
	enrolled in the Mental Health Waiver program participates in a Person-centered planning process leading to the development of an individualized Recovery Plan. The Mental Health Waiver allows individuals choice among credentialed providers and also a self-directed Recovery Assistant option. CT ADRC staff have been working with Agency for Community Living (ACL) staff on the development of a National Person-Centered Planning Training for community based organizations. In January 2016, SDA will be piloting this Person Centered Counseling Training program as part of its 2012 Enhanced ADRC Options Counseling Program.	
Achieve greater integration and uniformity of administration of State long-term services and supports serving both older adults and people with disabilities and their families, and emphasize policies related to function as opposed to age or diagnosis.	First steps are being made toward the alignment of all State agencies in regard to using the same terminology and rates for LTSS services with the addition of Staff Supervision in both the MFP and DDS waivers. The State's first common comprehensive assessment – the Universal Assessment (UA) was released in July 2015. The UA will be used across all 1915(c) waivers; 1915(i) state plan services; MFP, and CFC. The tool	Public Act 15-19: This bill (1) renames the Community Choices program as the Aging and Disability Resource Center (ADRC) program and (2) requires the Department on Aging (SDA) to administer it as part of the CHOICES program.

RECOMMENDATIONS	ADMINISTRATIVE AND OTHER ACTIONS	LEGISLATIVE ACTIONS AND NEW FUNDING
	will be automated within the State's No Wrong Door system. DDS continues to work with DSS and other agencies on designing a Universal Assessment. Common Core Standardized Assessment testing is underway at DDS and the development of a DDS staff focus group.	
Encourage communities to take an active role in planning and supporting long-term services and supports for their residents.	The LTSS Strategic Plan includes funding for local community planning efforts. $325,000 is budgeted for No Wrong Door efforts with local communities in both SFY 2016 and 2017. Community conversations and collaboratives will be held to determine the design of the continuum of LTSS that best meets the needs of their members. Then through a RFP process, communities will have the opportunity to participate in the No Wrong Door activities. In May 2015, Governor Malloy announced the second round of rebalancing grants to nursing facilities interested in diversifying their business model to provide community LTSS. Awarded facilities are required to partner with their local communities to jointly develop the local continuum of LTSS and to prioritize funding as they develop their proposals.	Public Act 13-109: Requires the Commission on Aging to establish a "Livable Communities" initiative to serve as a (1) forum for best practices and (2) resource clearinghouse to help municipal and state leaders design livable communities that allow residents to age in place (i.e., remain in their own homes and communities regardless of age or disability). The commission must report annually on the initiative to the Aging, Housing, Human Services, and Transportation committees, with the first report due by July 1, 2014. Public Act 14-73: By January 1, 2015, requires the Aging Commission, as part of the livable community initiative, to recognize communities that have implemented such initiatives allowing people to age in place and remain in the home setting they choose. The initiatives must include (1) affordable and

RECOMMENDATIONS	ADMINISTRATIVE AND OTHER ACTIONS	LEGISLATIVE ACTIONS AND NEW FUNDING
	In May 2014, the Commission on Aging launched a Livable Communities website - www.livablect.org. The website highlights ideas and innovations for creating Connecticut communities that are great places to grow up and grow older. The site shows where and how to begin to make changes, serves as a resource for policymakers and change agents, and connects related initiatives and partners to maximize energy, resources and talent On May 21, 2015, ACL announced a continuation grant for CT ADRC to continue work on refining the tools, metrics and key elements of a No Wrong Door System by piloting a No Wrong Door System Management Tool.	accessible housing, (2) community and social services, (3) planning and zoning regulations, (4) walkability, and (5) transportation-related infrastructure.
Address the long-term services and supports education and information needs of the Connecticut public, including specialized educational efforts to specific groups, such as baby boomers and employers.	Between 7/1/14-5/31/15, the CT Partnership for LTC (OPM in cooperation with the SDA and the AAAs) held five (5) public forums on Partnership LTC insurance and the importance of planning ahead for future LTC needs. Additionally, between 7/1/14-5/31/15 the Partnership disseminated 72 information packets and provided telephonic counseling and assistance to over 00 consumers.	

RECOMMENDATIONS	ADMINISTRATIVE AND OTHER ACTIONS	LEGISLATIVE ACTIONS AND NEW FUNDING
	The LTSS Strategic Plan provides funding for both SFY16 and 17 to develop and implement a No Wrong Communication plan to streamline access to LTSS information and resources. The plan also funds the development of tools to educate the public regarding home and community-based services, Medicaid eligibility, self-direction, etc. CHOICES Coordinators have been holding "New to Medicare" educational sessions in each region as part of the 2014 SHIP Grant.	
Address the anticipated long-term services and supports workforce shortage.	In partnership with communities, DSS will host local workforce outreaches to attract workers and assist with provider enrollment as well as integrate workforce concerns into community collaborative discussions. SDA's Senior Community Service Employment Program (Title V) continues to encourage participants to consider home healthcare employment opportunities. Several participants have completed or are currently training to be a Certified Nurse's Aide. The Mental Health Waiver's Administrative Service Organization – Advanced	Public Act 14-159: Allows a "sleep-time" exclusion from overtime pay requirements for certain employees employed by third-party providers (e.g., home care agencies) to provide "companionship services" as defined by federal regulations. In general, these regulations define "companionship services" to mean fellowship, protection, and limited care for an elderly person or person with an illness, injury, or disability. The bill's sleep-time exclusion aligns state law with changes in federal regulations effective January 1, 2015. Public Act 14-217, Sec. 159: Allows certain family child care providers and personal care attendants (PCAs) to collectively bargain with the state over their reimbursement rates and

RECOMMENDATIONS	ADMINISTRATIVE AND OTHER ACTIONS	LEGISLATIVE ACTIONS AND NEW FUNDING
	Behavioral Health – continues to provide regularly scheduled trainings for certified Recovery Assistants who can also be dually-trained to provide Recovery Assistant services for the Acquired Brain Injury II Waiver overseen by DSS. Recovery Assistant service was initially developed for the Mental Health Waiver as a combination of companion, homemaker, PCA and respite services with a focus on teaching independent living skills.	other benefits. Any provision in a resulting contract that would supersede a law or regulation must be affirmatively approved by the General Assembly before the contact can become effective. Public Act 14-217, Sec. 227: Current law limits the deduction of a personal care attendant's (PCA) union dues and fees to payments from the waiver program in which a PCA's consumer is participating. Thus, PCAs in non-waiver programs, such as the Connecticut Home Care Program for Elders, cannot have union dues or fees deducted from their payments. The bill removes this restriction and instead allows the dues and fees to be deducted from any program covered by their collective bargaining agreement. Public Act 14-47: Provides funding to DSS to support the PCA collective bargaining agreement. FY 2015 $1,730,000. Public Act 14-47: Provides funding of $1,418,000 for union contract costs for Personal Care Attendants (PCAs). Section 159 of PA 14-217 implements the provisions of the union contract.
Provide support to informal caregivers.	SDA expanded options for support to informal caregivers through the	Public Act 14-47: Provides funding to DDS of $4 million in FT 2015 to reflect half year

RECOMMENDATIONS	ADMINISTRATIVE AND OTHER ACTIONS	LEGISLATIVE ACTIONS AND NEW FUNDING
	CONNECTIONS Grant, funded by the Administration for Community Living. This grant established Cognitive Training as an innovative respite care option, as well as broadening the partnerships between community providers caring for individuals with Alzheimer's Disease. The DSS Strategic LTSS Plan includes continued funding for the caregiver's information initiative. This initiative is for MFP participants and their families. If the data collected indicates a successful intervention, statewide application will be considered. DDS has developed a Family Website link on their main website. This contains information on a wide variety of topics for families, individuals and caregivers.	funding of 100 individuals designated priority one placements on the department's Waiting List. The agency is to focus on providing residential services to those individuals with parents or caregivers age 70 and older. Public Act 14-47: Provides funding to DDS of $600,000 in FY 2015 for family support grants to serve individuals on the agency's Waiting and Planning Lists that are not currently receiving any residential services. Based on the average subsidy it is anticipated that approximately an additional 350 families can be provided subsidies. Public Act 15-32: This bill (commonly referred to as the Care Act) requires a hospital, when discharging a patient to his or her home, to: 1) allow the patient to designate a caregiver at, or before, the time the patient receives a written copy of his or her discharge plan. Patients are not required to name a caregiver; 2) document the designated caregiver in the patient's discharge plan; 3) attempt to notify the designated caregiver of the patient's discharge home; and 4) instruct the caregiver on post-discharge tasks with which he or she will assist the patient at home. Instruction may be proved to the caregiver live or in prerecorded formats. The bill specifies that it does not create a

RECOMMENDATIONS	ADMINISTRATIVE AND OTHER ACTIONS	LEGISLATIVE ACTIONS AND NEW FUNDING
		private right of action against a hospital or its employees, contractors, or consultants. It prohibits these entities and people from being held liable for services a caregiver provides or fails to provide to the patient in his or her home. Public Act 15-50: Under this bill, DSS must require any nursing home or residential care home, for each resident in its care, to keep on file contact information for (1) a family member designated by the resident or (2) the resident's legal guardian. The home must provide information to the family member or guardian about investigations into any reports that the resident has been abused, neglected, exploited, or abandoned or is in need of protective services. The DSS commissioner must also immediately notify the family member or guardian whenever the Commissioner has reason to believe the resident has been a victim of abuse, neglect, exploitation, or abandonment, unless the family member or guardian is the suspected perpetrator.
Preserve and expand affordable and accessible housing for older adults and individuals with disabilities, including assisted living, residential care homes, and other supportive housing and emergency housing options for older adults.	DMHAS continues to expand supportive housing options across all populations that receive DMHAS services, including those that are homeless. Specifically DMHAS manages over 1,000 units of Shelter Plus	In coordination with the Interagency Committee on Supportive Housing and Homelessness, DOH was awarded a twenty year contract under the federal Section 811 PRA, which provides project-based rental

RECOMMENDATIONS	ADMINISTRATIVE AND OTHER ACTIONS	LEGISLATIVE ACTIONS AND NEW FUNDING
	Care, a HUD rent subsidy program for homeless individuals with a mental health or substance abuse disorder. DMHAS works with various Housing Authorities to ensure that DMHAS clients are able to access Section 8 vouchers. DOH continues to offer MFP participants access to the state Rental Assistance program as well as the Security Deposit Guarantee program. DOH continues to providing funding for rehabilitation to increase accessibility of existing homes, also for the benefit of MFP participants. Funding to create accessibility in adult family homes is also available. Through rebalancing grants, DSS funded the renovation of Avery House in Hartford, CT into affordable housing apartments. The campus aims to increase community housing options so that people can age in place. Connecticut was awarded an 811 grant from HUD to build 150 new units for people who need LTSS including the chronically homeless, people with autism and the MFP participants.	assistance to support community based service-enhanced affordable housing. The first installment of $4.12 million will be implemented over the next five years, with additional funding for years 6 thru 20.

RECOMMENDATIONS	ADMINISTRATIVE AND OTHER ACTIONS	LEGISLATIVE ACTIONS AND NEW FUNDING
	DOH and The Connecticut Housing Finance Authority have prioritized permanent supportive housing in many of their capital development programs. DDS continues to work with partner agencies on the Interagency Committee on Supportive Housing and Homelessness to advocate for the development of affordable and supportive units for the ID/DD and ASD populations. DDS is a named participant in the HUD Section 811 Grant that will expand use of project-based housing subsidies for DDS' MFP participants and expands the opportunity to use housing subsidies to our Autism Spectrum Disorder Waiver participants. DDS continues to foster development of community based housing supports through its network of community Providers. DDS provides service funds, and in most cases housing subsidies through its self-managed rent subsidy program, to over 1,300 individuals living independently in their own home/apartment in community settings. An additional 1,500 + individuals receive supports in their family homes, in many cases preparing individuals to live independently in a community setting of their choice pending availability	

RECOMMENDATIONS	ADMINISTRATIVE AND OTHER ACTIONS	LEGISLATIVE ACTIONS AND NEW FUNDING
	of housing subsidies. DDS widely promoted the application process for entry onto the Waiting List for RAP and Section 8 housing subsidies in 2014 and DDS looks forward to other opportunities to expand the use of such subsidies within its supported population	
Encourage and enable the provider community to transform and develop services and supports that will help to achieve the goals of this Plan.	DSS's strategic plan and funding continues to support the business diversification of nursing facilities as well as increased application of person-centered philosophy for all providers. Multiple agencies have signed a Memorandum of Understanding regarding the creation of a Uniform Licensing Application and the operation of a web-based filing and storage system for required licensing documents. The goal is to develop a common application and, by utilizing the web-based system, to improve the efficiency of the licensing process. This should enhance the quality of licensing interactions between DCF, DDS and DPH and the organizations that provide services and supports to the public utilizing these licenses. Using the new system will limit the need for forms to be submitted multiple times to different or individual	

RECOMMENDATIONS	ADMINISTRATIVE AND OTHER ACTIONS	LEGISLATIVE ACTIONS AND NEW FUNDING
	state agencies.	
Expand and improve employment opportunities and vocational rehabilitation for persons with disabilities and older adults.	BRS continued its use of industry specific training programs designed to provide job seekers with disabilities the skills necessary for employment in a particular profession or type of business in addition to customary services. The agency added one additional program during this reporting period, for a total of 8 programs underway. DSS coordinates with BRS to match job seekers with disabilities to positions open in the direct support workforce. Supported employment continues to be offered as a MFP Demonstration service. Peer support is also available which offers additional opportunities for people with disabilities to become employed.	Public Act 13-7: Makes changes to the DORS statutes, including (1) eliminating a per person cap on the amount that DORS may spend to provide employment assistance to blind people; (2) increasing dollar thresholds for wheelchair and certain equipment purchases; and (3) expanding Assistive Technology Revolving Fund loan eligibility.
Increase availability of readily accessible, affordable, and inclusive transportation that accommodates the need for family and direct care worker companions.	There is now availability of accessible taxis and a voucher program that is funded through the FTA New Freedom grant program and is administered by the Connecticut Department of Transportation. The voucher program extends beyond the ADA paratransit service area and hours by providing a pre-paid taxi voucher card at a 50% reduced price to people defined as having a disability under the ADA	

RECOMMENDATIONS	ADMINISTRATIVE AND OTHER ACTIONS	LEGISLATIVE ACTIONS AND NEW FUNDING
	regulations. The voucher may be used for taxi trips that go beyond the ADA service area, during times that ADA paratransit is not available and for same day service. Personal Care Assistants may ride for free with an individual who requires assistance as long as the assistant starts and ends their ride with the voucher holder.	
Improve quality of life and reduce utilization of long-term services and supports and health care services by focusing on health promotion and disease prevention.	Behavioral Health Homes will be implemented in a targeted manner. Local Mental Health Authorities will provide Health Promotion Services to eligible enrollees. Health promotion activities will encourage and support healthy living concepts to motivate individuals to adopt healthy behaviors and promote self-management of their health and wellness. DDS is collaborating with Planned Parenthood in the development of Healthy Relationship training for individuals, staff, families and administration. DDS is working with other state agencies and stakeholders regarding coordination of care. DDS staff participate in the Complex Care duals demonstration to increase access to person centered medical care and equal	

RECOMMENDATIONS	ADMINISTRATIVE AND OTHER ACTIONS	LEGISLATIVE ACTIONS AND NEW FUNDING
	access to medical care. Motivational interviewing is a requirement for all MFP Specialized Care Managers (SCM). The Demonstration continues to offer motivational interviewing trainings for all new SCMs. Health coaches are funded under Community First Choice (CFC) and also integrated into the MFP initiative. "New to Medicare" presentations across the State provide information on Medicare preventative services that are now available through the Affordable Care Act (ACA). The SDA website highlights one Medicare preventative benefit each month. SDA, in partnership with DPH, provides statewide coordination of the delivery of the Chronic Disease Self-Management "Live Well" Program and Diabetes Self-Management Program under a federal ACL grant. Leader trainings and workshops are held statewide through regional partners including the five AAAs and Connecticut Community Care, Inc. (CCCI). SDA has a state-funded fall prevention	

RECOMMENDATIONS	ADMINISTRATIVE AND OTHER ACTIONS	LEGISLATIVE ACTIONS AND NEW FUNDING
	program, in partnership with the Yale Connecticut Collaboration for Fall Prevention. In SFY 2014, the Greater New Haven VNA embedded fall prevention into their programs, including community outreach, screening and intervention. In SFY 2014, 795 people were screened for falls. In terms of the impact on fall-related injuries, hospitalizations and health care costs, of the 421 individuals followed, 287 had fallen prior to the intervention and 22 were hospitalized at an estimated $610,390 in health care costs. Of the 421 individuals followed 6 months post intervention, 57 individuals had fallen and 7 were hospitalized with an estimated $194,215 in healthcare costs. At twelve months, the estimated fall-related injury health care costs averted totaled $416,175.	
Address emergency preparedness/disaster planning for older adults and persons with disabilities.	SDA provided an updated Continuity of Operations Plan – Pandemic Plan which was included with the previous submission from DSS. Additionally, SDA obtained updated emergency preparedness plans from the five Area Agencies on Aging as part of their submission of their Area Plans. SDA is a member of the Governor's	

RECOMMENDATIONS	ADMINISTRATIVE AND OTHER ACTIONS	LEGISLATIVE ACTIONS AND NEW FUNDING
	Emergency Communication Task Force. The Governor's Emergency Communication Task force is headed by the Commissioner of the Department of Emergency Services and Public Protection (DESPP). The SDA is a member of the sub-committee which is identifying the effective methods of communications to meet the needs of CT's residents. The Interim Report was issued in August 2014 regarding communication during emergencies. Use this link to access the report. http://www.ct.gov/despp/lib/despp/governors_emergency_communications_task_force/report_on_emergency_communications-_8-4-2014__final_pdf.pdf DORS also participates in this Task Force, and worked to incorporate some standards for communication into the Committee's report. One significant advancement was the commitment to have sign language interpreters at the State Emergency Operations Center (EOC) for press conferences related to emergency activation. The Long-Term Care Ombudsman Program continues to participate in scheduled LT-MAP regional meetings. The Ombudsman Program coordinates efforts with DPH	

RECOMMENDATIONS	ADMINISTRATIVE AND OTHER ACTIONS	LEGISLATIVE ACTIONS AND NEW FUNDING
	during emergency situations to ensure the well-being of long-term care residents. DPH works with the Long Term Care Mutual Aid Plan (LTC-MAP), which is a state-wide or region-wide agreement among participating long-term care facilities to provide pre-planned assistance to each other at the time of a disaster. This assistance may come in the form of: • Providing alternate care sites for residents evacuated from a disaster-struck facility. • Providing supplies, equipment, staff or pharmaceuticals to a facility when a disaster overwhelms their own community and isolates the facility. This plan supplements existing resources. The DSS nursing facility diversification RFP seeks proposals from nursing facilities who are interested in addressing emergency preparedness/disaster planning for older adults and persons with disabilities within their community and who have community support.	
SHORT TERM RECOMMENDATIONS		

RECOMMENDATIONS	ADMINISTRATIVE AND OTHER ACTIONS	LEGISLATIVE ACTIONS AND NEW FUNDING
Programs and Services		
▪ Adequately support and increase the number of slots of all the existing Medicaid home and community-based services waivers to meet the needs of all eligible applicants.	DDS continues to review the Medicaid waiver numbers and plans to add waiver participant slots based on additional funding for Waitlist recipients as well as participants migrating to the waivers from MFP. DSS made several enhancements to the Medicaid Waivers: ● Adult Family Living has been added as a service to both the PCA and CHCPE Waivers. ● MED has been added to the elder waiver. ● A second ABI waiver has been developed and is currently under review by CMS. ● The Mental Health Waiver has been amended and will serve 811 individuals who are currently in nursing facilities or who are at risk for this level of care. The waiver is operated by DMHAS with oversight by DSS.	Public Act 14-150: Requires the Department of Social Services (DSS) to continuously operate the current Medicaid acquired brain injury (ABI) waiver. It further specifies that services under this waiver not be phased out and that no individuals receiving services be institutionalized in order to meet federal cost neutrality requirements. The bill also requires the DSS commissioner to seek federal approval for a second ABI waiver. The bill establishes an advisory committee for the ABI waiver. The committee consists of the chairpersons and ranking members (or designees) of the Human Services, Appropriations and Public Health committees, as well as the commissioners of Social Services and Mental Health and Addiction Services. The committee must meet no less than four times per year. The committee must submit to the General Assembly an initial report concerning the impact of the individual cost cap in the proposed second ABI waiver by February 1, 2015. Public Act 14-47: Department of Social Services: ● Provides additional funding for the

RECOMMENDATIONS	ADMINISTRATIVE AND OTHER ACTIONS	LEGISLATIVE ACTIONS AND NEW FUNDING
		Connecticut Home Care Program for Elders (CHCPE) of $1.5 million in FY 2015 to reflect updated cost and caseload projections. • Provides funding of $750,000 in FY 2015 to serve an additional 100 children under the Katie Beckett Medicaid waiver. • Provides funding of $650,000 in FY 2015 in the Medicaid account to reduce the current waitlist for the Acquired Brain Injury Waiver. • The CT Home Care Program for Adults with Disabilities (CHCPD is currently capped at 50 slots. Provides funding of $600,000 in FY 2015 to expand the pilot for an additional 50 slots. Section 73 of PA 14-217, the budget implementer, implements the expansion of this program. • Provides funding of $377,000 in FY 2015 in DSS to reflect half year funding for the aid to the disabled (room and board component) services for 100 Medicaid eligible individuals designated priority one placements on the Department of Developmental Services Waiting List. Public Act 14-217, Sec. 73: Increases, from 50 to 100, the number of people who may receive services through the CT Home Care

RECOMMENDATIONS	ADMINISTRATIVE AND OTHER ACTIONS	LEGISLATIVE ACTIONS AND NEW FUNDING
		Program for Adults with Disabilities, a state-funded pilot program administered by DSS.
▪ In the State-funded tiers of the Connecticut Home Care Program for Elders, eliminate the required co-payment.		Senate Bill 1502, Sec 386: amends eligibility for the state funded portion of the CHCPE in fiscal years 2016 and 2017 by specifying that only individuals requiring nursing home level of care may qualify with the exception of individuals participating in the Assisted Living Demonstration Project. It also increases the required cost-share from 7% to 9% for qualified individuals on the state funded CHCPE program with the exception of individuals participating in the Assisted Living Demonstration Program.
▪ Identify skills needed for nursing facility residents who desire to transition back to the community and provide appropriate skill training and resources.	MFP SCMs continue to have access to a range of pre-transition supports including, peer support, alcohol and substance abuse interventions, and 1:1 engagement counseling. Because the Mental Health Waiver for individuals with SMI encompasses the recovery orientation adopted by the DMHAS, it emphasizes the following skill-building services: • Intensive psychiatric rehabilitation provided in the participant's home and in other community settings; • Attention to both psychiatric and	

RECOMMENDATIONS	ADMINISTRATIVE AND OTHER ACTIONS	LEGISLATIVE ACTIONS AND NEW FUNDING
	physical needs; • Emphasis on wellness and recovery; • Person-centered planning leading to development of an individualized recovery plan; and • Use of peer supports provided by people trained and certified in rehabilitative care, who know form first-hand experience about recovery from mental illness.	
▪ Expand funding for State-funded respite services, such as the Statewide Respite Program, the state-funded tiers of the Connecticut Home Care Program for Elders and the Department of Developmental Services in-home and out-of-home respite services in order to provide support to informal caregivers.	The DSS information caregiver support initiative will include a component for a new respite intervention. The design is due on August 1, 2013.	Public Act 14-47: Provides additional funding for FY 2015 to increase family grants that will assist families to access additional respite services.
▪ Support family caregivers through compensation with the development of the new Adult Family Living initiative.	Adult Family Living options became available during SFY 14.	
▪ Address isolation of all older adults and individuals with disabilities living in the community. Also, address the impact of isolation on elder abuse and exploitation.	SDA provides direction on obtaining free legal advice, elder abuse information and assistance. SDA collaborates with the aging network and law enforcement to support initiatives such as Triad to reduce criminal victimization of older persons. SDA formed the Coalition for Elder Justice to "communicate and collaborate with Public and Private stakeholders in CT to	

RECOMMENDATIONS	ADMINISTRATIVE AND OTHER ACTIONS	LEGISLATIVE ACTIONS AND NEW FUNDING
	address elder justice issues in order to prevent elder abuse and protect the rights, independence, security and well-being of vulnerable elders in CT." The kick-off call to action conference was Nov. 21, 2013 and was followed on Nov. 21, 2014 with a 2nd conference, "Abuse is getting old – A Connecticut Roadmap for Action." The Coordinating Council, which oversees the work of the Coalition, has grown from 15 to 22 members in 2015 expanding to encompass the disability community. Following the initial Council meeting in 2014, the Governor issued Executive Order 42 ordering relevant state agencies to support efforts by SDA and the Council that seek to prevent the abuse of elderly citizens. The first two Coalition workgroups that are operational include a Consumer Fraud Awareness Campaign and Financial Exploitation and Elder Abuse awareness training and reporting for financial institutions.	
▪ Strengthen the connection of State and local services by strengthening the relationship to senior centers, municipal government offices and services offered locally.	CHOICES programs at all AAAs across the state have recently begun to make a more strengthened effort to reach out to senior centers and either develop more sites for CHOICES counselors to see clients at the senior centers, or recruit and train more senior center staff or volunteers to be	

RECOMMENDATIONS	ADMINISTRATIVE AND OTHER ACTIONS	LEGISLATIVE ACTIONS AND NEW FUNDING
	CHOICES counselors. The Statewide CHOICES Coordinator participates in the CARSCH (CT Association of Resident Service Coordinators in Housing) chat room to strengthen its relationship to local services. Coordinators continue to recruit counselors for its training and to locate new sites for counseling. My Place CT will connect directly to local services in phase 3 of the website. SDA held a statewide meeting for senior center personnel and municipal agents on March 26, 2015 to build a stronger relationship with SDA, to solicit feedback and to foster improve communication. In October 2014, SDA established a weekly e-newsletter for municipal agents and senior centers to share and communicate information.	
Infrastructure		
▪ Achieve greater integration of and uniformity of administration of State long-term services and supports serving both older adults and people with disabilities and their families, and emphasize policies related to function as opposed to age or diagnosis.	SDA and DDS have developed a Memorandum of Understanding regarding collaboration around ADRC and No Wrong Door approaches.	Public Act 13-125 (SB 837): Completes the establishment of the Department on Aging by transferring to it all Aging Services Division programs and responsibilities, including federal Older Americans Act (OAA) programs,

RECOMMENDATIONS	ADMINISTRATIVE AND OTHER ACTIONS	LEGISLATIVE ACTIONS AND NEW FUNDING
	The National Alliance of Mental Illness (NAMI) offered "Mental Health 101" training to CHOICES volunteers, senior centers, municipal agents and resident service coordinators for improved understanding of the needs of persons with mental health disabilities. CHOICES worked with NAMI and the Local Mental Health Authorities to offer "New to Medicare" training to persons with Medicare due to disability throughout the State.	the Statewide Respite Program, the Community Choices Program, the Long-Term Care Ombudsman Office, OAA funding for the area agencies on aging, health insurance counseling, administration of state grants for elderly community services and programs, oversight of municipal agents for the elderly, elderly nutrition, and fall prevention.
▪ Under the Balancing Incentive Program (BIP), create the BIP infrastructure investments of a consumer friendly statewide No Wrong Door system, a conflict free case management, and a uniform assessment tool.	The State received a BIP award in the amount of $73M in October of 2012. ● The Advanced Planning Document (APD) was approved in October 2014. ● Release 1 was completed in June 2014. ● The design of Release 2 which includes the Pre-Screen and Universal Application is currently in development stages. Coordination is ongoing with DMHAS, DDS, DORs, and SDA. ● On July 1, 2015, the automated Universal Assessment will be launched.	

RECOMMENDATIONS	ADMINISTRATIVE AND OTHER ACTIONS	LEGISLATIVE ACTIONS AND NEW FUNDING
▪ With a focus upon hospital admission and discharge, use best efforts to divert individuals to an appropriate care setting of their choice.	My Place CT will include a portal for hospital discharge planners in phase 3. The portal will support electronic linkages between the discharge planner, formal supports and local supports. MFP tracks all hospital admission and discharge information as part of the quality management plan. 24 hour nursing has been added to MFP. DDS policy is decreasing reliance on Nursing Home placement. DDS has incorporated procedures for Private and Public CLAs to make additional supports as needed to support an individual living in a CLA to continue there upon discharge from a hospital and to avoid long term placement in a SNF. DDS has five state staff dedicated exclusively to MFP, moving individuals from nursing homes, institutions and hospitals. To achieve the Behavioral Health Home goal and outcome measure, *"Improve Quality by Reducing Unnecessary Hospital Admissions and Readmissions*," DMHAS Behavioral Health Home teams will	

RECOMMENDATIONS	ADMINISTRATIVE AND OTHER ACTIONS	LEGISLATIVE ACTIONS AND NEW FUNDING
	maintain collaborative relationships with hospital emergency departments, housing providers, psychiatric units of local hospitals, long-term care, detox providers and other applicable settings to ensure seamless transitional care to the least restrictive setting.	
▪ Address the historical fragmentation of the Medicaid home and community-based waivers, which are associated with specific age and diagnostic eligibility criteria.	Agreement was reached to tie MED Connect to all Medicaid waivers, including waivers for Elders during the next amendment. DMHAS was involved in a statewide initiative to develop a core assessment tool to be used with all home and community based waivers. The State's Community First Choice (CFC) option will be effective July 1, 2015. CFC will be the first cross disability option, based on functional need rather than diagnosis or age. DDS will be a partner with DSS in the development of the Community First Choice in CT.	Public Act 14-47: The federal Affordable Care Act authorizes the Community First Choice Option, which offers states a 6% increase in federal reimbursement on personal care assistance (PCA) services if the program meets certain criteria. DSS will provide coverage of self-directed PCAs as a Medicaid service for individuals at institutional level of care. Reduce funding by $470,000 in the Medicaid account to reflect savings as a result of higher reimbursement.
○ Explore the development of a broader 1915(i) State plan amendment to provide home and community-based supports based exclusively on functional		

RECOMMENDATIONS	ADMINISTRATIVE AND OTHER ACTIONS	LEGISLATIVE ACTIONS AND NEW FUNDING
limitations and financial need.		
▪ Provide timely eligibility decisions regarding eligibility in all government sponsored long-term services and supports programs.	DMHAS developed and implemented a two-times-weekly referral meeting to expedite mental health waiver referrals. DSS - MFP completed a comprehensive assessment of an asset verification system for application in CT. If adopted, information would be sent electronically from banks to DSS resulting in less of a burden to Medicaid applicants and an expedited process. DDS streamlined the eligibility process. Applications are available online. Reduction on materials requested and increased communication with individuals and families throughout the process. CHOICES and DSS have established a protocol for referrals to the escalation unit to resolve problem situations and expedite new MSP applications for individuals in great need.	Public Act 14-47: Provides DSS an additional 35 positions to assist with long-term care applications. FY 2015: 1,700,000.
▪ Expand Aging and Disability Resource Centers (Community Choices) statewide in support of providing information, referral, assistance and LTSS options counseling.	ADRCs are available statewide. ADRC received the 2012 ADRC Enhanced Counseling Options award and developed an MOA with the Connect to Work Center	2012 ADRC Enhanced Options Counseling Cooperative Agreement received funding from the federal Administration for Community Living.

RECOMMENDATIONS	ADMINISTRATIVE AND OTHER ACTIONS	LEGISLATIVE ACTIONS AND NEW FUNDING
	for $20,000 a year to work more closely with referrals from ADRC/Independent Living who need benefits counseling. This award is through federal fiscal 2015.	
▪ Achieve greater integration of employment of persons with disabilities into the Money Follows the Person Rebalancing Initiative and home and community-based services.	Supportive Employment continues to be offered as a demonstration service to MFP participants. DORS is partnering with DSS through the Balancing Incentive Program to ensure coordination.	
▪ Support improved coordination, communication and guidance among the medical care, behavioral health and long-term services and supports systems.	In an effort to integrate behavioral health into primary care, DMHAS convened a workgroup to advance a proposal on behavioral health homes based at local mental health agencies and/or other providers. DPH uses the Everbridge communication system as part of its strategy to communicate to its licensed facilities including hospitals, long term care facilities and residential care homes.	
○ Ensure that current and future initiatives such as Money Follows the Person, Rightsizing, and the Demonstration to Integrate Care for Medicare-Medicaid Enrollees (MMEs) are well coordinated	DMHAS continues to participate on the MFP Steering Committee. DDS continues participation on the MFP steering committee. To date, DDS has	

RECOMMENDATIONS	ADMINISTRATIVE AND OTHER ACTIONS	LEGISLATIVE ACTIONS AND NEW FUNDING
and complementary.	supported 135 individuals to move from institutional care to self-directed and provider supported services. 56 since 6/1/14. DDS continues to engage with ICF/IID providers and participants interested in transitioning their services to HCBS. DDS participates in the Complex Care committee representing the duals. SDA and the Long-Term Care Ombudsman Program continues to participate on the MFP Steering Committee. DSS Rebalancing Project Director participates on the Complex Care Committee. DOH continues to participate in the coordination of efforts with DSS around MFP and Rightsizing.	
○ Support the development of electronic health records by providers of long-term services and supports and exchange of electronic health records among providers across the Connecticut health care system to streamline care transitions, coordinate care delivery and improve quality and outcomes.	DSS is currently developing Personal Health Records and testing e-LTSS transfer protocols and ONC S & I Framework under the TEFT grant. Personal Health records will be integrated as part of the No Wrong Door initiative. The Mental Health Waiver is currently working with its Administrative Service	

RECOMMENDATIONS	ADMINISTRATIVE AND OTHER ACTIONS	LEGISLATIVE ACTIONS AND NEW FUNDING
	Organization, Advanced Behavioral Health, to have a complete electronic record system that will also integrate with the DSS Personal Health Records and testing e-LTSS transfer protocols and ONC S & I Framework under the TEFT grant.	
○ Support a learning collaborative approach to bring together providers across disciplines and perspectives, and to learn from older adults and individuals with disabilities.	DMHAS Older Adult Services chairs a workgroup comprised of public and private entities and has formalized a mission statement and goals around addressing older adult behavioral health issues – particularly through integrating behavioral and physical health concerns. Current initiatives include asset mapping of delivery system's strengths and needs and integrating SBIRT (Screening, Brief Intervention, and Referral to Treatment) trigger questions into assessments conducted by non-behavioral health service providers. SDA participates on DMHAS Chaired Behavioral Health and Older Adults workgroup (see above). The group, in partnership with SDA ADRC grant funds is currently undertaking an Older Adult and Behavioral Health Services asset mapping exercise that will take place through Sept 15th and will result in identified, community assets, gaps, services/referrals provided by	

RECOMMENDATIONS	ADMINISTRATIVE AND OTHER ACTIONS	LEGISLATIVE ACTIONS AND NEW FUNDING
	physicians and recommendations for linking physical and mental health in an efforts to better streamline the physical and behavioral health service system for older adults. Connect-Ability Distance-Learning Initiative Independent Living and Employment distance learning modules are now available to everyone through the Connect-Ability website. DDS is one of five states to receive a grant to participate in Community of Practice. The Connecticut Community of Practice team is part of a national team comprised of five states that received a grant to examine processes of improving supports to individuals with intellectual disabilities and their families across the span of their lifetime. This multi-year grant affords us the opportunity to learn with others how best to discover new and innovative ways to support more families. DDS is partnering with the Connecticut Council on Developmental Disabilities in this learning experience. DDS has engaged with over 170 stakeholders to date in this initiative. Learning Collaboratives are funded under the rebalancing sustainability plan.	

RECOMMENDATIONS	ADMINISTRATIVE AND OTHER ACTIONS	LEGISLATIVE ACTIONS AND NEW FUNDING
▪ Change the names of the Long Term Care Planning Committee and the Long Term Care Advisory Council to the Long Term Services and Supports Planning Committee and the Long Term Services and Supports Advisory Council.		
Financing		
▪ Achieve adequate and sustainable provider reimbursement levels that support the cost of long-term services and supports and quality requirements for all segments of the long-term services and supports continuum in order to ensure capacity to meet the evolving needs and demographics of Connecticut residents.		Special Act 13-7: Requires that the Council on Medical Assistance Program Oversight study obstacles to achieving an adequate health care provider network for Medicaid recipients and recommend, not later than January 1, 2014, strategies to improve (1) access to such providers, and (2) health outcomes for such recipients across racial and ethnic lines. The study must include administrative burdens faced by providers and the effect of Medicaid rates of reimbursement on achieving an adequate provider network. [The act does not specify whether it includes providers of long-term care.] Public Act 14-164: Allows the DSS to pay Temporary Family Assistance (TFA) and State Supplement Program (SSP) benefits directly to a licensed residential care home or a boarding or other "rated housing facility" through a per diem or monthly rate. Current law generally requires DSS to pay benefits directly to SSP

RECOMMENDATIONS	ADMINISTRATIVE AND OTHER ACTIONS	LEGISLATIVE ACTIONS AND NEW FUNDING
		and TFA participants. Also, the bill directs DSS to give rate increases, within available appropriations, for any capital improvement a residential care home makes for the health and safety of its residents. This provision is effective July 1, 2014. Public Act 14-47: Provides DSS a rate increase for mental health providers. FY 2015: $4,150,000. Public Act 14-47: Provides DSS a 1% COLA for Home Care Providers, effective January 1, 2015. FY 2015: 1,625,000. Public Act 14-217, Sec. 78: Requires DSS to analyze, by November 1, 2014, the cost of providing services under the (1) Connecticut home-care program for the elderly and (2) pilot program to provide home care services to persons with disabilities. The DSS commissioner must (1) include a determination of necessary reimbursement rates for providers and (2) report, by January 1, 2015, a summary of the analysis to the Appropriations and Human Services committees. Public Act 14-217, Sec. 195: Allows the DSS commissioner, at his discretion, to waive specified regulations and make other changes

RECOMMENDATIONS	ADMINISTRATIVE AND OTHER ACTIONS	LEGISLATIVE ACTIONS AND NEW FUNDING
		to residential care home cost reporting for rate-setting for FY 2015, subject to available appropriations. Such changes could affect rates paid by DSS to RCHs. Senate Bill 1502, Sec. 380: Makes $13 million available to increase wages for certain staff at nursing homes.
▪ Provide greater flexibility in the budgeting and use of Medicaid funds for long-term services and supports.		Public Act 14-142: Eliminates the statutory cost cap on community-based, waiver-funded services in the Connecticut Home Care Program for Elders (CHCPE), which is currently 60% of the weighted average cost of care in skilled nursing and intermediate care facilities. The bill also specifies that the state's cost for long-term facility care and all CHCPE services, not just the program's community-based services, cannot exceed the cost the state would have incurred without the program.
▪ Capture and reinvest cost savings across the long-term services and supports continuum.	Under the Mental Health Waiver program, realized cost savings allowed the program to increase the number of clients served.	
○ Reinvest savings resulting from Money Follows the Person, the Balancing Incentive Program and other emerging Medicaid long-term services and supports programs to enhance the availability and capacity of	Savings achieved due to the Balancing Incentive Program has resulted in new LTSS services. Savings from Money Follows the Person	

RECOMMENDATIONS	ADMINISTRATIVE AND OTHER ACTIONS	LEGISLATIVE ACTIONS AND NEW FUNDING
home and community based services.	has resulted in housing subsidies and funding for transitional services for individuals found ineligible for the MFP Demonstration.	
▪ Reform the Medicaid rate setting system to reflect quality, reimbursement related to the actual costs of care, and uncompensated care for all LTSS providers across the continuum consistent with long-term services and supports rebalancing, rightsizing and a range of home and community based service initiatives.		Senate Bill 1502, Sec. 397: Allows DSS to implement acuity-based methodology for reimbursement to nursing homes.
▪ Explore various methods to increase the private sector's greater involvement as a payer of long-term services and supports.		
o Explore the development of tax incentives for the purchase of private long-term care insurance, including tax incentives for employer-based coverage.		
▪ Work with the Federal government to preserve Older Americans Act funding. This federal funding source is currently at risk.	In FFY 2013, sequestration resulted in reduced Older Americans Act (OAA) funding to SDA. There was no additional OAA funding reduction in FFY 2014. Additionally, SDA secured Social Services block grant (SSBG) funding to supplement	

RECOMMENDATIONS	ADMINISTRATIVE AND OTHER ACTIONS	LEGISLATIVE ACTIONS AND NEW FUNDING
	nutrition funding. SDA Commissioner provided a letter of support for the Reauthorization of OAA, which included a recommendation to make discretionary grant programs such as ADRC, CDSMP and SMP permanent parts of the Act's core programs with appropriate funding to sustain these projects. In January 2015, SDA communicated with Congressional leaders to provide support for the proposed Older Americans Act Reauthorization of 2015.	
Quality		
▪ Enable a collaborative, flexible and efficient regulatory environment that is adaptive and receptive to individual provider's forward thinking ideas and planning. Such an environment would encourage providers of the long-term services and supports continuum to adjust, modernize and diversify their models of care to address current and future consumer needs and expectations, which in turn should lead to higher quality care.	DPH meets quarterly with the not- for-profit and for- profit long term care trade associations to discuss current issues and resolution to promote quality care in the long-term care setting. The DPH has established a voluntary program to implement the use of Medical Orders for Life Sustaining Treatment (MOLST) by health care providers. An advisory group was created comprised of health care providers and consumer advocates to make recommendations on the pilot program. Participating health care	Public Act 14-231, Section 7: Requires that in nursing facilities, Management Companies may provide services to manage the operations including the provision of care and services. If there has been a substantial failure to comply with the requirements or regulations adopted, the commissioner may require the nursing facility licensee and the nursing facility management service certificate holder to jointly submit a plan of correction. Public Act 14-95: Allows DSS to expand the state's "Small House Nursing Home" pilot

RECOMMENDATIONS	ADMINISTRATIVE AND OTHER ACTIONS	LEGISLATIVE ACTIONS AND NEW FUNDING
	providers must be trained in how to fully inform patients about the benefits and risks of MOLST. The pilot program will end by 10/1/16 and the commissioner will report to the governor and public health committee.	program. A small house nursing home is an alternative nursing home facility consisting of one or more units designed and modeled as a private home with no more than 14 individuals in each unit. The pilot's goals are to improve the quality of life for nursing home residents and provide nursing home care in a "home-like" rather than institutional living. Public Act 14-231: requires nursing homes to provide one-hour training in oral health and hygiene techniques to licensed and direct care staff and nurse's aides who provide patient care. Staff must complete the training within the first year of employment and annually thereafter.
▪ The Departments of Public Health and Social Services should work together to ensure consistency among their respective regulations.	DPH and DSS conduct a weekly call to discuss common issues and financial viability of long term care facilities. DPH and DSS also coordinate on the administration of medication by certified home health aides and risk in the community.	
▪ Review licensing certification requirements and Probate Court protocols (currently there is no licensing for conservators or guardians) for training of community-based formal caregivers, conservators and guardians to assure that	DPH is developing a guidance document to EMS providers and agencies. This information will be distributed to applicable communities and associations.	Public Act 14-194: Establishes mandatory Alzheimer's and dementia-specific training for a wide range of personnel, including emergency medical technicians (EMTs),

RECOMMENDATIONS	ADMINISTRATIVE AND OTHER ACTIONS	LEGISLATIVE ACTIONS AND NEW FUNDING
the specialized needs of the individual, such as those with Alzheimer's disease, are met and provide training where there are gaps.		probate judges, paid conservators, and protective services employees. It requires staff in Alzheimer's special care units hired on or after October 1, 2014 to complete the currently required initial Alzheimer's and dementia-specific training within the first 120 days of employment. Under current law, the training must be completed within six months of employment.
▪ Expand the scope of the Long-Term Care Ombudsman program to provide Ombudsman support to consumers receiving long-term services and supports regardless of setting in order to align the program with Medicaid LTSS rebalancing efforts. Additional appropriations to the Long-Term Care Ombudsman program would be necessary to expand beyond their current jurisdiction.	The DSS strategic rebalancing plan includes a strategy to incorporate Ombudsman into community LTSS infrastructure.	Public Act 13-234, Section 107: Requires the state ombudsman, beginning July 1, 2014, to personally, or through representatives of her office, implement and administer a pilot program serving home- and community-based care recipients in Hartford County. Senate Bill 1502, Sec. 371: Revises existing statute regarding implementation of the Community Ombudsman pilot program that serves home and community-based care recipients in Hartford County to specify that it be implemented and administered, within available appropriations.
Housing		
▪ Support programs that divert or transition individuals from nursing facilities or other institutions to community housing options.	Nurse Clinicians under the DMHAS Nursing Home Diversion and Transition Program are now cross-trained in diverting nursing home clients to the mental health waiver.	

RECOMMENDATIONS	ADMINISTRATIVE AND OTHER ACTIONS	LEGISLATIVE ACTIONS AND NEW FUNDING
	The Nursing Facilities Diversification program announced a second round of grants in May 2015. This program provides financial assistance to the owners of nursing facilities that are licensed by the Department of Public Health so that they can change or diversify their business model in a way that supports individuals on Medicaid who need Long Term Services and Supports (LTSS) living in the community. Owners proposed diversification plans must align with the State's Strategic Rebalancing Plan: A Plan to Rebalance Long Term Services and Supports 2013-2015, and assure informed choice to residents living in their facility and contribute to reducing the total number of nursing facility beds statewide. Owners are expected to develop relationships and partner with stakeholders in the community including, but not limited to, town governance, town residents, nonprofit entities, and existing home and community-based services providers. The Strategic Plan focuses on community partnerships in the development of innovative housing plus support models.	

RECOMMENDATIONS	ADMINISTRATIVE AND OTHER ACTIONS	LEGISLATIVE ACTIONS AND NEW FUNDING
▪ Address the community housing needs of nursing facility residents who are returning to the community because they no longer need this level of care but have lost their community residence.	Accessibility modification programs for MFP and the general population continue to be provided by the Corporation for Independent Living. In 2014 and 2015, DOH provided a grant to the Corporation for Independent Living totaling $1 million per year to continue accessibility modification programs for MFP and the general population.	
▪ Develop new housing alternatives for persons with serious and persistent mental illness who do not need nursing facility level of care.	DOH, in conjunction with the Interagency Committee on Supportive Housing and Homelessness, is providing $25 million in capital funding for the construction and/or substantial rehabilitation of affordable housing for the chronically homeless with disabilities. The five projects that were awarded will result in the creation of 150 units of affordable and supportive housing.	Public Act 14-47: Provides funding to DOH to support 110 additional Rental Assistance Program (RAP) certificates for scattered site supportive housing for individuals with psychiatric disabilities. FY $1,100,000. Public Act 14-217, Sec. 71: Current law permits the DMHAS commissioner, within available appropriations, to provide subsidies to people who receive DMHAS services and require supervised living arrangements. The bill specifies that such subsidies are for people who qualify for supportive housing under the state's permanent supportive housing initiative, which the department operates in collaboration with several other state agencies. Public Act 14-47: Provides funding to DOH of $1.1 million to support Rental Assistance

RECOMMENDATIONS	ADMINISTRATIVE AND OTHER ACTIONS	LEGISLATIVE ACTIONS AND NEW FUNDING
		Program (RAP) certificates for 110 units of scattered site supportive housing for individuals with psychiatric disabilities. Funding of $1.1 million under the Department of Mental Health and Addiction Services will support the services related to these units. Public Act 14-47: Reduces funding by $600,000 for the Money Follows the Person program to reflect savings due to slower than anticipated transition for individuals in the program. The savings will be repurposed to provide support services and rental assistance program (RAP) certificates for individuals with psychiatric disabilities.
▪ Support legislation that requires new homes to provide features to make it easier for individuals with mobility-impairments to live in and visit.		Public Act 14-98, Sec. 9i: Allocates $6 million in bonding money to the Department of Rehabilitation Services to provide grants to older adults and persons with disabilities to make home modifications and purchase assisted technology so they can remain in their own homes and age in place.
▪ Continue the progressive State investment in the development of housing that is affordable and accessible for older adults and persons with disabilities.	In addition to the supportive housing initiative above, DOH investments continue to be for affordable housing for persons and families of low and moderate income. During FY 14, DOH committed $70M and in FY 15 $100M in capital funding for the development of affordable housing. DOH	Public Act 13-247 (HB 6706), Section 60, authorizes DSS, DMHAS, Corrections, OPM and the Judicial Branch's Court Support Services Division to (1) develop a Plan to provide supportive housing services, including housing rental subsidies during FY 14 and FY 15 for an additional 160 individuals and

RECOMMENDATIONS	ADMINISTRATIVE AND OTHER ACTIONS	LEGISLATIVE ACTIONS AND NEW FUNDING
	continues to promote the inclusion of handicapped accessible/adaptable units in all of our projects, and continues to fund applications for capital financing to support affordable housing for the elderly, which includes persons and families over the age of 60 and the young disabled. DMHAS is part of an interagency collaborative that provides an additional 1100 units of permanent supportive housing, or housing that is dedicated to the homeless disabled population. DMHAS also has created innovative supportive housing models to individuals cycling between the homeless shelter system and the criminal just system as well as a program that provides supportive housing to those individuals discharging from an inpatient psychiatric setting. Currently DMHAS is collaborating with the Interagency Committee on Supportive Housing in the development of 53 additional units of permanent supportive housing through our fourth round of development. In addition, the Governor's biennial budget includes funding for an additional 150 units of supportive housing.	families who frequently use expensive state services and (2) enter into memoranda of understanding to reallocate, within existing appropriations, the necessary support and housing resource for this purpose. DOH and DMHAS are engaged in the Social Innovation Fund Housing Program which intends to house 160 homeless individuals that are also high users of Medicaid services. The elderly are eligible if they are deemed homeless and have high Medicaid costs. The goal of the program is to realize savings in Medicaid by providing permanent supportive housing.
▪ Encourage the growth and development of community-based service models that bring long- term services and	DOH is implementing the new 811 PRA funding, in coordination with DSS, DMHAS,	

RECOMMENDATIONS	ADMINISTRATIVE AND OTHER ACTIONS	LEGISLATIVE ACTIONS AND NEW FUNDING
supports to housing residents. Work with the federal government to secure at-risk housing subsidy, preservation, and development funds.	DDS and CHFA. In March 2015 DOH, in coordination with DSS, DDS, DMHAS and CHFA, recently was awarded $4.12 million in Section 811 project-based rental assistance over the next five years. This is a twenty year commitment of federal subsidies, of which the first award is intended to produce 150 units of affordable supportive housing. When implemented this program will be able to assist individuals discharged from a nursing home into an independent living situation with support services.	
Workforce		
Endorse the full recommendations of the Long-Term Services and Supports Workforce Development Strategic Plan.	The LTSS Strategic Plan includes the workforce development component for SFY16-18. Tactics include developing various types of trainings in partnership with community college systems, and partnering with communities by hosting workforce outreach collaboratives to assist with provider enrollment.	

APPENDIX G.

State Long-Term Services and Supports Programs and Expenditures

SFY 2014 – 2015

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

II. **State Long-Term Services and Supports Programs in Connecticut – SFY 2015**

III. **State Long-Term Services and Supports Program Expenditures in Connecticut – SFY 2015**

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

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

Department of Developmental Services (DDS): DDS provides case management, residential habilitation, individualized supports, campus settings, day habilitation, prevocational services, supported employment, respite care, and family support to approximately 16,328 persons with intellectual disabilities and their families. As of June 2015, 63.6 percent of those people eligible to receive services from DDS were living in their own or their family home, 22.9 percent lived in public or private community living arrangements, 2.3 percent lived in community training homes, 3 percent lived in campus settings and 2.3 percent were in skilled nursing facilities. In addition to individuals with intellectual disabilities (ID), DDS has begun to serve 124 people on the Autism Spectrum who would not meet the criteria for ID. 92% of these individuals reside in their family home with 8% living in their own home.

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

trauma, improve overall health, and are anchored to a recovery-oriented system of care that is culturally competent and rooted in evidence-based practices.

To this end, DMHAS operates, funds, and coordinates inpatient and community-based behavioral health services for adults (18 and older) with serious substance use and/or mental health conditions as well as provides programs for individuals with special needs (e.g., AIDS/HIV, gambling, substance abusing pregnant women, etc.) and defined target populations (e.g., young adults, including those transitioning out of the DCF system, and those involved with the criminal justice system) including persons with serious mental illness residing in nursing homes, military personnel and their families, and persons who are homeless. DMHAS is responsible for the state's behavioral health general funds and SAMHSA block grant allocations, and manages the clinical aspects of the Medicaid Behavioral Health Services Partnership for adults. DMHAS directly operates three inpatient hospitals and contracts with community hospitals and one private psychiatric hospital for inpatient and ambulatory care. Department-operated inpatient hospitals provide psychiatric care and medically managed detoxification and residential rehabilitation services. DMHAS administers the mental health service system through a network of 13 Local Mental Health Authorities (LMHAs) statewide, six state-operated and seven non-profit, along with over 90 affiliated nonprofit community-based organizations. LMHAs are the sub-state administrative and direct care component for the delivery and coordination of mental health services across the state. They develop, maintain, and manage a comprehensive system of mental health treatment, rehabilitative services, and recovery support for designated local service.

Department of Housing (DOH): The Department of Housing strengthens and revitalizes communities by promoting affordable housing opportunities. The Department seeks to eliminate homelessness and to catalyze the creation and preservation of quality, affordable housing to meet the needs of all individuals and families statewide to ensure that Connecticut continues to be a great place to live and work.

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

Department of Transportation (DOT): (DOT) provides about $160 million a year in subsidies to bus and paratransit systems throughout the state. The fixed route bus system provides discounted (half-fare) rides to seniors and people with disabilities. Out of a total of 39 million riders annually on the fixed-route system, about two million rides are

provided annually to elderly and disabled customers. DOT administers the Federal Section 5310 program, which provides vehicle grants to municipalities and non-profit organizations. Over 100 vehicles funded by this grant program are operating around the state. In addition, the federal Americans with Disabilities Act (ADA) requires that demand-responsive paratransit services be provided to pre-qualified individuals who are not able, due to their disability, to utilize the local fixed-route bus system. ADA paratransit services are available to origins and destinations within 3/4 mile of the local bus route and are operated during the same days and hours as the local bus service. The State currently spends over $25 million annually to support ADA services, and provides over 850,000 rides annually. The DOT-subsidized bus and paratransit operations serve 107 towns in the state. The State Legislature appropriated $3 million in fiscal 2012 and 2013 to a "State Matching Grant Program to Provide Demand Responsive Transportation to Seniors and People with Disabilities." This program allows municipalities to apply for a portion of the funds, determined by a formula, and requires an equal match by the municipality. The Federal Transit Administration New Freedom Program provides grant funds for transportation related programs that go beyond the requirements of the Americans with Disabilities Act of 1990. These grants are made available through the DOT and must be derived from locally-coordinated human services transportation - public transit plan.

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

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

Office of Protection and Advocacy for Persons with Disabilities (P&A): P&A is an independent State agency created to safeguard and advance the civil and human rights of people with disabilities. By providing various types and levels of advocacy assistance, P&A seeks to leave people with disabilities and their families better informed, equipped, and supported to advocate for themselves and others. During 2014, P&A provided information, referral, or short-term assistance to 3,447 people, while 639 individuals

received a more intensive level of advocacy representation. The Fatality Review Board for Persons with Disabilities (FRB) reviews the deaths of all persons receiving services from the Department of Developmental Services. There were 221 deaths reported and sixty-two reported deaths were subject to in-depth discussion, monitoring, investigation and/or review. The FRB also received and investigated three death notices from the Department of Mental Health and Addiction Services and three death notices from the Department of Correction. The P&A Abuse Investigation Division (AID) investigated or monitored 1,272 investigations into reports of suspected abuse or neglect of adults with mental retardation. Also, P&A staff provided training to over 1,600 individuals at 86 events on disability rights topics and disseminated information to more than 3,200 people. More than 10,000 P&A publications and program brochures were distributed. The P&A website is constantly updated and includes current news and a calendar of upcoming events; P&A program descriptions and agency publications; legislative updates; links to websites for disability rights and resources; and reports on developments in the field of disability rights. Last year, the P&A website had more than 148,200 hits for information and more than 52,200 publications were downloaded through the site. (www.ct.gov/opapd). P&A staff supported community based disability advocacy groups across Connecticut, providing training and technical assistance on organizational development issues and disability rights. The agency continued its support for African Caribbean American Parents of Children with Disabilities (AFCAMP), Padres Abriendo Puertas (PAP); ADAPT and the Americans with Disabilities Act Coalition of Connecticut.

Department of Rehabilitation Services (DORS): DORS receives both federal and state dollars to provide a broad array of services, equipment and supports to individuals with disabilities that promote independent living, community participation and employment. DORS implements these services and supports through a variety of programs. The Bureau of Rehabilitation Services (BRS) administers the Title I Vocational Rehabilitation and Title VI Supported Employment (SE) programs of the Rehabilitation Act of 1973, as amended. BRS services are provided to adults who have a mental or physical impairment that is an impediment to employment. Supports are individualized to each job seeker and may include services such as personal assistance for evaluation and training purposes. The Driver Training Program for Persons with Disabilities provides driver instruction for qualified permanent Connecticut residents who require specialized equipment to operate a motor vehicle. The BRS' Independent Living program provides comprehensive independent living services, through contracts with Connecticut's five community-based independent living centers. The Workers' Rehabilitation Program assists injured workers in a return to gainful employment in the most timely and cost effective manner possible while taking into account the needs of the individual. Deaf and Hard of Hearing Services (formerly the Commission on the Deaf and Hearing Impaired) works to advocate, strengthen and implement state policies affecting individuals who are deaf or hard of hearing. Services and supports include interpreting services for persons who are deaf and hard of hearing and counseling services and assistance to persons who are deaf and hard of hearing and their families. The Bureau of Disability Determination Services is charged with deciding eligibility for the Social Security Disability Insurance (SSDI) and Supplemental Security Insurance (SSI) programs. These programs provide cash benefits

to individuals who are unable to maintain employment due to the severity of their disabilities. The Bureau of Education and Services for the Blind (BESB) offers a comprehensive array of services to improve the independent living skills of adults and children who are legally blind or visually impaired. Services are customized to each consumer's specific situation and include vocational counseling, technology training, and teaching to improve activities of daily living, training in use of devices for safe travel, provision of low vision evaluations and aides, and self-advocacy training. Rehabilitation professionals are available to come to the homes, schools and places of employment of consumers, delivering specialized independent living, educational and vocational training. In addition, the agency Business Enterprises Program offers a unique opportunity for people who are blind to become entrepreneurs.

Department of Veterans' Affairs (DVA) – DVA provides health care, residential and rehabilitative services for veterans honorably discharged from the Armed Forces. An Adult Care Facility, operated by DVA, is licensed by the state DPH as a Chronic Disease Hospital and provides general medical care, Alzheimer's and related dementia care, end of life care, palliative care, long term care, rehabilitation, respite care, mental health and psychological counseling. It served 117 Veterans in SFY 2015. The Residential Facility is certified by the Federal Department of Veterans Affairs and served 222 veterans in SFY 2015. Veterans receive substance abuse treatment, social work services, educational and vocational rehabilitation, job skills development, self-enhancement workshops, employment assistance and transitional living opportunities.

Department on Aging (SDA) - The State Department on Aging, as the designated State Unit on Aging, ensures that Connecticut's older adults have access to the supportive services necessary to live with dignity, security, and independence. The Department is responsible for planning, developing, and administering a comprehensive and integrated service delivery system for older persons in Connecticut. The Department administers Older Americans Act programs for supportive services, in-home services, and congregate and home-delivered meals. It also administers programs that provide senior community employment, health insurance counseling, and respite care for caregivers. The Long-Term Care Ombudsman Program, administratively housed in the State Department on Aging, provides individual advocacy to residents of skilled nursing facilities, residential care homes and assisted living facilities. The State Ombudsman also advocates for systemic changes in policy and legislation in order to protect the health, safety, welfare and rights of individuals who reside in those settings. The Department works closely with the aging network partners to provide these services. Partners include Connecticut's five area agencies on aging, municipal agents for the elderly, senior centers, and many others who provide services to older adults.

II. State Long-Term Services and Supports Programs in Connecticut – SFY 2015

State Agency	Long-Term Services and Supports Program	Services	Settings	Eligibility	Demographics July 1, 2014 – June 30, 2015
DSS	Connecticut Home Care Program (CHCP)	Adult day health care Adult foster care Assisted living services Care management Chore services Companion services Home health aide services Home delivered meals Homemaker services Hospice services Info & referral MH counseling Minor home modifications Nursing services Nutritional services PCA services Personal emergency response system Physical, speech, respiratory & occupational therapy Respite care Transportation	Personal residences Adult day care centers Congregate housing Elderly housing Residential care homes Assisted living Alzheimer's facilities with private assisted living	Age 65 and over. Must have at least one critical need (bathing, dressing, toileting, transferring, eating/ feeding, meal preparation, medication administration). Medicaid Waiver income limit = $2,199/ month. Medicaid asset limit = Indiv $1,600/ couple $3,200. Medicaid 1915(i) income limit = 150% of FPL, $1,460/month. Medicaid asset limit = indiv. $1,600. State funded income limit = no limit. State funded asset limit = Indiv $35,766/ couple $47,688 (one or both receiving services)	Total Participants Total – 15,544 Waiver – 11,331 State – 3622 1915i- 544 Age 65-84: 61.8 85+: 38.2 Gender male: 26.5 female: 73.5ace/Ethnicity W = 666.1 AA = 13.5 Hisp = 17.4 Asian = .9 Am Ind = 0.1

State Agency	Long-Term Services and Supports Program	Services	Settings	Eligibility	Demographics July 1, 2014 – June 30, 2015
DSS	CT Home care Program for adults with Disabilities (CHCPD)	Adult day health care Adult foster care Assisted living services Care management Chore services Companion services Home health aide services Home delivered meals Homemaker services Hospice services Info & referral MH counseling Minor home modifications Nursing services Nutritional services PCA services Personal emerg. response system Physical, speech, respiratory & occupational therapy Respite care Transportation	Personal residences Adult day care centers Congregate housing Elderly housing Residential care homes Assisted living Alzheimer's facilities with private assisted living	Ages 18-64 Must be diagnosed with a degenerative neurological condition Must need assistance with at least 3 critical needs Must not be Medicaid active or eligible Financial eligibility is the same as the state funded portion of the CT Home care Program for elders	<u>Total Participants</u> 100 <u>Age</u> N/A <u>Gender</u> N/A <u>Race/Ethnicity</u> N/A
DSS	Personal Care Assistance Waiver	Personal care assistance services Personal emergency response system	Personal residences	Age 18-64. Chronic severe and permanent disabilities. Would otherwise require nursing facility care. Capable of self-direction.	<u>Total Participants</u> 948 <u>Age</u> Under 50: 528 Over 50: 420 <u>Gender</u> Male: 428 Female: 520

State Agency	Long-Term Services and Supports Program	Services	Settings	Eligibility	Demographics July 1, 2014 – June 30, 2015
				Medicaid income limit = 300% of SSI . Income in excess of 200% FPL applied to care.	<u>Race/Ethnicity</u> N/A
DSS	Acquired Brain Injury Waiver (ABI)	Case-management Chore Cognitive behavioral program Community living supports Companion Day Habilitation Durable medical equipment Family training Homemaker services Home delivered meals Independent living skill training Information and referral Personal care assistance Personal emergency response system Pre-vocational services Respite care Substance abuse Supported employment Transportation Vehicle modification Transitional living	Personal care residence Group residence	Age 18-64. Brain injury that is not a result of a developmental disability or degenerative condition. Dysfunction is not primarily the result of a mental illness. Would otherwise be institutionalized. Medicaid income limit = Less than 200% FPL. Medicaid asset limit = Individual $1,600	<u>Total Participants</u> 465 <u>Age</u> 18-49: 223 50+: 242 <u>Gender</u> Male: 324 Female: 141 <u>Race/Ethnicity</u> N/A

State Agency	Long-Term Services and Supports Program	Services	Settings	Eligibility	Demographics July 1, 2014 – June 30, 2015
DSS	Katie Beckett Model Waiver	Case management & Medicaid State Plan services	Personal Residences	Birth to 22 years old (those who are over age 22 as of 12/31/11 have the option to remain on the waiver) Would otherwise require care in a nursing home ICF/MR or chronic disease hospital. Medicaid income limit = $1,692. 300% of SSI? Medicaid asset limit = $1,000.$1,600? Income of parent or spouse not counted.	Total Participants 294 (as of 10/15/15) Age N/A Gender N/A Race/Ethnicity N/A
DDS	Home and Community-Based Services Waivers	Personal support Individualized home support Adult companion services Group day services Individualized day services Respite care Residential habilitation Supported employment services Environmental accessibility adaptations Personal emergency response system (PERS) Transportation Parenting Support	Personal residences Community living arrangement Community training home Community day program site Community employment	Individuals over the age of three. Person with mental retardation needing ICF/MR level of care. Medicaid program: Income less than 300% of SSI and assets less than $1600.	Total Participants As of June 2015 Comprehensive Waiver 5,023 Individual and Family Support Waiver 3,864 Employment and Supports Waiver 715 Autism Spectrum

State Agency	Long-Term Services and Supports Program	Services	Settings	Eligibility	Demographics July 1, 2014 – June 30, 2015
		Senior Supports Vehicle modifications Specialized medical equipment and supplies IFS family training Behavioral support Healthcare coordination			Disorder Waiver 96 Early Childhood Autism Waiver 24 Age N/A Gender N/A Race/Ethnicity N/A
DDS	Intermediate Care Facility for persons with Mental Retardation (ICF/MR)	Residential habilitation Day habilitation Prevocational services Supported employment services	ICF/MR	No age limit. Person with mental retardation needing ICF/MR level of care. Medicaid program: Income less than 300% of SSI and assets less than $1600.	Total Participants in DDS operated ICF/MRs 468 Age 0-18: 21 19-54: 165 55-64: 133 65+: 170 Total Participants in privately operated ICF/MRs 364 Age 0-18: 8 19-54: 239 55-64: 76

State Agency	Long-Term Services and Supports Program	Services	Settings	Eligibility	Demographics July 1, 2014 – June 30, 2015
					65+: 41 <u>Gender</u> N/A <u>Race/Ethnicity</u> N/A
DMHAS	Mental Health Standard Case management-	Info & Referral Transportation Case management	Personal Residences RCH NF Shelters Supportive housing sites Clubhouses	Adults age 18 and over. Primary diagnosis of a psychiatric disorder; Requires assistance in obtaining and coordinating treatment, rehabilitation, and social services without which the individual would likely require a more intensive level of care. No private insurance to pay for comparable services.	<u>Total Participants</u> 1,722 <u>Age</u> 18-20 79 21-25 229 26-34 298 35-44 278 45-54 370 55-64 359 65+ 108 Unknown 1 <u>Gender</u> Female 764 Male 957 Unknown 1 <u>Race</u> Am Ind 9 Asian 19 Black 35 Multi-race 7 Hawaiian 1

State Agency	Long-Term Services and Supports Program	Services	Settings	Eligibility	Demographics July 1, 2014 – June 30, 2015
					Other 280 Unknown 35 White 936 <u>Ethnicity</u> Hispanic 391 Non-Hispanic 1208 Unknown 123
DMHAS	Community Support Program	Mental health and substance use rehabilitation services and supports necessary to assist an individual in achieving and maintaining the highest degree of independent functioning. The service utilizes a team approach to provide intensive, rehabilitative community support, crisis intervention, individual, and group psycho-education and skill building for activities of daily living, peer support and self-management.	Personal residences Community settings	Adults age 18 and over with severe and persistent psychiatric disorders or co-occurring severe and persistent psychiatric and substance use disorders.	<u>Total Participants 5514</u> <u>Age</u> 18-20 105 21-25 369 26-34 746 35-44 855 45-54 1549 55-64 1476 65+ 413 unknown 1 <u>Gender</u> Female 2643 Male 2870 Trans* 1 Am Ind 32 Asian 62 Black 1016 Hawaiian 7 Other 551 Multi-race 19 Unknown 69 White 3758

State Agency	Long-Term Services and Supports Program	Services	Settings	Eligibility	Demographics July 1, 2014 – June 30, 2015
					Ethnicity Hispanic 846 Non-Hispanic 4490 Unknown 178
DMHAS	Mental Health Assertive Community Treatment (ACT)	A set of clinical, medical & psychosocial services, provided on a one-to-one basis, essential to maintaining an individual's ability to function in community settings. Services available 24/7.	Personal residences Community settings	Adults age 18 and over. Primary diagnosis of a psychiatric disorder; Would otherwise require more intensive and restrictive services. No private insurance to pay for comparable services.	Total Participants 1032 Age 18-20 110 21-25 249 26-34 181 35-44 128 45-54 182 55-64 141 65+ 41 Gender Female 421 Male 611 Race Am Indian 4 Asian 26 Black 243 Multi-race 8 Hawaiian 2 Other 117 Unknown 15 White 627 Ethnicity Hispanic 142 Non-Hispanic 835 Unknown 55

State Agency	Long-Term Services and Supports Program	Services	Settings	Eligibility	Demographics July 1, 2014 – June 30, 2015
DMHAS	Mental Health Intensive Outpatient Services	Individual, group or family psychotherapy; Psycho-educational groups; Classes on ADLs; Recovery oriented services.	Non-residential services provided in a general hospital, private free-standing psychiatric hospital, psychiatric out-patient clinic for adults, or a State-operated facility.	Adults age 18 and over. Primary diagnosis of a psychiatric disorder; Behavior does not pose an imminent risk of harm to self and other; Living environment can assure a reasonable degree of safety; Symptomology/ behavior warrants an increase in frequency and/ or intensity of clinical contact in an effort to stabilize the individual. No private insurance to pay for comparable services.	Total Participants 587 Age 18-20 27 21-25 92 26-34 154 35-44 109 45-54 111 55-64 82 65+ 12 Gender Female 319 Male 268 Unknown 0 Race/ Am Indian 3 Asian 2 Black 29 Multi-race 1 Other 21 Unknown 9 White 522 Ethnicity Hispanic 35 Non-Hispanic 531 Unknown 21

State Agency	Long-Term Services and Supports Program	Services	Settings	Eligibility	Demographics July 1, 2014 – June 30, 2015
DMHAS	Mental Health Outpatient Clinical Services	Individual, group or family counseling; Education to client and family; Support with connecting to/referral to natural community supports; Assistance with obtaining/ maintaining employment.	Non-residential services provided in a general hospital, private free-standing psychiatric hospital, a State-operated facility, a facility licensed by DPH to offer "outpatient treatment," or by a private independent psychiatrist or psychologist or private group practice.	Adults age 18 and over. Primary diagnosis of a psychiatric disorder. No private insurance to pay for comparable services.	Total Participants 39,426 Age 18-20 1,147 21-25 3,135 26-34 6,704 35-44 6964 45-54 9,930 55- 64 8,192 65+ 23,168 Unknown 6 Gender Female 21,704 Male 17,538 Unknown 3 Race Am Indian 236 Asian 364 Black 5,608 Mixed 91 Hawaiian 101 Other 5581 Unknown 903 White 26,362 Ethnicity Hispanic 7,887 Non-Hispanic 429,837 Unknown 1,522

State Agency	Long-Term Services and Supports Program	Services	Settings	Eligibility	Demographics July 1, 2014 – June 30, 2015
DMHAS	Methadone Maintenance				Total Participants 14,874 Age 18-20 67 21-25 1,098 26-34 4,510 35-44 3,505 45-54 3,425 55-64 1,985 65+ 283 Unknown 1 Gender Female 5,532 Male 9,334 Unknown 8 Race Am Indian 47 Asian 36 Black 1,204 Hawaiian 17 Multi-race 33 Other 2,527 White 10,826 Unknown 181 Ethnicity Hispanic 3,147 Non-Hispanic 11,138 Unknown 589

State Agency	Long-Term Services and Supports Program	Services	Settings	Eligibility	Demographics July 1, 2014 – June 30, 2015
DMHAS	Mental Health Residential - Group Home	Rehabilitative support focusing on areas of self-care and independent living skills.	Group home	Adults age 18 and over. Primary diagnosis of a psychiatric disorder; Significant skill deficits in the area of self-care and independent living as a result of the psychiatric disability. No private insurance to pay for comparable services.	Total Participants 246 Age 18-20 3 21-25 17 26-34 71 35-44 41 45-54 59 55-64 45 65+ 10 Gender Female 75 Male 171 Race Am Ind 2 Asian 2 Black 55 Hawaiian 1 Other 26 White 159 Ethnicity Hispanic 30 Non-Hispanic 208 Unknown 8

State Agency	Long-Term Services and Supports Program	Services	Settings	Eligibility	Demographics July 1, 2014 – June 30, 2015
DMHAS	Mental Health Residential - Supervised Apartments	Supportive counseling directed at solving day to day problems with community living; Psycho-education groups; Assistance with employment; Rehabilitative support.	Supervised housing	Adults age 18 and over. Primary diagnosis of a psychiatric disorder; Significant skill deficits in the area of independent living as a result of severe and persistent mental illness. No private insurance to pay for comparable services.	Total Participants 844 Age 18-20 64 21-25 142 26-34 134 35-44 106 45-54 210 55-64 147 65+ 41 Gender Female 310 Male 534 Race Am Ind 2 Asian 8 Black 170 Multi-race 5 Hawaiian 1 Other 75 Unknown 9 White 574 Ethnicity Hispanic 101 Non-Hispanic 696 Unknown 47

State Agency	Long-Term Services and Supports Program	Services	Settings	Eligibility	Demographics July 1, 2014 – June 30, 2015
DMHAS					
DMHAS	Social Rehabilitation	Independent living and community reintegration skill development.	Community setting	Adults age 18 and over. Primary diagnosis of a psychiatric disorder; Moderate impairment in vocational, educational and/or social functioning; Needs assistance with at least 2 ADLs. No private insurance to pay for comparable services.	Total Participants 6,277 Age 18-20 178 21-25 369 26-34 831 35-44 973 45-54 1951 55-64 1,639 65+ 424 Unknown 12 Gender Female 2591 Male 3682 Unknown 3 Transgender 1 Race Am Ind 33 Asian 40 Black 1,637

State Agency	Long-Term Services and Supports Program	Services	Settings	Eligibility	Demographics July 1, 2014 – June 30, 2015
					Mixed 28 Hawaiian 11 Other 636 Unknown 107 White 3,785 <u>Ethnicity</u> Hispanic 94 Non-Hispanic 5,105 Unknown 231
DMHAS	Crisis Stabilization Beds (respite)	Short-term residential services to help stabilize a rapidly deteriorating behavioral health condition and avert hospitalization.	A facility of not more than 15 beds staffed 24/7.	Adults age 18 and over. Primary diagnosis of a psychiatric disorder; Increased exacerbation of symptoms within the past 24 hours; Does not present as an imminent safety risk to self or others consistent with criteria for inpatient psychiatric care. No private insurance to pay for comparable services.	<u>Total Participants</u> 941 <u>Age</u> 18-20 31 21-25 106 26-34 188 35-44 188 45-54 261 55-64 146 65+ 21 <u>Gender</u> Female 374 Male 565 Transgender 1 Unknown 1 <u>Race</u> Am Ind 6 Asian 8 Black 238 Multi-race 11 Other 91

State Agency	Long-Term Services and Supports Program	Services	Settings	Eligibility	Demographics July 1, 2014 – June 30, 2015
					Unknown 17 White 570 <u>Ethnicity</u> Hispanic 144 Non-Hispanic 756 Unknown 41
DMHAS	Mobile Crisis Services	Psychiatric evaluation; Psychiatric stabilization; Brief clinical treatment; Medication evaluation; Hospital pre-screening.	Personal residences Congregate housing Elderly housing Residential care homes Nursing facilities Shelters On the streets	Adults age 18 and over. Primary diagnosis of a psychiatric disorder; Presentation of symptoms/ behaviors that place the individual at risk to self or others. No private insurance to pay for comparable services.	<u>Total Participants</u> 5814 <u>Age</u> 18-20 483 21-25 646 26-34 1035 35-44 900 45-54 1189 55-64 956 65+ 583 Unknown 22 <u>Gender</u> Female 2878 Male 2933 Trans* 2 Unknown 1 <u>Race</u>

State Agency	Long-Term Services and Supports Program	Services	Settings	Eligibility	Demographics July 1, 2014 – June 30, 2015
					Am Ind 22 Asian 42 Black 857 Multi-race 38 Hawaiian 10 Other 678 Unknown 412 White 3755 <u>Ethnicity</u> Hispanic 981 Non-Hispanic 4291 Unknown 542
DMHAS	Long-Term Psychiatric Hospitalization	Medication evaluation; Individual/ group counseling; Specialized treatment services.	Psychiatric hospital	Adults age 18 and over. Primary diagnosis of a psychiatric disorder; Chronic risk of being a danger to self or to others or chronic grave disability as a result of the psychiatric disorder. No private insurance to pay for comparable services.	<u>Total Participants</u> 1523 <u>Age</u> 18-20 59 21-25 197 26-34 309 35-44 279 45-54 324 55-64 263 65+ 90 Unknown 2 <u>Gender</u> Female 469 Male 1054 <u>Race</u> Am Ind 5

State Agency	Long-Term Services and Supports Program	Services	Settings	Eligibility	Demographics July 1, 2014 – June 30, 2015
					Asian 35 Black 379 Multi-race 6 Hawaiian 2 Other 187 Unknown 446 White 863 <u>Ethnicity</u> Hispanic 214 Non-Hispanic 1,219 Unknown 90
DMHAS	Substance Abuse Residential - Long-Term Care	Clinical/ therapeutic services Individual/ group counseling Psychosocial programming Relapse Prevention Employment skill development	Structured recovery environment	Adults age 18 and over with significant problems with behavior and functioning in major life activities due to substance abuse.	<u>Total Participants</u> 166 <u>Age</u> 18-20 1 21-25 9 26-34 42 35-44 41 45-54 54 55-64 19 Gender Female 2 Male 164 Race Am Ind 1 Black 13 Other 8 White 141

State Agency	Long-Term Services and Supports Program	Services	Settings	Eligibility	Demographics July 1, 2014 – June 30, 2015
					Unknown 3 Ethnicity Hispanic 14 Non-Hispanic 143 Unknown 9
DOH	Congregate Operating Subsidy Program	Assisted living services Care management Chore services Companion services Health insurance counseling Info & referral Nutritional services PCA services Recreation services Transportation	Congregate housing	Age 62 and over and frail. One ADL minimum. Annual income cannot exceed the "Low Income" for the area adjusted for family size as defined by HUD.	Total Participants 985 residents Age 65+: 985 Gender N/A Race/Ethnicity N/A
DOH	Elderly Rental Registry and Counseling	Funds provided to hire a Resident Service Coordinator to assist residents of State-funded elderly facilities.	Elderly Housing	N/A	Total Participants 4,964 units in 62 municipalities Age N/A Gender N/A Race/Ethnicity N/A

State Agency	Long-Term Services and Supports Program	Services	Settings	Eligibility	Demographics July 1, 2014 – June 30, 2015
DOH	Elderly Rental Assistance Program	Financial Assistance to make rents affordable to low/ moderate income elderly.	Personal residences	Age 62 and over or disabled. Certified disabled by Social Security Board or other federal board or agency as being totally disabled. Annual income cannot exceed the "Low Income" for the area adjusted for family size as defined by HUD.	Total Participants 2,789 Age 0-64: 522 65+: 1,206 Gender N/A Race/Ethnicity N/A
DOH	Housing Assistance and Counseling	Assisted living services Info and referral	Elderly Housing (federal 202 or 236)	Age 62 and over. Requires assisted living services (at least 1 ADL) as determined by Care Plan.	Total Participants 71 Age 65+: 71 Gender N/A Race/Ethnicity N/A
DORS	Independent Living (IL) Program	Provides comprehensive independent living services, including peer support, information and referral, advocacy and	Through contracts with Connecticut's five community-based independent living centers (ILCs) as part	No eligibility requirements. Some centers require a nominal ($1-$5_ membership fee	Total Participants 1,294 Age 0-5: 6

State Agency	Long-Term Services and Supports Program	Services	Settings	Eligibility	Demographics July 1, 2014 – June 30, 2015
		independent living skills training.	of the Aging & Disability Resource Centers		5-19: 49 20-24: 55 25-59:760 60 up: 419 Gender Female: 652 Male: 642 Race Am Ind/Alask: 3 Asian: 8 AA: 256 Hawaiian/PI: 2 White: 730 Hisp/Lat: 175 2 or more: 5 Unknown: 115 Disability Cognitive:131 Mental/Emot:168 Physical: 531 Hearing: 65 Vision: 23 Multiple: 337 Other: 24
DOT	Local Bus Services	Transportation (Local bus at half fare)	Community	All ages Seniors and people with a qualifying disability.	<u>Total Participants</u> 2,100,000 passenger trips (of 41,000,000 total trips)

State Agency	Long-Term Services and Supports Program	Services	Settings	Eligibility	Demographics July 1, 2014 – June 30, 2015
					Age N/A Gender N/A Race/Ethnicity N/A
DOT	ADA Paratransit Van Services	Transportation	Community (within 3/4 mile of local public bus routes)	All ages Any person with a disability who is unable, due to physical or mental impairment, and without the assistance of another individual, to board, ride or disembark from any public local bus. Also for those with a specific impairment-related condition that prevents them from traveling to or from a bus stop.	Total Participants Over 18,000 registered users Age N/A Gender N/A Race/Ethnicity N/A

State Agency	Long-Term Services and Supports Program	Services	Settings	Eligibility	Demographics July 1, 2014 – June 30, 2015
DOT	State Matching Grant Program	Demand Responsive Transportation to Seniors and People with Disabilities	Municipality applies for funds and provides matching funds	Seniors and people with disabilities of all ages.	Total Participants 140 municipalities applied Age N/A Gender N/A Race/Ethnicity N/A
DOT	Federal Transit Administration – New Freedom Program	Transportation related services that go beyond the Americans with Disabilities Act of 1990	Services must be derived from a locally-coordinated public transit human services transportation plan.	People with disabilities of all ages	Total Participants Not available Age N/A Gender N/A Race/Ethnicity N/A

State Agency	Long-Term Services and Supports Program	Services	Settings	Eligibility	Demographics July 1, 2014 – June 30, 2015
DPH	Facility Licensing and Investigations Section (FLIS)	Regulatory jurisdiction for state licensing programs. Conducts surveys/ investigations of health care entities that participate in Medicare and Medicaid.	Nursing Homes Residential Care Homes Hospitals Outpatient Clinics Dialysis Units Ambulatory Surgical Facilities Substance Abuse and Mental Health Facilities Home Health Agencies Assisted Living Services Agencies Homemaker Home Health Agencies	Institutions identified under CGS 19a-490. Medicare and Medicaid entitlement enrollment is a voluntary participation program open to various types of providers.	N/A
DVA	Veterans' Health Care Services	Licensed Chronic Disease Hospital provides continuous professional comprehensive healthcare services including: General medical care Alzheimer's/dementia care End of life care Palliative care Long term care Rehabilitation Respite care Mental health and Psychological counseling	John L. Levitow Healthcare Center (onsite)	Veterans as defined by CGS 27-103 who served honorably, are residents of Connecticut, and have a chronic disease/illness.	<u>Average Monthly Census</u> 117 <u>Age</u> N/A <u>Gender</u> 1 Female, 116 Male <u>Race/Ethnicity</u> N/A

State Agency	Long-Term Services and Supports Program	Services	Settings	Eligibility	Demographics July 1, 2014 – June 30, 2015
DVA	Residential and Rehabilitative Services	Provides domiciliary level of care to facilitate rehabilitation and return to independent living including: Residential services General medical care Substance abuse treatment Social work services Educational support Employment skill development	Residential domicile (onsite)	Veterans as defined by CGS 27-103 who served honorably and are residents of Connecticut	Average Monthly Census 222 Age N/A Gender 5 Female, 217 Male Race/Ethnicity N/A
SDA	CHOICES	Health insurance counseling Information & referral (Figures are only State Health Insurance Program - SHIP, counseling and do not include I&R statistics)	Senior Centers Libraries Personal residences Elderly housing Assisted living Hospice facilities Nursing facilities Area Agencies on Aging	Age 60 and over. Under 60 if Medicare eligible.	Total Participants Individual Clients - 32,575 Number Receiving Application Assistance: 6,419 Age 65 and over=26,744 64 and under=5,831 Gender F=21,932 M=10,625 Not available=18

State Agency	Long-Term Services and Supports Program	Services	Settings	Eligibility	Demographics July 1, 2014 – June 30, 2015
					Race/Ethnicity Percentage White, non-Hispanic = 81.4% Black, African American= 8.4% Hispanic, Latino or Spanish= 7.4% Other= 2.8% Total Outreach Events: 541 Beneficiaries Reached at Interactive Presentations or Enrollment Events= 8,598
SDA	SMP – Senior Medicare Patrol	Information & referral Train the trainer	Congregate housing Elderly housing Assisted living Senior centers	N/A	Total Participants Volunteers - 73 Presentations – 88 Beneficiaries who attended presentations – 2,290 Reached by community education events – 10,051

State Agency	Long-Term Services and Supports Program	Services	Settings	Eligibility	Demographics July 1, 2014 – June 30, 2015
SDA	CT Partnership for Long-Term Care - Information & Education Program	Information & referral One-on-one counseling Regional public forums	Personal residences Libraries Schools Senior Centers Variety of public venues	Age 18-89	Total Participants Calls for information - 265 Individuals counseled - 153 Attended public forums 293 Age 44-66 attended forums Gender N/A Race/Ethnicity N/A
SDA	Statewide Respite Care Program (for persons with Alzheimer's or related dementia)	Adult day care Care management Chore services Companion services Counseling Home health aide services Home delivered meals Homemaker services Information & referral Nursing services Personal emergency response system Short-term respite care Information and referral Support groups Cognitive training	Personal residences Adult day care centers Congregate housing Elderly housing Residential care homes Assisted living for short-term respite Hospice facilities Nursing facilities	No age requirement. Alzheimer's or a related dementia. $44,591 income $118,549 assets Co-pay of 20% of cost of service required (may be waived upon financial hardship)	Total Participants 828 Age N/A Gender N/A Race/Ethnicity N/A

State Agency	Long-Term Services and Supports Program	Services	Settings	Eligibility	Demographics July 1, 2014 – June 30, 2015
		Self-directed care Transportation			
SDA					
SDA	Supportive Services and Health and Wellness: Older Americans Act Title IIIB and Title IIID	Adult day care Care management Chore services Companion services Home health aide services Homemaker services Hospice services Information & referral Mental health counseling Nursing services PCA services Personal emergency response system Recreation services Respite care Transportation Medication monitoring Evidence-Based Health Promotion Programs	Area Agencies on Aging Personal residences Adult day care centers Congregate housing Elderly housing	Age 60 and over.	Total Participants 12,831 Age N/A Gender N/A Race/Ethnicity N/A
SDA	Elderly Nutrition Program: Older Americans Act Title IIIC and State Nutrition	Nutritionally balanced meals served through congregate meal sites and home delivery	Congregate meals: senior community cafes, congregate housing, restaurants, schools, churches Home delivered meals: residential homes	Age 60 and over and their spouses/ caregivers	Total Participants Congregate meals: 748,042 meals served to 16,467 participants Home delivered meals: 1,279,961 meals served to 6194 participants Nutritional counseling

State Agency	Long-Term Services and Supports Program	Services	Settings	Eligibility	Demographics July 1, 2014 – June 30, 2015
					= 1,596 individuals *Nutrition Education = 15,854 Units *Federal reporting does not require the count of people for this service, only units. Totals reflect units for FFY 2014.
SDA	CT's National Family Caregiver Support Program: Older Americans Act Title IIIE	Adult day care Assistive devices/ Supplemental services Care management Chore services Home health aide services Homemaker services Information & referral Personal emergency response system Transportation Grandparents support Support groups Cognitive training Self-directed care	Personal residences Adult day care centers Elderly housing Nursing facilities (for short term respite only)	Care recipient must be age 60 and over. Two or more ADL limitations. Children 18 yrs of age or younger for grandparent support.	<u>Total Participants</u> Respite – 330 Supplemental services – 606 One-on-one assistance – 11,374 Counseling, support groups, training – 839 Total caregivers caring for older adults = 1,211 Total grandparents and kinship caregivers caring for children and persons 18-59 with disabilities = 162 <u>Age</u>

State Agency	Long-Term Services and Supports Program	Services	Settings	Eligibility	Demographics July 1, 2014 – June 30, 2015
					Caregivers: N/A Gender: N/A Race/Ethnicity N/A
SDA	Congregate Housing Services	Adult day care Care management Chore services Companion services Home health aide services Information & referral Nutritional services Personal care attendant services Personal emergency response system Transportation Medication monitoring Foot care	Congregate housing	Age 60 and over. Frail adults with temporary or permanent disabilities.	Total Participants 269 Age N/A Gender N/A Race/Ethnicity N/A
SDA	Senior Community Service Employment Program	Employment & training	Community (AAA, Community Action Agencies, municipalities, community-based orgs.)	Age 55 and over. Income not exceeding 125% of the federal poverty level.	Total Participants 125 Age 55-64: 87 65-74: 35 75+: 3 Gender male: 46 female: 79 Race/Ethnicity

State Agency	Long-Term Services and Supports Program	Services	Settings	Eligibility	Demographics July 1, 2014 – June 30, 2015
					W = 68 AA = 51 Hisp = 10 Asian = 2 Am Ind = 0
SDA	Medicare Legal and Education Assistance Project	Health insurance counseling Information & referral Legal representation for Medicare appeals	Not setting specific	Medicare eligible by virtue of age or disability.	Total Participants 9,532 direct client assistance Age N/A Gender N/A Race/Ethnicity N/A
SDA	Elderly Health Screening Program	Mental health screening/ counseling Nutrition education Health promotion/ wellness education Geriatric assessment Health screening: breast, prostate, cholesterol, eye, Diabetes, oral health, cardiovascular, etc.	Personal Residences Congregate Housing Elderly Housing Any community setting Community Health Centers Public Health Departments	Age 60 and over.	Total Participants 820 (program for 6 months only: 7/1/14-12/31/14) Age N/A Gender N/A Race/Ethnicity N/A
SDA	Evidenced-Based	Chronic Disease Self-	Agencies on Aging		Total Participants

State Agency	Long-Term Services and Supports Program	Services	Settings	Eligibility	Demographics July 1, 2014 – June 30, 2015
	Health Program	Management Program (CDSMP), Statewide Fall Prevention Program Tai Ji Quan, Moving for Better Balance (TCMBB)	VNA's, hospitals Community centers, Senior Centers Health departments Municipal agencies		633 CDSMP course completers 2,350 Older adults received information on epidemiology of fall and associated risks and attended TCMBB programs and interventions.
SDA	Community Choices (Aging & Disability Resource Centers)	Assessment; Assistance; Advocacy; Care Transitions; Case Consultation; Decision Support; Follow-Up; Information; Options Counseling; Benefits, Employment, and Long Term Support; Referral; Short Term Support	Agencies on Aging Centers for Independent Living Connecticut Community Care Some hospitals Personal residences Other public places By phone	Any person across the lifespan who is a person with a disability, older adult caregiver or planning ahead for future long term care needs. Available statewide	Total Participants 2,696
SDA	Prevention of Elder Abuse, Neglect and Exploitation	Strengthen and carry out programs or activities by raising awareness to prevent, detect, intervene, investigate and respond to elder abuse, neglect and exploitation. -support of multi-disciplinary teams directed at advocacy to curtail elder abuse	Agencies on Aging State agencies Law Enforcement Aging, legal, victims, and disability networks Medical and educational organizations For-profit and non-profit, public and private organizations	Age 60+ and persons with disabilities	

State Agency	Long-Term Services and Supports Program	Services	Settings	Eligibility	Demographics July 1, 2014 – June 30, 2015
		- financial exploitation education and training - Coalition for Elder Justice in Connecticut			

III. State Long-Term Services and Supports Program Expenditures in Connecticut – SFY 2015

State Agency	Long-Term Care Program	Total Expenditures SFY 2015	State Expenditures	Medicaid Expenditures	OAA Title III Expenditures	Other Federal Expenditures	Other Expenditures
DSS	Connecticut Home Care Program (CHCPE)	$359,508,141	$43,113,894 (includes CHCPD expenditures)	$316,394,248			
DSS	Connecticut Home Care Program for Adults with Disabilities (CHCPD)	$912,168	$912,168 (Included in CHCPE expenditures)				
DSS	Personal Care Assistance Waiver	$35,883,175	NA	NA $35,883,175			
DSS	Acquired Brain Injury Waiver (ABI)	$53,018,326		$53,018,326			
DSS	ABI II	$1,221,782		$1,221,782			
DSS	Katie Beckett Model Waiver	$57,780		$57,780			

State Agency	Long-Term Care Program	Total Expenditures SFY 2015	State Expenditures	Medicaid Expenditures	OAA Title III Expenditures	Other Federal Expenditures	Other Expenditures
DDS	Home and Community Based Services Waivers	$693,438,314.35		$693,438,314			
DDS	Intermediate Care Facility for Persons with Mental Retardation (ICF/MR)	$180,416,718.83		$180,416,718 Does not include private ICF/MRs which are funded by DSS			
DMHAS	Case Management	$ 41,858,302	$ 39,705,414	$ 46,366		$ 1,065,294	$ 1,041,228
DMHAS	Assertive Community Treatment	$ 22,075,467	$ 21,766,216	$ 196,886		$0	$ 112,365
DMHAS	Home and Community Based Services Waivers	$8,501,658	$0	$8,501,658		$0	$0
DMHAS	MH Intensive Outpatient	$ 1,007,231	$ 601,188	$ 58,714		$158,192	$ 189,137

State Agency	Long-Term Care Program	Total Expenditures SFY 2015	State Expenditures	Medicaid Expenditures	OAA Title III Expenditures	Other Federal Expenditures	Other Expenditures
DMHAS	MH Outpatient Therapy	$ 91,407,552	$ 68,340,686	$ 9,095,752		$ 1,221,024	$ 12,750,090
DMHAS	MH Residential Group Home	$ 32,261,527	$ 24,603,975	$ 4,646,372		$0	$ 3,011,180
DMHAS	MH Supervised Housing	$ 54,594,380	$ 51,278,648	$ 3,985		$ 177,800	$ 3,133,947
DMHAS	MH Supported Housing	$ 41,969,539	$ 27,696,213	$ 0		$ 13,192,857	$ 1,080,469
DMHAS	MH Psychosocial Rehabilitation	$ 20,875,609	$ 18,250,632	$0		$ 1,316,350	$ 1,308,627
DMHAS	Crisis Stabilization	$ 10,552,658	$ 9,937,686	$0		$605,719	$ 9,253
DMHAS	Mobile Crisis Services	$ 14,434,228	$ 12,402,472	$ 135,362		$ 1,376,706	$ 519,688

State Agency	Long-Term Care Program	Total Expenditures SFY 2015	State Expenditures	Medicaid Expenditures	OAA Title III Expenditures	Other Federal Expenditures	Other Expenditures
DMHAS	Long Term Psychiatric Hospitalization	$ 142,489,428	$ 140,428,969	$ 835,766		$0	$ 1,224,693
DMHAS	Substance Abuse Residential Long Term Care	$ 2,261,727	$ 1,172,607	$0		$ 138,571	$ 950,549
DMHAS	Substance Abuse Residential Long Term Treatment	$ 33,739,898	$ 21,552,574	$ 407,244		$ 3,326,645	$ 8,453,435
DMHAS	Substance Abuse Residential Transitional / Halfway House	$ 5,709,411	$ 3,069,690	$0		$ 271,244	$ 2,368,477
DOH	Congregate Operating Subsidy Program	$7,554,430	$7,554,420				
DOH	Elderly Rental Registry and Counseling	$1,196,144	$1,196,144				

State Agency	Long-Term Care Program	Total Expenditures SFY 2015	State Expenditures	Medicaid Expenditures	OAA Title III Expenditures	Other Federal Expenditures	Other Expenditures
DOH	Elderly Rental Assistance Program	$1,781,221	$1,781,221				
DOH	Housing Assistance and Counseling	$438,400	$438,400				
DORS	Independent Living (IL) Program	$519,971.99	$519,971.99				
DOT	Local Bus Services	190,725,038 Data for SFY 2014	134,662,212 Data for SFY 2014			1,613,089 Data for SFY 2014	3,257,294 (local) 50,731,806 (passenger fares+other 460,637) Data for SFY 2014
DOT	ADA Paratransit Van Services	34,899,348 Data for SFY 2014	32,124,012 Data for SFY 2014				627,264 (local) 1,917,197 (passenger fares+other revenue) Data for SFY 2014

State Agency	Long-Term Care Program	Total Expenditures SFY 2015	State Expenditures	Medicaid Expenditures	OAA Title III Expenditures	Other Federal Expenditures	Other Expenditures
DOT	State Matching Grant Program	$4,093,168 Data for SFY 2014	$4,093,168 Data for SFY 2014				
DOT	Federal Transit Administration - New Freedom Program **Data for SFY 2014**	$1,826,450 Data for SFY 2014	$406,050 Data for SFY 2014			$1,069,505 Data for SFY 2014	$350,895 Data for SFY 2014
DVA	Veterans' Health Care Services	$14,427,572	$14,002,124				$425,448
DVA	Residential and Rehabilitative Services	$2,970,798	$2,164,539				$806,259
SDA	CHOICES	$1,134,587	$419,910			$714,677	
SDA	SMP – Senior Medicare Patrol	$179,444				$179,444	

State Agency	Long-Term Care Program	Total Expenditures SFY 2015	State Expenditures	Medicaid Expenditures	OAA Title III Expenditures	Other Federal Expenditures	Other Expenditures
SDA	CT Partnership for LTC - Information & Education Program	$15,000				$15,000	
SDA	Statewide Respite Care Program (for persons with Alzheimer's or related dementia)	$2,179,669	$2,179,669				
SDA	Supportive Services and Administration	$5,460,623	$90,997		$5,369,626		
SDA	Health and Wellness (Title IIID)	$293,762	$4,789		$288,973		
SDA	Elderly Nutrition Program (Title lllC and NSIP)	$13,441,192	$2,652,163		$10,789,029		
SDA	CT's National Family Caregiver Support Program (Title lllE)	$2,075,261			$2,075,261		

State Agency	Long-Term Care Program	Total Expenditures SFY 2015	State Expenditures	Medicaid Expenditures	OAA Title III Expenditures	Other Federal Expenditures	Other Expenditures
SDA	Congregate Housing Services	$545,782	$134,230			$411,552	
SDA	Senior Community Service Employment Program	$814,618				$814,618	
SDA	Medicare Legal and Education Assistance Project	$314,226	$314,226				
SDA	Elderly Health Screening Program	$146,343	$146,343				
SDA	Evidenced Based Health Program: CDSMP-Chronic Disease Self-Management Program	$207,217				$207,217	

State Agency	Long-Term Care Program	Total Expenditures SFY 2015	State Expenditures	Medicaid Expenditures	OAA Title III Expenditures	Other Federal Expenditures	Other Expenditures
SDA	Evidenced Based Health Program: Fall Prevention	$475,000					$475,000
SDA	CHOICES: Aging & Disability Resource Centers	$1,033,320				$1,033,320	
SDA	Prevention of Elder Abuse, Neglect and Exploitation	$70,671			$70,671		