The Connecticut Home Care Program for Elders

Annual Report

July 1, 2021 - June 30,2022

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Preface: A History of the Connecticut Home Care Program for Elders

In the mid-1980s, the federal government offered states the opportunity to expand home care under Medicaid "home and community-based service waivers." Waivers allow states to "waive" certain Medicaid rules. The rationale rested in the belief that individuals, who would otherwise be institutionalized at the state's expense, could be diverted from this costly option if services were available to support them in the community. The federal waiver option thus allowed states to receive federal matching funds (50% match in Connecticut) for services which previously had been paid primarily with state funds.

In 1985, the Connecticut General Assembly voted to establish an expanded home care program taking advantage of the new waiver option. The program, then called the Preadmission Screening and Community-Based Services program began statewide operation in 1987. It was targeted to frail elders identified by hospital or nursing facility staff as likely to be admitted to a nursing facility within sixty days.

Under Public Act 92-16, May special session, the General Assembly merged three major programs: the Preadmission Screening and Community-Based Services program, the Promotion of Independent Living program, and the elder services portion of the Adult Services program and reinstated the state-funded portion of the home care program. The program was then renamed the Connecticut Home Care Program for the Elderly.

Public Act 95-160 eliminated the licensing of coordination, assessment and monitoring agencies and substituted in their place a new entity called an "access agency." The Department of Social Services (DSS) consulted with the Home Care Advisory Committee to develop standards for these new access agencies and issued regulations and a Request for Proposals (RFP). The RFP in 2013 resulted in four agencies awarded contracts to provide case management services under the Connecticut Home Care Program through June 30, 2022.

Public Act 07-185 established the Connecticut Home Care Program for Adults with Disabilities. This pilot program was the result of advocacy efforts to develop a program that offered a package of services to individuals aged 18 – 64 with degenerative neurological conditions and cognitive impairments who need case management as well as other supportive services and who do not meet the financial eligibility criteria for Medicaid.

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

Several program changes have occurred over the years. Personal care assistance (PCA) services were originally offered in the form of a state-funded pilot program with only a limited number of slots available and a waiting list. Agency-based PCA services are now a waiver service, PCA

services have evolved to include 12-hour shifts and live-in services, and self-directed PCA services are now covered by Medicaid under Community First Choice through the 1915(k) state plan option.

DSS contracted with Ascend Management Innovations to develop a web-based participant database. This system improved efficiency, timeliness of documentation and submission of required forms. The system features a critical incident reporting module which has improved the ability to monitor, track, trend and take appropriate actions to address issues of abuse, neglect, exploitation, and other issues impacting program participants.

The Department's Office of Quality Assurance convenes a Quality Assurance Committee, which includes representatives from the fiscal intermediary (FI) and the Department of Consumer Protection. The Committee identifies and discusses issues with homemaker/ companion agencies, including which agency will investigate/audit and address non-compliance with State of Connecticut regulations and CHCPE requirements. The Committee works to improve quality assurance by devising new strategies, policies and actions to take when issues arise. The two state agencies and the FI work together to ensure the most suitable agency is identified to investigate. Results of each investigation are shared with the Committee to develop a plan of action to address deficiencies.

New services have been added during waiver renewals including care transitions, assistive technology, bill payer, chronic disease self-management, recovery assistant and tiered case management. Tiered case management offers different levels of case management intensity based on participant needs. The waiver was renewed effective July 1, 2020.

Department staff, in conjunction with the contracted Medicaid Management Information Services (MMIS) vendor, Gainwell, created a care plan portal in which access agency care managers enter specific program services with date ranges and specific units of service. Providers can only bill and receive payment for authorized services. Utilization of this system provides greater provider agency accountability.

Many home and community-based services (HCBS) provided by caregivers under Medicaid are now required to utilize electronic visit verification (EVV). DSS and its MMIS vendor, Gainwell Technologies, partnered with Sandata Technologies, LLC to implement this EVV as well as to provide program orientation and training. EVV is a telephonic and computer-based system that documents the time caregivers arrive and leave, and services provided. DSS implemented EVV to ensure that individuals are receiving the services authorized and that the claim submitted for payment contains the correct information. EVV was federally mandated under the 21st Century Cures Act, which was signed into law in December of 2016.

Additional progress with the implementation of the Act's requirements for EVV include:

- A participant/employee portal to allow participants to view, correct and approve visit data and employees to view and correct visits.
- A fiscal management portal to allow the fiscal intermediary to view and correct visit data for use in payroll processing.

- A business intelligence reporting tool to enable robust analytics.
- A caregiver speaker verification to ensure the correct employee is providing services.
- Capacity for the participant to verify the visit at the point of care.
- Use of the system by the EVV-mandated list of direct service providers under DSS' Connecticut Home Care, Personal Care Assistance and Acquired Brain Injury waiver programs, as well as Community First Choice.
- Training for employers and employees to use the Sandata Learning Management System portal. Requiring consumer-employers (the participants) to approve employees' time recorded via EVV.

The Connecticut Home Care Program continues to evolve and change to respond to needs for new services, increasing emphasis on person-centered goals, provider quality assurance and accountability, new quality assurance initiatives and procedures to improve efficiency.

The COVID-19 pandemic affected everyone's lives and was especially difficult for those who live alone or rely on others for assistance. The pandemic negatively impacted services, community activities and seeing friends and family. Participants reported that COVID-19 made it harder to receive services due to staffing shortages. Other participants cancelled their services to limit exposure. Some kept their services while expressing concerns about caregiver vaccination status and the risk of exposure. The Department of Social Services provided personal protective equipment (PPE), including gown, gloves and masks to clients and caregivers to help prevent the spread of the virus. Virtual assessments and reassessments were offered during this period. The Department provided extensive guidance on in person visits during this period and fitted case managers with N95 masks to mitigate the risk of exposure. In addition, remote Adult Day Services was approved and made available to program participants.

I. PROGRAM DESCRIPTION AND ORGANIZATION

The Department's Community Options Unit administers the Connecticut Home Care Program for Elders, as well as the Acquired Brain Injury, Personal Care Assistance, and Autism waivers, and provides administrative oversight of the Mental Health waiver, operated by DMHAS, and the three waivers operated by the Department of Developmental Services. The mission of the Community Options Unit is to develop a dynamic system that includes a flexible array of cost-effective, community-based and institutional long-term care alternatives, which are responsive to the needs and preferences of individuals and families with continuing care needs.

This mission supports the Department's broader mission to serve families and individuals who need assistance in maintaining or achieving their full potential for self-direction, self-reliance and independent living. Clinical staff from the Community Options Unit screen individuals when a need for long-term care is identified to ensure that the option of home care is considered before institutional care.

As detailed below, CHCPE is organized under a multi-tiered structure, which enables individuals to receive home care services at the level corresponding to their functional needs and financial

eligibility. Eligibility limits and other program requirements are described in more detail later in this report. For a brief summary, please refer to the category chart in Appendix B and the legislation in Appendix A.

Category 1: This category targets individuals 65 years of age and older with one or two critical needs, who are at risk of short-term hospitalization or nursing facility placement if preventive home care services are not provided. This category is closed to new applicants. Participants may be discontinued or change to a different category should their needs and/or their financial situation change. This category is fully state funded.

Category 2: This category targets individuals 65 years of age and older with three critical needs, who are frail enough to require long-term nursing facility care but have resources which would prevent them from qualifying for Medicaid upon admission to a nursing facility. Care plan limits for these individuals cannot exceed 50% of the weighted average Medicaid cost in a nursing facility. This category is fully state funded.

Category 3: This category targets individuals 65 years of age and older with three critical needs and/or cognitive deficit, who would otherwise require long-term nursing facility care funded by Medicaid. To assure cost effectiveness, individual care plan costs cannot exceed 125% of the weighted average Medicaid cost in a nursing facility. Services for individuals under Category 3 qualify for federal reimbursement under the Medicaid waiver program.

Category 4: This category is the Connecticut Home Care Program for Disabled (CHCPD) pilot for persons ages 18 to 64 with degenerative neurological conditions. The financial eligibility and care plan cost limits are the same as Category 2. This category is fully state funded.

Category 5: This category targets individuals who are functionally equivalent to Category 1 but are enrolled in Medicaid. Category 5 participants receive services under a 1915(i) Medicaid state plan option, which allows service expenditures to be federally matched.

Assisted Living Services Component

The State of Connecticut has developed alternatives to nursing facility care which includes assisted living facilities. Connecticut offers assisted living in congregate housing facilities, federally funded U.S. Department of Housing and Urban Development (HUD) residences and four subsidized assisted living residences in Connecticut communities.

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

Assisted Living is offered in several settings under the Connecticut Home Care Program for Elders. Public Act 02-7, May special session, allowed the Department to establish the Private Assisted Living Pilot that became effective January 1, 2003. The Private Assisted Living Program offers 125 participants the opportunity to remain in their private assisted living facility after they have spent down their assets. From July 1, 2021, to June 30, 2022, this program served a total of 102 participants at a cost of $1,804,596. This figure includes both core and assisted living service charges. (Core services include light housekeeping, laundry and one meal per day).

Public Act 00-2, June special session, also grants Managed Residential Community (MRC) status to approved state-funded housing and federally funded HUD facilities for the purpose of providing assisted living services and allows the Department of Public Health (DPH) to waive provisions of the assisted living services agency regulations on a case-by-case basis. Since state funding ended for HUD facilities, they are now combined with congregate sites.

Over the past ten to fifteen years, DSS, in collaboration with DPH, the Department of Housing (DOH), the Office of Policy and Management (OPM), and the Connecticut Housing Finance Authority (CHFA), developed the Assisted Living Demonstration Project which provides 300 subsidized assisted living units in both urban and rural settings.

This unique project combines the development financing through CHFA, the necessary housing component through rental subsidies from DOH, and CHCPE services. There are four approved demonstration projects: Herbert T. Clark in Glastonbury, The Retreat in Hartford, Luther Ridge in Middletown, and Smithfield Gardens in Seymour.

From July 1, 2021, to June 30, 2022, 175 participants received services in the demonstration project facilities participating in the assisted living pilot at a cost of $4,110,058. This figure includes both core and assisted living service charges.

The pandemic adversely affected assisted living census due to applicants' apprehension about moving to a congregate facility with increased risks of contracting COVID-19.

Care Management

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

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

Quality Improvement

The goal of quality improvement is to monitor the unique needs and quality of services provided to our participants.

The quality assurance team:

- Conducts on-site administrative and chart audits of access agencies, assisted living service agency records, provider agencies and residential care homes to ensure the Centers for Medicare & Medicaid Services (CMS) performance measures are met.
- Reviews access agency reports to identify any trends, issues, and questions on the reported information.
- Monitors the timeliness of access agency information received and provides any necessary follow-up with the access agencies.
- Reviews and investigates critical incidents through a web-based application that allows tracking and trending of data both participant specific and system wide.

Various quality assurance activities are conducted to monitor provider compliance with CHCPE regulations and policies and to measure participant satisfaction with services. Six care management agency offices were audited during SFY 2022. The Department launched the utilization of an experience of care survey under the Testing Experience and Functional Tools (TEFT) federal grant. The goal is to utilize the data from the survey to develop a quality improvement strategy across the Medicaid waivers. To accomplish this, DSS partnered with the University of Connecticut Center on Aging to develop one consistent approach to reward quality and facilitate reporting. The Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey was implemented July 1, 2017, providing the HCBS community with one universal cross-ability tool to assess and improve HCBS program quality.

Goals for State Fiscal Year 2022:

- Monitor agency compliance with requiring PCAs to complete the training curriculum that was developed collaboratively with the provider community. Work to implement improved methods of tracking compliance.
- To meet or exceed performance measures specified in the 1915(c) and 1915(i) waiver documents and report findings to CMS.

- The Quality Assurance Committee will review various aspects of program operations and quality of care issues and develop quality improvement strategies.
- The Quality Assurance Committee will identify and work on strategic processes to improve waiver compliance and quality, with the goal of ensuring comprehensive, collaborative, and integrated oversight and monitoring.
- Develop and implement a cross-waiver quality improvement strategy utilizing data sources from the universal assessment and the HCBS CAHPS experience of care survey.

II. COST EFFECTIVENESS OF THE WAIVER

Program Cost and Projected Savings

To establish cost-effectiveness under the federal standards for Medicaid waivers, the Department must demonstrate budget neutrality. The federal standards assume that every participant served by the waiver would otherwise be institutionalized, and thus, using that assumption, DSS must show that the per capita cost for program participants is less than the cost of institutional care in order for the waiver program to be considered cost-effective.

When the CHCPE waiver was established, the Connecticut General Assembly mandated that the program be designed to be not only cost-effective on an individual basis but also cost-neutral overall. Section 17b-342(a) of the Connecticut General Statutes (Appendix A) specifically provides that:

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

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

The Department formulated a cost effectiveness model that computes the total state cost of providing home care services under the waiver. This is calculated by adding together the actual cost of services (waiver services plus skilled nursing and other home health services), and the program's administrative costs provided to persons receiving home care, which would not be incurred if these persons entered a nursing facility. The program is considered cost-effective and the total savings of $ 438,678,647.

SUMMARY OF PROGRAM COSTS AND SAVINGS UNDER THE WAIVER *

Connecticut Home Care Waiver Program	SFY 2022
Waiver Assessments & Status Reviews	$ 848,644
Program Services	437,035,228
Community First Choice	38,042,506
Home Health	25,794,725
Total Services Costs	**$ 501,721,103**
Total Administrative	**$ 2,674,521**
Total Services & Administrative	**$ 504,395,623**
Federal Medicaid Reimbursement	(285,587,070)
State Share of Program Cost	**$ 218,808,553**
Participants Served	*14,835*
Average Cost per Participant After Federal Reimbursement	$ 14,749
Average Cost per Nursing Home Resident After Federal Reimbursement	44,320
Cost Differential	**$ 29,571**
Estimated Total Nursing Home "Savings" **	**$ 438,678,647**

** Totals are for the 1915(c) waiver participants (Category 3) only.*
*** Reflects cost differential times number of participants served.*
**** Average days of waiver participation was 320 for SFY 2022.*

The analysis of these factors reveals that the CHCPE program costs are significantly less than nursing facility expenditures. The amount of the difference represents the estimated savings realized due to the CHCPE waiver.

An estimate of the savings attributed to the program was developed based on what the costs would have been if all waiver participants would have entered a nursing facility in the absence of the program, which we know is an overstatement. There is no definitive way, however, to calculate the true savings from the program.

The Department continues to monitor program expenditures, estimated savings and to update its analysis based upon the best information available.

While the state has a moratorium on the addition of nursing facility beds, there are vacancies in many facilities. In the face of a growing population of older adults, this apparent leveling of nursing home growth can in part be attributed to the availability HCBS alternatives such as CHCPE, resulting in reduced institutional expenditures.

III. CONNECTICUT HOME CARE PROGRAM OVERVIEW

Financial Eligibility – Medicaid Waiver

To qualify financially for the waiver portion of the program, an elderly person (age 65 or older) must meet the income and asset rules applicable to an institutionalized Medicaid applicant. As specified in the federal waiver, this means that the gross income limit is 300% of the SSI payment, or $2,523 in 2022. The asset limit for an unmarried applicant is $1,600, although a number of resources such as a residence, car, burial reserve and $1,500 face value life insurance policy are exempt. There are special provisions in federal law regarding the treatment of assets for married couples when one spouse is considered "institutionalized," which allows for the protection of assets for the community spouse. As of January 2022, the law allowed a community spouse to protect assets from $50,000 up to $137,400, depending upon the couple's original assets, in addition to the $1,600 that the "institutionalized" person can keep. If both spouses require waiver services, each can only have assets of $1,600 after exemptions.

Financial Eligibility – State-Funded

While the state-funded portion of the program has no income limit, applicants over the income limit may be required to pay applied income based on the amount of their income over the limit. The financial eligibility difference between the state-funded program and the Medicaid waiver is related to asset limits. When the state-funded programs were consolidated in 1992, an asset limit was established to enable individuals with more assets than the Medicaid limit, but not unlimited assets, to qualify for state-funded home care. However, existing participants with assets higher than the new limit were allowed to continue receiving services. The asset limit for individuals and couples in the state-funded portion of the program is 150% and 200%, respectively, of the minimum amount that a community spouse could have under Medicaid. As of January 2022, this equates to $41,220 for individuals and $54,960 for couples.

Financial Eligibility – 1915(i)

HCBS Medicaid waivers and long-term services and supports demonstration waivers generally allow higher income limits than under a state's Medicaid state plan. This varies by state. Participants in this category of service are Medicaid recipients whose income is at or below 150% of the federal poverty level. The annual income limit is $19,332 for Category 5 participants while the income limit for participants on the Medicaid waiver is 300% of the poverty level, or $30,276.

Community First Choice

The Affordable Care Act added section 1915(k) to the Social Security Act allowing states the option of providing home and community-based personal care attendant services and supports through their Medicaid state plans. Section 1915(k), also known as the Community First Choice (CFC) benefit is designed to provide long-term services and supports (LTSS) to individuals in their homes or communities rather than in institutional settings. These benefits are consistent with – and support CMS' goal of – rebalancing Medicaid LTSS spending; encouraging a person-centered, long-term support system; and providing enrollees the opportunity to decide where they live and to increase control over services received. With the implementation of CFC, individual-hire PCAs continue to be paid through the state-funded program but are no longer paid through the CHCPE waiver. Agency-based PCAs continue to be covered under the waiver.

Mandatory Medicaid Applications

As noted above, all state-funded participants served by the Department are required to apply for Medicaid if their financial information indicates that they would qualify. This ensures that the state, whenever possible, receives federal matching funds and lowers the percentage of participants whose services are fully supported with state funds. State-funded participants who appear to be eligible for Medicaid continue to be identified when their income and assets are reviewed during annual reassessments of functional status.

Target Population

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

Assessment, Plan of Care Development, and Care Management

Contracted access agencies serving different regions of the state provide care management to program participants receiving home care services. Care managers are required to be nurses, social workers or those with a related degree and have two years' experience. The care manager conducts an assessment to determine applicant or participant needs, offers services and a list of providers, connects participants with services of their choice, monitors the participant's health status, reviews the care plan regularly and fully reassesses the participant's level of need annually. Care management includes ensuring that services are provided in accordance with the plan of care.

The access agency care manager conducts a full assessment of the individual to determine service needs. Based on the results of the assessment, the care manager and client develop a written, individualized plan of community-based social and medical services. The comprehensive plan of care specifies the type, frequency, duration and cost of all services needed for each participant.

The care manager is required to use the participant's informal support system and pursue other funding sources such as Medicare and third-party payors before utilizing program funds. Care managers use a care plan portal to enter participants' care plans and prior authorizations. This measure improves quality assurance and ensures that service providers can only bill what is authorized.

Application of Cost Limits

Once the plan of care is completed, the care manager must ensure that the state's cost for the participant's total plan of care, including both medical and community based social services, does not exceed the average state cost of nursing facility care. The average state cost of nursing facility care is calculated by deducting the average applied income contribution from the weighted average monthly Medicaid rate for nursing facility care.

As of March 2022, the maximum amount for a total plan of care for Medicaid waiver participants was $7,584**.** The maximum care plan cost limit on the state-funded portion of CHCPE was $3,792, 50% of the maximum cost of a nursing home bed.

Participant Fee

Individuals who qualify for services under the special institutional income limit used for the waiver and the state-funded component have a portion of their income applied to the cost of their care if their income exceeds 200% of the federal poverty level plus the cost of any medical insurance premiums paid and other allowable deductions from the individual's gross income. Any remaining income must be paid toward the cost of care.

During SFY 2022, state-funded participants were required to pay a 3% cost share each month based on the participants' paid claims data for that month. The fiscal intermediary is responsible for collecting the applied income and/or cost share from participants. Participants who fail to pay the cost share and/or the applied income may be discontinued from the program.

Acceptance of Services

The care manager offers the individual the choice to accept a person-centered plan of home and community-based care as an alternative to institutional care. This choice is required by federal law and must be documented in writing. The individual and the care manager sign the plan of care. Individuals who accept a plan of care are expected, to the extent they are able, to take an active part in creating and changing their plan of care as needed. Individuals have the right to refuse the plan of care, or any services suggested and be informed of the likely consequences of such refusal. In SFY 2022, 3,900 new participants accepted plans of care for home and community-based services. This represents 34% of the persons referred for assessment.

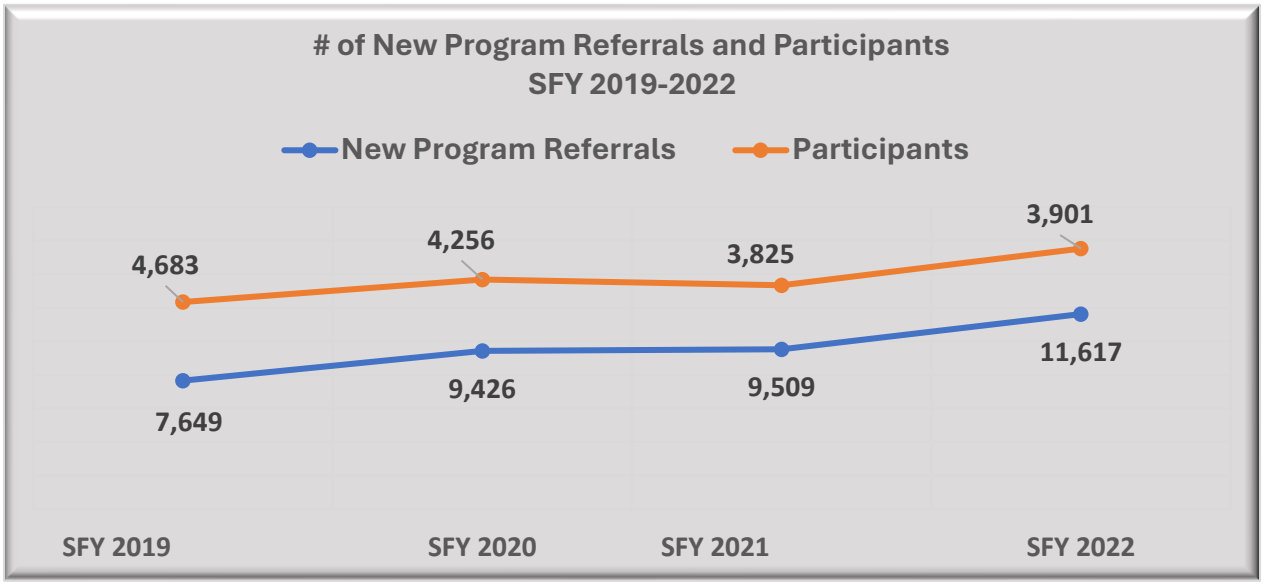
IV. CASELOAD TRENDS

New Program Referrals and Placement Activity

Throughout SFY 2022, 11,617 individuals were referred to an access agency care manager for a full assessment of their needs to consider their potential for community living with supportive services in place. The Covid pandemic caused fear, and many clients were reluctant to accept services and allow caregivers in their homes. In SFY 2022 3,900 new participants accepted services through the CHCPE program.

New Program Referrals and New Participants

SFY	Referrals	New Participants
SFY 2019	7,649	4,683
SFY 2020	9,426	4,256
SFY 2021	9,509	3,825
SFY 2022	11,617	3,901



This chart illustrates the number of new participants that resulted from new program referrals from SFY 2019 through SFY 2022. During SFY 2022, 34% of new referrals became active program participants. Pre-pandemic, approximately 50% of new referrals resulted in new participants.

The top four reasons for applicants not progressing from referral to active participants are:

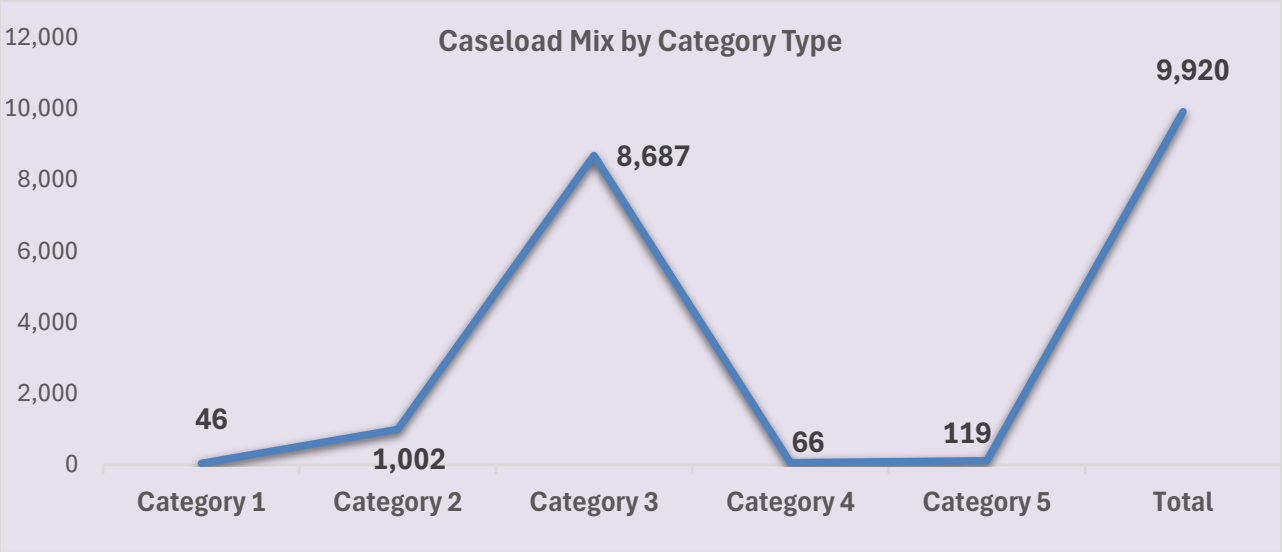
- Pandemic-related issues
- Not eligible, either financially or functionally.
- Cost share – participants and/or their families do not agree to pay the current rate of cost share for their services.

- Estate recovery – participants and/or their families/authorized representatives refuse participation in the program when advised that the participant's estate would be subject to recovery by the state upon the death of the participant.

Caseload Mix by Category

As of June 30, 2022, there was a total of 9,920 active participants on the program.

The graph below indicates that 86% of persons receiving CHCPE services are Medicaid waiver participants. As state-funded participants spend down their assets, most transfer to Category 3. The Category 3 cost cap allows more services than state-funded coverage, which has lower cost caps.



All state-funded CHCPE participants are required to apply for Medicaid if their financial information indicates that they would qualify. While the number of waiver participants has steadily increased each year, the number of state-funded participants has steadily decreased.

The state legislature placed a freeze on new referrals to CHCPE Category 1 as of August 1, 2016. The only transfers into Category 1 are active Category 5 participants with assets above the limit or active Category 2 participants with fewer functional needs.

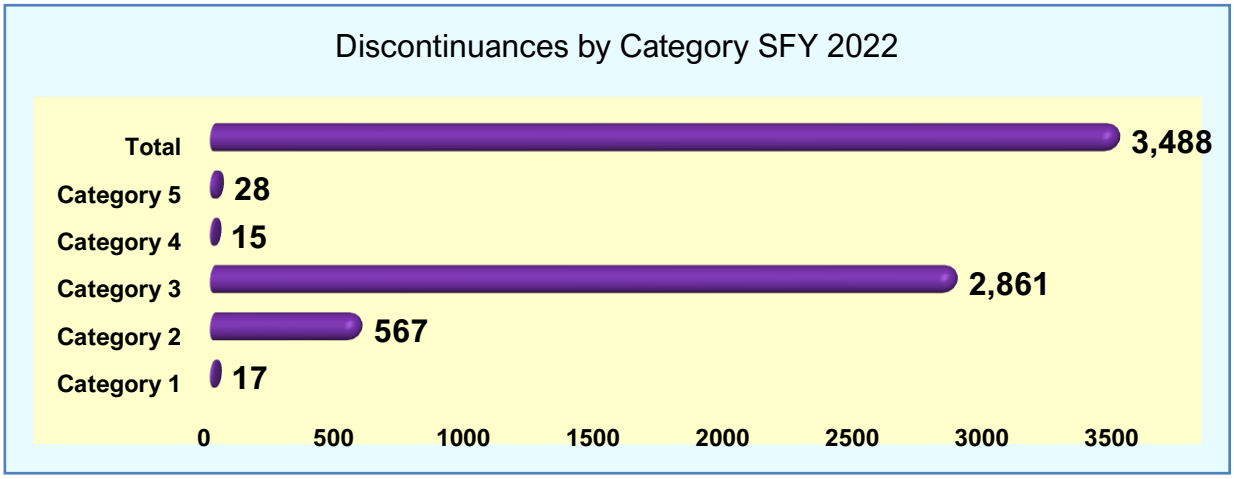
V. PROGRAM ACTIVITY

Admissions and Discharges

The targeted population has to meet nursing home level of care for admission to the CHCPE program. Nursing home level of care is determined by the outcome of the universal assessment tool. Most discontinuances from the program are from Category 3 participants, due to the death.

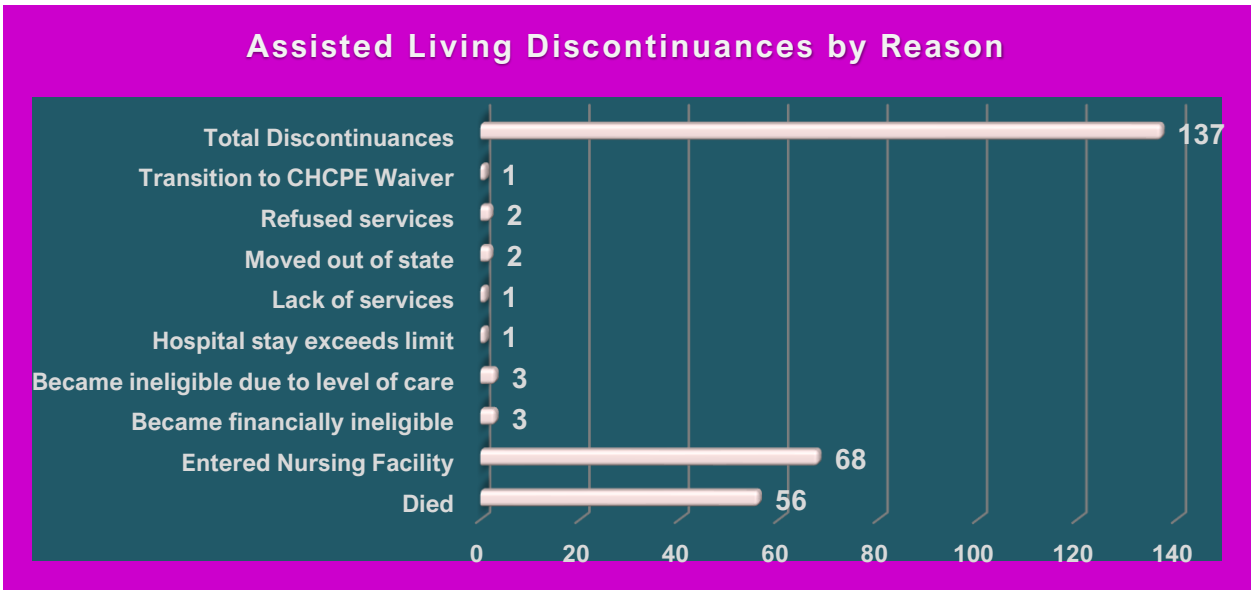
Category 2 participants, whose services are state funded, are also required to meet nursing home level of care. Category 2 and 3 participants who enter a nursing facility, do so primarily because

they have become too ill to stay at home and/or the cost of their care plan exceeds program limits for being less expensive than nursing home care.



Category 1 and Category 5 participants are considered at risk for nursing home admission but do not meet the criteria for nursing home level of care. Category 5 participants are Medicaid participants receiving services under the 1915(i) state plan which allows for federal matching funds. Prior to the approval of the 1915(i) in 2012, all HCBS for these participants were 100% state funded.

Category 4 is the state-funded pilot program for those diagnosed with a neurodegenerative condition.



VI. TRANSFERS WITHIN THE PROGRAM

CHCPE participants who experience a change in functional or financial status may qualify for a change in their category of services designation. This change enables them to access increases in

the care plan cost limits. Those who qualify for Category 3 gain access to full Medicaid benefits. The change to Category 3 enables the Department to maximize federal financial participation under Medicaid.

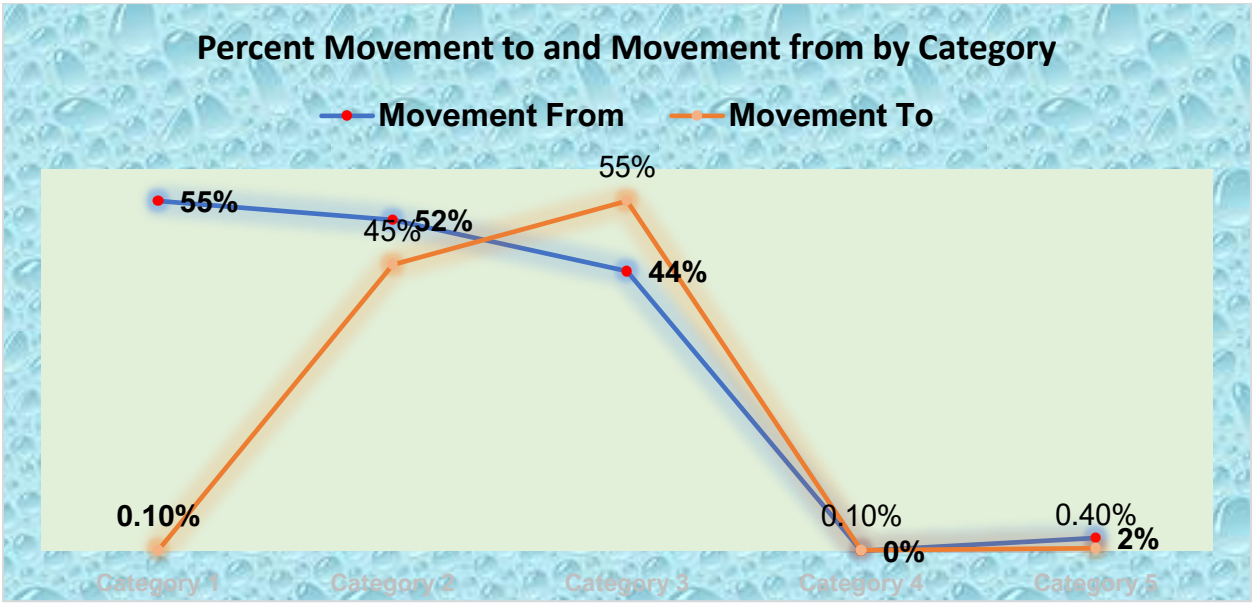
Category 5 participants are Medicaid participants receiving services under the 1915(i) state plan which allows for federal matching funds for home and community-based services.

Reasons for participants moving to different categories include:

- Change in functional status
- Change in financial status
- Category 4 participants moving to Category 3 on their 65th birthday and have spent down their assets.

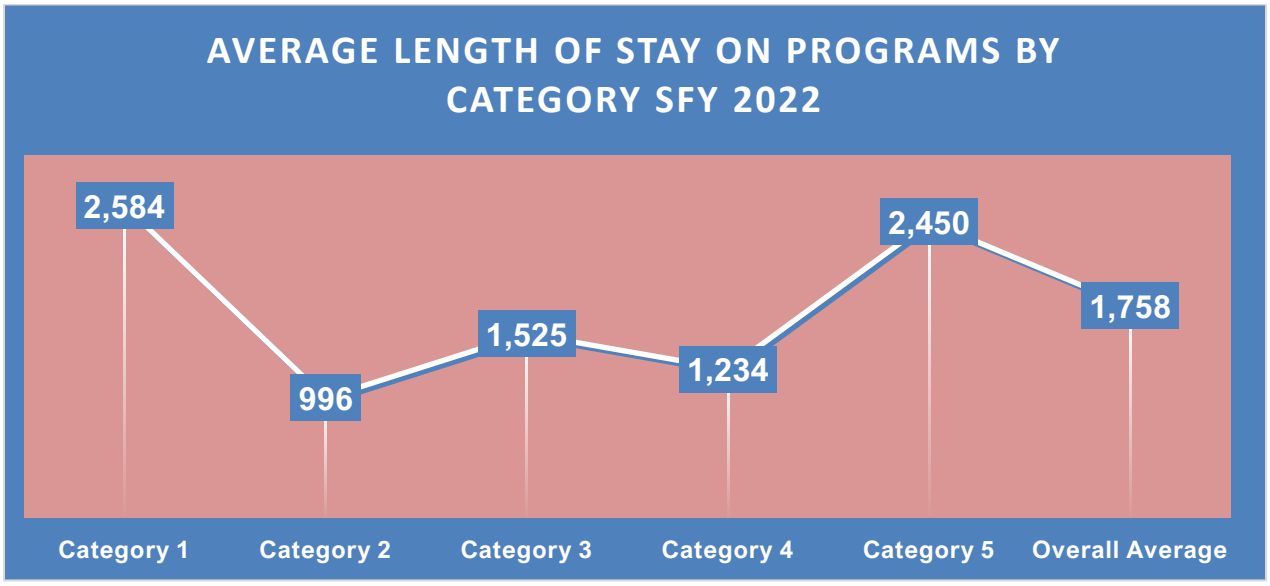
Although historically most participants transfer to Category 3, in FY 2022 most transitioned to Category 2. Category 2 transfers include those transitioned from Category 1 due to increased functional needs and/or participants who met functional criteria but exceeded the Medicaid asset limit. Medicaid participants who transfer into Category 5 are those who no longer meet the functional criteria for Category 3 due to an improvement in condition. Category 4 transfers are to either Category 2 or 3 when they age out of Category 4 and become financially eligible for Medicaid.

Category Change	Movement From	Movement To
Category 1	55%	0.10%
Category 2	52%	45%
Category 3	44%	55%
Category 4	0%	0.10%
Category 5	2%	0.40%



VII. LENGTH OF STAY

Factors that affect length of stay include level of need and financial eligibility. Category 1 and Category 5 participants are considered "at risk" of institutionalization and do not meet the criteria for nursing home level of care. While Category 2 is considered nursing home level of care, the cost cap for Category 2 is lower than Category 3. Category 3 participants, with the greatest level of need, have a higher cost cap, tend to require more help with activities of daily living and have more serious and chronic health conditions or disabilities which result in a greater length of stay. Participants on the state-funded categories (i.e., Categories 1, 2 and 4) often transition to Category 3, the Medicaid waiver, when they have spent down their assets.



VIII. PROGRAM EXPENDITURES

Program Expenditures
7/1/21-6/30/22

Program Expenses	Waiver	1915(i)	State-Funded	Total
Assessments / Status Reviews	$ 848,644	$ 4,767	$ 1,473,436	$ 2,326,847
Home and Community-Based Services	437,035,228	4,929,571	32,733,534	474,698,333
Community First Choice	38,042,506	-	-	38,042,506
Home Health	25,794,725	14,658	668,380	27,177,762
Total Expenses	**$ 501,721,103**	**$ 5,648,995**	**$ 34,875,349**	**$ 542,245,448**

Administrative Services	Waiver	1915(i)	State-Funded	Total
Salaries	$ 1,386,017	$ 32,233	$ 193,398	$ 1,611,647
Fringe Benefits	1,288,504	29,965	179,791	1,498,260
Annual Administrative Costs	**$ 2,674,521**	**$ 62,198**	**$ 373,189**	**$ 3,109,908**

Net Costs	Waiver	1915(i)	State-Funded	Total
Total Cost	$ 504,395,623	$ 5,711,194	$ 35,248,538	$ 545,355,355
Federal Reimbursement for Administrative Expenses	(1,337,260)	(31,099)	-	(1,368,359)
Federal Reimbursement for Program Expenses	(284,249,810)	(3,174,735)	-	(287,424,546)
Net State Costs	**$ 218,808,553**	**$ 2,505,359**	**$ 35,248,538**	**$ 256,562,450**

Note: Pursuant to the Families First Coronavirus Response Act, waiver, 1915(i) and home health expenditures are estimated at 56.2% federal financial participation (FFP) and Community First Choice expenditures are estimated at 62.2% FFP due to enhanced federal match available for the period 7/1/2021–- 6/30/2022.

APPENDIX A

Connecticut General Statutes, Section 17b-342
Connecticut Home-Care Program for the Elderly

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

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

(c) The community-based services covered under the program shall include, but not be limited to, the following services to the extent that they are not available under the state Medicaid plan, occupational therapy, homemaker services, companion services, meals on wheels, adult day care, transportation, mental health counseling, care management, elderly foster care, minor home modifications and assisted living services provided in state-funded congregate housing and in

other assisted living pilot or demonstration projects established under state law. Personal care assistance services shall be covered under the program to the extent that (1) such services are not available under the Medicaid state plan and are more cost effective on an individual client basis than existing services covered under such plan, and (2) the provision of such services is approved by the federal government. Recipients of state-funded services and persons who are determined to be functionally eligible for community-based services who have an application for medical assistance pending shall have the cost of home health and community-based services covered by the program, provided they comply with all medical assistance application requirements. Access agencies shall not use department funds to purchase community-based services or home health services from themselves or any related parties.

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

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

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

(g) The commissioner shall report annually, by June first, to the joint standing committee of the General Assembly having cognizance of matters relating to human services on the program in such detail, depth and scope as said committee requires to evaluate the effect of the program on the state and program participants. Such report shall include information on (1) the number of persons diverted from placement in a long-term care facility as a result of the program, (2) the number of persons screened, (3) the average cost per person in the program, (4) the administration costs, (5) the estimated savings, and (6) a comparison between costs under the different contracts.

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

(i) (1)The Commissioner of Social Services shall, within available appropriations, administer a state-funded portion of the program for persons (A) who are sixty-five years of age and older; (B) who are inappropriately institutionalized or at risk of inappropriate institutionalization; (C) whose income is less than or equal to the amount allowed under subdivision (3) of subsection (a) of this section; and (D) whose assets, if single, do not exceed one hundred fifty per cent of the federal

minimum community spouse protected amount pursuant to 42 USC 1396r-5(f)(2) or, if married, the couple's assets do not exceed two hundred per cent of said community spouse protected amount. For program applications received by the Department of Social Services for the fiscal years ending June 30, 2016, and June 30, 2017, only persons who require the level of care provided in a nursing home shall be eligible for the state-funded portion of the program, except for persons residing in affordable housing under the assisted living demonstration project established pursuant to section 17b-347e who are otherwise eligible in accordance with this section.

(2) Except for persons residing in affordable housing under the assisted living demonstration project established pursuant to section 17b-347e, as provided in subdivision (3) of this subsection, any person whose income is at or below two hundred per cent of the federal poverty level and who is ineligible for Medicaid shall contribute four and one-half per cent of the cost of his or her care. Any person whose income exceeds two hundred per cent of the federal poverty level shall contribute four and one-half per cent of the cost of his or her care in addition to the amount of applied income determined in accordance with the methodology established by the Department of Social Services for recipients of medical assistance. Any person who does not contribute to the cost of care in accordance with this subdivision shall be ineligible to receive services under this subsection. Notwithstanding any provision of the sections 17b-60 and 17b-61, the department shall not be required to provide an administrative hearing to a person found ineligible for services under this subsection because of a failure to contribute to the cost of care.

(3) Any person who resides in affordable housing under the assisted living demonstration project established pursuant to section 17b-347e and whose income is at or below two hundred per cent of the federal poverty level, shall not be required to contribute to the cost of care. Any person who resides in affordable housing under the assisted living demonstration project established pursuant to section 17b-347e and whose income exceeds two hundred per cent of the federal poverty level, shall contribute to the applied income amount determined in accordance with the methodology established by the Department of Social Services for recipients of medical assistance. Any person whose income exceeds two hundred per cent of the federal poverty level and who does not contribute to the cost of care in accordance with this subdivision shall be ineligible to receive services under this subsection. Notwithstanding any provision of sections 17b-60 and 17b-61, the department shall not be required to provide an administrative hearing to a person found ineligible for services under this subsection because of a failure to contribute to the cost of care.

(4) The annualized cost of services provided to an individual under the state-funded portion of the program shall not exceed fifty per cent of the weighted average cost of care in nursing homes in the state, except an individual who received services costing in excess of such amount under the Department of Social Services in the fiscal year ending June 30, 1992, may continue to receive such services, provided the annualized cost of such services does not exceed eighty per cent of the weighted average cost of such nursing home care. The commissioner may allow the cost of services provided to an individual to exceed the maximum cost established pursuant to this subdivision in a case of extreme hardship, as determined by the commissioner, provided in no case shall such cost exceed that of the weighted cost of such nursing home care.

(j) The Commissioner of Social Services shall collect data on services provided under the program, including, but not limited to, the: (1) Number of participants before and after copayments are reduced pursuant to subsection (i) of this section, (2) average hours of care provided under the

program per participant, and (3) estimated cost savings to the state by providing home care to participants who may otherwise receive care in a nursing home facility. The commissioner shall, in accordance with the provisions of section 11-4a, report on the results of the data collection to the joint standing committees of the General Assembly having cognizance of matters relating to aging, appropriations and the budgets of state agencies and human services not later than July 1, 2022. The commissioner may implement revised criteria for the operation of the program while in the process of adopting such criteria in regulation form, provided the commissioner publishes notice of intention to adopt the regulations in accordance with section 17b-10. Such criteria shall be valid until the time final regulations are effective.

(k) The commissioner shall notify any access agency or area agency on aging that administers the program when the department sends a redetermination of eligibility form to an individual who is a client of such agency.

(l) In determining eligibility for the program described in this section, the commissioner shall not consider as income (1) Aid and Attendance pension benefits granted to a veteran, as defined in section 27-103, or the surviving spouse of such veteran, and (2) any tax refund or advance payment with respect to a refundable credit to the same extent such refund or advance payment would be disregarded under 26 USC 6409 in any federal program or state or local program financed in whole or in part with federal funds.

Appendix B
Category Chart

DEPARTMENT OF SOCIAL SERVICES						
CONNECTICUT HOME CARE PROGRAM & 1915(i) State Plan Option - FEE FOR SERVICE USE ONLY						
rev: 01/22	Effective 1/1/2022					
Category Type	Description	Functional Need	Financial Eligibility	Care Plan Limits	Funding Source	Intake Status
Category 1 CHCPE	Limited home care for moderately frail elders (1 or 2 critical needs)	At risk of hospitalization or short term nursing home placement	Individual Income= No Limit* Assets: Individual = $41,220.00 Couple= $54,960.00	<25% NH Cost ($1896.00 Monthly)	STATE	Intake frozen effective 07/01/2015 (Wait-list)
Category 2 CHCPE	Intermediate home care for very frail elders with assets above the Medicaid limits.	In need of short or long term nursing home care (NF LOC)	Individual Income= No Limit* Assets: Individual = $41,220.00 Couple= $54,960.00	<50% NH cost ($3792.00 Monthly)	STATE	OPEN
Category 3 CHCPE	Extensive home care for very frail elders who would other-wise be in a nursing home on Medicaid.	In need of long term nursing home care (NF LOC)	Individual Income=$2523.00/Mth Assets: Individual $1,600.00 Couple: both as clients = $1600.00 each one as client = $1600 + CSPA**	100% NH Cost ($7584.00 Monthly) Social Services 125% NH Cost ($9480.00 Monthly)	MEDICAID WAIVER	OPEN 100% Subacute*** ($10389.00 Monthly) 125% Subacute*** ($12986.00 Monthly)
Category 4 CHCPD	Intermediate home care for individuals under age 65 with a degenerative neurological condition ineligible for Medicaid	In need of short or long term nursing home care (NF LOC)	Individual Income= No Limit* Assets: Individual = $41,220.00 Couple= $54,960.00	<50% NH cost ($3792.00 Monthly)	STATE	OPEN limited to 100 slots
Category 5 1915(i)	Same as category 1.. active on categorical needy Medicaid S01, S02, S03, S04 Must be age 65 or older	At risk of hospitalization or short term nursing home placement (1 or 2 critical needs)	Individual Income - $1,611.00 Assets: Individual $1,600.00	50% Federal Reimbursement		OPEN

Notes:

1. Clients in the higher income range are required to contribute to the cost of their care. Applied income starts at $2265.00
* 2. There is no income limit for the State Funded portion. The Medicaid Waiver income limit remains at 300% of SSI which is $2,523.00
3. CHCPE Services available in all categories include the full range of home health and community based services.
*1915(i) State Plan Option has limited PCA services to 14 hours weekly and homemaking services are limited to 6 hours weekly.
4. Care plan limits in all categories are based on the total cost of all state-administered services.
5. 1915(i) State Plan option covers individuals on Medicaid but who qualify for category 1 services.
CT will claim 50% reimbursement from the federal government for home and community based services not reimbursable under Medicaid.
6. Some individuals under category 2 may become financially eligible for the Medicaid Waiver.
In these cases, the client must apply for Medicaid and cooperate with the application process.
** 7. Married couples who are over this asset limit for category 3 may be eligible based on the special spousal asset protection rule.
8. Functional need is a clinical determination by the Department about the applicant's critical need for assistance in the following areas:
Activities of Daily Living (ADL's) :Bathing, Dressing, Toileting, Transferring, Eating/Feeding,
Needs factors : 1. Behavioral Need - Requires daily supervision to prevent harm. 2. Medcation supports - Requires assistance for administration of physician ordered daily medications. Includes supports beyond set up.
9. NF LOC is defined as;
    1. Supervision or cueing ≥ 3 ADL's + need factor
    2. Hands-on ≥ 3 ADL's
    3. Hands-on ≥ 2 ADL's + need factor
    4. A cognitive impairment which requires daily supervision to prevent harm
*** 10. Subacute LOC is defined as;
    1. Participant requires comprehensive medical monitoring but does not require intensive diagnostic and/or invasive procedures
    2. Participant requires intense medical supervision and therapy such as nursing interventionintermittenly throughout the day and/or the need for ancillary or technological services(such as laboratory, pharmacy, nutrition, diagnostic)
    3. Participant may require services such as brain injury rehabilitation, high intensitystroke or orthopedic programs, ventilator programs, complex wound care or specialized infusion therapy.
11. Care Plan limits are for CHCP fee for service only
12. For contracted Access Agencies use only.

APPENDIX C
TIERED CARE MANAGEMENT CONTINUUM

Recognizing that all participants do not require the same intensity of care management, tiered care management was added July 1, 2017.

Intensity levels are decided clinically by using four categories of care management intervention: Crisis Intervention, Service Brokerage and Advocacy, Risk Management, and Participant Engagement.

***Crisis Intervention** has two principle aims: 1) cushion the stressful event by immediate or emergency emotional or environmental first aid, and 2) strengthen the person in his or her coping through immediate therapeutic clarification and guidance during the crisis period.*

***Service Brokerage and Advocacy** requires that the care manager facilitate continual interaction between various segments of the service delivery system, including activities around finding and keeping providers for participants with difficult service needs, pre and post transitioning from an inpatient setting to the community, hospice and end of life care.*

***Risk Management** includes the identification of potential and perceived risks to the individual, which fall into four general categories: health risks, behavior risks, personal safety risks, and in-community risks. Managing these risks includes identifying and documenting risks, developing written plans for addressing them, negotiating with participants the risks presented while keeping participant choice central to the process, and monitoring outcomes related to the risk.*

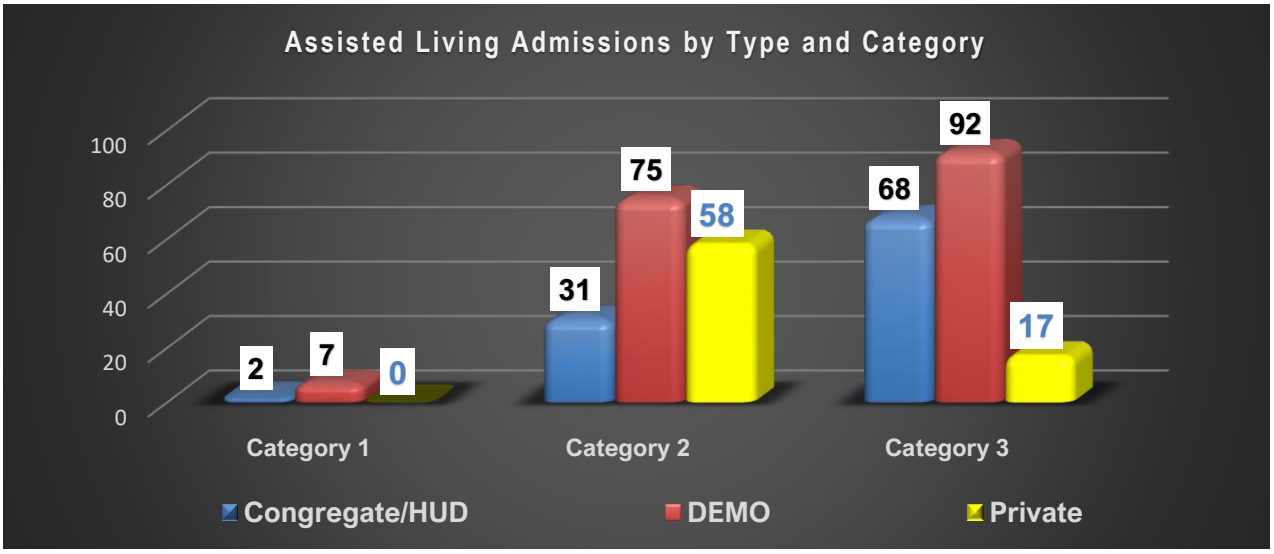
***Participant Engagement** refers to the process through which participants become actively involved in their care plans and participate in the program. The engagement process focuses on several interventions designed to enhance participant engagement: receptivity, expectancy, investment, and working relationship. Care management interventions are weighted according to complexity, severity and number of tasks required.*

APPENDIX D
ASSISTED LIVING PROGRAM GROWTH

CHCPE offers various services in assisted living settings: 1) state-funded congregate housing facilities with on-site coordination of services that facilitate daily living activities and six HUD facilities participate with CHCPE; 3) Demonstration Project established by DSS, in collaboration with the Department of Public Health, the Department of Economic and Community Development, the Connecticut Housing Finance Authority (CHFA), and the Office of Policy and Management to provide subsidized assisted living services for persons residing in affordable housing; 4) Private Assisted Living for applicants age 65 and older who have spent down their assets and require help paying for home care services who reside in approved private assisted living communities.

Individuals Receiving Services from an Assisted Living Services Agency (ALSA)
07/01/2021 - 06/30/2022

Assisted Living Type	Category 1	Category 2	Category 3	Category 5	Category Totals
ALSA Congregate/HUD	2	31	68	1	102
ALSA Demonstration	7	75	92	1	175
ALSA Private	0	58	17	0	75
Total Individuals	9	164	177	2	352



Assisted Living Discontinuances by Reason

Reason	Count
Died	56
Entered nursing facility	68
Became financially ineligible	3
Became ineligible due to level of care	3
Hospital stay exceeded program limit	1
Lack of services	1
Moved out of state	2
Refused services	2
Transitioned to CHCPE	1
Total Discontinuances	**137**

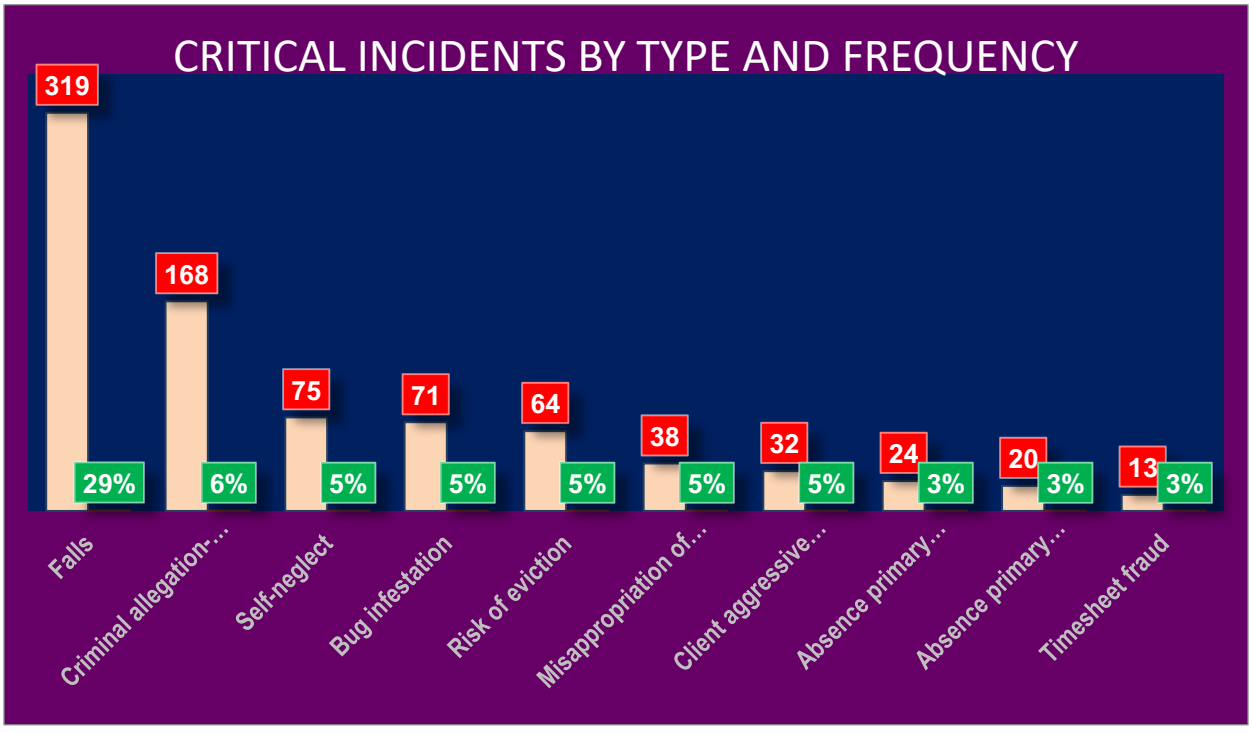
APPENDIX E
CRITICAL INCIDENT REPORTS

Quality Assurance
System for Reporting Abuse, Neglect and Exploitation

Critical Incidents are reported by access agencies using the Ascend online system. There are several types of critical incidents. Community Options quality assurance staff review these incidents and provide feedback to the access agency regarding methods to prevent further occurrences, if applicable. Many of the abuse, neglect and exploitation incidents are reported to Protective Services for the Elderly which lies within the Social Work Division of DSS. The Quality Assurance Committee works to strengthen policies and procedures to enable more rapid reporting time and responses, in addition to efforts to reduce the incidents across all categories. Quality assurance staff have transitioned into playing a more active role in investigations.

CMS requires the state to demonstrate it has designed and implemented an effective system for assuring waiver participant health and welfare. The state must demonstrate that an incident management system is in place that effectively resolves those incidents and prevents further similar incidents to the extent possible. CMS requires the state to demonstrate that it identifies, addresses and seeks to prevent instances of abuse, neglect, exploitation and unexplained death. To that end, Community Options quality assurance staff review critical incidents with an eye on what interventions may have prevented the critical incident.

Top Reasons for Critical Incidents SFY 2022



Emergency Department Visits and Unplanned Hospitalizations

Emergency department (ED) admissions account for approximately 80% of unplanned hospitalizations and create financial and resource issues for the healthcare system. Older adults are more likely to use the ED due to chronic diseases, physical limitations, cognitive impairment and falls. Some ED admissions are potentially preventable.

ED visits and unplanned hospitalizations are reported as critical incidents which average out to about half of all critical incidents. Nurses were added to the designated staff to review critical incidents and recommend medical interventions with the goal of preventing unnecessary ED visits. Community Options nursing staff review critical incidents, assess unmet medical needs, such as skilled nursing, primary care doctor or specialist visit, and medication administration, and suggest recommended services.

SFY	Hospitalizations and ED Visits
2022	488
2021	570
2020	514
2019	669
2018	564
2017	560
Average	**575**

Personal Care Assistant Training

Adequate training of PCAs was identified as an issue contributing to the frequency of critical incidents. Community Options quality assurance staff and subject matter experts from community provider agencies produced the PCA Training Modules and Certification Test. The training is now a requirement for all agencies who employ PCAs. The training is available on the Community Options webpage. (https://portal.ct.gov/DSS/Healthhttps://portal.ct.gov/DSS/Health-And-Home-Care/Long-Term-Care/Community-Options/DocumentsAnd-Home-Care/Long-Term-Care/Community-Options/Documents)

Most Common Critical Incidents

Allegations of abuse, neglect or exploitation may be reported to Protective Services for the Elderly (PSE) available for participants 60 years of age and older. PSE received referrals for 448 (11.63%) of the total number of critical incidents in SFY 2022. Connecticut does not have protective services for adults.

Self-neglect is a worldwide, serious public health issue that can have serious and devastating health outcomes. Interventions may be challenging. Potential indicators of self-neglect include unkempt hair, nails, or clothes, unexplained weight loss, unkempt home, unpaid bills and debts, inability to manage activities of daily living, suicidal acts or ideation, self-imposed isolation, refusing medical attention, lack of medical care for serious illnesses or conditions, and not keeping medical appointments.

Falls, a preventable and leading cause of injuries in older adults, may result in fractures, cuts, and serious head and brain injuries that can be fatal. There is a variety of fall prevention assistive technology that can be utilized to prevent and detect falls. Community Options quality assurance staff review the critical incident and may make recommendations for prevention strategies.

Types of Critical Incidents

• Unexpected absence of the primary caregiver
• Untimely death
• Emergency department visit or unplanned hospitalization
• Suicide attempt
• Serious criminal allegation
  ○ Participant as victim
  ○ Participant as perpetrator
• Allegations of abuse, neglect, or exploitation of participant
• Risk of eviction
• Homelessness
• Self-neglect (participant refusing to care for self, refusing needed services)
• Bug infestation
• Unhealthy/unsanitary living conditions
	• Falls
	• Fire in residence with significant risk to participant
	• Missing person reported to police
	• Misappropriation of participant's funds
	• Seclusion
	• Restraint
	• Participant aggressive behavior toward caregiver
	• Caregiver under the influence of alcohol/drugs
	• Motor vehicle accident
	• Domestic dispute
	• Medication errors
	• Cancellation of utilities (heat, electricity)
	• Timesheet fraud

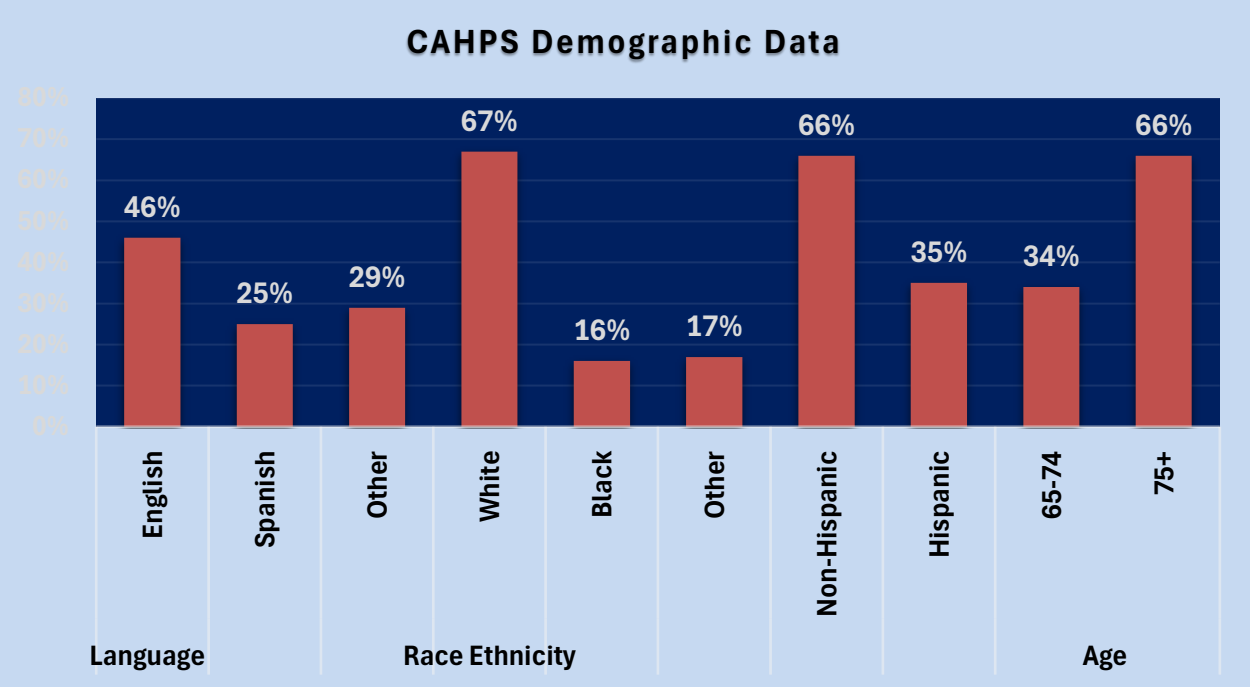
APPENDIX F
PARTICIPANT ASSESSMENT OF HEALTH PROVIDER SYSTEMS HOME AND COMMUNITY-BASED SERVICES (HCBS CAHPS) SURVEY

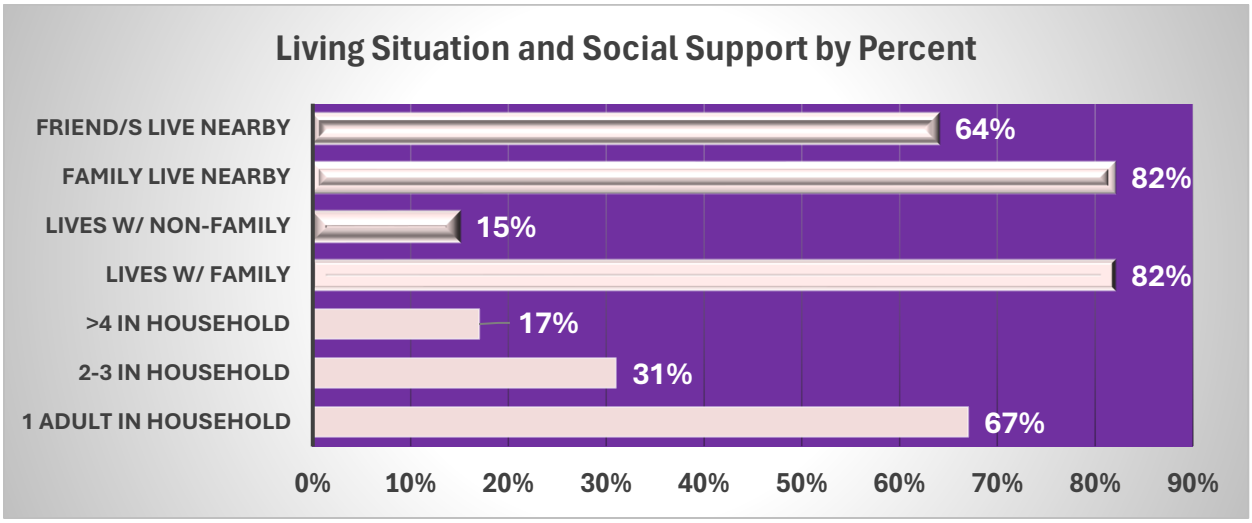
Connecticut has seen continued growth in the use of Medicaid-funded home and community-based services (HCBS) along with increasing use of access agencies contracted for care management. Historically each agency has used its own survey to provide the quality assurance data required by CMS and the state. This lack of a standardized, universal instrument has made it challenging to compare and report results across Medicaid programs and care management providers.

To provide the HCBS community with one universal, cross-disability tool to assess and improve HCBS program quality, Truven Health Analytics created the Experience of Care (EOC) survey. The EOC survey received approval from the national Participant Assessment of Health Provider Systems consortium and was endorsed by the National Quality Forum as a standardized, cross-disability tool to measure the quality of HCBS.

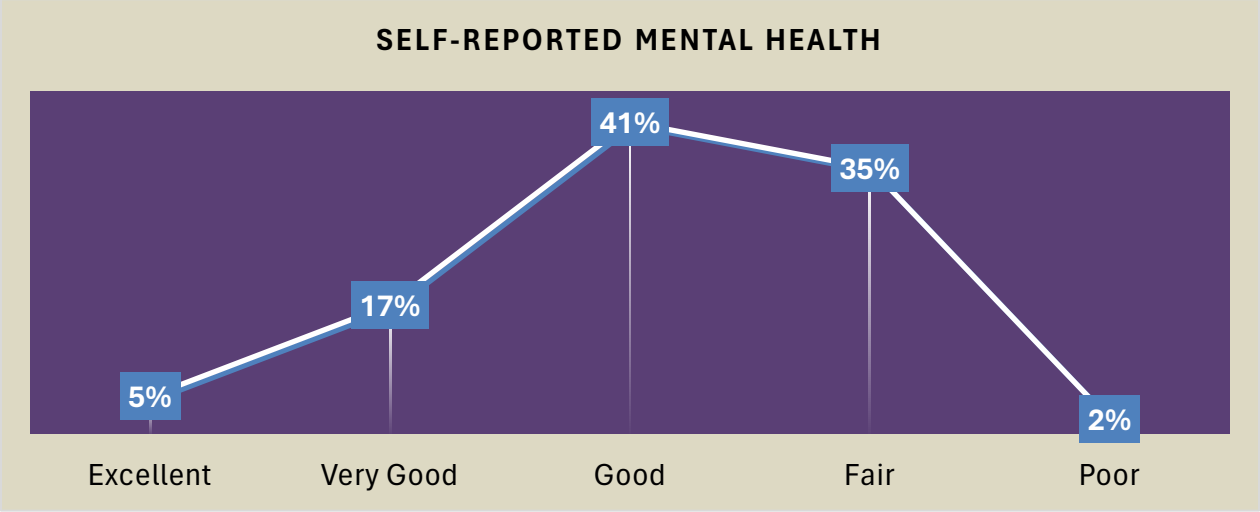
SFY 2021 was the first year the survey was utilized. For global ratings, respondents were asked to rate the help they get from each type of staff based on a scale from 0 to 10 or using a worded scale from poor to excellent or definitely no, probably no, probably yes, or definitely yes. Mental health is an area of potential concern. Approximately one out of every three CHCPE participants rated their overall mental or emotional health as fair or poor.

CAHPS Survey Results



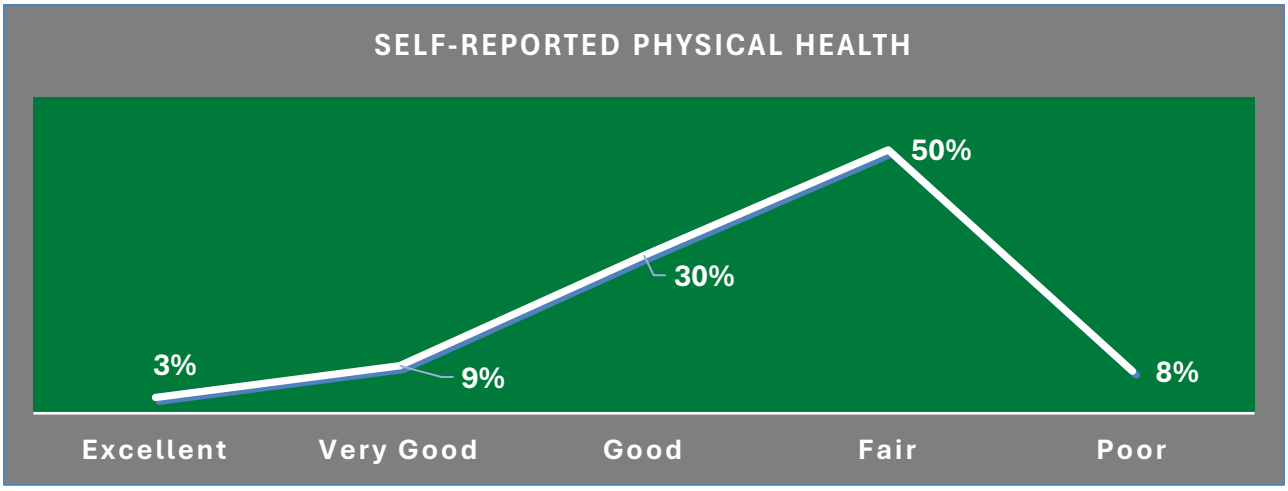


CAHPS Health Survey



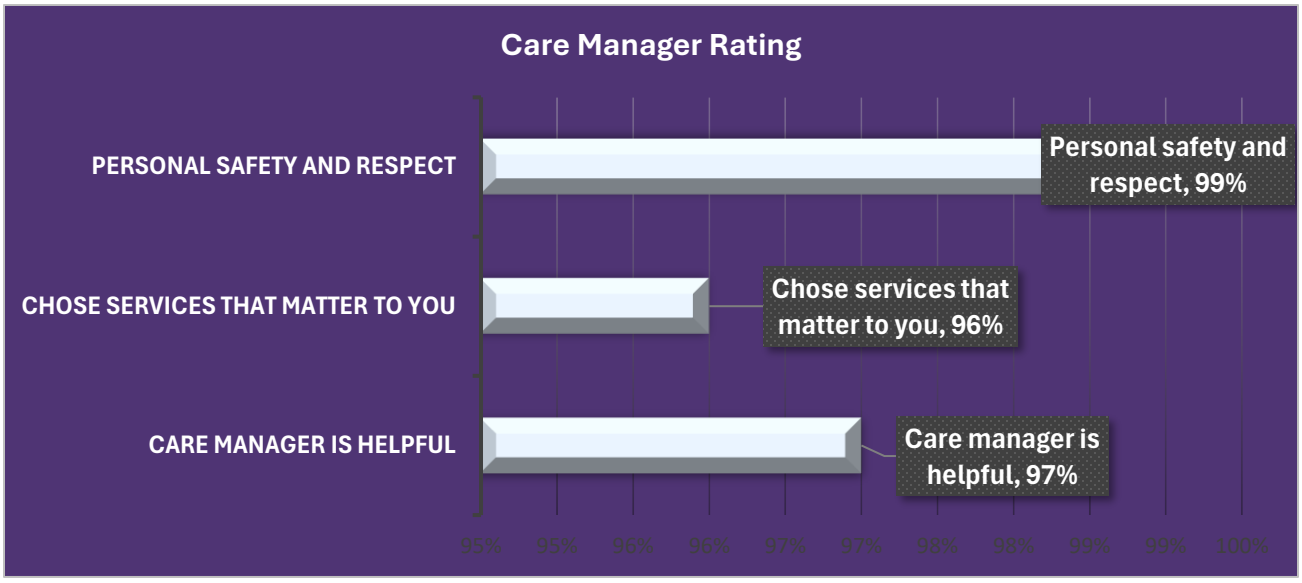
Mental Health and Older Adults

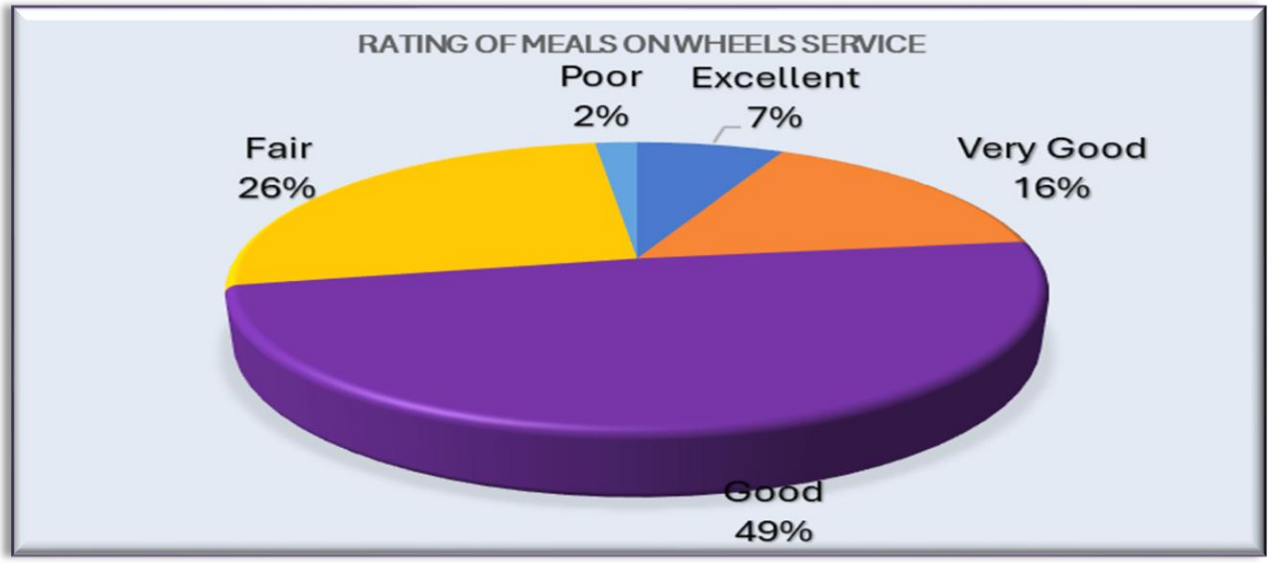
About 20% of those aged 55 years or older experience some type of mental health concern. The most common conditions include anxiety, severe cognitive impairment, and mood disorders (such as depression or bipolar disorder). Depression is associated with distress and suffering and can lead to impairments in physical, mental, and social functioning. Anxiety is a common illness among older adults which may be affected by medical conditions, life circumstances or a condition that results in cognitive impairment. Many older adults with mental and/or substance use disorders do not receive treatment. Untreated anxiety can contribute to cognitive decline and reduce a person's quality of life. Alcoholism is commonly overlooked or misdiagnosed by health care providers. Alcohol has an especially strong impact on older adults due to age-related changes in the body, chronic health conditions, prescription medications and other factors.

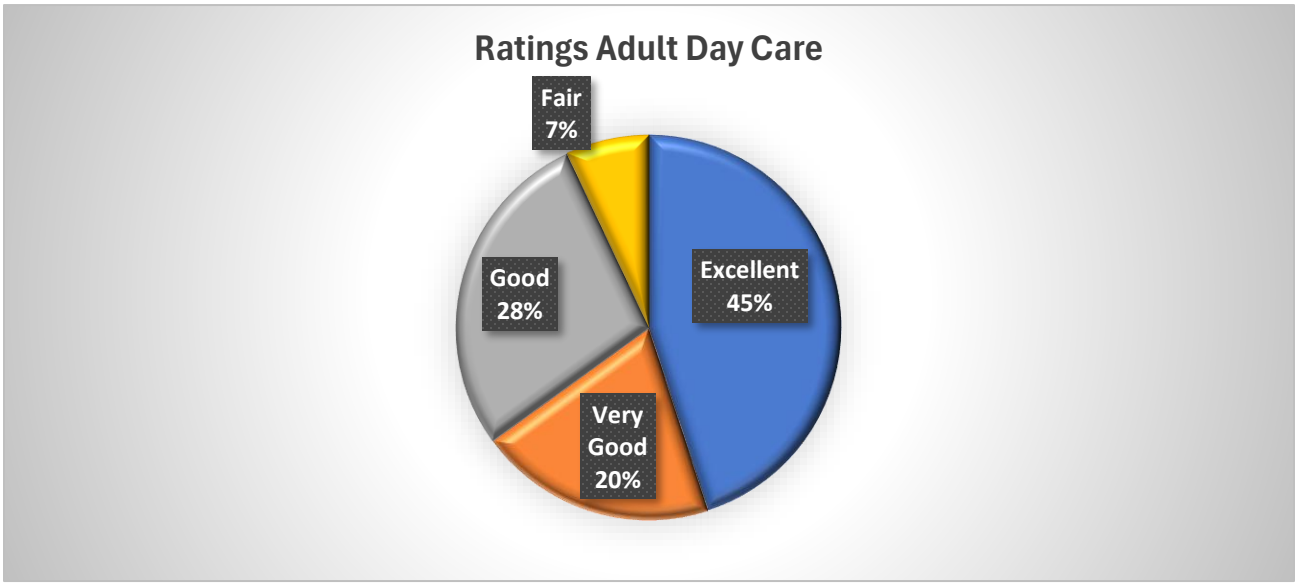


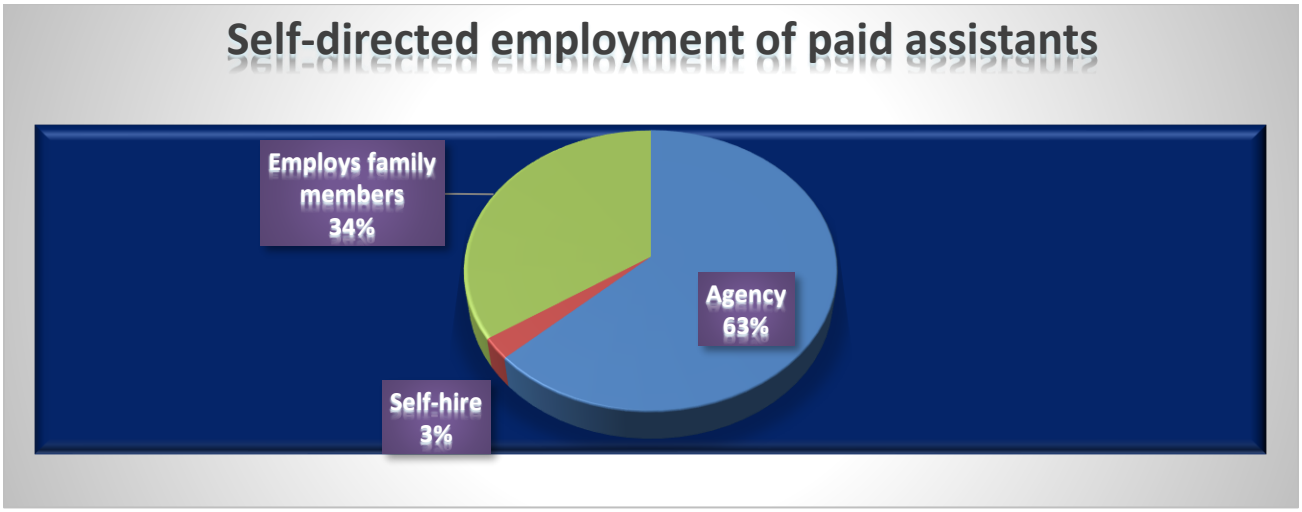
Many older adults live with chronic conditions that negatively impact quality of life and difficulty performing activities of daily living. These include heart disease, chronic obstructive pulmonary disease, cancer, diabetes, arthritis, and many other conditions.

CAHPS Services Ratings




RATING OF MEALS ON WHEELS SERVICE
Poor
2%
Excellent
7%
Fair
26%
Very Good
16%
Good
49%


Ratings Adult Day Care
Fair
7%
Excellent
45%
Good
28%
Very
Good
20%


Self-directed employment of paid assistants
Employs family
members
34%
Agency
63%
Self-hire
3%

APPENDIX G
CHCPE ANNUAL AND MONTHLY COSTS SFY 2022

Connecticut Home Care Program for Elders
SFY 2022

		Title XIX			State Funded			1915i			Total		
	MAR COS	Annual Recipients	Annual Expenditures	Monthly Cost / Service	Annual Recipients	Annual Expenditures	Monthly Cost / Service	Annual Recipients	Annual Expenditures	Monthly Cost / Service	Annual Recipients	Annual Expenditures	Monthly Cost / Service
Screening Services													
Assessments	611,581	2,548	$ 800,705	$ 26	4,489	$ 1,440,344	$ 27	14	$ 4,439	$ 26	6,952	$ 2,245,487	$ 27
Reviews	612,582	573	$ 47,939	$ 7	295	$ 33,092	$ 9	8	$ 328	$ 3	868	$ 81,359	$ 8
Sub-Total			**$ 848,644**			**$ 1,473,436**			**$ 4,767**			**$ 2,326,847**	
Waiver Services													
Case Management	601,571	14,835	$ 21,309,579	$ 120	2,452	$ 2,706,835	$ 92	336	$ 535,177	$ 133	17,225	$ 24,551,590	$ 119
Adult Day Health	841,594	856	$ 8,641,305	$ 841	74	$ 464,356	$ 523	45	$ 522,968	$ 968	962	$ 9,628,629	$ 834
Chore	842,595	78	$ 117,181	$ 125	6	$ 13,235	$ -	0	$ -	$ -	87	$ 130,416	$ 125
Companion	843,596	2,280	$ 21,425,988	$ 783	301	$ 1,318,431	$ 365	181	$ 1,362,519	$ 627	2,706	$ 24,106,938	$ 742
Elderly Foster Care	84D,59G	2,904	$ 77,587,971	$ 2,226	250	$ 4,569,421	$ 1,523	26	$ 552,945	$ 1,772	3,147	$ 82,710,338	$ 2,190
Meals	844,599	3,558	$ 6,185,167	$ 145	442	$ 513,848	$ 97	127	$ 320,143	$ 210	4,075	$ 7,019,158	$ 144
Homemaker	845,598	2,894	$ 11,726,363	$ 338	523	$ 1,489,424	$ 237	214	$ 753,218	$ 293	3,568	$ 13,969,004	$ 326
Mental Health Couns.	846,59C	352	$ 273,413	$ 65	31	$ 18,550	$ 50	12	$ 11,064	$ 77	392	$ 303,028	$ 64
Personal Emerg. Resp.	847,59A	8,062	$ 4,244,613	$ 44	1,165	$ 484,587	$ 35	194	$ 112,223	$ 48	9,275	$ 4,841,422	$ 43
Respite Care	848,59B	687	$ 4,208,687	$ 511	43	$ 109,604	$ 212	3	$ 19,674	$ 546	729	$ 4,337,964	$ 496
Non-Medical Transp.	849,59D	23	$ 48,109	$ 174	3	$ 1,587	$ 44	2	$ 1,021	$ 43	27	$ 50,716	$ 157
Assisted Living	60C,572	263	$ 4,447,060	$ 1,409	276	$ 4,128,098	$ 1,246	5	$ 44,046	$ 734	536	$ 8,619,205	$ 1,340
PCA Agency	84A,591	8,192	$ 276,240,584	$ 2,810	1,393	$ 15,751,698	$ 942	59	$ 693,117	$ 979	9,418	$ 292,685,399	$ 2,590
Minor Home Modification	84B	52	$ 254,875	$ 408	0	$ -	$ -	0		$ -	52	$ 254,875	$ 408
Assistive Technology	84C	93	$ 103,714	$ 93	4	$ 4,300	$ 90	0	$ -	$ -	97	$ 108,014	$ 93
PCA Individual	60G	7	$ 162,087	$ 1,930	82	$ 1,158,488	$ 1,177	0	$ -	$ -	86	$ 1,320,575	$ 1,280
Care Transitions	84F	125	$ 21,883	$ 15	2	$ 145	$ 6	0	$ -	$ -	127	$ 22,028	$ 14
Bill Payer	84G,59I	110	$ 36,652	$ 28	6	$ 927	$ 13	2	$ 1,455	$ 61	115	$ 39,034	$ 28
Chron Disease Self Mgmt	84H	0	$ -	$ -	0	$ -	$ -	0	$ -	$ -	0	$ -	$ -
Support Broker	84I	0	$ -	$ -	0	$ -	$ -	0	$ -	$ -	0	$ -	$ -
Recovery Assist Agency	84J	0	$ -	$ -	0	$ -	$ -	0	$ -	$ -	0	$ -	$ -
Sub - Total (c)		**14,835**	**$ 437,035,228**	**$ 2,455**	**2,452**	**$ 32,733,534**	**$ 1,112**	**336**	**$ 4,929,571**	**$ 1,223**	**17,225**	**$ 474,698,333**	**$ 2,297**
Community First Choice (d)		**1,170**	**$ 38,042,506**	**$ 2,710**	**12**	**$ 173,336**	**$ -**	**0**	**$ -**		**1,170**	**$ 38,042,506**	**$ 2,710**
Home Health Services (e,f)			**$ 25,794,725**			**$ 668,380**			**$ 714,658**			**$ 27,177,762**	
Total - Comm. Svcs.		**14,835**	**$ 501,721,103**	**$ 2,818**	**2,452**	**$ 35,048,685**	**$ 1,191**	**336**	**$ 5,648,995**	**$ 1,401**	**17,225**	**$ 542,245,448**	**$ 2,623**

(a) The source of all Screening Services, Waiver Services, Community First Choice expenditures and unduplicated recipients is a Data Warehouse query.
(b) Avg. Montly Cost per Recipient reflects the Annual Expenditures divided by 12 and by the Total Unduplicated Count of Recipients.
(c) Source of the undpulicated recipients is the figure shown for "Case Management".
(d) Community First Choice costs by waiver participation are estimated using a data Warehouse query.
(e) Home Health Expenditures for waiver and 1915i recipients are estimated using a Data Warehouse query.
(f) Some recipients receive services under more than one category during the year, therefor the total recipients is less than the sum of the categories.