Home and Community Based Services

Mental Health Waiver

Working for Integration Support and Empowerment

Annual Report
To the Legislature
Waiver Year 6
Period ending March 31, 2015

Introduction

The Mental Health Home and Community-Based Services (HCBS) Waiver is designed for adults with serious mental illness who are being discharged or diverted from nursing home care. This Medicaid Waiver provides participants with the medical and psychiatric services and supports necessary to live independently in the community. The Waiver was authorized to serve a total of 553 individuals through March 31, 2017, the end of the approved waiver period, who are currently in nursing facilities or who are at risk for this level of care. For this reporting period, April 1, 2014 through March 31, 2015 the benchmark noted in the approved waiver is 374 individuals served. Service delivery emphasizes psychiatric rehabilitation and recovery from the disabling effects of psychiatric disorders. Waiver services are provided face to face, in the participant's home or in other community settings (non-office based). Individualized assessment, Recovery Plan development, and service delivery emphasize participant strengths and assets, utilization of natural supports and community integration.

The HCBS Waiver is operated by the Department of Mental Health and Addiction Services with oversight by the Department of Social Services, Connecticut's Single State Agency for Medicaid. The Mental Health Waiver Program works in collaboration with Connecticut's Money Follows the Person Rebalancing Demonstration, resulting in a decrease in institutional care. To date, a series of initiatives funded by the Centers for Medicare and Medicaid Services (CMS) have supported some of the infrastructure and service delivery changes necessary to achieve the rebalancing benchmarks identified in the State's Long-Term Care Plan. Funding directed towards the Governor's rebalancing initiatives and associated benchmarks indicate progress towards rebalancing under the latest broad based initiative to support rebalancing, by focusing on individuals who have been in nursing homes for more than 3 months, and who are either elders or persons with any of a broad range of disabling conditions including mental illness. Each individual receives MFP services for one year and then has the option of continuing to receive their home and community services under the waiver. This 1915(c) waiver will thus play a critical role in supporting the provision of ongoing services to individuals with mental illness who transitioned out of nursing homes under MFP.

Overview of Mental Health Waiver

The HCBS 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 because of its emphasis on:

- Intensive psychiatric rehabilitation provided in the participant's home, and in other community settings;
- Attention to both psychiatric and medical 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 from first-hand experience about recovery from mental illness.

The HCBS waiver program, authorized in §1915(c) of the Social Security Act, allows the State to furnish an array of home and community-based services that assist Medicaid beneficiaries to live in the community and avoid institutional care. The State had broad discretion to design its waiver program to address the needs of the waiver's target population. Waiver services complement and/or supplement services available to participants through the Medicaid State plan and other federal, state and local public programs as well as natural supports that families and communities provide.

Overview of Money Follows the Person Program

The Money Follows the Person program (MFP) was created by Section 6071 of the Federal Deficit Reduction Act (DRA) of 2005 (P.L. 109-171), which authorized $1.75 billion to support efforts to move nursing home residents back into their communities. MFP is a Demonstration Project administered by DSS in partnership with other state agencies. The goal of Connecticut's MFP is to rebalance Connecticut's long-term care systems with an emphasis on home and community-based services rather than nursing home care. MFP provides services to a broad range of persons with disabilities including persons with intellectual disabilities, persons with physical disabilities, persons with brain injuries, persons who are elderly, and persons with mental illness. Eligibility for services funded by MFP is based on Medicaid eligibility and a minimum 3 month length of stay in an institution. MFP funded services for persons who have a mental illness include a) home and community based services identical to those available under the MH Waiver, b) services otherwise authorized by the Medicaid State Plan and c) demonstration services not authorized under any waiver. Once an MFP participant with mental illness has received MFP services for 365 days, the participant may transition to the MH Waiver program.

MFP was initiated in December 2008.

Program Organization

Connecticut Department of Mental Health and Addiction Services with oversight by the Department of Social Services, Connecticut's Single State Agency for Medicaid, operate the Mental Health Waiver program. The Mental Health Waiver authorized in Section 1915(c) of the Social Security Act permits the Secretary of the U.S. Department of Health and Human Services to set aside Medicaid regulations and to allow funding to provide a variety of home and community based services (excluding room and board) to individuals with serious mental illness who would otherwise require nursing home care. This Mental Health Waiver enables Medicaid to cover the cost of services designed to assist participants in acquiring, retaining, and improving the self-help, socialization, and adaptive skills necessary to reside successfully in home and community based settings.

DSS and DMHAS contract with a Fiscal Intermediary who serves as the Connecticut Medicaid Billing Provider for MFP/MH Waiver Services and Credentialing. MFP/MH Waiver Services are available to adults with serious mental illness that are being discharged or diverted from nursing home care and are receiving Connecticut Medicaid benefits.

MH Waiver Admission and Service Provision

Eligibility Criteria

Criteria set forth in the waiver application permit voluntary enrollment of Medicaid eligible adults who meet requirements for care in a nursing home and have a diagnosis of serious mental illness. These individuals may be: A) currently residing in a nursing home (potential discharges), B) living in the community but have an active psychiatric disorder are being considered for nursing home placement (potential diversions), or C) have already been discharged from a nursing home under the Medicaid Money Follows the Person (MFP) program.

In addition, the person must: A) have two or more serious life problems due to mental illness, B) not be in need of emergency psychiatric hospitalization, and C) need rehabilitation and professional assistance in developing and implementing their plan for recovery.

Referral/Screening Process

Individuals may apply for services by completing the Waiver Request Form and forwarding it to the DMHAS Waiver Staff for review and follow up. The initial Waiver request form is screened to determine if the individual is psychiatrically, functionally and financially eligible for the Waiver. Psychiatric and functional eligibility is confirmed by Waiver staff and financial eligibility is determined by DSS. Once these criteria are established, a DMHAS Community Support Clinician will schedule a face to face interview to continue Level of Care determination.

Eligibility Determination

The Community Support Clinician conducts a level of care assessment to evaluate whether an individual needs nursing facility level of care. As outlined in the approved waiver application level of care is described as requiring assistance with at least three critical needs including: bathing, dressing, toileting, and transferring, eating/feeding, meal preparation and medication administration; or two critical needs and four or more cognitive deficits; cognitive deficits may include: orientation, concentration, abstract reasoning, comprehension, planning, judgment, attention, and memory.

In addition to determining need for nursing facility level of care the Community Support Clinician will also evaluate if the cost of the waiver services is expected to remain within the cost limit established by the state assuring health and safety needs can be met. If these criteria are satisfied an individual is determined to be eligible to receive waiver services.

Recovery Plan

Following determination of eligibility, the Community Support Clinician would continue assessment process with the applicant to develop a comprehensive recovery plan and to determine the most appropriate services to assist the participant to live in the community.

The initial Recovery Plan includes the following:

- A summary of strengths, needs, and preferences indicating the need for services;
- Client's desired outcome;
- Specific short-term objectives and long-term goals,
- A description of risk factors and special procedures recommended for the health and safety of the client.

In addition, the Recovery Plan includes the specific services to be provided and the frequency of services. The plan identifies all services and supports needed by the individual regardless of the payer. It also identifies (when applicable) the specific organization that will be requested to offer more formal treatment and support services.

Service Monitoring

The DMHAS Community Support Clinician is responsible for monitoring the Recovery Plan semiannually in a face to face meeting with the client, or more frequently if needed, to determine whether:

- Services are furnished in accordance with the Recovery Plan;
- Participants have access to MFP/waiver services identified in the service plan;
- Services continue to meet the needs of the participant;
- Back-up plans are effective;
- Participant health and welfare is ensured;
- Participants continue to be offered and exercise free choice of providers; and,
- Participants have access to non-waiver services identified in the Recovery Plan, including access to health services.

The meetings also review the service implementation status, care efficacy, and participant progress. Participant safety, and health and welfare are also reviewed. At these meetings, Recovery Plans are adjusted congruent with client needs.

Waiver Service Package

Each person enrolled in the waiver participates in a ***Person-Centered Planning*** process leading to the development of an individualized ***Recovery Plan***. The plan, developed collaboratively with the participant and a DMHAS Community Support Clinician, includes at least one of the following services:

Rehabilitative and Support Services:

- **Adult Day Health** – programs provide a variety of health and social services needed to ensure the optimal functioning of the participant. Services provided in a supervised group setting.
- **Assistive Technology** - An item, piece of equipment, or product system that is used to increase, maintain, monitor or improve functional capabilities of participants to perform Activity of Daily Living (ADL), or Instrumental Activities of Daily Living. (IADL).
- **Brief Episode Stabilization** – services designed to stabilize a participant in an emerging crisis situation or following discharge from an institutional level of care.
- **Community Support Program (CSP)** – a flexible, team-based approach to community rehabilitation. Provides supports to achieve and maintain independent living skills.
- **Home Delivered Meals** – commonly known as "meals on wheels," will provide one or two meals per day for persons who are unable to prepare or obtain nourishing meals on their own.
- **Personal Emergency Response System** – electronic device worn by individual to secure help in an emergency may include an electronic medication management system.
- **Peer Support** – an alternative or "step-down" and follow-up to CSP provided by a trained and certified peer specialist
- **Recovery Assistant** – homemaker, companion, personal care, and in-home respite services deigned to help a participant maintain his/her own home.
- **Supported Employment** – an effective array of mental health supports designed to help participants find and sustain competitive employment.
- **Transitional Case Management** – services provided during the weeks prior to, and immediately following discharge from a nursing home, to help locate and set up a suitable apartment or other living arrangement.

Residential Based Services:

- **Assisted Living Service Agency** - personal care and services, provided in a licensed community care facility, provided to residents of the facility. This service includes 24 hour on site response staff.
- **Overnight Recovery Assistant** - service would provide supervision and assistance as needed during evening and overnight hours to enable individuals to live safely in an independent community setting. Staff could provide support for up to six individuals living in close proximity. No more than four individuals shall live together.

Detailed descriptions of these services are included in Appendix A.

Referral and Enrollment Status

DMHAS began accepting referrals from MFP in January 2009. All referrals were assessed for eligibility. Individuals meeting the eligibility criteria were engaged in Person Centered Planning and the development of a Recovery Plan to guide service utilization and delivery in the community. The tables below outlines the status of referrals received and processed for each waiver year period. Individuals enrolled were discharged from a long term care facility or diverted from admission to a nursing facility. Cases closed represent individuals who were found eligible for participation that later chose to withdraw from participation, chose alternate service settings, or were determined no longer eligible.

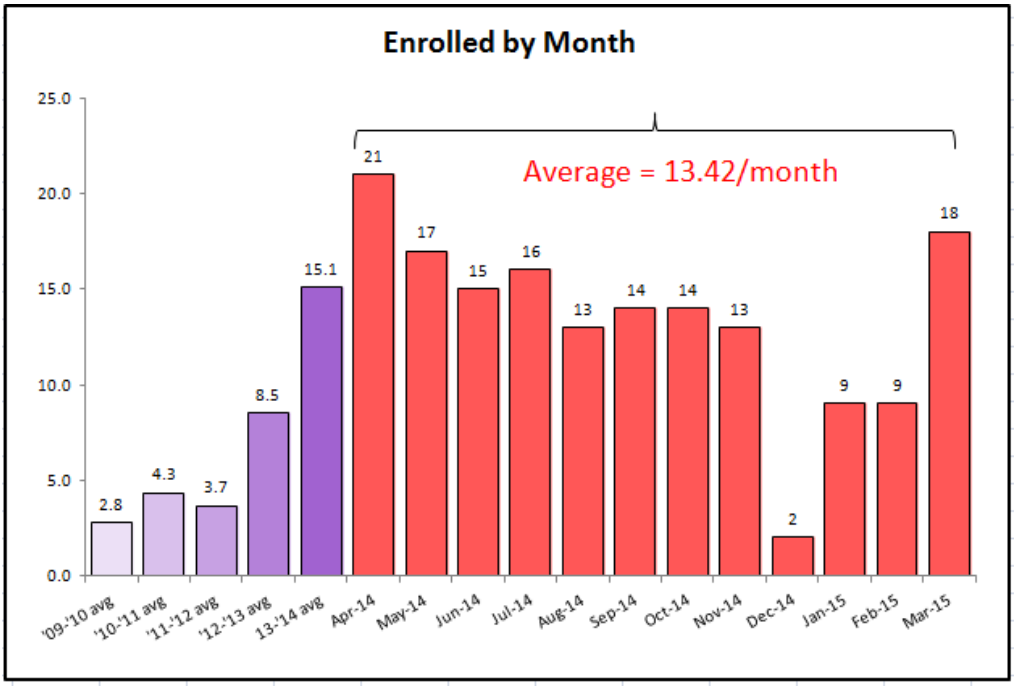
		Program Referrals					
	Year 1	**Year 2**	**Year 3**	**Year 4**	**Year 5**	**Year 6**	**Total**
Referrals	233	116	170	253*	452**	683	1907
Eligible	94	48	98	145	236	318	939
	40%	*41%*	*58%*	*57%*	*52%*	*47%*	*49%*
Not Eligible	139	68	72	108	216	365	968
	60%	*59%*	*42%*	*43%*	*48%*	*53%*	*51%*

* does not include 16 closed through pre screening
** does not include 99 closed through pre screening

	Status of Eligible Clients						
	Year 1	**Year 2**	**Year 3**	**Year 4**	**Year 5**	**Year 6**	**Total**
Newly Enrolled – Received Services	33	52	44	102	181	161	412

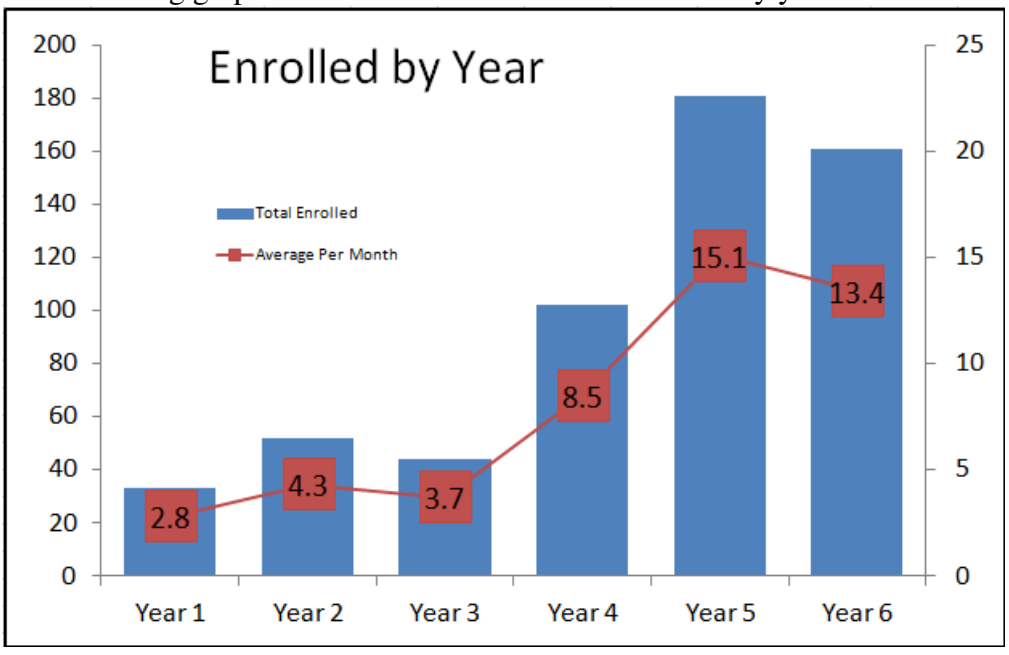
Enrolled by Month

The following graph illustrates enrollment of individuals by month:



Enrolled by Year

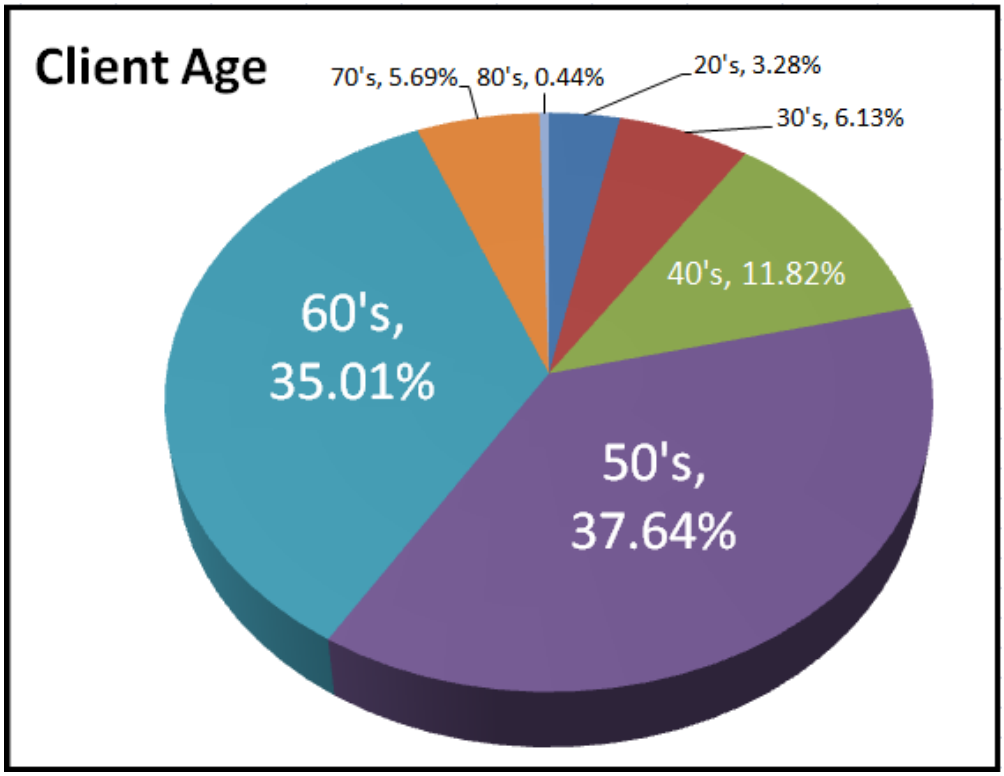
The following graph illustrates enrollment of individuals by year:



Client Characteristics

The average age of individuals enrolled on the Mental Health Waiver is 56. Fifty five (55) percent of participants are female while forty five (45) percent of participants are male. Demographic breakdown is further outlined in the following graph.

Ages of Enrolled Mental Health Clients



Service Delivery/ Utilization

Service Delivery is based on date of claim payment and not on date of service. Units represented in one Waiver Year period may include services rendered in the previous Waiver Year.

Total Claims Paid April 1, 2014– March 31, 2015- Current Reporting Period

	Num. of Trans.	Clients	Amount Paid
Adult Day Health	220	3	10,672.68
Assisted Living (ALSA)	6,358	12	180,675.95
Brief Episode Stabilization	0	0	0
Community Support Program	12,219	336	1,762,275.19
Home Adaptation	0	0	0
Non-Medical Transportation	0	0	0
Peer Supports	145	2	7,817.22
Personal Emergency Response Systems (PERS)	2042	230	88,438.31
Recovery Assistant	69,670	405	6,793,752.99
Specialized Medical Equipment (SME)	374	65	38,560.89
Supported Employment	40	2	2,460.88
Transitional Case Management (TrCM)	169	46	12,832.01
TOTAL	**91,237**		**8,913,151.24**

Total Claims Paid April 1, 2009– March 31, 2015

	Num. of Trans.	Clients	Amount Paid
Assertive Community Treatment	742	2	78,378.63
Assisted Living (ALSA)	7,423	17	209,906.25
Brief Episode Stabilization	4	3	1,592.01
Community Support Program	33,558	627	4,655,322.18
Home Adaptation	13	11	43,224.80
Non-Medical Transportation	4	1	48.16
Peer Supports	628	6	33,395.97
Personal Emergency Response Systems (PERS)	3,574	390	152,747.04
Recovery Assistant	195,886	760	16,789,533.92
Specialized Medical Equipment (SME)	2,441	204	175,078.56
Supported Employment	195	12	10,491.12
Transitional Case Management (TrCM)	866	144	67,962.22
TOTAL	**244,571**		**22,094,437.26**

Cost Neutrality

Cost containment is maintained through hard cost cap on the individual plan of care. The cost of a plan of care cannot exceed 125% of the average cost of nursing facility level of care for the past three (3) years. For the current Waiver year, the maximum allowable cost of annual services cannot exceed $87,000. If a client's level of need changes while enrolled in the MH Waiver, the

plan must be altered to accommodate these needs. If the needs cannot be met safely within the cost allotment, the client will be referred to a higher level of care.

Service System Development

Provider Recruitment

DSS and DMHAS contract with a fiscal intermediary to perform various administrative functions and assist mental health waiver participants who choose to self-direct their recovery assistant services. The fiscal intermediary also serves as the Medicaid Billing Provider for all Waiver services. Under the DSS and DMHAS contractual agreement, the fiscal intermediary had been required to develop and implement a network of waiver service providers by recruiting and credentialing qualified providers.

During waiver year 6, twelve (12) credentialing applications were received. The table below summarizes the number of credentialed providers active for each service as of March 31, 2015:

Service Type	Providers Credentialed
Community Support Program (CSP)	24
Recovery Assistant (RA)	20
Transitional Case Management	20
Supported Employment	9
Peer Support (PS)	4
Brief Episode Stabilization	3
Assisted Living Service (ALSA)	1
Specialized Medical Equipment	5
PERS	2
Home Adaptations	12
Non Medical Transportation	0
Home Delivered Meals	0
Adult Day Health	1

Per the MH Waiver, Recovery Assistant (RA) services must be re-credentialed every two (2) years and Community Support Program (CSP), Peer Supports and Transitional Case Management (TCM) services must be re-credentialed every three years. One (1) site visit was conducted in waiver year 6 by Advanced Behavioral Health, Inc. with one(1) agencies re-credentialed to provide RA services.

Recovery Assistants

Using the concept of Recovery and Psychiatric Rehabilitation, a unique service provided by Recovery Assistants was designed for use by the participants of the Mental Health Waiver. Recovery Assistants encourage individuals to work towards their personal goals, dreams, hopes and aspirations. This service combines the job function of homemaker, personal care assistant, respite worker and companion. The focus of work centers on teaching, coaching, cuing and training individuals to increase capacity for recovery and independence.

Beginning in June 2013, the RA training was converted from a two-day in person training to a hybrid model. The first day of training is now a mandatory online training format. RAs that pass the online section are provisionally credentialed to provide RA service and are required to complete a one day in-person training within 60 days from passing the online section. See Appendix B for curriculum of this training. In an effort to assess if the RA training accomplishes its learning objectives and responds to the learning needs of the participants, evaluations are conducted at the conclusion of each day of training. Results of the evaluation are used to modify the curriculum as appropriate.

Quality Assurance and Quality Improvement Processes

The Quality Assurance and Quality Improvement Processes for the Mental Health Waiver are two methods that are utilized to continuously monitor the unique needs and range of services provided to our clients.

The Quality Assurance Process has three components:

1. The Quality Assurance Review Team provides ongoing monitoring of programs, services and client satisfaction. Utilizing on-site visits, record reviews and reports, the Quality Assurance Review Team records and reports:

- Participant accessibility and eligibility process
- Participant's involvement in planning of services
- Provider Agencies' qualifications, service planning and delivery, safeguards, fiscal integrity and client satisfaction.

DMHAS, in collaboration with the Fiscal Intermediary, developed and utilizes a data system that examines a range of indicators to monitor how the Mental Health Waiver services can better support program participants. Data is submitted from providers on an ongoing basis according to established contractual requirements. On-site visits to providers are conducted, which include client record reviews and face-to-face interviews.

2. The Mental Health Waiver Project Team reviews Provider Agency reports and data, client feedback, issues and trends. In collaboration with DSS, recommendations are addressed in quarterly Quality Assurance meetings. Please refer to Appendix C- 1 for the Annual Quality Assurance report.

3. The Mental Health Advisory Council meets semi-annually to review issues and trends and make recommendations for system improvements. The Council is comprised of clients, families,

a DSS representative, Waiver staff and community providers. Please refer to Appendix C-2 for Advisory Council members.

The Quality Improvement Process:

In an effort to improve the quality of psychiatric rehabilitation services provided to Mental Health Waiver clients, Quality Improvement (QI) allows for continual examination and improvement. During the process of implementation, QI, along with the flexibility and assistance of staff, providers, and advisory counsel members, has produced immediate systemic improvements. The QI process involves auditing, chart review, claim and encounter note review, client and provider satisfaction survey, and appropriateness of care procedures and tools.

The DMHAS Research Division is continuing its work to evaluate the effectiveness of services provided through the waiver. During this past reporting period, the Research Division staff has evaluated the Level of Care (LOC) Skills Assessment - a primary tool used to assess a participants' level of need - to evaluate its effectiveness as a tool to put in place the appropriate waiver and community services to respond to an individual's needs. Results of the research indicate that the highest areas of need derived from the LOC Skills Assessments are the following: Independent Living Skills, Memory/Cognition, Medication Management, and Health Awareness. Mental Health Scores considered of highest priority are as followed: Meal Preparation, Medication Administration, Memory/Cognition Deficit, and Bathing.

The LOC Skills Assessment tool was then crosswalked against the Universal Assessment Tool (UAT) currently under development by the Department of Social Services (DSS) to ensure compatability. DMHAS representatives have been involved in the development and testing of the UAT and attended an individual meeting with UAT software developer to discuss program specific requirements and data collection and storage methods for the MH Waiver

Federal Waiver Assurances

In accordance with 42 CFR §441.302, the State provides the following assurances to CMS:

Level of Care (LOC)

- An evaluation for LOC is provided to all applicants for whom there is reasonable indication that services may be needed in the future
- The levels of care of enrolled participants are re-evaluated at least annually or as specified in the approved waiver
- The processes and instruments described in the approved waiver are applied appropriately and according to the approved description to determine participant level of care

Service Plan

- Service plans address all participants' assessed needs (including health and safety risk factors) and personal goals, either by the provision of waiver services or through other means
- The state monitors service plan development in accordance with its policies and procedures
- Service plans are updated/revised at least annually or when warranted by changes in the waiver participant's needs
- Services are delivered in accordance with the service plan, including type, scope, amount, duration, and frequency specified in the service plan
- Participants are afforded choice: Between waiver services and institutional care; and between/among waiver services and providers

Qualified Providers

- The state verifies that providers, initially and continually, meet required licensure and/or certification standards and adhere to other standards prior to their furnishing waiver services
- The state monitors non-licensed/non-certified providers to assure adherence to waiver requirements
- The state implements its policies and procedures for verifying that provider training is conducted in accordance with state requirements and the approved waiver.

Health and Welfare

- The state, on an ongoing basis, identifies addresses and seeks to prevent the occurrence of abuse, neglect and exploitation.

Financial Accountability

- State financial oversight exists to ensure that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver

Administrative Authority

- The Medicaid Agency retains ultimate administrative authority and responsibility for the operation of the waiver program by exercising oversight of the performance of waiver functions by other state and local/regional non-state agencies (if appropriate) and contracted entities.

Compliance with CMS Waiver Assurances is monitored through the Quality Assurance Review Team and quarterly record audits. During the waiver year no assurances required remediation activity.

Waiver Amendment

As part of an ongoing Quality Improvement efforts and to assure that the Mental Health Waiver provides services responsive to the needs of the individuals it is targeted to serve, a request to amend the waiver application was submitted to CMS for review. The proposed changes would be, effective July 1, 2015 and would include the following changes:

- Add Assistive Technology as a waiver service
- Increase annual census numbers from 374 to 421 in Year 3, 465 to 607 in Year 4, 553 to 811 in Year 5
- Clarify Waiver language regarding electronic record keeping
- Remove Community Living Support Services due to non utilization of the service

The Amendment enables the state to provide a broader range and flexibility of services.

Conclusion

The Mental Health waiver program in Connecticut is one of several initiatives by the Departments of Social Services and Mental Health and Addiction Services designed to help divert and discharge people with serious mental illness from long term care facilities. While long term care may be necessary for some individuals with psychiatric disabilities who have co-occurring physical conditions, their stay in these facilities should not be prolonged beyond the period necessary for recovery from their medical condition. The Mental Health waiver provides valuable psychiatric rehabilitation services to support individuals in the community.

APPENDIX A

REHABILITATIVE and SUPPORT SERVICES:

Adult Day Health - The service is provided 4 or more hours per day on a regularly scheduled basis for one or more days per week, or as specified in the service plan, in a non-institutional, community-based setting and shall encompass both health and social services needed to ensure the optimal functioning of the participant. Transportation to and from the center is included in the service definition and in the rate structure. Meals provided as part of these services shall not constitute a full nutritional regimen. Claims will denied by any Adult Day Health provider attempting to bill for transportation procedure codes. These procedure codes are not included on the Adult Day Health fee schedule and will deny as edits are built into the claim processing system to prevent duplicative transportation services for Adult Day Health from occurring.

Services Covered and Limitations

A program nurse shall be available on site for not less than fifty percent of each operating day. The program nurse shall be a registered nurse, except that a program nurse may be a licensed practical nurse if the program nurse is supervised by a registered nurse who can be reached by telephone at any time during the operating day and who can be called to the center if needed within one half hour of the request. The program nurse is responsible for administering medications as needed and assuring that the participant's nursing services are coordinated with other services provided in the adult day health center, health and social services currently received at home or provided by existing community health agencies and personal physicians. Assistance with ADL needs shall be provided as specified in the individual plan of care, including but not limited to, bathing and transferring. Facilities for bathing are available as part of the physical plant.

Ongoing training shall be available to the staff on a regular basis including, but not be limited to, orientation to key specialty areas such as physical therapy, occupational therapy, speech therapy and training in techniques for recognizing when to arrange or refer clients for such services; and individual therapeutic and rehabilitation services shall be coordinated by the center as specified in the individual plan of care including but not limited to, physical therapy, occupational therapy and speech therapy.

To be considered a Medical Model the provider shall provide the above services and have nursing available the entire day. Additionally the center shall have the capacity to provide therapeutic and rehabilitation services on site. This requirement shall not preclude the provider of adult day health services from also arranging to provide therapeutic and rehabilitation services at other locations in order to meet needs of individual clients.

Payment for adult day services shall include the costs of transportation, meals and all other required services except for individual therapeutic and rehabilitation services. Individual therapeutic and rehabilitation services are provided as part of state plan services and may be billed accordingly.

Brief Episode Stabilization - This service may be used to stabilize an individual following discharge from an institutional setting or to avert admission to this level of care. The service utilizes brief, concentrated interventions directed to stabilize psychiatric conditions, behavioral and situational problems and to prevent escalation of psychiatric symptoms, and wherever possible to avoid the need for hospitalization or other more restrictive placement. Services and interventions are highly individualized and tailored to the needs and preferences of the participant, with the goal of maximizing independence and supporting recovery.

Brief Episode Stabilization services are provided to restore a participant's ability to manage his or her illness and their ability to utilize treatment. These services are designed to restore prior functional level and reduce the likelihood of crisis recurrence. Interventions include practical problem-solving advice and assistance designed to address and remediate the antecedent causes of an emerging psychiatric or behavioral crisis; or to manage stressors related to exacerbation of ongoing medical conditions.

Services would take place in the participant's home or in other community (non-residential) settings. This intervention typically takes place in 4 to 8 hour blocks of time, and might last up to 24 or 48 hours. If the individual cannot be stabilized within this time period, a more intensive intervention is usually needed.

Covered services
Brief Episode Stabilization services of at least 15-minutes duration provided to the participant in his/her home and in other community settings. These services include:

1. Observation, evaluation and monitoring in order to reduce the participant's risk of harm to self or others, and to determine whether additional supports are necessary;
2. Practical problem-solving advice and assistance designed to address and remediate the antecedent causes of an emerging psychiatric or behavioral crisis;
3. Crisis intervention and supportive counseling designed to stabilize functioning, reduce stress, calm the participant and prevent further deterioration;
4. Communication with supervisory staff to report the participant's condition and determine whether any additional assistance is needed;

Community Support Program (CSP) consists of mental health and substance abuse rehabilitation services and supports necessary to assist the individual in achieving and maintaining the highest degree of independent functioning. The services utilize a team approach to provide intensive, rehabilitative community support, crisis intervention, group and individual psycho-education, and skill building for activities of daily living.
CSP includes a comprehensive array of rehabilitation services, most of which are provided in non-office settings by a mobile team. Services are focused on skill building with a goal of maximizing independence. Community-based treatment enables the team to become intimately familiar with the participant's surroundings, strengths and challenges, and to assist the participant in learning skills applicable to his/her living environment. The team services and interventions are highly individualized and tailored to the needs and preferences of the individual.

Covered services
CSP services of at least 15-minutes duration provided to the participant by a direct-care staff member of the CSP team in the participant's home and in other community settings. These services include:

1. Rehabilitation assessment and development of the rehabilitation plan;
2. Re-evaluation and adjustment of the rehabilitation plan;
3. Crisis response services either face-to-face or telephonic;
4. Psycho-education services for rehabilitation from psychiatric or substance abuse disorders;
5. Clarification of goals and motivational support for pursuing goals related to employment, education, community involvement, and use of natural supports. (NOTE: Documentation shall be maintained in the file of each participant receiving work or education-related services that such services are not available under a program funded under section 110 of the Rehabilitation Act of 1973 or the Individuals with Disabilities Education Act (20 U.S.C. 1401 et seq.));
6. Residential supports, such as motivating the participant to find and lease an apartment, and assistance with tenancy issues and problems;
7. Skill building and support for Activities of Daily Living, including:
    a) Teaching, coaching and assisting with daily living and self-care skills such as the use of transportation, nutrition, meal planning and preparation, housekeeping and basic household tasks, dressing, personal grooming and hygiene, management of financial resources, shopping, use of leisure time, interpersonal communication, personal safety, child care and parenting, basic first aid, and problem solving;
    b) Other skill development activities directed at reducing disability, restoring participant functioning and achieving independent participation in social, interpersonal, family, or community activities and full community re-integration and independence as identified in the waiver Recovery Plan;
    c) Teaching of recovery skills in order to prevent relapse such as symptom recognition, coping with symptoms, emotional management, relaxation skills, self administration and appropriate use of medications, and preparation of illnesses related advance directives;
    d) Development of self-advocacy skills for the purpose of accessing natural supports, self-help, and other advocacy resources; and
    e) Health and wellness education
8. Education, support, and consultation to family members (and significant others) of the participant, provided these activities are directed exclusively toward the rehabilitation treatment of the participant;
9. Group treatment, involving not more than four persons receiving care, focusing on any of the activities listed in items #4 through #7 above.

Home Delivered Meals – This service will provide the preparation and delivery of up to two meals per day for persons who are unable to prepare or obtain nourishing meals on their own. Provided meals must meet a minimum standard of one-third of the current daily recommended dietary allowance and requirements as established by the Food and Nutrition Board of the National Academy of Sciences National Research Council.

Covered Services
Up to two meals per day, seven days per week, depending on the individual's recovery plan. Payment for Home Delivered Meals shall include the costs of transportation, and all other required services.

Peer Support –includes face-to-face interactions that are designed to promote ongoing engagement of persons covered under the waiver in addressing residual problems resulting from psychiatric and substance use disorders, and promoting the individual's strengths and abilities with respect to socialization, recovery, self-advocacy, development of natural supports, and maintenance of community living skills. Peer support also includes communication and coordination with behavioral health services providers and others in support of the participant.

Covered services
Peer Support services of at least 15-minutes duration provided face-to-face with the participant in his/her home and in other community settings. These services include:

1. Coaching and support related to:
    a. Continued use of recovery skills;
    b. Involvement in community activities and positive relationships with family and friends;
    c. Attention to personal hygiene and appropriated dress;
    d. Involvement in vocational, volunteer or educational activities;
    e. Follow through on personal obligations and commitments;
    f. Self advocacy during self-help, peer support and community meetings;
    g. Self advocacy during meetings with providers to facilitate linkage, communication and improved continuity of care;
    h. Development of natural supports;
    i. Filing complaints and follow-up with proposed resolution as needed, finding resources;
2. Assisting with avoidance of:
    a. Behaviors that might lead to a psychiatric crisis;
    b. Risky behaviors (e.g., unprotected sex, smoking/excessive use of tobacco products, unsafe driving/driving without seatbelt, unsafe relationships, criminal activities);
    c. Substance abuse;
    d. Overspending;
    e. Unnecessary conflict;
3. Mentoring and advice to facilitate development of effective decision making and problem solving skills;

Recovery Assistant - A flexible range of supportive assistance provided face-to-face in accordance with a Waiver Recovery Plan that enables a participant to maintain a home/apartment, encourages the use of existing natural supports, and fosters involvement in social and community activities. Service activities include: performing household tasks, providing instructive assistance, or cuing to prompt the participant to carry out tasks (e.g., meal preparation; routine household chores, cleaning, laundry, shopping, and bill-paying; and

participation in social and recreational activities), and; providing supportive companionship. The Recovery Assistant may also provide instruction or cuing to prompt the participant to dress appropriately and perform basic hygiene functions; supportive assistance and supervision of the participant, and short-term relief in the home for a participant who is unable to care for himself/herself when the primary caregiver is absent or in need of relief.

The Recovery Assistant service can also be provided in a group setting with a 2:1, 3:1 or 4:1 client to staff ratio. Reimbursement rates are tiered based on the number of clients with the individual rate billed to each client served. With this methodology, the provider receives additional funds but in an amount less than what would be paid out for working with 1, 2, or 3 clients individually. When all 2, 3 or 4 clients are billed, the provider receives roughly 150%, 175% and 200% respectively of the unit rate for a single client.

Covered services

Recovery Assistant services of at least 15-minutes duration provided to the participant in his/her home and in other community settings. These services include:

1. Performing the following tasks if the participant (by reason of physical or psychiatric disability) is unable to perform them, or assisting, or cuing the participant to perform them:
    a. Meal planning and preparation, shopping, housekeeping (e.g., changing linens, washing dishes, vacuuming/dusting, laundry, mending clothing repairs), basic household tasks (e.g., regulating home temperature, storing food appropriately, resolving issues about bill paying).
    b. Dressing, personal grooming and hygiene (e.g., bathing, dressing, and oral care).
    c. Appropriate use of emergency medical services.
2. Assisting or cueing the participant to perform or become engaged in:
    a. Family, social, and recreational activities.
    b. Appropriate use of natural community supports (e.g., social clubs, faith-based supports).
    c. Appropriate use of routine medical/dental services.
    d. Use of medications as prescribed, including self administration of medications.
    e. Healthy habits (e.g., healthy diet, exercise, and behaviors designed to alleviate stress).
    f. Fulfillment of personal commitments, and adherence to scheduled appointments/meetings (e.g., clinical, vocational, educational, and judicial/court).
3. Assisting or cuing the participant to avoid:
    a. Risky behaviors (e.g., unprotected sex, smoking/excessive use of tobacco products, unsafe driving/driving without seatbelt, unsafe relationships, criminal activities).
    b. Substance abuse.
    c. Overspending.
    d. Unnecessary conflicts.
4. Supportive and problem solving-oriented discussions with the participant.
5. Establishing and maintaining a helpful, supportive, companionship relationship with the participant that involves such activities as:

a. Escorting the participant to necessary medical, dental, or personal business appointments;
b. Reading to or for the participant;
c. Engaging in or discussing recreational, hobby, or sport-related activities;

6. Other activities directed at reducing disability, restoring participant functioning and achieving independent participation in social, interpersonal, family, or community activities and full community re-integration and independence;

Supported Employment – Services consist of intensive, ongoing supports that enable participants, for whom competitive employment at or above the minimum wage is unlikely absent the provision of supports, and who, because of their disabilities, need supports, to perform in a regular work setting. Supported employment may include assisting the participant to locate a job or develop a job on behalf of the participant. Supported employment is conducted in a variety of settings; particularly work sites where persons with disabilities are employed. Supported employment includes activities needed to sustain paid work by participants, including supervision and training. When supported employment services are provided at a work site where persons without disabilities are employed, payment is made only for the adaptation, supervision and training required by participants receiving waiver services as a result of their disabilities. It does not include payment for the supervisory activities rendered as a normal part of the business setting.

Covered Services

Supported Employment services of at least 15-minutes duration provided to the participant face-to-face or telephonically in the participant's home, employment location, or other community settings. These services include:

1. Training, skill building and support to assist the participant with managing his/her symptoms or other manifestations of disability in the workplace or job interview;
2. Assessment of the participant's:
    a. Individualized career development goals and employment ideas/preferences; and
    b. Work related skills and vocational functioning;
3. Assistance in developing and periodically evaluating the individualized employment services component of the participant's waiver Recovery Plan.
4. Support and guidance through the process of obtaining and maintaining employment, including:

    a. Teaching strategies to explore career development, write a resume, conduct job networking, pursue job leads, complete job applications, obtain interviews, and succeed in obtaining and maintaining employment;
    b. Training and skill building regarding proper work habits, and appropriate interactions with coworkers and the public;
    c. Advocating for the participant with potential and current employers; and
    d. Assisting with and reinforcing work-related problem solving skills;
5. Reinforcement of recovery skills designed to promote job retention and success in the workplace, including:
    a. Healthy habits (e.g., healthy diet, exercise, medication management and behaviors designed to alleviate stress);

b. Fulfillment of personal and work-related commitments (e.g., adherence to the work schedule, avoidance of unnecessary tardiness and absences from work); and
c. Identification and use of natural supports;

6. Assistance to support self-employment, including:
    a. Aiding the participant to identify potential business opportunities;
    b. Assisting in the development of a business plan, including potential sources of business financing and other assistance in developing and launching a business;
    c. Identification of the supports that are necessary in order for the participant to operate the business; and
    d. Ongoing assistance, counseling and guidance once the business has been launched.
7. Participation in waiver Recovery Plan development and quarterly Recovery Plan update meetings, if requested by the DMHAS Support Coordinator; and
8. Travel with a participant when the Supported Employment provider is also engaged in a qualifying waiver service activity.

Transitional Case Management – Services provided to persons residing in institutional settings prior to their transition to the waiver to prepare them for discharge, or during the adjustment period immediately following discharge from an institution to stabilize them in a community setting. These services also assist participants with other aspects of the transition to community life by helping them gain access to needed waiver and other state plan services, as well as medical, social, housing, educational and other services and supports, regardless of the funding source for the services or supports to which access is gained. The state shall claim the cost of case management services provided to institutionalized persons prior to their transition to the waiver for a period not to exceed 180 days.

Covered Services

Transitional case management services of at least 15-minutes duration include:

1. Referral and related activities to help an participant obtain needed services, including activities that help link eligible individuals with medical, social, educational providers or other programs and services that are capable of providing needed services, such as making referrals to providers for needed services and scheduling appointments for the individual;
2. Monitoring and follow-up activities, including activities and contacts that are necessary to ensure the waiver Recovery Plan is effectively implemented and adequately addressing the needs of the eligible individual, and which may be with the individual, family members, providers, or other entities and conducted as frequently as necessary to help determine such matters as:
    a. Whether services are being furnished in accordance with an individual's Recovery Plan;
    b. Whether the services in the Recovery Plan are adequate; and
    c. Whether there are changes in the needs or status of the eligible individual, and if so, making necessary adjustments in the Recovery Plan and service arrangements with providers.

3. Contacts with the participant to assist preparation for discharge from an institutional setting and adjustment to community life immediately following discharge;
4. Contacts with landlords and vendors designed to locate and secure suitable housing, and make preparations necessary for the arrival of the participant, including such items as assuring:
    a. A lease is signed and a security deposit is made, if needed;
    b. Utilities or service access is obtained (telephone, electricity, heating and water);
    c. Essential home/apartment furnishings are obtained and in place;
    d. Other basic essentials are obtained and are in place, including window coverings, food preparation items, bed and bath linens, and personal care items;
5. Introducing the participant to other professionals or paraprofessionals involved in the waiver Recovery Plan;
6. Providing information, education and training for the participant regarding:
    a. Household budget, living costs, and lease and utility arrangements;
    b. Security features and the safe operation of appliances in the home, and
    c. Availability and how to access community resources;
7. Assisting with or making arrangement for setting up the new home, including procuring, moving, and arranging finishing, appliances, and other household items;
8. Supervised visits with the participant to the participant's home, or to locate a suitable home during the transition from an institutional setting;

RESIDENTIAL SERVICES:

Assisted Living Services Agency - Personal care and services, homemaker, chore, attendant care, companion services, medication oversight (to the extent permitted under State law), therapeutic social and recreational programming, provided in a home-like environment in a licensed (where applicable) community care facility, provided to residents of the facility. This service includes 24 hour on site response staff to meet scheduled or unpredictable needs in a way that promotes maximum dignity and independence, and to provide supervision, safety and security. Other individuals or agencies may also furnish care directly, or under arrangement with the community care facility, but the care provided by these other entities supplements that provided by the community care facility and does not supplant it.

Personalized care is furnished to individuals who reside in their own living units (which may include dually occupied units when both occupants consent to the arrangement) which includes kitchenette and living rooms and which contain bedrooms and toilet facilities. The participant has a right to privacy. Each living unit is separate and distinct from each other. The facility must have a central dining room, living room or parlor, and common activity center(s)(which may also serve as living rooms or dining rooms). The participant retains the right to assume risk, tempered only by the individual's ability to assume responsibility for that risk. Care must be furnished in a way which fosters the independence of each consumer. Routines of care provision and service delivery must be participant-driven to the maximum extent possible, and treat each person with dignity and respect.

Recovery plans will be developed based on the individual's service needs. There are four levels of service provided in assisted living facilities based on the consumer's combined needs for personal care and nursing services. The four levels are occasional, which is 1-3.75 hours per

week of service, limited which is 4-8.75 hours per week of service, moderate which is 9-14.75 hours per week of service and extensive which is 15-25 hours per week of service. Level of service assigned depends upon the volume and extent of services needed by each individual and is not a limitation of service.

The following activities are Not Billable, but have been factored into payment rates:
Payment is not made for 24-hour skilled care. Federal financial participation is not available for room and board, items of comfort or convenience, or the costs of facility maintenance, upkeep and improvement.

Overnight Recovery Assistance -

Service would provide support necessary to enable an individual to live in an independent or shared apartment or dwelling within walking distance from the overnight staff. This could include a single apartment complex or multiple buildings in close proximity. Overnight RA Services provide opportunities for individuals that require overnight staff access due to health and safety issues to live independently in the community. Determination of need is established by the Community Support Clinician through functional skills assessment and development of an individual recovery plan. Recovery Assistant services are provided to assure individual health and wellness and may include supervision of and assistance with: self-care; communication and interpersonal skills; socialization; problem-solving skills; and ability to manage activities safely in an independent setting.

Overnight Recovery Assistant services will not duplicate personal care services that are included in the state plan.

Services may be provided for up to six individuals in dwellings clustered within walking distance of overnight staff, with no greater than four unrelated individuals sharing a single dwelling. Unlike traditional Recovery Assistant services, overnight Recovery Assistant service provides access to support and does not require all billable time to be provided face to face, but rather that staff be available to provide support during the overnight hours. Unlike CLSS service may be provided for less than 12 hour increments and in more than one dwelling.

Services purchased by 15 minute increment. Staff may provide support for up to six participants during the overnight period, not to exceed twelve hours (i.e. 8:00 p.m. through 8:00 a.m.). Staff will be awake during the period billed. The amount of service billed overnight is divided by the number of individuals utilizing the service during the time period rather than by the intensity of service provided to any one individual (e.g., For a 12 hour period, one staff member serving six clients would bill two hours for each client, three hours for each of four clients, etc.)

APPENDIX B

Recovery Assistant Training Curriculum

Online Training

Waiver Overview
Definition of Recovery/Person Centered Planning
Providing Support Services
Overview of Mental Illness
Boundaries
Documentation

Learning Objectives

1. Participant will be able to explain the role of the Recovery Assistant in facilitating the client's recovery.
2. Participant will understand the concepts and operations of a Home and Community Based waiver.
3. Participant will be able to discuss common symptoms of mental health conditions.
4. Participant will have a minimal understanding of Recovery in Mental Health
5. Participants will have a basic understanding of boundary issues

Participants must pass an online exam with at least an 80% score to begin work as a recovery assistant. Participants must take the full day training within 60 days to continue working as a recovery assistant.

Recovery Assistant Training Curriculum

Full Day Training

Introduction/Video Review of Role of the RA	FI Manager
Mental Health	FI Staff
Mental Health Medications	FI Staff
Providing Support/Recovery Plans/Skill Building	FI Manager
Living with Mental Illness Video	FI Manager
Lunch	
Working as a Recovery Assistant/Group Activity	FI Manager
Documentation Review	FI Manager
Wellness	FI Staff
Boundaries	FI Manager
Review/Q&A	FI Manager
Test & Evaluation	FI Staff

Learning Objectives

1. Participant will be able to identify boundary violations in working with people with mental conditions.
2. Participant will be able to identify ethical breaches in working with people with mental conditions.
3. Participant will be able to discuss common medical conditions and health challenges of people with serious mental illness.
4. Participant will be able to identify emotional and practical challenges of people with serious mental illness leaving institutional care.
5. Participants will be able to maintain accurate, complete and timely records that meet Medicaid requirements.
6. Participant will be able to discuss the role of the Recovery Assistant in performing, assisting and cueing clients in homemaking, personal care, respite and companion services

Certification will be awarded to participants who complete the full day of training and receive at least an 80% on the exam.

APPENDIX C - 1

DMHAS MH Waiver/MFP
Quality Improvement Report

April 1, 2014 – March 31, 2015

Enrollment Status

Total Enrolled Current Waiver Year – 145 MFP - 31 MHW – 114

Change of status: 84 un-enrolled
- 20 Died
- 1 Exceeded hospital limit stay
- 2 Ineligible financially
- 15 Ineligible due to not meeting Level of Care (LOC)
- 1 Care plan over allowable cost limit
- 4 Moved out of state
- 13 Entered LTC facility due to health
- 3 Entered LTC facility due to client choice
- 15 Refused Services
- 10 Other (e.g., transferred to another program or residential setting)

Total Served - 364

Record Documentation

Case Record Audits -
YTD – 80 completed 100% compliance

CMS Compliance

Critical Incidents YTD - 16
Review conducted – one corrective action recommended re timely reporting

Health and Welfare – new measure added
Participants received information about how to report abuse, neglect and exploitation.
YTD- 100% compliance

	Initial Plan	*Semi-annual Review*
Recovery Planning YTD -	100% compliance	100% compliance

Fiscal Intermediary Quality Indicators

ABH has met contractual obligations for Quality Management as outlined in the DMHAS/DSS contract and approved Quality Management Plan
YTD - 100% compliance

APPENDIX C - 2

MENTAL HEALTH WAIVER ADVISORY COUNCIL MEMBERS	
Abraham, Robin New England Home Care	Hall, Karyl Lee Connecticut Legal Rights Project
Andrews, Tammy DMHAS, Community Support Clinician	Pentore, Janina Volunteer, Berlin
Bruni, Kathy, LCSW DSS, Manager of H.C.B.S (formerly A.C.U.)	Providence, Brenda, R.N. DSS, H.C.B.S. (formerly A.C.U.)
Evans , Fay Handz-On, Inc.	Reagan, Laurel, APRN DMHAS, Director of Older Adult Services and The Mental Health Program
Gerwien, Dan ABH, Quality Assurance Supervisor	Schroeter, Florence Volunteer, DMHAS Research Division
Gibbs, Derrick Change, Incorporated	Luongo, Ann Marie ABH, Program Manager
Giordano, Daniela NAMI CT	Walker, Patti, MSW Continuum of Care
	Wall, Sharon MS DMHAS, Program Manager for the Mental HealthProgram

Membership: DMHAS Waiver Project Managers, individuals and families receiving DMHAS waiver services and supports, representatives from the mental health and Waiver provider community, and a representative from NAMI or other interested parties.

Frequency of meeting: Semi Annual

Mission: The purpose of the Waiver Advisory Council is to provide opportunity for input from individuals and families receiving DMHAS waiver supports and services as well as other interested parties, to review key quality findings and data trends in order to make recommendations for system improvement. The Council will also offer input for the annual Quality Improvement Plan. Feedback and recommendations will be communicated to the Waiver Project Team and DSS/DMHAS Joint Committee.

Appendix D

History of Mental Health Waiver

This Medicaid Home and Community-Based Services (HCBS) waiver represents an historic opportunity to divert and discharge adults with serious mental illness from Connecticut nursing homes. It offers great promise in establishing a package of community based long term care services as an alternative to nursing home care.

This waiver builds on two decades of work that Connecticut has undertaken to reduce our reliance on institutional long term care services, in favor of community based services and housing supports. The first use of home and community based services (HCBS) in the State of Connecticut occurred in 1987, when the elder waiver and the waiver for people with developmental disabilities (DDS waiver) were created. For the first time, those persons who participated in Medicaid were given a choice of where they received their services and support. As the supply of HCBS increased and as more people became aware of their long term care options, the reliance on institutional care decreased. This inverse relationship between increased utilization of HCBS and the resulting decrease on reliance of institutional care is called rebalancing.

Increases in the supply of HCBS continued to offer choice and decrease reliance on institutional care throughout the 1990s. Additional HCBS waivers were funded, including the personal care assistance waiver (PCA waiver) and a waiver for persons with acquired brain injury (ABI waiver). These waivers marked the first steps towards self-direction. Both waivers provided opportunities for the participant to hire and manage staff with payroll assistance from a fiscal intermediary.

In 1998, the legislature created the Long-Term Care Planning Committee to address both coordination concerns between state agencies relative to long-term care, and also to initiate a proactive planning process. In 2004, LTCPC introduced a single plan for all elders and disability categories with a unifying vision: *To assure Connecticut residents access to a full range of high-quality long-term care options that maximize autonomy, choice and dignity*. This plan was the first to include rebalancing benchmarks for the State of Connecticut.

Legislative, Stakeholder and Public Input

During the 2005 legislative session, the Connecticut General Assembly passed PA 05-280 (HB 7000) "An Act Concerning Social Services and Public Health Budget Implementation Provisions." Section 85 of the Act called for the Commissioners of Social Services and Mental Health and Addiction Services to jointly convene a Taskforce to study the feasibility of obtaining a Medicaid Home and Community-Based Services Waiver for adults with serious mental illness being discharged or diverted from nursing home care. The Taskforce[1] concluded that a HCBS

[1] The Taskforce included state legislators, state agency representatives, mental health clients and service providers, and other community members.

Waiver was feasible and recommended that such a program be established. Subsequently, in 2006, the legislature gave permission for DSS to pursue a waiver in order to establish and implement a Medicaid Home and Community Based waiver for adults with severe and persistent mental illness diverted or discharged from nursing homes (see S.B. No. 703, Sec. 32). Finally, in 2008, a study of Connecticut's long term care needs funded by the General Assembly recommended the State "provide access to and financing for comprehensive community-based mental health care services" such as those needed to facilitate discharge of people with mental illness currently residing in nursing homes.[2] The draft HCBS Waiver application was disseminated for public comment in connection with its review by the Connecticut General Assembly. Public comments were reviewed and incorporated as appropriate into the final Waiver document.

[2] Connecticut Long-Term Care Needs Assessment – Focused Report II: Identifying the Long-Term Care Needs of People with Mental Illness. March 2008, University of Connecticut Health Center.