Connecticut's
Money Follows the Person Rebalancing Demonstration
Operational Protocol

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MFP OPERATIONAL PROTOCOL

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A. Project Goals and Benchmarks

The State must address the four key demonstration objectives as outlined in the statute in their project introduction. These objectives are:

1. *Rebalancing: increasing use of HCBS rather than institutional, long-term care services;*
2. *MFP: eliminate barriers that prevent/restrict flexible use of Medicaid funds to receive long-term care in HCBS;*
3. *Continuity of Service: assure continued provision of HCBS after one-year transition period; and*
4. *QA/QI: ensure at least same level of QA for MFP participants as available to other HCBS beneficiaries.*

Statutory requirement: "Describe the extent to which the MFP demonstration project will contribute to the accomplishment of [the 4 above objectives] - §6071-(c) (7) (ii).

Introduction

Under the Money Follows the Person (MFP) demonstration, Connecticut Department of Social Services (DSS) was awarded $24.2 million to build on their Choices are for Everyone, a prior Nursing Facility Transition Program (NFTP) funded by a Real Choice Systems Change grant in 2001. The State has a goal of transitioning 700 individuals from nursing facilities and other institutions to home and community-based settings by 2012. The targeted population groups are individuals with mental illness, physical disabilities including acquired brain injury, intellectual disabilities, and elderly. Six support staff and 25 transition and housing coordinators will guide the transition process. Targeted priority areas include the provision of rental assistance for qualified, needy applicants, in addition to accessibility modifications, increased access to and utilization of appropriate assistive technology, and strengthening of quality management systems for people living in home and community-based settings.

Connecticut anticipates that the initial phase of the MFP demonstration will rely on the currently approved 1915(c) waivers and the MI waiver (once it has been submitted to CMS). Connecticut has worked three years to develop a draft MI waiver and has already begun to input the draft onto the CMS HCBS waiver application website. Submission will be imminent. Pending approval of the committees of cognizance, the Department intends to submit the MI waiver by 6/30/2008. Phase II will include the Chronic Care waiver implementation. Phase-in of clients would begin once the Chronic Care waiver has been submitted and appears likely to be approved by CMS.

Background

The first use of home and community-based services (HCBS) in the State of Connecticut occurred 20 years ago, in 1987, when the elder waiver and the waiver for people with intellectual disabilities were created. Those persons who participated in Medicaid were given a choice of where they received their services and support for the first time. 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.

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. For example, for the first time more individuals are receiving Medicaid long-term care services in the community than are receiving institutional care. Connecticut has shown progress on seven benchmarks outlined in its Long-Term Care Plan.[1] Connecticut has been successful in obtaining a total of nine different systems change grants. Among other changes sustained by these initiatives, was the development of new self-directed waivers under the Independence Plus template, the design and implementation of a new QA/Quality Improvement (QI) initiative and the development of a transition system.

In her FY2008-09 Midterm Governor's Budget Adjustments, Governor M. Jodi Rell recommended funding for additional infrastructure and service delivery changes as part of her long-term care rebalancing strategy. If approved, funding directed towards the Governor's rebalancing initiatives and associated benchmarks indicating progress towards rebalancing will be reported under Connecticut's MFP Rebalancing Demonstration. Key elements of the Governor's proposed initiatives include: 1) expansion of home and community-based supports and services to address existing gaps in Connecticut's community based infrastructure; 2) expansion of transition services so that persons living in institutions may move to the community; 3) development and implementation of an on-line nursing home placement screening system; and 4) development of a QI initiative under MFP.

Discussions over the past several months were primarily focused on expansion of home and community-based supports and services. Connecticut's MFP proposal described the design and implementation of a ***single common waiver*** authority serving all target populations. It was proposed to address key problem areas within the existing HCBS structure. Initial communication with CMS explored utilization of various authorities to achieve a simpler waiver structure. Through this analysis it was determined that a broader approach to HCBS may be appropriate and that the State should be asking how Connecticut can design a service delivery system that meets its citizens' needs rather than how it can administratively simplify its system.

Given the existing limitations of Medicaid authorities, Connecticut's service delivery system will have an expanded accessibility to the existing 1915(c) waivers for core long-term care services. The underlying core waivers will reflect the required separation of services for people with mental illness, people with intellectual disabilities, and people who are in the elderly/physical disability group. A new 1915(c) waiver will be implemented for persons with mental illness. It will address gaps in Connecticut's existing HCBS structure by providing coverage for this previously uncovered group. A new "Chronic Care" 1915(c) waiver for persons in the elderly/physical disability group will address gaps in existing 1915(c) waivers for high-needs persons in these target populations. Extensive analysis of the existing two waivers serving the elderly and persons with physical disabilities examined HCBS service gaps leading to institutionalization or inability to transition to the community. The new waiver addresses implementation of self-direction as a delivery system under MFP and will provide participants with the greatest range of options for control. The new 1915(c) waiver also combines the

[1] Connecticut Long-Term Care Planning Committee, Long-Term Care Plan: A Report to the General Assembly, January 2007, p. 5.

administration of services for persons who are elderly and persons with physical disabilities for the first time. While the new waiver will be designed initially to serve those with the highest needs in the MFP demonstration, the evaluation component of the demonstration will focus on the effectiveness and efficiency of the new combined waiver, with the goal of expanding coverage to include persons served in lower levels of care in the existing waivers at a future date.

The real challenge in designing a service delivery system is in addressing the differences between the existing HCBS systems administered by different units and agencies for the benefit of different target populations. Any reduction in the multiple differences between waivers will be a step in the right direction. For this reason, one of the objectives of the MFP QI Committee will be to examine assessment tools, service names and definitions, rates, etc., across all HCBS and to make recommendations regarding improved efficiency and effectiveness. The future HCBS system strives to have commonality in the services and delivery of HCBS across all populations.

Connecticut is committed to assuring the vision of choice, dignity and autonomy. With this in mind, Connecticut proposes the following goals and objectives for its MFP rebalancing demonstration.

Goals of MFP

Goal 1: Increase access to home and community-based services
Note: Objectives 1-3 are the first three goals under the MFP statute. Objectives 4-6 are electives supporting the additional benchmarks, addressing the Governor's broader rebalancing goals beyond the 700 participants transitioning under the MFP demonstration. These expenditures are subject to the appropriation process. Connecticut is a gross appropriation state. Investments under objectives 4-6 will be tracked and reported to CMS as part of the required 25% rebalancing. The expenditures under the reinvestment will more than exceed the 25% rebalancing. The 25% rebalancing *refers to the anticipated rebalancing fund due to enhanced FMAP.*

Objective 1: Increase the use of home and community-based, rather than institutional, long-term care services:
Connecticut will accomplish this objective by helping up to 700 people who are long-term residents of institutions relocate to community settings.

- Expand the existing transition system to include 20 field-based transition coordinators for initial assessment, identification and coordination of transitional activities
- Establish a separate pool of funds to provide accessibility in affordable housing above and beyond that which is allowable within cost caps
- Develop and implement training opportunities to support staff development
- Implement housing strategy including:
    - Establish five housing coordinators to identify existing affordable, accessible housing, assure linkages with the new housing registry, and coordinate accessibility modifications
    - Implement an extensive outreach campaign to inform persons in institutions about options to live in the community

  - Provide eligible persons transitioning with a rental subsidy (eligibility based on Section 8 rules and based on need)
- Address gaps in the HCBS system for elderly persons and persons with physical disabilities by developing a new package of services at the Chronic Care Level
- Address gaps in HCBS system for persons with mental illness by developing a new package of services, including self-direction
- Increase utilization of assistive technology
- Advance opportunities for self-direction by developing a self-direction option for persons at the Chronic Care Level in the elderly and physical disability target population

Objective 2: Eliminate barriers or mechanisms, whether in the State law, the State Medicaid Plan, the State budget or otherwise, that prevent or restrict the flexible use of Medicaid funds to enable Medicaid-eligible individuals to receive support for appropriate and necessary long-term services in the settings of their choice:

- Continue global budgeting for long-term care appropriations. The current State appropriation process allows the Medicaid Agency to move funds from institutional budgets to home and community based budgets. Reallocation between the lines that comprise the Medicaid appropriation is at the discretion of the executive branch. For example, the State executive branch has the authority to reallocate funds from the institutional line to the home and community based waiver line depending upon demand for services without any additional authority required.
- Establish flexible budget for participants to purchase transitional supports not currently available under the Medicaid system

Objective 3: Increase the ability of the State Medicaid program to assure continued provision of home and community-based long-term care services to eligible individuals who choose to transition from an institution to a community setting:

- Sustain new package of services for persons with mental illness by funding a new 1915(c) waiver at the end of the demonstration year
- Sustain new package of services for persons who are elderly or who have physical disabilities by funding a new Chronic Care 1915(c) waiver at the end of the demonstration year
- Address gaps in the HCBS system for persons with mental illness by developing a new package of services, including opportunities for self-direction

Objective 4: Increase in availability of self-directed services and supports beyond MFP participants[2]:

- Develop and implement services and supports for persons with mental illness including a new 1915(c) waiver
- Explore and implement and array of services which may include an HCBS State Plan option and a personal assistance state plan amendment

[2] Objective 4 is an elective supporting the additional benchmarks, addressing the Governor's broader rebalancing goals beyond the 700 participants transitioning under the MFP demonstration. These expenditures are subject to the appropriation process.

Objective 5: Decrease the number of inappropriate hospital discharges to nursing facilities[3]:

- Develop online nursing home placement screening system (Pre-admission Screening and Resident Review or PASSR)

Objective 6: Increase number of persons who return to the community within six months of admission to institution[4]:

- Develop profile for 'high-risk'
- Develop assessment tool
- Develop and implement identification methodology
- Provide staff for identification and transition activities
- Transition persons institutionalized less than six months

Goal 2: Improve the efficiency and effectiveness of the long-term care system
This is the fourth statutory goal under MFP.

Objective: Ensure that a strategy and procedures are in place to provide QA for eligible individuals receiving Medicaid home and community-based long-term care services and to provide for continuous QI in such services.

- Fully develop and implement a cross agency, data driven, and comprehensive QA/improvement initiative
  - Identify members
  - Provide staff to support appropriate meeting structure

- Assuring Quality
  - Review, analyze and take appropriate corrective action on reports referenced under the quality management section of the protocol
  - Review and make recommendations on assessment tools, service definitions, descriptions and rates, etc.
  - Produce quality reports on MFP

- Continuous QI
  - Establish 'goal standards' for demonstration year regarding factors such as:
    - Length of time in community
    - Self-direction
    - Consumer satisfaction
    - Length of time to transition
    - Workforce reliability
    - Assistive technology reducing reliance on hands-on care
  - Focus initially on improving workforce reliability

[3] Objective 5 is an elective supporting the additional benchmarks, addressing the Governor's broader rebalancing goals beyond the 700 participants transitioning under the MFP demonstration. These expenditures are subject to the appropriation process.
[4] Objective 6 is an elective supporting the additional benchmarks, addressing the Governor's broader rebalancing goals beyond the 700 participants transitioning under the MFP demonstration. These expenditures are subject to the appropriation process.

        - Fund 24-hour back-up triage system to collect data and address and develop an emergency staffing plan to address back-up issues
        - Make recommendations for additional interventions based on common themes
        - Study impact of interventions on workforce reliability

- Evaluate effectiveness of new HCBS services and delivery system for broad application across elderly and physical populations not just those who were institutionalized
    - Essential questions
        - Does self-direction lead to better health outcomes and higher participant satisfaction than traditional service delivery systems in Connecticut?
        - What is the financial impact of self-direction compared to the traditional agency model?
        - What is the impact of assistive technology both on cost and level of independence compared to traditional model?
        - What is the impact of peer assistance both on the participant's full participation in community and cost?

    These questions are intended to be incorporated as part of the State's MFP Quality Strategy not included as a separate part of the evaluation. The intent is for the evaluation staff and the MFP Quality staff to work in coordination with each other. For example, the evaluation staff will complete all consumer satisfaction surveys. Survey results will be incorporated into the State Quality Management Strategy in a continuous quality improvement process.

A.1 Case Studies: Through the eyes of the people we serve

Provide a detailed description, from a demonstration participant's perspective, of the overall program and the interventions for transition and rebalancing that the State proposes to use under the demonstration. The case study should walk the reader through every step of the proposed processes. These steps include, but are not limited to, the initial process of participant identification, processes that will occur prior to transition, those processes employed during the actual transition into community life, and those processes that will be utilized when the individual has been fully transitioned into a home and community-based program.

CMS recognizes that each transitioned population may require specific programmatic interventions and processes. A single case study may not incorporate all the elements needed to address the unique needs, and resultant processes, for different populations. To that end, within each case study, the awardee is advised to describe those elements that may differ for each proposed population. Please describe the interventions and processes from the participant's perspective and then indicate if and when separate processes will be utilized to address population-specific elements.

The case study is intended to be a detailed narrative of the interventions employed under the demonstration. Operational procedures need not be included in the case study, as they will be provided in subsequent sections. For example, the State will provide detailed descriptions of eligibility and enrollment processes and mechanisms as part of Section i, Eligibility and Enrollment. Similarly, detailed information regarding the service delivery system, for each population transitioned, will be provided in Section h. Benefits and Services.

The following are case studies demonstrating the transition process for the major categories of individuals transitioning from institutional settings to community placement, as seen through the eyes of the people served. For additional case studies for the Elderly, Intellectually Disabled and ABI populations, please see Appendix O.

Transition of Chronic Care Population

Alma is a 50-year old wife and mother of three sons. Even though she continues to worry about them, her sons are now young adults out on their own. This should be the time in their lives when Alma and her husband, Sydney, are rediscovering each other and enjoying spending time together again. Instead, at age 46, Alma was diagnosed with Amyotrophic Lateral Sclerosis (ALS), more commonly known as Lou Gehrig's disease. This is not how Alma expected things to be when the boys were gone.

She remembers as if it was yesterday when she received the diagnosis from Dr. Reed. The date was May 15, 2004. She knew that the condition was serious, she could tell this based upon the information that Dr. Reed was sharing with her. But she had no idea of how serious or how severely the disease would impact her life. She had never heard of ALS. Alma quickly set out to find out as much as possible about ALS. What her research revealed was very discouraging. She was facing a relatively short lifespan complicated with loss of control and dependency. She had always prided herself on being an independent person. And now she was facing a condition where she would ultimately become totally dependent on others for her welfare. She was too

young to think about dying. She wanted to spend time with Sydney traveling, to see her sons married with children and to spoil her future grandchildren. How could this happen to her?

Alma remembers how dark those days were. So much of that early time following her diagnosis was a blur. She slipped into a very deep, debilitating depression. She could not get out of bed and refused to get any help for her depression. This went on for a few months.

Late one night she and Sydney received a call from the hospital informing them that their youngest son, Damon, had been in a car accident. They rushed to the hospital to discover that while Damon was severely injured, he would survive. Like a jolt, from that moment on Alma knew that she had to live for her family and was determined to do all that she possibly could to fight for as long as she could.

Alma and Sydney were determined that she would remain at home for as long as possible. For the first year following diagnosis this was not a problem. Alma seemed to be beating the odds; the progression of the disease during this first year was relatively slow in comparison to the statistics. By Christmas of 2005, Alma was no longer able to speak and while she had lost a little of the muscle control in her arms, she was still able to take care of herself, with a little assistance from Sydney, and communicated by writing on a note pad that she kept with her at all times.

The progression of the disease steadily increased after this point. By the end of 2006, Alma had lost all control of her arms and hands. But she did not let this stop her. She even learned to type on the computer with her feet. It was at this time she and Sydney hired the first of several personal assistants/nurses aides to help care for her for a few hours during the day.

By August 2007, Alma had lost total muscular control of her legs and feet and was confined to a wheelchair. She fed intravenously through a tube in her stomach and was given medication to enable her to sleep. She still had the ability to blink, so, very cleverly she turned this into her means of communicating. One blink meant yes and two blinks meant no. Those who knew her well were even able to help her form words and sentences by running their fingers along the keyboard of a child's toy and stopping on the letter selected by Alma.

The cost to care for Alma in the home was eventually more than they could bear. Sydney had retired from his position as an auto mechanic in September 2006. By the time Alma reached this stage, they had depleted their meager savings. They were forced to sell their home and move into a small apartment in a dilapidated neighborhood. This apartment was all that they could afford. Unfortunately their sons were in no position financially to help their parents.

In September 2007, because they had no choice, Alma was admitted to a nursing home. The only nursing home with a vacancy at the time was more than 45 miles away from their apartment. Since Sydney's vision was impaired at night, when he traveled alone to visit Alma, which was the case most of the time, his visits were limited to daylight hours, which was problematic during the shorter winter days. He wanted to spend as much time with Alma as possible.

If asked, Alma would describe herself as trapped. But of course she was never asked. Her disease trapped her mind in a dysfunctional body. Mentally she was the same person. She had the same thoughts and dreams but no one knew that! It was so very frustrating. Now, in the nursing home, she was also trapped by her physical environment.

The information her son Kenny (their only son in the area) shared with her about the MFP program sounded really interesting. During one of his visits, Kenny had seen the flyer on the bulletin board of the nursing home and brought it to her attention. Alma was anxious to find out more information about the program. Kenny contacted the MFP program office and found out that an informational meeting would be held at the nursing home within the next two weeks. Kenny told his mother that he would plan to come back and go with her to the meeting. He did and brought his father with him.

At the meeting Alma, Sydney and Kenny received an informational packet and had an opportunity to talk with Anna, the transition coordinator. Kenny and Sydney were concerned about whether or not Alma would be a candidate. Anna, made it clear that Alma's condition in and of itself would not serve as a deterrent from participating in the demonstration, encouraged them to apply and gave them an application. Kenny and Sydney took Alma back to her room and talked about what they should do. It seemed like their last hope for Alma to get out of the nursing home before it was too late. They all agreed that there was nothing to loose and together they filled out the application. After they left the nursing home, Kenny and Sydney stopped by the nearest post office to mail the application.

Over the next few weeks, Alma was very anxious. She did not want to be too hopeful but at the same time she couldn't help herself. 'Was this finally the answer to her prayers?' Not only would she be able to leave the nursing home, but she also noticed that specialized medical equipment was covered. 'Maybe there was technology available that would help me to communicate with my care givers.' This had been a very big problem at the nursing home. Alma was still able to blink yes and no and had brought the child's toy with the keyboard with her to the nursing home, but rarely did the nurses or aides try to communicate with her using this technique. She wanted to scream 'I am in here!' but of course she could not.

Three weeks after the application was mailed, on May 21, 2008, Alma received a letter and package of materials from the DSS MFP program office confirming her eligibility and assigning her a transition number 25. The package of materials included a guide to the transition process, self-assessment tool and a guide to rights and responsibilities under MFP. Two days later Sydney received a phone call from Anna to set up a time for him and Alma to talk with Anna. Anna reminded Sydney to be sure to work with Alma to complete the self-assessment tool. The meeting was scheduled for May 28.

Alma was nervous about completing the self-assessment tool. She was afraid that if she answered the questions in the wrong way she would not be allowed to participate in MFP after all. Sydney shared this with Anna during their meeting. Anna assured her that this was not the case and she did something that Alma was not used to, she asked Sydney and Alma how best to communicate with Alma. They shared with her how Alma blinks her eyes as well as uses the keyboard of the child's toy to communicate. Alma was so grateful that Anna took the time to

find out how to communicate with her. She knew that she would like working with her. Anna shared with them the 24-hour back up triage system. The more Anna talked, the more comfortable Sydney felt about the supports that would be available to Alma upon her transition to the community. Alma signed the informed consent for MFP at this first meeting.

Anna set up a second meeting for the following week to talk with Alma about her housing options. As Anna had asked, Sydney and Alma had gathered all of Alma's personal documents including her birth certificate and her Social Security Number. On Alma's behalf, Sydney signed all the necessary documents and letter of interest. Alma made it clear that she wanted to live with Sydney once again. Sydney echoed Alma's desire to be able to live together once again, but shared with his wife and Anna that he did not want Alma coming back to the apartment because he did not think the community was safe. He then proceeded to share with them a story about an elderly woman in the apartment complex living on her own who recently had been robbed and brutally attacked. Anna said that she would communicate with the housing coordinator about the need for the two to be together again, in a safe community placement. Anna prepared the paperwork for submission to the DSS for a rental subsidty at the second meeting. About 4 weeks, after this meeting Alma received notification that she would receive rental assistance that helped her and Sydney afford their new apartment.

The next week Alma was visited by a social worker from Connecticut Community Care Incorporated (CCCI) who completed her assessment for community supports. Sydney was present for this assessment. CCCI informed Alma that she was eligible for the new Chronic Care aging/disabled waiver. CCCI staff discussed with Alma working with her to determine the appropriate assistive technology device to enable her to facilitate her ability to communicate. This was joy to Alma's ears. CCCI staff also offered Alma the option to self-direct her care. Alma decided to self-direct. Her emergency back-up plan included her son Kenny and Sydney as well as a friend from church. The necessary supports that were in place included ensuring that Kenny, Sydney, and the friend from church understood the back-up plan. Alma and Sydney already had all of the items needed for the apartment and a son (Kenny) in the area willing to assist as needed.

A follow-up meeting was scheduled two weeks later. Alma was more excited about this meeting than any others, for during this meeting they would be visiting two of the apartments the housing coordinator had identified as options for Alma and Sydney. Kenny, Anna and CCCI staff would also participate in this onsite meeting. Alma did not like the first apartment, but the second apartment was just right with plenty of room for her and Sydney, and a lovely view of the park across the street. Alma could see herself sitting and watching the people enjoying the park. A minimum budget of $75.00 was established since Alma and Sydney have most of the items that they need for their new apartment.

Alma received the assistive technology that was discussed during the transition planning as a loan from Connecticut's assistive technology loan closet prior to discharge from the nursing home. This allowed Alma the chance to try the technology out and determine that it was appropriate before the MFP funds were used to purchase the technology.

A final team meeting was scheduled prior to Alma's discharge to ensure that all the necessary supports were in place prior to her transition back into the community. This meeting was also an opportunity to address any questions or concerns that Alma and her family might have about what to expect. The meeting was scheduled so that all of Alma's sons could participate. During this meeting Anna also reminded Alma and Sydney of the 24-hour back-up triage system. Alma's sons helped Sydney with the move from the old apartment to the new apartment. This was also the week when all three of Alma's sons came home to help Sydney move to the new apartment. They wanted time to make sure that the apartment was just right for their mother.

Alma was scheduled for discharge on July 31. Moving out of the nursing facility and into her new apartment was one of the happiest days of Alma's life. Using self-direction, for which she was trained via a supports broker, Alma hired her own attendant and received Personal Care Attendant (PCA) services. A visiting nurse provided ongoing training and oversight regarding the tube feed/flushing and suctioning to avoid aspiration. The PCA and spouse can easily perform the services but needed the proper training to know when and how to perform the functions. Alma also received Occupational Therapy to identify other adaptive equipment to maximize her functioning and Physical Therapy for training the PCAs/caregivers on caregiving techniques such as transferring, turning, exercises, etc. Speech therapy was also provided for Alma to address suctioning, aspiration, and esophageal stricture concern. Finally, Alma and her family received mental health counseling to help this address the various aspects of loss.

Anna checked on Alma and Sydney several times during the first few months following the transition to ensure that all was well. After the transition year, Alma was reevaluated and assessed and continued to receive services under the new Chronic Care waiver.

Transition of Mentally Ill Population

Five years ago, Ray went from being homeless, living in a shelter, to living in a nursing home. While it was good to have a roof over his head and three meals a day, Ray knew he didn't want to be there anymore especially since he didn't have a great deal in common with the nursing home's primarily elderly residents. At age 50, he was bored and missed his freedom to do whatever he wanted – especially having a drink once in awhile. However, he didn't know what to do. The only family members left were two siblings. Ray's brother Henry called him infrequently. So without the nursing home, he would be homeless again. Ray felt resigned to his situation.

For years, prior to the nursing home, Ray had been living a marginal existence. Despite a college degree, he was unable to hold a job. He would display an unusually high level of productivity when he started a job. This might last for months before he slipped into a depressive state that made it difficult for him to show up for work. Employers couldn't depend on him. Every time he lost a job, Ray would binge drink on alcohol which made things worse. With no income, he couldn't pay the rent for his apartment.

For awhile, Ray's friends would take him in; give him food and a place to sleep. But eventually, he alienated them with his mood swings and drinking. At this point, if Ray allowed himself to dwell on the course of his life, he thought it probably wasn't worth living. One night while staying at a shelter, he expressed that thought to a volunteer who became concerned Ray was suicidal. He was hospitalized and finally diagnosed with bipolar disorder.

Upon discharge, Ray was referred to the local mental health agency for services. He had an appointment, but didn't think they could really help him. With no place to live, he was again on the streets by day and making the rounds of shelters by night. Without treatment, exacerbations of symptoms led to several crisis interventions. More hospitalizations followed and more failed appointments.

Finally, a persistent homeless outreach worker succeeded in getting Ray to the mental health agency. He was started on medication and encouraged to talk to a clinician every week. But before too long, Ray was noncompliant with treatment. His drinking resumed, and medical problems involving his heart and liver ensued.

By now, Ray was miserable and contemplating suicide. He didn't think he had the guts to do it, but if he drank enough, maybe it wouldn't hurt. Ray tempted fate by standing precariously on the narrow ledge of the third level of a city parking lot. Losing his balance, he plummeted to the driveway below. Remarkably he survived, but sustained fractures to both legs and his left arm.

Ray was in the hospital for a couple of months before being transferred to a nursing home for rehabilitation. While the nursing home was the first stable environment he'd experienced in years, Ray became seriously depressed and lost his motivation to get better. Only through consistent psychiatric treatment and staff support was he able to heal.

Overall, Ray was in much better shape than he was five years ago. Even though he needed to walk with a cane and had only partial use of his left arm, he was sober, taking his medications regularly so that his mood swings and medical conditions were under control, and he was participating in recreational activities that appealed to him. He was even able to reconnect with Henry.

It was hard to imagine living outside the nursing home, but Ray would find himself daydreaming about having his own apartment again and actually working. How would he be able to manage this, considering his disabilities? Where would he live? It was useless to think about living on his own again.

So there he was, sitting on his bed in the nursing facility and looking at the four green walls of his cluttered room just as he had been doing for the past 5 years. Gerald, his 80-year old roommate, was snoring through his usual nap. Two other residents who were also elderly were yelling at each other in the hallway. And Ray could hear the medication cart squeaking as it moved from room to room, signaling the dispensing of afternoon meds. What a life!

Just as he thought he might take a nap too, a young woman carrying a briefcase poked her head into his room, asking if she might speak to him for a moment. During the morning, he had seen her and some other strangers talking with residents. He had heard they were from the "state." Earlier, he overheard one of them talking with Gerald about how he was doing in the nursing home, and whether he had received a letter about "MFP," a new program he might be eligible for. Ray vaguely remembered receiving such a letter, but didn't really read it, thinking it was mistakenly sent to him.

The young woman's name was Gloria. She worked for the Department of Mental Health and Addiction Services (DMHAS) and was following up with residents with mental illness who received a letter about a new program called Money Follows the Person, or MFP. According to Gloria, if Ray was eligible, MFP might help him get out of a nursing home. He would be able to access the medical and psychiatric services he needed in the community.

Gloria pulled a brochure from her briefcase. The brochure briefly described the MFP program, including who was eligible. Ray was all "ears" as Gloria told him that MFP was a demonstration program run by the Department of Social Services (DSS) that would help people in institutions, such as nursing homes, return to the community with supports. Ray could actually choose where he wanted to live and the services he wanted. If he was interested in the program, he should contact the MFP office at DSS and request more detailed information. Gloria pointed out the MFP toll-free telephone number. She also explained there would be an informational session on MFP for all residents of the nursing home. The facility's Director of Social Services was in the process of arranging the session for next week.

Ray asked about eligibility. He was informed that this would be determined by DSS, but basically, he would have to have been in a nursing home for at least 6 months and be eligible for Medicaid. Also, he would have to agree to cooperate with the demonstration program and want to move out of the nursing home. Ray wasn't sure what "cooperate with the demonstration program" meant, but he definitely had been in the nursing home well over 6 months, and he was pretty sure he wanted out.

Gloria went on to say that once Ray called the MFP office, they would mail him a package of materials, including an application, a transition guide, a self-assessment tool, and a description of his rights and responsibilities (was *this* the cooperation piece?) as an MFP participant. Once he was determined eligible, he would be assigned a "Transition Coordinator."

This sounded pretty good to Ray. But he wanted to learn more about the rights and responsibilities part. According to Gloria, this information was part of the package he would receive, but essentially it involved informed consent between him and the program. Further information would be shared with all residents at next week's meeting. And once he met his Transition Coordinator, it would be an important focus of their discussion.

Ray also wanted to know what services were available. Gloria explained Ray could call the MFP office directly to ask for that information over the phone. The list of services would also be included in the package he would receive. However, she gave examples, such as a homemaker/home heath aide, medical/social services, and recovery services for his mental illness.

After Gloria left, Ray felt overwhelmed by their conversation. Even though he wanted to leave the nursing home, it was a scary prospect. After all, he hadn't lived in his own apartment for a long, long time. He wasn't even sure he could cook a meal. Maybe Donna, the Director of Social Services, could talk to him about it. She agreed to meet with him the following morning after breakfast.

The next morning Ray shared his fears and anxieties with Donna. She was very supportive, encouraging Ray to call DSS and explore his options. Since he didn't have his own phone, Donna suggested he call the MFP office from hers. Within four days of the call, Ray received the packet of information and the application form. Donna helped him complete the application and mail it to the MFP office.

Waiting for a response from DSS, Ray's mood fluctuated between feeling positive he was eligible for MFP to feeling like it was all a joke. However, approximately four weeks after mailing the application, he received a letter confirming his eligibility. And Victor, Ray's Transition Coordinator, called him less than three days later to set up their first meeting on June 10th.

To prepare for the meeting, Ray read through the MFP materials and tried to complete the self-assessment form. It was tough to try to identify what *he* thought he needed in the way of help. For so long, he had been told by *others* what he needed, like being in this nursing home. He felt powerless.

Meeting with Victor helped him realize that he did have the power to change his life. Victor gave examples of people who were quite disabled that were making it in the community after years in an institution. While it was important to hear how Ray came to be where he was; about his history of homelessness and his mental illness, Victor also wanted to hear about Ray's strengths and his hopes and dreams. This was new territory for Ray; he thought he was getting too old to actually have hopes and dreams. Victor thought otherwise, pointing out Ray's intelligence and college education. Some kind of work might be in his future if that's what he wanted to do.

Victor explained how MFP worked; that he and Ray would act as a team to create a transition plan based on what *Ray* wanted. Together they reviewed the list of services he could choose from, the housing guide, medical release forms, and informed consent documentation. Like Gloria had said, Victor explained Ray's rights and responsibilities around participating in the MFP program.

Reviewing the partially completed self-assessment tool, Victor encouraged Ray to be as honest as possible about what would help him transition back to and stay in the community. Ray thought back to how difficult his life had been in the community and expressed worry about "falling apart." What if there was an emergency, like the visiting nurse didn't show up with his medication, or he felt sick, even suicidal? Victor explained there would be an emergency back-up system available to him. Through a toll-free telephone line specifically for MFP participants, Ray could call for help. Victor added that this was a smart consideration on Ray's part.

At the end of the meeting, Victor asked Ray to sign the informed consent and medical releases. He also gave Ray a homework assignment: gather all his documents, like his social security card and birth certificate. Maybe his brother Henry could help with this task. For the first time in years, Ray felt good about himself. He was on his way.

A week later, Victor and Ray met again to review his medical records. They talked a little about housing options and where Ray wanted to live. Victor also talked about other members of the transition team, such as a social worker from DMHAS and one from DSS. Each would help Ray develop his plan for community living. If Ray was interested in working, a Bureau of Rehabilitation Services (BRS) counselor would help with a vocational plan. And a housing coordinator would help with finding an apartment. Victor asked Ray if there was a family member or friend that he would like to be part of this team. Ray thought about asking Henry to join the team for additional support. Another meeting was scheduled in two weeks.

At the appointed time, Victor arrived with the DMHAS and DSS social workers. Henry had been invited, but was unable to attend because of his job. Since Donna had been so supportive, Ray asked her to be there. While he was eager to begin discussing his transition plan, all these people focusing on what *he* wanted to do with his life was overwhelming. Fortunately, the team was sensitive to this and took time to explain the next steps so that Ray could easily process the information. Ray's questions helped them all understand the need to coordinate their efforts.

The first step to be taken was to compile a joint assessment, drawing upon Ray's self-assessment as well as that of the transition team. Before meeting with Ray again, Victor and the DMHAS and DSS social workers met together to share information and design an assessment that would avoid duplicative questions of Ray. They wanted to avoid conducting three individual assessments getting at the same information.

By the end of June, everyone met again at Ray's nursing home. This time Henry was able to attend. The meeting took about 90 minutes and focused on what Ray wanted to do and especially on the supports and services he thought he needed. Ray told the team that first, he just wanted to settle in to an apartment and re-learn what it was like to be on his own again. He was open to having a roommate as he was afraid of being alone. Once he gained his confidence, he wanted to pursue his interest in art. While in the nursing home, he had tried painting in watercolors and really enjoyed it. He found painting to be very calming. Then he might think of working again, maybe in an art supply store. Also, he loved being around the animals volunteers brought to the nursing home. Maybe he could get a job in a pet shop or animal shelter.

The team compiled all this information and planned to include the BRS counselor in the next meeting. Meanwhile, Ray told the team he would especially like having peer support in the community as he felt learning to manage his psychiatric disability on his own was going to be challenge. Henry agreed, raising the issue of Ray's past abuse of alcohol, probably as a way to self-medicate. He suggested that a support group like AA be considered a part of the plan. Ray confessed to the team that he liked the taste of alcohol, but didn't want drinking to jeopardize his success. Maybe he should start attending AA before actually transitioning.

Ray was also concerned about being able to keep up his apartment and perform personal care. Because of limited use of his left arm, an aide in the nursing home helped him with dressing and aspects of bathing. If he could start learning how to care for himself more independently before he transitioned from the nursing home, he might feel more confident. The team complimented Ray on his insight and agreed to support his decisions. The team also reviewed Ray's finances and Donna agreed to help Ray apply for SSI.

Over the next month, the housing coordinator (Jim) took Ray around to look at apartments. Since Ray had difficulty climbing stairs, accessibility was an issue. He was also looking for a two-bedroom apartment as he considered having a roommate. However, Jim suggested if a roommate was really important to him, they might look for someone willing to share an apartment from the beginning. That might make it easier to afford what he wanted. Ray wanted to move forward with his *own* apartment, so the search continued. Eventually, they found something that seemed relatively perfect for his needs – although it was not located exactly where he wanted it. At least it was on a bus line.

The next month was very busy. Jim applied for a RAP certificate to help pay for housing. The DMHAS social worker connected Ray with the LMHA covering the area he would be living in. They would provide the out-patient psychiatric services he would need. A peer support person (Gene) was brought on board, ensuring Ray's voice was heard. And since Ray decided he wanted to self-direct his care, he had to start interviewing and hiring the homemaker/home health aide who would help him keep his apartment clean, shop for groceries, do laundry, and assist with dressing and bathing. The DSS social worker helped him with this. Also, a back-up plan to ensure continuity of service needed to be accounted for. Henry would help if needed, and probably his wife. The transition team reiterated the availability of the toll-free back-up line in case of any type of emergency. They made sure this number was prominently written into Ray's community service plan of which he had a copy.

Furniture and household supplies, even some new clothes for Ray, were necessary for the move. The whole team, including Henry, helped collect these items.
By the end of August, Ray was ready to move. Victor made sure he had enough medication for both his psychiatric and medical conditions to tie him over until his appointments at the LMHA and with his primary care physician. The VNA was in place to administer his medications. The homemaker/home health aide was also in place. And Ray, with the help of Gene, engaged with an AA group near his apartment. Gene would also help him learn how to take the bus. Finally, the nursing home was gracious enough to allow Ray to take with him the few art supplies he used at the facility.

On September 1st, Victor drove Ray to his new home. To Ray, it was amazing to see the furniture moved in and new clothes in his closet. This was it. While he knew Victor would be checking in with him as he adjusted to his new home, Ray was finally on his own again; free at last.

During Ray's first year on his own, there were a few rough spots. Treatment compliance issues cropped up once again. Crisis intervention was necessary at least once. Ray had been psychiatrically stable for quite awhile in the nursing home, so he thought his mental illness might not be as serious as everyone thought. The LMHA and Gene provided psychoeducation to Ray and he eventually accepted the fact that compliance with medications was extremely important. There were also issues about getting to AA meetings. Through motivational interviewing, the LMHA clinician helped Ray examine this part of his life. During the winter months, there were a few heavy snowstorms making it difficult for Joan, the homemaker/home health aide, to make it to Ray's apartment. The emergency back-up line was extremely helpful in these situations.

Ray also had to learn how to direct Joan with his care as for years, either he never did it himself, or he was dependent on nursing home staff. Joan was wonderful in that she knew how to gently push Ray towards more independence. Because she had training in behavioral management, she picked up on exacerbations of bipolar disorder symptoms that needed attention from the visiting nurse and the LMHA.

Initially, there were two really positive outcomes from Ray's transition. One, he produced several paintings that Henry helped frame for his apartment walls. And two, the close connection that occurred between Henry and his family. Ray was on his own, but not alone.

Ray completed his satisfaction surveys on time, reporting high satisfaction despite the rough spots he experienced. He also kept in touch with Victor. At the end of the demonstration year, Ray's supports continued under the MI waiver.

A.2 Benchmarks

This section must include the two required benchmarks:
1) projected number of eligible individuals in each target group to be assisted in transitioning, and
2) qualified expenditures for HCBS during each year of the demonstration program.

In addition, the State must select at least three additional benchmarks measuring progress in:
1) directing savings from enhanced FMAP towards system improvements, or
2) enhancing ways in which money can follow the person.

Benchmarks 3-5 are the additional benchmarks addressing the Governor's broader rebalancing goals beyond the 700 participants transitioning under the MFP demonstration. These expenditures are subject to the appropriation process. Connecticut is a gross appropriation state. Investments under benchmarks 3-5 will be tracked and reported to CMS as part of the required 25% rebalancing fund. The expenditures under the reinvestment will more than exceed the 25% rebalancing fund.

Benchmark 1: Transition 700 people to the community
Connecticut will transition 700 persons from institutions to HCBS.

Table 1. Benchmark 1: Number of people transitioned to the community

Number of People Transitioned by Target Population by Calendar Year								
	Elderly	**Physical Disability**		**MI**	**MR**		**Chronic Care**	**Total**
		PCA	ABI		Ind	Comp		
2008	10	6	1	5	1	1	0	24
2009	85	45	10	41	10	10	2	203
2010	78	41	10	41	10	10	14	204
2011	94	49	13	54	13	13	33	269
Total	267	141	34	141	34	34	49	700
Percentage	38%	20%	5%	20%	5%	5%	7%	100%

Benchmark 2: Increase dollars to HCBS

Connecticut expects to increase dollars to the community by $4.4 billion over the next four years. Major contributors to this increase will be the new waiver for persons with mental illness and the waiver for the combined populations of persons who are elderly and/or who have a physical disability. In addition, the existing waiver structure will continue to provide long-term care options to persons with disabilities and elders. Most notable is the Connecticut Home Care Program for Elders which serves over 14,000 and currently has a no waiting list policy.

Table 2. Benchmark 2: Increasing funds to HCBS

Qualifying Gross Medicaid Expenditures to Rebalance Connecticut's Long Term Care						
	Qualified MFP Expenses	Demonstration MFP Expenses	Supplemental Demonstration MFP Expenses	Total MFP Expenses	Other HCBS Expenses	Total Expenses
2008	215,803	37,960	599,440	853,203	815,493,359	816,346,563
2009	4,302,577	230,372	1,525,705	6,058,654	837,943,213	844,001,867
2010	8,982,740	230,912	1,593,941	10,807,593	877,084,320	887,891,913
2011 & 2012	19,699,633	386,763	1,669,426	21,755,822	1,872,687,056	1,894,442,878
Total	33,200,753	886,007	5,388,513	39,475,273	4,403,207,949	4,442,683,221

Benchmark 3: **Increase the percentage of persons receiving long-term care services in the community relative to the number of persons in institutions**

Rebalancing initiatives include transitional housing to specifically address the needs of persons with mental illness. In addition, an HCBS State Plan Amendment and a Personal Care State Plan Amendment will be explored to provide services to Medicaid participants who do not yet meet the nursing facility level of care criteria. Development activities will be tracked under this benchmark, as well as new services costs, to those beyond MFP participants. The existing trend is a one percentage point increaseincrease in the shift to the community. Estimating a two percentage point shift should be attainable.

Table 3: Percentage of participants receiving care in HCBS versus institutions

Percentage of Medicaid LTC Participants Receiving Care in Community Compared to Institutions		
	Percentage of persons living in institutions	**Percentage of persons living in the community**
2008	**47%**	**53%**
2009	**46%**	**54%**
2010	**45%**	**55%**
2011	**43%**	**57%**

Data Source: Office of Policy and Management, Trends in Long-term Care Annual Report

Benchmark 4: Decrease the hospital discharges to nursing facilities among those requiring care after discharge

Connecticut ranks among one-third of all states with the highest share of discharges from hospitals to nursing facilities. Over the last five years, discharge placement trends have remained constant. Of those persons requiring care after discharge, approximately 51% are discharged to

nursing homes, while 49% are discharged to home care. A recent assessment of nursing facilities raised concerns about the screening process for admission and the choices offered to residents upon discharge. To address this concern, initiatives will include the development and implementation of a new web-based screening tool to replace the existing PASSR system. Success of the web-based tool will be determined by measuring the change in number of hospital discharges to nursing homes. Hospital discharge practices will be analyzed as part of this benchmark. Factors such as case mix, age, access to alternative care in the geographic region, and discharge options will be part of the analysis.

Table 4: Percentage of hospital discharges to nursing facilities compared to community services among those requiring care after discharge

Percentage of Hospital Discharges to Nursing Facilities Compared to Community Services among those Requiring Care after Discharge (Medicaid and Medicare)		
	Percentage of persons discharged to institutions	**Percentage of persons discharged to the community**
2008	**51%**	**49%**
2009	**50%**	**50%**
2010	**48%**	**52%**
2011	**46%**	**54%**

Data Source: Connecticut Office of Health Care Access

Benchmark 5: Increase the probability of persons returning to the community within first six months of admission.

Connecticut proposes an 'early intervention program' focusing on individuals who have not yet been institutionalized for six months and not eligible for MFP. The purpose of the intervention is to identify persons at risk for long-term institutionalization, inform them about HCBS options and to coordinate a plan back to the community. Each AAA and CIL will receive funding to support staff dedicated to this assessment and transition effort.

The baseline for this benchmark will be the existing ratio of people who move back to the community within six months of institutionalization compared to the number admitted. Data from the MMIS system will be used to identify all persons on Medicaid in a nursing facility on a monthly basis. All persons will be tracked to identify discharge dates over the first six months following admission. Ratios will be calculated on the first day of each month. The ratio submitted as the benchmark will be the quarterly average. Part of the evaluation will be to determine if people who receive the intervention return to the community. Currently, Connecticut admits an average of 1,200 persons per month to nursing facilities. Of the 1,200 persons, approximately 480 return to the community within the first six months representing a 39% probability of return upon admission. Approximately 100 additional transitions per year are estimated from this intervention.

The intervention includes funding the development of a risk assessment tool to identify persons at high risk of not returning to the community. Persons who are identified as high risk will receive options counseling and be offered transition assistance. Through the rebalancing effort, Connecticut will fund staff statewide to implement this intervention. Training and technical assistance will be given to all transition coordinators under MFP.

Table 5: Increase probability of persons returning to community within first six months of admission

Increase Probability of Persons Returning to Community within First 6 Months of Admission	
2008	**39% discharged within first 6 months**
2009	**40%**
2010	**41%**
2011	**42%**

A.2 Benchmarks

A.2 Benchmarks

MFP Rebalancing Benchmarks

Money Follows the Person Rebalancing Demonstration

INPUTS	ACTIVITIES	OUTPUTS	BENCHMARKS	IMPACTS
Long Term Care Needs Assessment Literature Review Supports/Service inventory Needs of Providers Needs of Participants Existing Systems Efforts Administrative Structure and Support Community Commitment and Involvement Steering Committee/Stakeholders	**Develop outreach campaign to inform public about community options**	**Annual Summit, posters, regional outreach, brochures**	**700 Persons Transitioned** **$4.4 billion increase in HCBS funding**	**Choice, Dignity, Autonomy**
	Expand existing transition system	**20 transition coordinators, bimonthly training**		
	Develop flexible pool of funds (One-time Transitional Fund)	**Budget $600 per transition, policy**		
	Develop new 1915(c) waivers to address service gaps	**MI waiver; Chronic care waiver – elderly/physical**		
	Increase opportunities for self-direction	**Self-direction; support brokers**		
	Develop training for providers, state agency staff and participants	**100% values-based training – MFP staff/contractors;**		
	Increase in the availability of self-directed services and supports beyond MFP participants	**MI waiver, State-funded supports and services for persons with MI, HCBS State Plan option**	**43% of LTC population served in institutions; 57% of LTC population served with HCBS**	
	Develop an online nursing home placement screening system	**60,000 level 1 screens; 1500 level 2 screens per year; Assessment for community supports, training in hospitals**	**46% discharged to nursing facilities; 54% discharged to community**	
	Develop identification and transition system for persons at risk of long-term institutionalization	**Provide case managers, risk profile, flexible funds, training**	**2% annual inc in ratio of persons discharged within 6 months/persons admitted**	
	Develop QI initiative	**Reports, 24-hour triage back up interventions, review rates**	**Inc in workforce reliability; inc in length of time in the community post transition**	
	Evaluate effectiveness and efficiency of new Chronic Care elderly/disability waiver	**Report on assistive technology; cost**	**Waiver serving all persons in elderly/physical disability group not just MFP participants**	
	Develop and implement housing strategy	**RAP, housing inventory, 5 housing coordinators, housing modification funds; partnership with HUD**	**Decrease length of time in transition by increasing accessibility modifications.**	

B. Demonstration Implementation Policies and Procedures

B.1 Participant Recruitment and Enrollment

Describe the target populations(s) that will be transitioned and the recruitment strategies and processes that will be implemented under the demonstration. Specifically, please include a narrative description that addresses the issues below. In addition, please include samples of all recruitment and enrollment materials that will be disseminated to the enrollees.

a. *The participant selection mechanism including the criteria and processes utilized to identify individuals for transitioning. Describe the process that will be implemented to identify eligible individuals for transition from the inpatient facility to a qualified residence during each fiscal year of the demonstration. Please include a discussion of: the information/data that will be utilized (i.e., use of MDS or other institutional data); how access to facilities and residents will be accomplished; and the information that will be provided to individuals to explain the transition process and their options, as well as the state process for dissemination of such information.*

The Connecticut MFP identification process depends on referrals and one-on-one outreach in a manner similar to the existing nursing facility transition program. Connecticut's existing transition program focuses on Medicaid-eligible persons institutionalized at least six months. In general, eligibility criteria in the existing program are very similar to MFP criteria as shown in Table 6. Identification of MFP eligible individuals will be accomplished using multiple strategies listed below.

Table 6. Eligibility criteria for MFP Compared to the Existing Transition Program

Existing Transition System	MFP
Medicaid Eligible or income and assets within Medicaid limits based on interview	Medicaid Eligible or income and assets within Medicaid limits based on interview and eligible for a qualified benefit package
Length of time in institution generally 6 months or more (average length of time 3 years);	Minimum length of time in institution 6 months
Agreement to cooperate with demonstration	Agreement to cooperate with demonstration
Desire to move to the community from the institution	Desire to move to the community from the institution

Strategy 1: **Identification and transfer of eligible participants to MFP**
While there are some exceptions, 95% of the participants in the existing program qualify under the MFP criteria. Connecticut's existing program will continue to operate during the development of MFP. After approval of the protocol, Connecticut will review profiles of existing participants and offer anyone meeting MFP eligibility an opportunity to participate in the new program. Participants not eligible for MFP or who opt not to participate in MFP will continue to transition from the institution through the existing program.

Strategy 2: Identification of eligible participants not currently enrolled in the existing transition program

Expand existing outreach to educate public about MFP opportunity

Getting information to residents regarding MFP has been, and will continue to be, a challenge. MFP offers the opportunity to design new strategies resulting in one-on-one conversation with residents that have proven in the past to be the most successful method of outreach.

Connecticut plans to increase awareness and interest through an extensive outreach campaign as described in Section B.3. The outreach will be designed to educate the general public about HCBS and, more specifically, MFP. As noted in the proposal, it will include some specific targeted outreach to groups such as nursing home social workers, attorneys, AARP members, nursing home residents, etc. Letters will be sent directly to residents of qualified institutional settings. Letters will offer very basic information about MFP and will be designed to encourage the reader to either call the toll free number for additional information or attend an informational meeting at their institutional residence.

Telephonic requests for additional information and/or referrals will be directed to the MFP program office. The initial screen will gather self-reported information about three essential factors: length of time in institutions, Medicaid financial eligibility, and interest in moving to the community from the institution. Assuming that the resident wants to move to the community and that the self-reported length of time in the institution and the financial eligibility is consistent with MFP criteria, the resident or their representative will be sent a MFP packet of materials. The packet will include an informational brochure, an explanation of the application process, including selection methodology, and an application. The caller will be invited to review the information and complete the application in the packet for further consideration. Residents who have questions about the information in the packet will be encouraged to call the MFP program office for additional assistance, including the option of MFP staff completing the application through a telephone interview. For residents who are interested in meeting with a transition coordinator to review the packet, MFP staff will refer the call to transition staff. Transition staff will schedule appointments to meet with potential applicants. Applications will be returned to the DSS MFP unit. Applications will be screened upon receipt for confirmation of eligibility in MFP. Persons who are not eligible will receive a letter of notice within 10 days of receipt of application.

Establishment of Connecticut's MFP Transition

Connecticut will initiate transition planning in the order in which individuals apply. Eligible participants will be assigned transition numbers in the order in which their applications are received subject to transition targets.

Assessment of residents for transition

Connecticut currently uses a self-assessment tool developed under the 2001 Nursing Facility Transition grant. Currently, a nursing facility resident completes a self-assessment to anticipate what support will be needed in the community. A transition coordinator then reviews the assessment and assists the participant with identifying needs that may have been missed. Under MFP, this process will be replicated in Other Qualified Facilities such as IMDs, hospitals, and intermediate care facilities for persons with intellectual disabilities (ICF/MR). It is anticipated

that some additional assistance may be required with the self-assessment for individuals with intellectual disabilities. Conservators or guardians will be included when it is appropriate.

In addition to the self-assessment, the transition coordinators will interview the resident during the first visit. Information may also be obtained through discussion with the facility social work staff. Facility charts will be a primary source of information supporting assessment.

Fully informing residents

Transition Process

Connecticut plans to modify transition materials developed under the 2001 Nursing Facility Transition grant to explain the transition process and options. Modifications will reflect the expanded capacity of Connecticut's transition system to include the Area Agencies on Aging. Materials include a transition guide and a housing guide. Please see Appendix B for example copies and a flow chart of information.

Rights and Responsibilities under MFP

Providing information in multiple formats regarding rights and responsibilities, and at various intervals of time, is essential to supporting informed choice. Informed consent materials are reviewed in Section B.2.

Connecticut will review rights and responsibilities at three key points prior to discharge from the institution. The chart below describes the key points of discussion during transition including receipt of information in the mail, review with transition coordinator prior to transition planning process, and review with care planner prior to discharge to community. See Appendix B for a flow chart of information sharing.

Statewide transition activities from qualified settings

Connecticut plans for 20 transition coordinators across the state. Outreach has been designed to support informed choice. Transition coordinators will respond to consumer demand on a first-come-first-served basis. Individual institutional settings and specific geographic locations will not be prioritized.

b. The qualified institutional settings that individuals will be transitioning from, including geographical considerations and targeting, the names of the facilities for the first year, and an explanation of how the facilities being targeted meet the statutory requirements of an eligible institution.

Verification of qualified setting

Qualified settings will be verified based on status as a licensed Medicaid provider within the following categories: Skilled Nursing Facility, Institute for Mental Disease, Intermediate Care Facilities for persons with intellectual disabilities, or Chronic Disease Hospital. Active status will be verified within Connecticut's MMIS. A list of all qualified residences in the State is located in Appendix G.

Exceptions to the first-come-first-served policy: facility closure
Connecticut is planning for the possibility of institutional closures. In the event that an institution closes, the population of residents within the facility will be prioritized for participation in MFP. Transition staff may be temporarily assigned to the affected facility to ensure smooth transition and to address the immediate need. The transition staff will conduct focused outreach activities directed towards persons in the affected facility for over six months offering them the choice of community services as appropriate.

c. *The minimum residency period in an institutional setting and who is responsible for assuring that the requirement has been met.*

MFP staff within the Medical Care Administration will determine eligibility for MFP. Data elements supporting the two required factors for participation are included in the chart below. All data elements are stored in Connecticut's data warehouse including data from Connecticut's MSIS system and eligibility determination system. Facility charts will be used to determine whether or not the participant has been in an institution for six months.

Table 7A. Data required determining MFP eligibility

Required factor	Data elements
Minimum period of institutional stay	Name, date of birth, social security number, Medicaid number, name of institution, admission date to institution, sequential institutional addresses and billing over 6-month period
Medicaid eligible on month prior to transition	Name, date of birth, social security number, assignment of Medicaid number, determination of community Medicaid

Persons transitioning under MFP must be eligible for one of the qualified service packages offered under the demonstration and must meet the financial eligibility requirement for Medicaid waivers (300% of SSI) 30 days prior to transition.

Persons with income 300% in excess of SSI will be handled the same during the MFP demo period as on day 366+. All financial and clinical eligibility rules for MFP participants will be the same as those of the target waiver and additional state plan services under which participants will be served on day 366. All approved waivers including the Elder waiver, the PCA waiver, the ABI waiver, the Individual and Family Support wavier and the Comprehensive waiver include coverage for the Special Home and Community Based Waiver Group under 42 CFR Section 435.217 with a special income level of 300% of SSI. Additionally, waivers include coverage for the TWWIIA Basic Coverage Group as provided in Section 1902(a)(10)(A)(ii)XV) of the Act whereby persons in Connecticut maintain Medicaid eligibility up to an income level of $75,000. Likewise, the 2 proposed waivers will include coverage for aforementioned groups. While, Connecticut's state plan provides coverage for the Medically Needy Group, none of Connecticut's approved nor proposed waivers include coverage for this group. Eligibility for waiver services is a requirement. All participants served under MFP will be subject to existing

Medicaid community financial eligibility rules according to their coverage group either defined in an approved 1915C waiver or a proposed 1915C waiver.

d. The process (who and when) for assuring that the MFP participant has been eligible for Medicaid a month prior to transition from the institution to the community.

Applications will be received by the DSS central office. Assuming that the applicant is Medicaid eligible in the institution, chooses to return to the community, and has been institutionalized for at least 6 months, a transition coordinator will be assigned. After the initial visit by the transition coordinator, the transition coordinator will determine the most likely target waiver. The coordinator will then contact the operating agency of the target waiver. The operating agency will be responsible for verifying level of care and performing a level of need assessment according to procedures described in the proposed or approved 1915C waiver.

All applications will be sent to DSS. Once applications have been received at DSS, eligibility will be verified by central office staff using the eligibility management system. Applicants will receive a letter confirming their eligibility within 30 days of application contingent upon financial and Level of Care clinical evaluation for community services. Those persons who are not eligible for MFP will be directed to call the MFP program office for assistance regarding other HCBS in the State. Persons transitioning under MFP must be eligible for one of the qualified service packages offered under the demonstration and must meet the financial eligibility requirement for Medicaid waivers (300% of SSI) 30 days prior to transition. During the transition process, coordinators will assist participants with information regarding special needs trusts for those in the medically needy group.

Level of Care evaluations and overall administration of the MI and Chronic Care Waivers will fall in the Alternate Care Unit in Medical Administration in DSS. The Department of Mental Health and Addiction Services has a piece of the waiver administration on Mental Illness. The Alternate Care Unit employs nurses and social workers who perform the Level of Care evaluations.

The needs assessment process which occurs after the Level of Care evaluation for the qualified package will generally occur within the first 2 months of transition planning. The transition coordinator will contact the appropriate care planner (Table 10) to initiate this process. The need assessment for the qualified service packages under MFP will be the same as the need assessment for waivers. Likewise, the care planners who perform assessments under MFP are the same entities that perform assessments as part of the waiver system. All MFP participants will be reevaluated for Level of Care determination and need assessment for entry into the waiver during the 11th month of MFP participation. All persons who continue to meet the financial and Level of Care clinical criteria for participation in the waiver will be served.

The following process chart details the operating agency and staff responsible for enrollment into MFP according to the target waiver. This process will be repeated for each MFP participant after 11 months in the community to determine waiver eligibility. The only change in staff functions will be relative to approval of the Care Plans. While MFP staff will be involved in Care Plan approval prior to enrollment in MFP, they will not be involved Care Plan approval prior to

enrollment in the waiver. As long as the participant continues to be eligible for the target waiver, they will be enrolled into the waiver on day 366.

Table 7B: Staffing for Level of Care, Plan of Care, and Eligibility Determinations

Target Waiver	LOC	LON and Care Plan Development	Approval of Care Plans (Waiver Clinical Approval)	Financial Eligibility Determination	Eligibility for MFP
Elder Waiver	DSS Medical Care Administration (Nurses)	Contracted to Access Agencies (Care Planners)	DSS Medical Care Administration (Nurses and MFP staff)	Regional DSS Eligibility Service Worker	MFP Program Staff
ABI Waiver	DSS State Unit on Aging (Regional Office Social Workers)	DSS State staff: (Regional Office Social Workers)	ABI Waiver Manager and MFP staff	Regional DSS Eligibility Service Worker	MFP Program Staff
PCA Waiver	DSS State Unit on Aging (Regional Office Social Workers)	DSS State Staff: (Regional Office Social Workers)	PCA Waiver Manager and MFP staff	Regional DSS Eligibility Service Worker	MFP Program Staff
IFS Waiver	DDS (Regional Office case Managers)	DDS (Regional Office case Managers)	PRAT (MOA with Medicaid Agency for retrospective review quarterly)	Regional DSS Eligibility Service Worker	MFP Program Staff
Comprehensive Wavier	DDS (Case Managers)	DDS (Case Managers)	PRAT (MOA with Medicaid Agency for retrospective review quarterly)	Regional DSS Eligibility Service Worker	MFP Program Staff
MI Waiver	Medical Care Administration (Nurses)	DMHAS Social Workers	DSS Medical Care Administration (Nurses) and MFP staff	Regional DSS Eligibility Service Worker	MFP Program Staff
Chronic Disease Waiver	Medical Care Administration (Nurses)	Proposed Contract to Access Agencies (Care Planners)	DSS Medical Care Administration and MFP staff	Regional DSS Eligibility Service Worker	MFP Program Staff

Involuntary termination of MFP services including qualified, demonstration, and supplemental will be decided jointly by the waiver manager of the operating agency and the MFP project director.

e. *The State's policy regarding re-enrollment into the demonstration. That is, if a participant completes 12 months of demonstration services and is readmitted to an institution including a hospital, is that participant a candidate for another 12 months of demonstration services? If so, describe the provisions that will be taken to identify and address any existing conditions that lead to re-institutionalization in order to assure a sustainable transition.*

Re-enrollment policy
Connecticut's policy regarding re-enrollment into the demonstration reflects guidance from CMS.

An MFP participant who is reinstitutionalized during the demonstration period for a period of time in excess of 30 days is deemed **disenrolled** from the MFP demonstration. All MFP participants are entitled to the same notice and hearing protections available to individuals currently enrolled in home and community-based waiver programs, when they are disenrolled or when their services are changed or reduced. Any disenrolled participant may reenroll providing that the total number of days of reinstitutionalization does not exceed six months, and that the disenrolled participant continues to meet financial and clinical HCBS criteria. The disenrolled participant meeting this criteria will be reenrolled in the demonstration and fully eligible for demonstration and supplemental services. Reenrollment of former demonstration participants will be prioritized over new applicants for the demonstration. Connecticut will be eligible for enhanced FFP on all services according to the demonstration rules for a period not to exceed 365 days of HCBS services. The policy would be applied as follows given an MFP participant who was reinstitutionalized 45 days post transition and who subsequently reenrolled after 65 days of reinstitutionalization. Total days allowable for enhanced FFP ─ 365; total days billed at enhanced FFP ─ 45; days of disenrollment due to reinstitutionalization (not counted) ─ 65; remaining days allowable for enhanced FFP upon reenrollment ─ 320.

Former participants who are reinstitutionalized during the demonstration period and who remain in an institution for a period of time in excess of six months are eligible to apply for the demonstration as a new participant. All policies regarding application and enrollment to the demonstration will apply including waiting lists. No priority status will be awarded.

All participants in the demonstration will be flagged within Connecticut's eligibility determination system to facilitate data collection and verification on a regular basis.

B.2 Informed Consent and Guardianship Process

a. *Provide a narrative describing the procedures used to obtain informed consent from participants to enroll in the demonstration. Specifically include the State's criteria for who can provide informed consent and what the requirements are to "represent" an individual in this matter. In addition, the informed consent procedures must ensure all demonstration participants are aware of all aspects of the transition process, have full knowledge of the services and supports that will be provided both during the demonstration year and after the*

demonstration year, and are informed of their rights and responsibilities as a participant of the demonstration. Include copies of all informed consent forms and informational materials.

This first step in the informed consent process is a self-directed step with the goal of reviewing, understanding and completing a self-assessment process. The participant will be part of the transition process from the very beginning, assuming the highest degree of self-direction possible. Each eligible participant will receive a Transition Guide developed under the 2001 Nursing Facility Transition Program, as well as special materials developed under the MFP demonstration. The Transition Guide provides a step-by-step process to transition and is written for use by the participant. Included in the Guide is a self-assessment tool. Potential participants will be asked to review both the Transition Guide and complete the self-assessment prior to meeting with a transition coordinator. Both tools are designed to facilitate an important thought process towards independent living in the community. Those applicants who need assistance with the self-assessment process will be supported by MFP staff during their first meeting. The applicant will begin to have an understanding of the responsibilities and risks involved in community living as they participate in the planning process.

Transition coordinators will contact applicants no less than three days after information materials are sent from central office to schedule the first planning meeting.

The initial meeting will include the following objectives:

1) The applicant will understand the purpose, procedures, risks and benefits of participating in the MFP demonstration.
2) The applicant will understand the transition process and will have full knowledge of the services and supports he/she can expect both during the demonstration and after the demonstration year.
3) The applicant will understand procedures designed to ensure privacy of the participants and confidentiality of the data.
4) The applicant will understand their options for self-direction.
5) The applicant will understand the ways in which they will have a choice in selecting their community-based residence.
6) The applicant will understand their rights.
7) The applicant will understand the responsibilities of participating in the demonstration.

Applicants should already have some level of understanding regarding the above mentioned learning objectives as a result of reviewing materials. The meeting with the transition coordinators will provide an additional opportunity for specific dialogue focused on the learning objectives to assure clear understanding and to provide a forum for questions. After discussion, residents interested in moving to the community who are not conserved or who do not require a guardian (DDS), will indicate their preference by completing the intake process which includes informed consent documentation. A draft of the informed consent form may be found in Appendix D. Residents interested in moving to the community who are conserved will sign a Letter of Interest. The transition coordinator will review the Probate Court decree (either available in the facility or through Probate Court) to gather the particulars of the conservatorship, including the appointment of a conservator of person and/or estate and what duties and authorities have been assigned to the conservator. Based on the findings, the signed Letter of Interest will be mailed to the conservator of record accompanied by an explanation of

the MFP demonstration; or it will be determined that the client has retained decision-making authority over this process. The letter will seek participation of the conservator in the transition process and inform the conservator to expect a call within a week to discuss the transition process and interest of the MFP applicant. The purpose of the phone conversation will be to address concerns the conservator may have and engage the support of the conservator in the transition process. The letter will also seek authorization to initiate the process indicated by signing and returning informed consent documentation. For DDS clients who have a guardian, DDS procedures for obtaining informed consent will apply.

b. *Provide the policy and corollary documentation to demonstrate that the MFP demonstration participants' guardians have a known relationship and do interact with the participants on an ongoing basis; and have recent knowledge of the participants' welfare if the guardians are making decisions on behalf of these participants. The policy should specify the level of interaction that is required by the State. In addition, the State must set the requirements for, and document the number of visits, the guardian has had with the participant in the last six months. This information must be available to CMS upon request.*

Recent changes in Connecticut State Statue address new criteria for determining who can provide informed consent and what the requirements are to represent an individual in this matter. Guardians and conservators may both provide informed consent in the State. Guardians are appointed by the court system to act on behalf of minors and for persons with intellectual disabilities who cannot represent themselves. Conservators of the person (C.G.S Sec. 45a650) are appointed by courts when the court finds, by clear and convincing evidence, that the adult respondent is incapable of caring for him or herself or is incapable of managing his or her affairs and that the appointment of a conservator is the least restrictive means of intervention available to assist the respondent. When determining whether a Conservator should be appointed, the court must consider evidence of the respondent's past preferences and life style choices, and any supportive services that are available to assist the respondent in meeting his or her needs, among other factors. Conservators of the person may have the authority to consent to medical or professional care, counsel, treatment or services. As of October 1, 2007, a conserved person retains all rights and authorities not expressly assigned to the conservator by the Probate Court. The new language may lead to some confusion regarding who can provide informed consent. Some conservators may feel that they are responsible for informed consent when in fact the right of informed consent was never taken from the participant. For that reason, transition coordinators will seek supporting documentation from the Probate courts.

At times, persons who are interested in moving to the community may have a conservator responsible for informed consent who has an inadequate relationship with the participant or who is uncooperative or an obstructionist. Should this occur, transition coordinators may seek the advice of Connecticut's Probate Court for consideration of an alternate conservator. After establishing a relationship with a new conservator for six months, the resident may reconsider participation in the MFP demonstration.

Regardless of whether the conservator is a family member or someone else the court appointed, the relationship between the resident and the conservator or guardian must be documented. The following requirements must be met prior to accepting informed consent from a conservator or guardian:

- Evidence of visits: A minimum of one visit between the conservator of person or guardian and the participant must be documented within the six-month period prior to transition. The visit does not have to occur in the nursing home. For example, the participant may visit the conservator at an office or at the family home. Exceptions to this policy may be submitted based special circumstances that the conservator or participant would like to have considered. Exceptions will be reviewed on an individual basis by DSS with advice from the Steering Committee within seven days of request. Written justification for approval or denial of the waiver will become part of the transition case record. Special circumstances include situations where there is clear evidence of a strong relationship between the conservator of person and participant but where distance hinders regular visitation. Facility records will be used to provide documentation supporting visits.

- Evidence of knowledge of participant welfare: Multiple sources of documentation will be reviewed and collected to support evidence of knowledge regarding participant welfare. The following is a partial list of sources for information:
  - Nurse notes
  - Care plan notes
  - Social Services' notes
  - Doctor's notes
  - Hospital notes

Copies of relevant supporting documentation will be kept in transition coordinator's case files. Sources of documentation will reflect participation of the conservator in care planning, including but not limited to, attendance at meetings, phone conversations, and case notes reflecting active participation in decision making.

a. How training and/or information is provided to participants (and involved family or other unpaid caregivers, as appropriate) concerning the State's protections from abuse, neglect, and exploitation, including how participants (or other informal caregivers) can notify appropriate authorities or entities when the participants may have experienced abuse, neglect, or exploitation.

Connecticut employs strict protocols regarding the reporting of abuse, neglect, and exploitation. Each of the three operating agencies for the delivery of services under MFP has demanding and prescriptive procedures for incident and management reporting systems. These procedures are dictated by State statute and regulation. While the procedures and managing systems are different, each has the same objective: to identify, address and seek to prevent instances of abuse, neglect and exploitation. See the table below for a summary of each agencies' procedures.

Table 7C. Summary of Agency Protocols for Reporting of Abuse, Neglect and Exploitation

Agency	Level of reporting	Reporters	Timeframe
Persons served by Department of Social Services (DSS) waivers and programs PSE Statute 17b-450-461; Adults and elders	Serious incident involving abuse/neglect or other immediate risk to participant	All staff employed directly by individual, provider or agency including case manager, central office staff. In addition, clergy, police officers, medical professional and nursing home staff are mandatory reporters for elders	Immediate contact to appropriate agency; written report no later than 5 PM next business day. Data entered into on-line data system Immediate contact to family, case manager, broker
	Sensitive incident	Same	Reported no later than 48 hours; Data entered into on-line data system
Persons served by Department of Developmental Services (DDS) waivers and programs I.F.PO.001	Abuse/ Neglect and other critical incidents	All staff employed directly by individual, provider or agency including case manager, central office staff.	Immediate contact to appropriate agency; reports transcribed and faxed to Division of Investigation. In matters involving sexual abuse, State police are notified. Immediate contact to family, case manager, broker
	Non-critical incidents	Same	Submitted within 5 business days and entered into CAMRIS.
Persons served by Department of Mental Health & Addiction Services (DMHAS) waivers and programs Commissioner's Policy Statement No. 81	Critical Incident including abuse and neglect	All staff employed directly by individual, provider or agency including case manager, central office staff	Verbal report within 3 hours reported to Commissioner; Written report within 24 hours;

See Appendix M for a complete listing of resources that illustrate the ways that participants, family members, caregivers and/or legal representatives are provided information about protections from mistreatment, and are told how to report concerns or incidents of abuse, neglect and exploitation. Training is provided to all participants and involved family or other unpaid caregivers via transitional services and by case managers.

For critical incidences reported directly to the MFP program through the triage and 24 hour hotline, MFP will ensure that all reporting requirements are met. The hotline staff will adopt reporting strategy meeting the strictest protocol for all three agencies. For example, all incidences of abuse and neglect will be reported immediately to MFP program director and operating agency contact. In addition, incidences regarding sexual abuse will be reported to state police. All other critical incidences involving serious impacts to participants will be reported within 3 hours to the MFP office and operating agency contact. If the incidence is not an immediate issue and does not put participant at risk, then the triage contractor must contact the MFP program and operating agency within 48 hours. Written reports are expected within one business day to MFP and operating agency contact. All critical incidences will be followed up

on in within 30 days or the specified earlier deadline specified by regulation. Once the program office or operating agency is contacted, any requirements that fall to the MFP staff will be met. For example, the staff is required to communicate incidences to the family and remainder of the team within 24 hours. In addition, MFP staff will meet all reporting deadlines (e.g., reports to family, Case Manager or broker). Reporters are all staff employed directed by the individual family or provider agency including Case Manager, Social Worker, cognitive behaviorist, conservator, triage and 24 hour hotline staff, and MFP staff.

b. *Identify the entity or entities that are responsible for providing training and/or information and how frequently training and education are furnished.*

State case managers or contracted care planners provide direct information to participants at a minimum on a yearly basis. The State is responsible for all caregiver training content including the obligations of mandatory reporters per statute.

B.3 Outreach, Marketing and Education

Submit the State's outreach, marketing, education, and staff training strategy. Note: All marketing materials are draft until the Operational Protocol is approved by CMS. Please provide:

a. *The information that will be communicated to enrollees, participating providers, and State outreach/education/intake staff (such as Social Services workers and caseworkers);*

Brochures, transition guides and housing guides created under the 2001 Nursing Facility Transition grant are all being modified to reflect the expanded network of transition coordinators to include the AAAs. Materials appropriate for distribution to residents of institutions, family members, social workers, providers, municipal agents, senior centers, AARP, nursing facility administrators, advocacy organization, etc., may all have the same general facts, but may be designed differently to meet the needs of the target population.

General information that will be communicated includes the following:

- Real life stories about people who moved from institutions to the community
- Eligibility requirements
- Process for selection and enrollment
- Process of transition – What to expect?
- Target populations
- Institutions identified for outreach
- Qualified Residences – Where will I live?
- Services and supports available under MFP
- Options for self direction
- Consumer supports
- Participant responsibilities during the demonstration including participation with data collection
- Participant rights
- Contact information for additional information
- What happens if a participant has to go back into the institution?

b. Types of media to be used;

Connecticut plans a multi-media approach to raise general awareness about the MFP demonstration and to assist with the appropriate referral of persons in institutions to the program.

c. Specific geographical areas to be targeted;

The demonstration is Statewide.

d. Locations where such information will be disseminated;

- Newspapers: A press release will offer the press general information. Several newspapers across the State continue to focus on MFP. Connecticut anticipates statewide newspaper coverage during the five-year demonstration. Outreach will include targeting publications that cater to Hispanic persons. Target audience is the general public.
- Web-based Communication: DSS is redesigning components of its website to become a stronger information center for long-term care services and supports offered through the Department. For those services not offered through the Department, additional links will be added to the site. The long-term care website and all State agency websites should include fact sheets info. Target audience is the general public.
- Broadcast**:** Coverage is also anticipated in radio and public affairs programming. Target audience is the general public.
- Print: Fact sheets are being developed to provide general information about MFP. Print sheets will support both group and individual presentations about MFP. In addition to print materials developed to provide general information, materials will also be developed for the application packet. These materials will be targeted to potential applicants and will be designed to support the informed consent process detailed in Section B.2.
- Print materials providing general information about MFP will be available at several locations statewide. Below is a list of community locations where information will be.
    - Qualifying institutions: One-on-one outreach to social workers and residents
    - Nursing homes: Residents' councils will have information regarding MFP and will be asked to host an outreach forum during their April meeting
    - Annual Voices conference: This annual gathering of nursing home residents from each nursing home is sponsored by the Ombudsmen and offers a unique opportunity to inform residents of community options under MFP
    - Town Hall: Municipal agents offer information on a regular basis to persons with disabilities and elderly people at a local level
    - Churches
    - Independent Living Centers and Area Agencies on Aging; community-based organizations providing information and referral as the ADRC is developed
    - Advocacy organizations: Each organization provides a unique opportunity to inform members of MFP. Organizations include Connecticut Legal Services, Greater Hartford Legal Services, and Statewide Legal Services
    - Connecticut Bar Association: The Elder Law section of the Bar is a partner in the implementation of MFP

  - Probate courts: Persons experiencing a change in status will have information accessible at these locations
  - Professional organizations for social workers, personal care assistants, physicians, nurses, and providers. Informing the workforce is essential.
  - Connecticut Association of Not for Profit Providers for the Aging and Connecticut Association of Health Care Facilities: Both associations for State nursing facilities are important partners with MFP and, therefore, important distribution points for information
- Print/Letters: Letters will be written to administrators of qualified institutional settings from which individuals will be transitioning. Letters to administrators will introduce administrators to the project and let them know what to expect over the four-year demonstration. Contact information will be readily available to address any concerns they may have. Letters will also be mailed to Medicaid participants living in qualifying institutions and/or their representatives. Letters to residents will inform them about the demonstration and opportunities that they may have to live in the community. Letters will include an invitation to an upcoming forum in their residence where MFP staff and/or contractors will be available to answer questions. Letters will also provide residents and/or their representative with the toll free phone number for the MFP program office which they may call for information and to receive an application packet
- Evaluation and outreach: All outreach activities will be evaluated by DSS with advice from the MFP Steering Committee, for effectiveness and modified accordingly
- Toll free line: A dedicated toll free line will be available for persons seeking information about or participation in MFP. The toll free line will be a "must answer" line within the MFP program unit during the hours of 9:00 a.m.─5:00 p.m. After business hours, an answering machine will provide the opportunity for the caller to leave a message. If the call is related to an emergency after hours, the caller will be directed to call the emergency backup line where assistance is available 24 hours a day, seven days a week. Calls left on the machine will be returned on the following business day. Staff will receive training on the screening protocol, as well as training on other community-based services available in the State. Consumer satisfaction with the screening system will be assessed on the quarterly Consumer Satisfaction Survey that is telephonically administered by the University of Connecticut as part of the MFP evaluation. The screening function will be responsible for:
  - Providing information about MFP
  - Counseling regarding eligibility for MFP
  - Directing callers to other resources in the State for those not eligible for MFP
  - Mailing informational materials and applications to potentially eligible callers
  - Assisting with completion of application, if required

e. Staff training schedules, schedules for State forums or seminars to educate the public;

Education
Opportunities to discuss HCBS with the public, and more specifically the Dignity of Risk, are essential to the success of rebalancing. The past year of outreach within the State has underscored the larger cultural and societal shift that must occur within the State before rebalancing can be successful. Connecticut is a state where approximately 65 out of every 1,000 seniors live in an institution. Institutional care has become an expectation for many as part of the aging process. State forums will provide opportunities to educate stakeholders.

Outreach Forums
Once the Operating Protocol is approved, Connecticut plans to host forums statewide so that the general public, family members and advocates at a local level will have access to information regarding MFP. A minimum of 20 outreach meetings are planned statewide for the general public. Specifically these meetings will be targeted to family members, attorneys, community providers, etc. Five of the 20 forums will be hosted within the first four weeks of the demonstration. The meetings will be held in accessible locations such as the local Chamber of Commerce, local hospital and local community center. Additional forums will be held at institutions to provide opportunities for residents and staff to learn about the demonstration. These forums will be scheduled as follow-up meetings subsequent to the statewide mailing mentioned under 'Print/Letter' outreach above.

State Forum
Connecticut DSS plans to host a State forum (Rebalancing Summit) annually, beginning in October 2008. The forum will provide opportunities for stakeholders including professionals and providers, to better understand the demonstration and how persons with disabilities may benefit. It will also provide a forum for sharing progress toward rebalancing. The Commissioner plans to host a summit annually to report the rebalancing benchmarks status to the State's stakeholders. The meeting will be designed to assure maximum participation of those who attend. In addition to a status update on MFP, the summit will provide the opportunity for recognition of direct workforce staff. Strategies will be designed to include those who attend in the 'next steps' of MFP.

Training
Transition Coordinators
The State of Connecticut expects to increase the number of transition coordinators under MFP. Over the past five years, the existing transition system has developed a high level of expertise regarding the very challenging work of transition. Connecticut staff assisted in the development of the Independent Living Research Utilization's transition training and participated as key members of the national training team. The curriculum that was developed will be distributed to all new transition staff. In addition, three Independent Living sites have been identified as training centers.

Training centers' staff will provide training support to all new transition coordinators over a six-week orientation. Required training for all transition coordinators will continue to occur biweekly. Coordinators will continue to identify specific areas for technical assistance through a case review process. Persons with expertise in identified areas will provide training as needed during biweekly meetings. Specific training relative to MFP includes: data collection changes, MFP Operating Protocol, new services, self-direction, and the role in quality management under

MFP. In an effort to meet the professional development needs of the contracted staff, Connecticut will offer staff the opportunity to complete an assessment of their personal training needs. Information from the assessment will be used to determine additional training needs and to prioritize topics.

Initial instruction will focus on an understanding of the following objectives:

- The menu of services available to MFP participants
- The referral and intake process
- Rights and responsibilities of participants in the demonstration
- Policies and procedures regarding informed consent
- The importance of consumer files and staff time records
- The process of interviewing and information gathering
- The importance of the self-assessment process
- How to assist with forming a circle of support
- how to develop and monitor a transition plan
- how to apply for programs and/or waivers
- how to coordinate with State agency resources and the housing coordinators
- Financial planning, benefits, entitlements and budgeting
- How to identify related needs such as utilities, phone, transportation, social, leisure, recreational and vocational pursuits, furnishings, household goods, basic food start-up, moving and settling in
- How to use the 'final checklist' for transition
- How to develop a follow-up plan for the first six months post transition
- How to complete all data collection and other required paperwork

Table 8. Schedule for field-based mentoring over the first six weeks

Week 1	Trainee shadows trainer for 3 days.
Week 2	Trainee develops nursing home visitation schedule ─ either to establish a relationship or to follow up on a referral; trainer accompanies trainee for two days. Participate in biweekly transition training for all coordinators.
Week 3	Continue outreach – trainer accompanies trainee for two days.
Week 4	Works with trainer in trainer's nursing homes and on paperwork for two days; visits NEAT and the Board of Education Services for the Blind. Participate in biweekly transition training for all coordinators.
Week 5	Trainee works independently.
Week 6	Trainee plans one day with trainer in a qualified institution/office. Trainer identifies additional need for technical assistance, if necessary. Participate in biweekly transition training for all coordinators.

Training for care planners, including social workers and DDS case managers

Staff meeting the qualifications referenced in Section B5 will perform the assessment for HCBS and the care plan function of MFP. The care planners role is different from transition coordinators. Transition coordinators do not create care plans for HCBS services. They coordinate the move to the community which includes coordination with care planners. In contrast, care planners develop the care plan. During the first 30 days after approval of the protocol, MFP staff will host the first training for all care planners participating in the demonstration. Learning objectives will include:

- Understanding of the assessment tool
- Understanding of person-centered planning
- Understanding of self-direction as a delivery option

Subsequent semi-annual training over the four-year demonstration will include the following content areas:

- "Dignity of Risk ─ the Role of Medicaid"
- Quality Management
- Assistive Technology

Providers of MFP Services
Connecticut has over 120 home health agencies providing services to Medicaid participants. Those participating in MFP will be required to attend training on a semi-annual basis. The content of the training will be similar to the training for care planners.

Content areas for year-one training will include:

- "Dignity of Risk ─ the Role of Medicaid"
- Assistive Technology

Subsequent annual on-going training will be based on input from providers and needs of the program identified by the QI Committee.

f. The availability of bilingual materials/interpretation services and services for individuals with special needs;

Materials are available in alternate formats including Braille, large print, CD, etc. Materials are also available in Spanish and other languages as required. Upon request, DDS will make available alternate language interpretation and services for the deaf and hearing impaired. Language Line will be used to support the need for communication in multiple languages.

g. A description of how eligible individuals will be informed of cost sharing responsibilitie.

Financial responsibilities for participation in the demonstration will be fully explained both in writing and through discussion with transition coordinators as part of the transition process.

B.4 Stakeholder Involvement

Describe how the State will involve stakeholders in the Implementation Phase of this demonstration, and how these stakeholders will be involved throughout the life of the demonstration grant. Please include:

a. *A chart that reflects how the stakeholders relate to the organizational structure of the grant and how they influence the project.*

The chart below includes the members of the DSS advisory Steering Committee and their affiliation. Please refer to Chart 2 in Section C for an organizational structure chart.

Chart 1: Membership of the MFP Rebalancing Steering Committee

MFP Rebalancing Steering Committee	
Member	**Representation**
Quincy Abbot	The ARC of Connecticut
Susan Blaszak	Self-advocate
Kevin Brophy	CT Legal Services
Marsha Brown	Board of Education Services for the Blind
Martha Dale	Leeway – Nursing Facility Administrator
Pat Droney	National Alliance for the Mentally Ill
Julia Evans Starr	Commission on Aging
Maggie Ewald	Long-term Care Ombudsman
Molly Gavin	Connecticut Community Care, Inc.
Liz Giannini	Family member
Pamela Giannini	Director, State Unit on Aging
Jennifer Glick – Co-Chairman	Department of Mental Health and Addiction Services
Michele Jordan	Bureau of Rehabilitation Services
Brenda Kelley	AARP
Stan Kosloski	Disability Advocacy Collaborative
Kelly Kulesa – Co Chairman	Self-advocate
Diana LaRocco	University of Hartford
Armand Legault	Self-advocate
Beth McArthur	Department of Developmental Services
Fran Messina	Department of Economic and Community Development
Melinda Montovani	Brain Injury Association
Pauline Morrissette	Self-advocate
Peter Morrissette	Self-advocate
David Parrella	Director, Medicaid
Martha Porter	UCONN Center on Aging
Susan Raimondo	National Multiple Sclerosis Society
Neysa Stallman Guerino	Area Agency on Aging
Joe Stango	Family member
Karyl Lee Hall	CT Legal Rights

--- **Family member or self-advocate**

b. A brief description of consumers' and institutional providers' involvement in the demonstration.

Both consumers and institutional providers groups are represented on the DSS Steering Committee and its various workgroups. The Steering Committee has five years of experience in transitional activities, having served as the Steering Committee for the Nursing Facility Transition Project. The Steering Committee meets on a monthly basis and acts as an advisory body to DSS for MFP. The Steering Committee had comments and input into the design of the Operating Protocol. Steering Committee workgroups discussed various sections of the Operating Protocol. For example, a transition workgroup developed input into design elements, including participant recruitment and enrollment, outreach and guardianship. Workgroup meetings were held biweekly for several months to discuss protocol requirements. MFP staff facilitated meetings and provided draft documents to workgroups for review and comment. Draft documents were reviewed by the Steering Committee and comments were provided. The draft protocol was reviewed by the Commissioner of DSS and other key leaders including the Medicaid Director. An excellent working relationship between the MFP Steering Committee and the Commissioner of DSS and his staff has been essential to the implementation of MFP.

Supports to assure participation

Consumers' participation in the MFP Steering Committee and workgroups is both supported and encouraged. Reasonable accommodations such as interpreters or conference calling into a meeting are budgeted within the administrative expense of the demonstration. Likewise, transportation expenses are budgeted in recognition that many persons with disabilities could not afford to participate unless the demonstration supports their transportation.

The MFP Steering Committee is a large diverse group. In addition, workgroups add to the diversity by including many content area experts who contribute to the design of the activities.

c. A description of the consumers' and institutional providers' roles and responsibilities throughout the demonstration.

The role of the Steering Committee is to act as an advisory body to the Commissioner of DSS for the MFP demonstration. Co-chairs are responsible for leading meetings. One of Connecticut's co-chairs is the administrator of a nursing facility. The other is a person with a disability. All members of the Steering Committee and workgroup have the responsibility to attend meetings on a regular basis. They also have the responsibility to serve as a representative of their respective organizations. Representatives communicate on a regular basis with their organizations to ensure that the Steering Committee represents organizations rather than the individuals representing the organization. Additional responsibilities of Steering Committee members include active participation and respectful debate.

d. The operational activities in which the consumers and institutional providers are involved.

Over the past year workgroups were aligned with the various components of the Operating Protocol. With the protocol in place, the workgroups will reorganize around the selected benchmarks. Members of the Steering Committee may select membership on various

workgroups, including QA, transition, housing, workforce and evaluation. The Steering Committee will continue to meet on a monthly basis. Workgroups will meet according to the demands of their respective priority areas. It is anticipated that all workgroups will meet at least monthly during the first year of the demonstration. Workgroups will be responsible for the design of the activities and oversight plans to assure success and attainment of all benchmarks.

B.5 Services and Benefits

Provide a description of the service delivery system(s) used for each population that the State will serve through the MFP demonstration. Include both the delivery mechanism (fee-for-service, managed care, self-directed, etc.) and the Medicaid mechanism through which qualified HCBS will be provided at the termination of the demonstration period (waiver, 1115 demonstration, Medicaid State Plan, etc.).

List the service package that will be available to each population served by the demonstration program. Include only services that are provided through the demonstration (home and community-based long-term care services and supplemental services). Divide the service list(s) into Qualified Home and Community-Based Program services, demonstration services, and supplemental demonstration services reflecting the categories of services that are listed in the solicitation. For demonstration services and supplemental services, indicate the billable unit of service and the rate proposed by the State. For supplemental demonstration services, provide any medical necessity criteria that will be applied as well as the provider qualifications.

Qualified Services

These services include the following Medicaid State Plan option benefits: skilled nursing, physical therapy, speech therapy, homemaker/home health aide services, occupational therapy, medical social services, durable medical equipment and a rehabilitation option for individuals with mental illness. It also includes services available under each of the home and community-based services waivers described below. The State will explore the possibility of an HCBS State Plan Option or Personal Care Assistance State Plan Amendment.

Level of need assessments, care plan development, service qualifications and rates will vary based on the qualified service package. Connecticut will utilize six different packages of services under the authority of MFP. Persons in the elderly and physical disability target population who meet clinical and financial eligibility will have access to the Chronic Care Aging/Disability qualified package. This package will be sustained in year two under the authority of a new 1915(c) waiver. Individuals not qualifying under the Chronic Level of Care will be enrolled in the existing Aged and Disabled waivers depending upon eligibility. Persons with mental illness who meet clinical and financial eligibility criteria will also have access to a new qualified package of services which will be sustained under the authority of 1915(c) in year two. Persons with brain injury and persons with intellectual disabilities will be served with existing qualified service packages previously authorized under 1915(c).

Connecticut anticipates that the initial phase of the MFP demonstration will rely on the currently approved 1915(c) waivers and the MI waiver (once it has been submitted to CMS). Connecticut has worked three years to develop a draft MI waiver and has already begun to input the draft onto the CMS HCBS waiver application website. Submission will be imminent. Pending approval of the committees of cognizance, the Department intends to submit the MI waiver by

6/30/2008. Phase II will include the Chronic Care waiver implementation. Phase-in of clients would begin once the Chronic Care waiver has been submitted and appears likely to be approved by CMS.

The State has hired a significant number of persons to support the infrastructure required for implementation of both the Chronic Care Waiver and for the MI waiver. Regarding the MI waiver, the State has the infrastructure and is prepared to begin serving individuals once the MFP protocol is approved. The Level of Care is anticipated to be a nursing facility Level of Care. A waiver manager, a nurse clinician and 4 social workers have been hired to implement the program. In addition, the State recently established a new position in the DMHAS, Director of Older Adult Services. This position has been filled in anticipation of MI waiver services. MFP staff work in close collaboration with DMHAS staff. The Chronic Care Waiver is anticipated to be a smaller program with services already approved under other waiver programs in the State. The Level of Care is anticipated to be a Chronic Care Hospital Level of Care. Staff within Medicaid is responsible for the development and implementation of this new waiver, which will be administered by the Alternate Care Unit.

Services are already in place and offered under state funded MI programs. In addition, all MI staff has been attending joint trainings with case managers involved in existing transition activities.

As noted above under eligibility, persons accessing qualified packages under MFP must meet financial and clinical eligibility requirements for waiver services. For example, persons whose income is in excess of 300% of SSI and assets of more than $1,600, will not have access to qualified service packages (waivers). In addition, persons who do not meet clinical criteria for qualified service packages will have access to State Plan services, but will be subject to medically needy income rules.

Rehabilitative services include the following: individual, family and group counseling; behavior management training and intervention; supportive counseling directed at solving daily problems related to community living and interpersonal relationships; psycho-educational groups pertaining to the alleviation and management of psychiatric disorders; teaching, coaching and assisting with daily living and self-care skills such as the use of transportation, meal planning and preparation, personal grooming, management of financial resources, shopping, use of leisure time, interpersonal communication and problem-solving; assistance in developing skills necessary to support a full and independent life in the community; support with connecting individuals to natural community supports; orientation to and assistance with accessing self help and advocacy resources; development of self-advocacy skills; health education; teaching of recovery skills in order to prevent relapse; and other rehabilitative support necessary to develop or maintain social relationships, to provide for independent participation in social, interpersonal or community activities, and to achieve full community reintegration. In addition, the facility provider shall conduct ongoing assessment and service planning and supervise and monitor self-administration of medications. Restraint and seclusion are not provided within these facilities.

Service Delivery System

Home and community-based services and supports are provided under the Medicaid State Plan and waivers, State-funded programs and the Older Americans Act. Connecticut currently

administers several home and community-based waivers that were created under section 1915(c) of the Social Security Act. Listed below is a brief description of Connecticut's systems of care that provide home and community-based supports. In addition to the new 1915(c) waiver for the MI and the new 1915(c) waiver for Chronic Care, these systems will be available to MFP participants who are otherwise eligible at the end of the demonstration year.

The chart below provides a visual representation of changes to Connecticut's existing HCBS service and delivery infrastructure demonstrated under MFP. Existing services available to target populations are indicated in white, while new services are marked in pink. Service changes are a direct result of gap analysis over the past four years. The absence of these services was identified as a barrier to transition and/or to participation in the community. The addition of the services for the benefit of the target populations is predicted to reduce reliance on institutionalization.

Most notably, changes are anticipated for persons identified at the Chronic Level of Care for the elderly and physical disability target population as well as in the target population of persons with mental illness. In both cases, new waivers will be developed. Development will continue over the first year of MFP to assure that 1915(c) authorities are in place before the 366th day post transition. New 1915(c) waivers will be submitted to CMS on or before April 2009. Full descriptions of qualified service packages for the new waivers and rates under the demonstration may be found in Appendix F. Connecticut hopes to simplify the service delivery system by analyzing and potentially aligning service packages, definitions, terms and rates.

The State will analyze and consider adopting a statewide methodology for rates under MFP. Current rates under MFP were established according to the following methodology:

- Consideration of existing rates and concerns or problems with vendors
- Consideration of variances between agencies for similar services
- Reference to DOL prevailing job rates
- Analysis of reasonableness of private market rates compared to public rates

Billable units and rates for all new qualified services indicated in pink are detailed in Appendix F. Definitions and qualifications of providers are also detailed.

Table 9. Services under Money Follows the Person by target population
Expansion of service menus for PCA and CHCPE will be considered based on remaining documented gaps.

			Physically Disabled			
	Elderly	MR	PCA	ABI	Chronic Care	New MI
Qualified Services						
State Plan Services for MFP Participants						
Targeted Case Management		X				X
Qualified Outpatient and Home and Community-Based State Plan Services	X	X	X	X	X	X
Qualified Services in Waivers for MFP Participants (shaded boxes are new services which will be demonstration services until approved in the proposed 1915(c) waivers)						
Personal Care		X	X	X	X	
Chore Services	X			X	X	
Homemaker	X			X	X	
Case Management	X			X	X	X[5]
Prevocational		X		X	X	
Respite	X	X		X	X	
Assisted Living	X	X			X	
Adult Day Health	X				X	
Companion	X	X		X	X	
Peer Support						X
Home Adaptation	X	X		X	X	X
Non-Medical Transportation	X	X		X	X	X
Training to unpaid Caregivers		X				
Specialized Medical Equip	X	X			X	X
Delivered Meals	X			X	X	
PERS	X	X		X	X	
Community Transition Services					X	
Individual Directed Goods and Services		X				
Habilitation Residential		X				
Habilitation Day		X		X		
Habilitation Expanded		X		X		
Independent Living Skills				X		
Supported Employment		X		X		X

[5] The MI waiver proposes to provide Case Management defined as a distinct service from the services provided under TCM.

			Physically Disabled			
	Elderly	MR	PCA	ABI	Chronic Care	New MI
Substance Abuse				X		
Consultative Services	X				X	
Interpreter		X				
Vehicle Adaptations		X		X	X	
Independent Broker		X			X	
Intensive Staffing Support		X				
Cognitive Behavioral Services				X		
Assertive Community Treatment						X
Community Support Program				X		X
Recovery Assistant						X
Short-term Supervision and Support						X
Demonstration Services in Year 1						
One-time Transitional Costs in non-provider settings	X	X	X	X	X	X
Accessibility Modifications	X	X	X	X	X	X
24/7 Emergency Back-up Triage System	X	X	X	X	X	X
Supplemental Services in Year 1						
Housing Coordination	X	X	X	X	X	X
Transition Coordination	X	X	X	X	X	X
One-time Transitional Costs in provider settings	X	X	X	X	X	X

New services developed under MFP

Note: Persons eligible for the elder waiver will have access to a state funded personal care assistance service already in existence. The Chronic Care waiver will address this for the highest need individuals.

Coordinating Care Plans

Assessment for HCBS services and development of a care plan are responsibilities of the care coordinator/manager. Coordination of care plans will be handled differently, depending upon the qualified service package most appropriate for the individual transitioning.

Table 10. Care coordination responsibilities for MFP target populations

	Department	Contractor	Individual Qualifications
Elderly	Department of Social Services oversees contractor *(Chronic Care or Aging waivers)*	**'3 Access Agencies'** Connecticut Community Care, Incorporated; Agency on the Aging of South Central Connecticut; Southwestern Connecticut Area Agency on Aging	Care Manager
Physical/ABI	Department of Social Services *(ABI, PCA, and Chronic Care waiver)*		Social Worker
Mental Illness	Department of Mental Health and Addiction Services *(Mental Illness waiver)*		Social Worker
Intellectual Disability	Department of Developmental Disabilities *(Comprehensive waiver; Individual and Family Support waiver)*		Case Manager

Care Plan Management

Chronic Care Aging/Physical Disability

Level of Care Assessment, Care Plans and Case Management in the community

Persons age 18 and over who otherwise meet the financial eligibility criteria of Connecticut's existing elder and PCA waiver and the Chronic Care Level of Care will be served under the new package of services and delivery system (Chronic Care waiver). The waiver will operate on an individual cost cap at the Chronic Care level of care. The level of need assessment and case management will be contracted to the three agencies for the same services as under the existing Home Care Program for Elders. The assessment tool will model the tool currently used by DDS. These agencies, referred to as 'access agencies,' include the agencies referenced to in the chart above, including: Connecticut Community Care, Incorporated; Agency on the Aging of South Central Connecticut; and Southwestern Connecticut Area Agency on Aging. Contracts to Access Agencies are anticipated to be executed by October 2008.

Services for persons in the aging/physical disability target population will be delivered on a fee- for-service basis. Providers will contract directly with the access agencies for provision of these services. As an alternative, participants may elect a self-directed option for delivery of services. This option provides a range of flexibility and choice permitting the participant to choose which services will be self-directed and which will not. For those choosing self-direction, fiscal intermediaries will provide administrative functions for the implementation of the care plan. Administrative functions provided for the benefit of the participant include payroll and tax functions for staff hired by participant, budget controls and payment systems to assure disbursement to selected vendors, Medicaid claims documentation, and all financial reporting.

Qualifications for these positions are as follows

Persons performing care management will be a registered nurse licensed in the State or a social services worker who is a graduate of an accredited four-year college or university. The nurse or social services worker is required to have a minimum of two years of experience in health care or human services. A bachelor's degree in nursing, health, social work, gerontology or a related field may be substituted for one year of experience. The position of care manager requires the following additional qualifications:

- Demonstrated interviewing skills which include the professional judgment to probe as necessary to uncover underlying concerns of the applicant
- Demonstrated ability to establish and maintain empathetic relationships
- Experience in conducting social and health assessments
- Knowledge of human behavior, family/caregiver dynamics, human development and disability
- Awareness of community resources and services
- The ability to understand and apply complex services reimbursement issues
- The ability to evaluate, negotiate and plan for the costs of care options

Mental Illness

Level of Care Assessment, Care Plans and Case Management in the community

A new waiver will be developed to serve persons in the mental illness disability target group. For persons with mental illness, level of care assessment, care plans and case management will be performed by DMHAS social workers.

Qualifications for these positions are as follows

Knowledge of social work methodology, casework, group work and community mobilization; knowledge of family and interpersonal relationship dynamics; knowledge of values, sanctions, purposes and ethics of professional social work; knowledge of social, cultural, economic, medical, psychological and legal issues which influence attitudes and behaviors of clients and families; knowledge of mental illnesses and approaches to treatment; considerable interpersonal skills; considerable oral and written communication skills; ability to devise and implement a treatment plan with measurable goals that address client needs; ability to independently apply current psychiatric treatment modalities to address client needs. In addition, they are required to have the following training and/or experience: licensure as a clinical social worker in the State of Connecticut.

Home and community-based waivers available to the aged, blind and disabled

- **Home Care Program for Elders waiver** (CHCPE) provides in-home and residential options to adults who meet nursing facility level of care. See Table 9 for a listing of services that will be provided under the MFP demonstration.[6]
- **Personal Care Assistance waiver** (PCA) provides self-directed personal care services for disabled adults who meet nursing facility level of care. See Table 9 for a listing of services that will be provided under the MFP demonstration.[7]
- **Acquired Brain Injury** (ABI) provides persons with acquired brain injury who meet the clinical and financial eligibility for Connecticut's existing ABI waiver with the ABI waiver package of services under the MFP demonstration. Level of care assessment, care plans and case management will be performed by social workers who are employed by the DSS.[8] See Table 9 for a listing of services that will be provided under the MFP demonstration.

Home and community-based waivers available for individuals with an intellectual disability

- Persons with intellectual disabilities who meet the clinical and financial eligibility for Connecticut's existing Comprehensive or Individual and Family Support waiver will be served by the respective waiver service packages under the MFP demonstration. See Table 9 for a listing of services that will be provided under the MFP demonstration.[9]

Fiscal Intermediaries

See Section B.7.

Demonstration Services

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[6] Qualifications for case manager positions are the same as under the Chronic Care waiver.

[7] Qualifications for case manager positions are the same as under the Chronic Care waiver.

[8] Qualifications for these DSS social worker positions are as follows: knowledge of social work methodology, casework, group work and community mobilization; knowledge of family and interpersonal relationship dynamics; knowledge of values, sanctions, purposes and ethics of professional social work; knowledge of social, cultural, economic, medical, psychological and legal issues which influence attitudes and behaviors of clients and families; knowledge of mental illnesses and approaches to treatment; considerable interpersonal skills; considerable oral and written communication skills; ability to devise and implement a treatment plan with measurable goals that address client needs; ability to independently apply current psychiatric treatment modalities to address client needs. In addition, they are required to have the following training and/or experience: licensure as a clinical social worker in the State of Connecticut.

[9] Persons performing assessments and case management in DDS meet the following set of qualifications: considerable understanding of nature of clinical assessments; considerable knowledge of services available to persons who have intellectual disabilities; knowledge of residential programs for persons with intellectual disabilities; knowledge of interdisciplinary approach to program planning; knowledge of intellectual disabilities, causes and treatment; considerable skill in facilitating positive group process; oral and written communication skills; considerable ability to translate clinical findings and recommendations into program activities and develop realistic program objectives; ability to collect and analyze large amounts of information; familiarity with automated data systems. In addition, they are required to demonstrate the following experience. General Experience: six years of experience in working with individuals with developmental disabilities involving participation in an interdisciplinary team process and the development, review and implementation of elements in a client's plan of service. Special Experience: two years of the General Experience must have involved responsibility for developing, implementing and evaluating individualized programs for individuals with developmental disabilities in the areas of behavior, education or rehabilitation.

This category will include services not currently available under either Medicaid State Plan optional benefits or HCBS waivers. Demonstration services under the waiver include accessibility modifications and one-time transitional costs.

Table 12: Budget for Demonstration Services

	5-Year Total
Accessibility Modifications	$283,007
One-time Transitional Costs in non-provider settings	$378,000
24/7 Emergency Back-up Triage System	$225,000
Total	$886,007

Accessibility Modification Funds

Any modification expenses to a person's home in excess of those allowable as a qualified expense will be billed and tracked as a demonstration expense. The Department of Economic and Community Development is in the process of securing bond funding to support accessibility modifications in affordable housing. The $1 million bond funding would be reserved for the benefit of those transitioning under MFP. This funding will be used to supplement accessibility modification funds that are part of the qualified service package. Decisions regarding accessibility modification projects under this funding stream will be made on a case-by-case basis. In general, Connecticut anticipates an average expenditure of $50,000 per unit. It is anticipated that there will be 20 new affordable units, including modifications to existing units provided via funding from the bond. Bond modification money will be managed by the Department of Economic and Community Development through a contract with the Corporation for Independent Living. This contractor manages several accessibility modification grants for the benefit of persons with disabilities and is the largest housing developer in the State. All work will be performed by contractors licensed in the State of Connecticut for specific services to be rendered, i.e., electrical, plumbing, general contractor. Acceptable standards for work performed will be guided by NFPA Life Safety Code and State Building Code.

One-time Transitional Costs

Connecticut has established a pool of flexible funds under the MFP demonstration in the amount of $420,000. It was established at an average anticipated expenditure of $600 per person. The fund will be managed on an aggregate basis. Decisions for funding in excess of $600 per person will be made on a case-by-case basis. Funding will be participant directed. Individual budgets will be administered through the fiscal intermediaries.

The MFP project will coordinate with the State's Assistive Technology (AT) equipment loan programs. The AT needs of participants will be identified, equipment loans arranged for a trial period, and data collected relative to utilization of technology. Successful trial periods will be followed by the purchase of appropriate technology within Medicaid-allowable rates.

Funds will also be used to pay non-recurring set-up expenses for individuals who are transitioning from a qualified institution to a living arrangement in a private residence where the person is directly responsible for his or her own living expenses. One time transitional costs for

individuals moving into another provider-operated living arrangements (e.g., a group home of 4 beds) will be paid for under supplemental services and would primarily include assistive technology services. Allowable expenses are those necessary to enable a person to establish a basic household and may include:

- essential household furnishings and moving expense required to occupy and use a community domicile, including furniture, window coverings, food preparation items and bed/bath linens;
- set-up fees or deposits for utility or service access, including telephone, electricity, heating and water;
- services necessary for the individual's health and safety such as pest eradication and one-time cleaning prior to occupancy; and
- moving expenses.

One-time transitional funds are furnished only to the extent that they are reasonable and necessary as determined through the service plan development process and clearly identified in the service plan. The funds are only available if the person is unable to meet such expenses or when the services cannot be obtained from other sources. Transitional funds do not include room and board; monthly rental or mortgage expense; regular utility charges; and/or household appliances or items that are intended for purely diversional/recreational purposes.

24 Hour Back-up Triage System

For a complete description of this demonstration service, please refer to Appendix P. The system is also described in Section B.6.b below.

Supplemental Services

The MFP supplemental services, including screening, eligibility, transition coordination and housing coordination, will be the same for all persons transitioned. Also, any one time transitional costs for individuals moving into assisted living or other provider-operated living arrangements will be paid for under supplemental services.

Table 13: Budget for Supplemental Services

	5-Year Total
Housing Coordination	$1,003,723
Transition Coordination	$4,342,790
One-time Transitional Costs in provider settings	$42,000
Total	$5,388,513

Housing Coordination

The MFP demonstration will contract for Housing Coordination support. Five full-time housing coordinators will be located at a local level so they get to thoroughly know their territory, i.e., the available housing stock or lack thereof, and to foster relationships with housing providers. They will work to become good will ambassadors to local government officials who may in the future allow housing of this type to be built in their town. They will provide support to the transition team by finding and coordinating housing services for the benefit of the participant. Each housing coordinator is anticipated to assist 40 participants per year.

Housing Coordination services will include:

- Locating affordable and accessible housing in communities of choice
- Fostering relationships with town officials
- Fostering relationships with housing providers
- Negotiating with landlords
- Coordinating rental assistance paperwork
- Locating and arranging the move for appropriate furnishings
- Initiating and guiding the participant through the accessibility modification application process
- Coordinating plan for accessibility modification
- Locating/coordinating any other types of housing assistance based on individual's circumstances, as required, i.e., fuel assistance, financial counseling, security deposits, understanding legal rights and responsibilities as a tenant, fair housing
- Coordinating installation of assistive technology

Provider qualifications are as follows:
Bachelor's degree in human services; knowledge of community resources; strong skills in project coordination; strong written and communication skills, including negotiations, knowledge of housing markets and rehabilitation/development; and knowledge of federal and state housing subsidies and supports for persons with disabilities and elders. Prior experience is defined as experience in systems advocacy and community organizing, along with project management. Six years of experience in housing may substitute for the educational requirement.

Connecticut is in the early stages of contract negotiation for these services. Execution of contracts is anticipated by October 2008.

Transition Coordination

Transition coordination services are provided to persons residing in institutional settings prior to their transition to the waiver or other HCBS services. These services prepare them for discharge and assist during the adjustment period immediately following discharge from an institution. Pre-transition services help people 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 coordinator helps identify and coordinate specialized supports in each of the aforementioned areas (medical, social, housing, educational, etc.) at the request of the participant. Together all individuals involved in the planning form a team for the benefit of the participant.

All persons transitioning will be offered assistance. Dedicated MFP transition coordinators within community-based organizations will coordinate all transitions under MFP. Transition coordinators will lead the transition process and collaborate with MFP housing staff, community providers, Access Agencies, other state agencies, etc. Connecticut has chosen to operate MFP at a local level by expanding capacity of the existing network of Corporation for Independent Living (CIL) centers and AAAs. Key staff at three sites have been identified as MFP trainers. Trainers were selected based on past performance. A staff ratio of 1:15 participants is expected. MFP ramp-up assumes that each of the 20 trained transition coordinators will provide transition

services to 10 individuals a year. Past data suggests that each coordinator will work with 30 people on an annual basis to achieve the goal of 10 transitions.

The transition planning activities include the following:

- Completion of a self-assessment
- Overall coordination of planning team
- Coordination of housing resources, including accessibility modifications, housing coordination
- Assessment of proposed Common Sense fund allocation
- Coordination of peer support
- Coordination of agency responsible for HCBS service delivery

Provider qualifications are as follows:
Bachelor's degree in human services, knowledge of the Independent Living philosophy, knowledge of community resources, strong written and communication skills, and knowledge of an assets approach to care that focuses on a person's strengths, rather than deficits. Ten years of experience with State HCBS systems may substitute for the educational requirement. Prior experience is defined as experience in systems advocacy and community organizing. A job description for the position of transition coordinator is located in Appendix E.

Connecticut has begun contract negotiation for these services. Execution of contracts is anticipated by October 2008.

B.6 Consumer Supports

Describe the process and activities that the State will implement to ensure that the participants have access to the assistance and support that is available under the demonstration, including back-up systems and supports, and supplemental support services that are in addition to the usual HCBS package of services. Please provide:

a. A copy of the educational materials used to convey procedures the State will implement in order for demonstration participants to have needed assistance and supports and how they can get the assistance and support that is available.

Case managers, housing coordination services and transition coordination services, including the organizations and entities providing support to consumers under the MFP, were discussed in detail in the previous section with the exception of fiscal intermediaries and support brokers, and emergency back-up supports. As noted above, each participant will be provided transition coordination services prior to transition. These services will ensure that the participants have access to the assistance and support that will be available under the demonstration. Fiscal intermediaries and support brokers are discussed under Section B.7, Self Direction. This section will focus on the emergency back-up support system.

Table 14. Organizations and entities providing support under the MFP demonstration

	Elderly	Physical		Chronic Care	MI	MR
		Physical	ABI			
Transition Coordination	AAA or CIL	AAA or CIL	AAA or CIL	AAA or CIL	AAA or CIL	AAA or CIL
Housing Coordination	MFP Housing Contractors	MFP Housing Contractors	MFP Housing Contractors	MFP Housing Contractors	MFP Housing Contractors	MFP Housing Contractors
Care Planning	Case Manager	Case Manager	Case Manager – no budget authority; self-direction	Case Manager or Individual with support of Support Broker	Case Manager with individual	Case Manager or Individual with support of Support Broker
Fiscal Intermediary	Sunset Shores of Milford, Inc. Public Partnerships, LLC Allied Community Resources, Inc.[10]	Allied Community Resources, Inc.	Allied Community Resources, Inc.	Sunset Shores of Milford, Inc. Public Partnerships, LLC Allied Community Resources, Inc.	Sunset Shores of Milford, Inc. Public Partnerships, LLC Allied Community Resources, Inc.[11]	Sunset Shoresof Milford, Inc. Public Partnerships, LLC Allied Community Resources, Inc.
Support Broker	None	Yes	None	Yes	None	Yes
Emergency Back-up System	Yes	Yes	Yes	Yes	Yes	Yes

b. *A description of any 24-hour back-up systems accessible by demonstration participants including services and supports that are available and how the demonstration participants can access the information (such as a toll free telephone number and/or website). Include information for back-up systems including but not limited to:*
   i. *Ttransportation*
   ii. *Direct service workers*
   iii. *Repair and replacement for durable medical and other equipment (and provision of load equipment while repairs are made); and*
   iv. *Access to medical care: individual is assisted with initial appointments, how to make appointments and deal with problems and issues with appointments, and how to get care issues resolved.*

[10] These fiscal intermediaries will serve as the FIs for the self-direction under the One-time Transitional Fund services.
[11] These fiscal intermediaries will serve as the FIs for the self-direction under the One-time Transitional Fund services.

Existing system for emergency back-up supports
Back-up plans for personal care assistants and other supports and services are an integral component of each plan before a participant moves to the community. Participants are required to identify informal networks such as family, friends and neighbors who have agreed to support the participant on an emergency basis. The informal emergency network is part of the community plan. Such networks commit to assisting the participant, if needed, during periods of time when paid staff does not arrive on schedule or when staff quits unexpectedly. Occasionally, existing staff agree to participate as part of a back-up plan by accepting additional hours on a temporary basis. Alternatively, Connecticut maintains a registry of professional personal care assistants who are available to be part of an individual's back-up plan in the community. A participant could design a back-up plan with both informal and formal supports in place. Regardless of which options an individual identifies as part of his or her back-up plan, a viable plan must be in place before a move to the community is supported by MFP. Independent brokers or case managers are available to assist with the development of an emergency back-up plan prior to transition. As an additional transitional service, transition coordinators remain involved during the first few months after a participant transitions to the community to assure that the plan conceptualized in the inpatient facility is working as designed in the community.

While Connecticut has the requirement for all care plans to address emergency back-up systems, the State does not currently fund a system to support the care plans as required under MFP. To address this requirement, Connecticut proposes to implement a 24-hour back-up triage system for MFP participants.

24-hour back-up triage system
The MFP rebalancing demonstration includes access to a newly designed 24-hour back-up triage system. The triage system was designed as one type of intervention that is part of Connecticut's MFP QI initiative, focusing on the improvement of workforce reliability. The triage system has the following objectives:

- Provide an additional level of security for those transitioning under the program
- Address perceived and real workforce reliability issues while documenting gaps
- Reduce reliance on acute care facilities

Connecticut plans to contract with CCCI. An overview of the MFP back-up system may be found in Appendix P. Staff at CCCI have been involved with emergency back-up systems for over 10 years. They have formed an advisory committee for the purpose of supporting MFP to assure that relevant data elements are stored in the data base. CCCI staff will attend ongoing training offered on a semiannual basis by the MFP unit. Additional training needs identified by CCCI include training on TTY and other communication devices. There is full-time staff dedicated to answer the after-hours line. In addition, there is staff available to answer the "must answer line" during business hours. Contract execution is anticipated prior to enrollment beginning.

Emergency back-up triage other than personal care assistants
Back-up plans are developed through assistance from fiscal intermediaries and support brokers as required as part of a typical 1915(c) procedure.

Triage of Calls
For those calls where emergency back-up is required, the on-call staff will call the appropriate contact/vendor on behalf of the participant and document the request for emergency back-up service. All information regarding anticipated timeliness in addressing the need will also be documented. Listed below are specific supports and services that will be addressed by the 24-hour triage system.

Transportation
Connecticut uses a brokerage agency for coordination of medical non-emergency transportation. The brokerage agency is responsible for locating accessible transportation appropriate to meet the needs of the participant. In the event that the transportation does not appear to support the participant, it is the responsibility of the brokerage agency to identify back-up transportation.

Agency-based direct workforce
All vendors on contract with the State are required to find replacements for essential direct workers in the event that their staff cannot provide services as scheduled. The 24/7 triage will not supplant contractual relationships already in place and are responsible for back-up staff. Rather, the triage will document reliability of the provider and will assist with calls to the provider when necessary. Documentation will be reviewed by the QI Committee.

Repair and replacement of durable medical equipment
All vendors on contract with the State of Connecticut are required by contract to address 24/7 emergency equipment situations. For less critical but important equipment failure, vendors are required to repair equipment within a reasonable amount of time. The triage service will coordinate with medical equipment vendors and record gaps in service

Monitoring responsiveness and timeliness of agency to participant
As previously stated, emergency staff situations will be reported to the DSS MFP director within 24 hours. All other reports and data collected will be reported on a monthly basis. Call logs will be reviewed for content of case notes and timely follow-up. Ongoing monitoring of the 24-hour emergency system will be conducted through data collected on the quarterly Consumer Satisfaction Survey. Additionally, for each participant who requires emergency back-up staff or otherwise experiences an emergency, contact will be made by the MFP program office within 24 hours.

Relationship of back-up system to QI
The emergency back-up system plays a key role as an intervention in Connecticut's QI initiative relative to increasing workforce reliability. As stated previously, the objectives of the back-up system are as follows:

- Provide an additional level of security for those transitioning under the program
- Address perceived and real workforce reliability issues while documenting gaps
- Reduce reliance on acute care facilities

Evidence of meeting the objectives will be measured by answering the following essential questions:

- Did access to the State's emergency back-up system improve the feeling of safety for transitioning participants?
- Were participants satisfied with the service they received from the emergency back-up system?
- What common themes emerged relative to the gaps documented (vendor, situation, weather)?
- Do participants who have access to the 24-hour emergency back-up system rely less on acute care facilities than the general population of those who transition?
- What are the costs per person associated with the intervention?
- What was the rate of success for addressing the emergency?

Of these questions, the most essential factor relative to addressing workforce reliability is the documentation of gaps. It is anticipated that some workforce reliability issues are more common with some vendors than with others. Additionally, it is anticipated that some workforce reliability issues may relate to wage. Data collected through this intervention will translate into action targeted at whatever reasons appear to be impacting workforce reliability. For example, contract corrective action plans will be targeted at vendors with worse than average workforce reliability.

c. *Describe the complaint and resolution process when the back-up systems and supports do not work and how to address it when such issues occur.*

MFP complaint process
Participants have several options for registering complaints about services or any other aspect of their care. Complaints may be registered directly with the DSS/MFP program office or with Office of Protection and Advocacy, community providers, or agency social workers. Participants may register complaints about anything the Department does or is responsible for that they perceive as affecting them negatively in any way. The complaint system is operated by DSS through the Medical Care Administration.

To protect participant rights, some types of complaints are immediately directed to other formal systems rather than being addressed through the MFP grievance process. Complaints not handled through the grievance process include the following:

1) Complaints of abuse, neglect or financial exploitation of a vulnerable adult or child – These complaints are referred immediately to the formal protective systems of respective agencies detailed in Section B.8 and Appendix M of the protocol.

2) Consumer disputes about services that have been denied, reduced, suspended or terminated – Participants calling about these matters are informed of their rights upon receipt of the complaint and referred to the administrative hearing process detailed above.

3) Complaints about possible Medicaid fraud – These complaints are immediately referred to the Medicaid QA Unit.

4) Complaints about back-up systems are referred directly to the CCCI 24/7 triage system for immediate resolution. See description above.

Complaints or disputes about services can be received and addressed at any level of the organization. However, DSS/MFP always strives to address the grievance/complaint at the lowest level possible.

Upon receipt at any level, all DSS/MFP staff and contractors are required to respond to 'in-person' or telephone complaints within one business day. Written complaints must receive a response within seven days. Complaints are forwarded to the person who is directly responsible for the focus area of the complaint. For example, complaints regarding case management are forwarded to the case manager responsible for the case. If the person directly responsible for the focus area of the complaint is unable to resolve the complaint, the person is referred to the supervisor. The supervisor has 10 business days from date of receipt to resolve the complaint. If the person continues to feel that their complaint is not resolved, they are referred to the State level MFP program office. The program office has 10 days to address the complaint and must notify the person in writing of the resolution. All steps in all complaints are logged. Logs are reviewed as part of the QA process.

As part of the MFP demonstration, an outline of the complaint process will be drafted. This document will help direct complaints to the appropriate level of the organization and inform the public of the complaint resolution process.

Opportunity to request a fair hearing

Applicants and recipients of services may request and receive a fair hearing in accordance with the rules of the Department's Medical Assistance Program. Applicants receive a copy of the DSS W-1035, Freedom of Choice/Hearing Notification Form, during the first visit with the case manager. Examples of valid appeals, specific to the MFP program, where fair hearings may be provided, would be in the following instances when the Department:

1) denies the application for any reasons other than the limitations on the number of individuals who can be served and/or funding limitations as established in the approved qualified package or demonstration services;
2) disapproves the individual's service plan;
3) denies, reduces or terminates a service of the individual's choice;
4) denies or terminates payment to a qualified provider of the individual's choice;

5) reduces the individual's service package or service budget; or
6) discharges the individual from the MFP demonstration.

In accordance with Medicaid rules [Connecticut General Statutes (17b-60-66)], a Notice of Action (NOA) is issued to the participants when any service is denied, reduced, suspended or terminated. The NOA and Freedom of Choice/Fair Hearing Notification are also provided in Spanish to support providing persons with LEP or non-English proficiency.

The participant may request a hearing orally or in writing. If the request is oral, the participant must additionally provide a signed, written request. If a current service is reduced or denied, the request for a hearing must be made within 10 days of the service reduction/denial in order to continue to receive the service. The participant is notified that, if the reduction or denial is upheld, the participant can be held responsible for payment of these services. Additionally, the participant may request a hearing up to 60 days after the date the NOA was mailed. The participant will be notified of the time and location for the hearing. Prior to the hearing, the participant has the right to examine his/her case file, documents and records. If the participant questions the hearings officer's decision, an appeal can be filed in Circuit Court.

B.7 Self-Direction

a. Voluntary Termination of Participant Direction. Describe how the State accommodates a participant who voluntarily terminates participant direction in order to receive services through an alternate service delivery method, including how the State assures continuity of services and participant health and welfare during the transition from participant direction.

Through the Individual Plan process, individuals may request the termination of self-direction and his or her Self-Directed Support Agreement and Individualized Budget. Individuals seeking termination may choose an alternative support service. The case manager, support broker or regional designee (depending upon the agency) discusses with the individual/family all the available options and resources available, updates the Individual Plan, and begins the process of referral to those options. Once the new option has been identified and secured, the case manager, support broker or regional designee will fill out the form for termination of their individual budget. The form is sent within 10 business days to the Vendor Fiscal Employer Agent (VFEA), Resource Administrator or regional designee, and the regional fiscal office representative. In the absence of a regional fiscal office representative, the form is sent to the appropriate central office.

b. Involuntary Termination of Participant Direction. Specify the circumstances when the State will involuntarily terminate the use of participant direction and require the participant to receive provider-managed services instead, including how continuity of services and participant health and welfare is assured during the transition.

Each individual who self-directs by hiring his or her own workers has an Agreement for Self-Directed Supports describing the expectations of the participant. Termination of the participant's self-direction opportunity may be made when a participant or representative cannot adhere to the terms of the Agreement for Self-Directed Supports. Key terms are:

- to participate in the development and implementation of the Individual Planning Process;
- funds received under this agreement can only be used for items, goods, supports, or services identified in the service recipient's Individual Plan and authorized individual budget;
- to actively participate in the selection and ongoing monitoring of supports and services;
- to understand that no one can be both a paid employee and the employer of record;
- to authorize payments for services provided only to the recipient according to the Individual Plan and budget;
- to enter into an agreement with the provider agency/agencies or individual support worker(s) hired. The agreement is outlined in the Individual Family Agreements with Vendor and Employees and identifies the type and amount of supports and services that will be provided;
- to submit timesheets, receipts, invoices, expenditure reports or other documentation on the required forms, to the fiscal intermediary on a monthly basis or within the agreed upon timeframe;
- to review the VFEA expenditure reports on a quarterly basis and notify the case manager, broker and VFEQ of any questions or changes;
- to follow cost standards and cost guidelines for the Department for all services and support purchased with the allocation;
- to get prior authorization from the Department to purchase supports, services or goods from a party that is related to the individual through family, marriage or business association;
- to seek and negotiate reasonable fares for services and reasonable costs of items, goods or equipment, and to obtain three bids for purchases of items, equipment or home modifications over $2,500;
- any special equipment, furnishings or item purchased under the agreement are the property of the service recipient and will be transferred to the individual's new place of residence or day program, or will be returned to the State when the item is no longer needed;
- to participate in the Department's quality review process;
- to use qualified vendors enrolled by the Department;
- to ensure that each employee has read the required training materials and completed any individual-specific training in the Individual Plan prior to working with the person;
- to offer employment to any new employee on a conditional basis until the criminal history background check, driver's license check and Department Abuse Registry check has been completed. Anyone on the Department Abuse Registry cannot be employed to provide support to the individual; and
- to notify the case manager/broker when the individual is no longer able to meet the responsibilities for self-directed services.

The approved waivers will apply the above criteria on an individualized basis. Intentional fraud is the only instance anticipated where involuntary termination of an individual from self-direction would be considered for a first-time offense in all waivers across the board. In all other instances, violations would result in training and warnings, until a consistent pattern of non-compliance could be documented. The individual acknowledges that the authorization and payment for services that are not rendered could subject him/her to Medicaid fraud charges under state and federal law. Breach of any of the above requirements, with or without intent, may disqualify the individual from self-directing services given the individuals circumstances.

An Agreement for Self-Directed Supports can be terminated by the operating agency and MFP staff if the participant does not comply with the agreed upon requirements. The Department case manager would coordinate the transition of services and assist the individual to choose a qualified provider to replace the directly hired staff.

c. *Goals for Participant Direction. Annually, the State will report to CMS the number of participants who elect to direct their demonstration services.*

See Appendix A., Table E-1-n for a chart demonstrating the annual goals for each year that the demonstration is in effect and listing the unduplicated number of demonstration participants who are expected to elect each applicable participant direction opportunity.

Table 15A. Self-direction options under the existing system, Limitations, and Plans to Address Limitations

Waiver	Existing Nature, Scope and Limits of Self-direction	Why the limits exist	MFP Plan for Addressing Limits
Individual and Family Support	Participants may choose from a range of self-directed options as well as the traditional case management option. Options for self-direction include: ❖ Developing and managing personal budget; ❖ Hiring and managing own staff; ❖ Hiring family members as paid staff; ❖ Choosing an agency with choice model to have some choice over staff but not employer responsibilities; ❖ Choosing an independent support broker to assist with self direction; ❖ Managing anywhere from 1 to all services; ❖ Working with the support of a fiscal intermediary to process payroll and vendor payments	DDS has the highest degree of self-direction permissible under 1915C authority	There are no changes planned.
Comprehensive	Same as above	Same as above	Same as above
Mental Illness	Participants may be the employer of record for their recovery assistant. There is no agency with choice option and no independent support broker as a service. Participants are important members of the team to develop their care plan, however, the care plan is developed by a qualified care planner. Participants have no budget authority. Other services are directed by their care planner	This is a new waiver. Connecticut chooses to be conservative in approach to self-direction where there is no history relative to waivers.	The waiver will be evaluated relative to successful outcomes attributed to self-direction. If evidence suggests that

Waiver	Existing Nature, Scope and Limits of Self-direction	Why the limits exist	MFP Plan for Addressing Limits
			self-direction was successful, the structure of the wavier will be revisited upon renewal.
Acquired Brain Injury	Participants may hire their own staff, including family members, as personal assistants. There is no agency with choice option and no independent support broker as a service. Participants are important members of the team to develop their care plan, however, the care plan is developed by a qualified care planner. Participants have no budget authority.	The waiver has not yet been updated for the new waiver template and instructions.	MFP evaluation component will recommend changes relative to increased self-direction.
Personal Care Assistance	Participants may hire their own staff, including family members as personal assistants. There is no agency with choice option and no independent support broker as a service. The definition of personal assistance does not include assistance for cueing. Participants have no budget authority.	The waiver has not yet been updated for the new waiver template and instructions.	MFP evaluation component will recommend changes relative to increased self-direction.
Elder	Participants may not hire their own staff nor may they have any budget authority. They may however, be enrolled and choose to manage and hire their own personal assistants (PA) under a state funded self-directed component. The state funded pilot is capped at 250 persons and establishes a waiting list for persons who choose to self direct but for whom there is no slot. The state funded PA option allows for the hiring of family members, excluding spouses.	The waiver has not yet been updated for the new waiver template and instructions.Personal care assistance is not a service under the waiver but is available to individuals on the state funded pilot.	MFP evaluation component will recommend changes relative to increased self-direction.
Chronic Disease (High level of need waiver for elderly and physical disability group.)	Participants may choose from a range of self-directed options while the traditional case management option remains. Options for self-direction include: ❖ Developing and managing personal budget; ❖ Hiring and managing own staff; ❖ Hiring family members as paid staff;	This waiver would include the highest degree of self-direction permissible under 1915C authority	Analysis of outcomes from this waiver will inform HCBS systems change. See logic model and evaluation

Waiver	Existing Nature, Scope and Limits of Self-direction	Why the limits exist	MFP Plan for Addressing Limits
	❖ Choosing an agency with choice model for a live in to have some choice over staff but not hiring responsibilities; ❖ Choosing an independent support broker to assist with self direction; ❖ Managing anywhere from 1 to all services;		plan.
One-time transitional funds under the MFP demonstration	All enrollees in MFP may self-direct using budget and hiring authority for the initial one-time transition fund services.	This demonstration would include the highest degree of self-direction permissible under MFP authority	Analysis of outcomes from this waiver will inform HCBS systems change.

Connecticut's existing HCBS system reflects varying degrees of self-direction. The existing PCA and ABI waivers allow participants to hire and manage their own PCA staff with a fiscal intermediary. The Home Care Program for Elder Participants enters the program through an assessment conducted by an experienced professional to identify unmet needs and recommended supports. Older adults are empowered to make adjustments in the frequency, duration and intensity of services without prior approval. There are 250 slots in a state funded program that elders may access and allows for self-direction of personal care staff. DMR waiver recipients are allowed to hire people directly for many services, including but not limited to supported living, supported employment, respite and personal support. Participants are provided a fiscal budget limit within which they can choose services in their package of support.

Connecticut acknowledges that it has several gaps in the existing system to deliver self-directed services. It is Connecticut's goal to have a continuum of long-term care options supporting the highest degree of self-direction.

For persons with acquired brain injury, consumer budget authority is not yet available. The consumer, with input from his/her guardian or conservator, may choose any willing and qualified provider(s); receive information about providers; and select whom to interview [meet, interview and select the provider(s)]. The services outlined in the care plan are tailored specifically to the interests, needs and competencies of each individual. The care plan reflects the choices made by the individual and/or guardian/conservator and ensures compliance with the Freedom of Choice requirement. Self-direction is available to the extent that an individual chooses to directly manage services and supports. Numbers of persons self-directing will be reported by case managers on a quarterly basis to the MFP project director. Care plans for those self-directing will be monitored as described under Section B.8.

Table 15B. Self-direction options under the existing system and the MFP demonstration

	ABI		Elder		Chronic Care Aging/Disabled Waiver		Physical Disability		MR		MI	
	Hire own staff	Budget Authority	Hire own staff	Budget Authority	Hire own staff	Budget Authority	Hire own staff	Budget Authority	Hire own staff	Budget Authority	Hire own staff	Budget Authority
Existing waiver services	Yes	No	No	No	N/A	N/A	Yes	No	Yes	Yes	N/A	N/A
Waiver Services after MFP	Yes	No	No	No	Yes	Yes	Yes	No	Yes	Yes	Yes	No
Demo One Time Transitional Services	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes

Explain system for monitoring and documenting the number of MFP participants choosing self-direction in all programs.

Individuals will learn about options to self-direct from their transition coordinator. Persons will gain an understanding of their options early in the transition process. If the participant elects self-direction, it will become one of their transition goals. Care planners will offer additional counseling regarding options during the assessment. The participant will select their delivery option after the budget has been determined.

Individuals who self-direct and hire their own workers have the authority to recruit and hire staff, verify staff qualifications, obtain and review criminal background checks, determine staff duties, set staff wages and benefits within established guidelines, schedule staff, provide training and supervision, approve time sheets, evaluate staff performance, and terminate staff employment.

Individuals who self-direct by hiring their own staff within the DDS system will have a DDS case manager or a DDS individual support broker to assist them to direct their plan of individual support. Alternatively, an individual may opt to select an independent support broker who meets the qualifications specified in Section B.7. For persons in the Chronic Care waiver, the option of the individual support broker is also available. Persons served under the waiver for persons with mental illness will have a DMHAS case manager for assistance.

Describe which agencies or individuals are responsible for participant-level counseling on how to manage the service budget, or hire and manage personal care staff.

Independent support brokers

Support brokers offer a different range of services than those offered under case management. Support Brokers assist individuals to access community and natural supports, and advocate for

the development of new community supports as needed. They assist individuals to monitor and manage the individual budgets. Brokers may provide support and training on how to hire, manage and train staff and to negotiate with service providers. They assist individuals to develop an emergency back-up plan and may assist the individual to access self-advocacy training and support. In general, support brokers are important components of a self-directed system since they can facilitate self-direction in many instances where it would otherwise be too challenging for the individual.

Specific services offered by an independent support broker include the following:

- Assistance with developing a natural community support network
- Assistance with managing the individual budget
- Support with and training on how to hire, manage and train staff
- Accessing community activities and services, including helping the individual and family with day-to-day coordination of needed services
- Developing an emergency back-up plan
- Self-advocacy training and support

List the financial management agencies under contract with the State (or local) agencies that will provide these services for those choosing self-direction.

Fiscal intermediaries

- The services of a VFEA are required for all individuals who self-direct their service and supports. The VFEA assists the individual, family and/or personal representative to mange and distribute funds contained in the individual budget, including but not limited to, the facilitation of employment of service workers by the individual or family, including federal, state and local tax withholding/payments; processing payroll or making payments for goods and services; and unemployment compensation fees, wage settlements, fiscal accounting and expenditure reports; support to enter into provider agreements on behalf of the Medicaid agency; and providing information and training materials to assist in employment and training of workers. This service is required to be utilized by individuals and families who choose to hire their own staff and self-direct some or all of the waiver services in their individual plan. The service will be delivered as an administrative cost and is not included in individuals' budgets. See Table 14 for a listing of fiscal intermediaries**.**

Agency with choice option for persons with intellectual disabilities and persons served under the Chronic Care Aging Disability waiver

Persons served under the waivers for persons with intellectual disabilities may choose to be the direct employer of the workers who provide waivers services, or may select an Agency with Choice. The Agency with Choice is the employer of record for employees hired to provide waiver services for the individual, however the individual maintains the ability to select and supervise those workers. The individual may refer staff to the Agency with Choice for employment. In both arrangements, the individual and/or family have responsibility for managing the services they choose to direct.

B.8 Quality

a. *If the State plans to integrate the MFP demonstration into a new or existing 1915(c) waiver or HCBS SPA, the State must provide written assurance that the MFP demonstration program will incorporate, at a minimum, the same level of quality assurance and improvement activities articulated in Appendix H of the existing 1915(c) HCBS waiver application during the transition, and during the 12-month demonstration period in the community.*

   The State need not provide documentation of the quality management system already in place that will be utilized for the demonstration. But, rather, provide assurances in the protocol that: i. this system will be employed under the demonstration; and ii. the items in section (c) below are addressed. In addition, the State should provide a brief narrative regarding how the existing waiver already includes oversight/monitoring services or will be modified to ensure adequate oversight/monitoring of those demonstration participants that are recently transitioned.

DSS plans to integrate the demonstration into existing or new 1915(c) and State Plan quality strategy. The Department intends to use the guidance provided under its 1915(c) applications as the basis for its quality management system; it will design a system that largely reflects the current waiver quality management systems. Other qualified services (State Plan, MI package and Chronic Care package) will use the proposed quality management plan.

DSS has a comprehensive QI plan reflecting CMS' Quality Framework and is currently evaluating the quality framework for each Medicaid waiver. Each of the State's Home and Community-based Services waiver programs has a quality management component in place, but there is no mechanism in place for formally sharing information. The Department will try to better coordinate its quality monitoring activities to ensure necessary information is shared across departments and divisions, focusing on improvements made to the delivery of service to consumers. One method for improving coordination will be to improve staff communication through the establishment of a MFP committee. This committee will meet every two months to share information about the MFP program. The committee will be responsible for enhancing the MFP quality management (QM) strategy. The UCONN Center on Aging will support the demonstration by collecting information relative to consumer satisfaction and other quality indicators.

DSS plans to transition persons from institutions onto HCBS waivers under the authority of MFP after the first year post transition. Waiver assurances are fully operational without ongoing action plans for Connecticut's ABI waiver, PCA waiver, Home Care for the Elderly waiver, Individual and Family Support waiver and Comprehensive waiver. Persons in the MFP demonstration whose needs are best met by the range of services and benefits available under these waivers, will be served by the existing qualified service packages, with MFP demonstration services and supplemental services in addition. The only difference will be in the authority under which the services are delivered.

Persons in the target populations, including elderly, physical disability and mental illness will be served by a new qualified service delivery system where Appendix H is not yet approved by CMS. For all persons served under these new packages of services, as well as persons served by

State Plan services alone, the MFP demonstration will provide all assurances. The overview below serves as brief introduction to the MFP QM Strategy.

b. The Quality Management System under the MFP demonstration must address the waiver assurances articulated in Appendix H of the 1915(c) HCBS waiver application and include: i. Level of care determinations; ii. Service plan description; iii. Identification of qualified HCBS providers for those participants being transitioned; iv. Health and welfare; v. Administrative authority; and vi. Financial accountability.

Table 16: Overview and Assurances of MFP Quality Management Strategy

Overview and Assurances of MFP Quality Management Strategy					
Requirement	Monitoring Activity	Monitoring Responsibilities	Evidence	Reports	Frequency
Level of care	1) Review of assessment after developed 2) QA review process	1) Case Management Supervisor 2) DSS/MFP QA staff	1) Timeliness and appropriateness of Level of Care 2) Level of care determination consistent with policies and procedures; paperwork in file	Yes	1) All plans every 12 months 2) Continuous; representative sample of all case managers per year
Service Plans address assessed needs of enrolled participants, are updated annually, and document choice of services and providers.	1) Review of plan after developed 2) QA review process	1) Case Management Supervisor 2) DSS/MFP QA staff	1) Service plan checklist in file 2) Consumer interview	Yes	1) All plans every quarter; 2) Continuous; representative sample of case plans per year

Requirement	Monitoring Activity	Monitoring Responsibilities	Evidence	Reports	Frequency
Providers meet required qualifications	1) Annual compliance review; 2) QA files and organization outcomes review	1) Central office staff, case managers and fiscal intermediaries 2) DSS/MFP QA staff	1)Documentation of certification; reliability of performance 2) Required certification or licensure; access for participants and reliability of performance	Yes	1) Sample 100 HCBS providers per year 2) All files annually
Health and welfare	1) Service plans address health/welfare; individualized emergency back-up plans. 2) Incident reporting to DSS 3) Abuse and neglect	1) Case managers 2) Providers with compliance checks by QA staff 3) Waiver managers and/or DSS Protective Services	1) Service plans 2) Incident reports 3) Abuse/neglect reports, Consumer Satisfaction Survey/interview	Yes	1) Continuous 2) Continuous 3) Continuous

Requirement	Monitoring Activity	Monitoring Responsibilities	Evidence	Reports	Frequency
The DSS retains authority and responsibility for program operations and oversight	1) Program oversight by DSS' Medical Care Administration 2) DSS' QA initiative	1) Program specialist 2) MFP QA coordinator	1) State Plan, administrative rules, provider manuals 2) QA plan and activity tracking ─ Data sources: Medicaid claims Pharmacy claims Assessment data Consumer survey Program records/reports Chart reviews	1) Yes	1) Continuous 2) Continuous
DSS maintains financial accountability through payment of claims for services that are authorized and furnished to enrolled participants by qualified providers	1) MMIS system assures claims are paid within authorized limits for each individual 2) QA audits	1) Program specialist 2) MFP QA coordinator	1) Authorization data 2) Financial reports, management letters; state audit	1) Yes	1) Continuous 2) Continuous

MFP Quality Management (QM)

Overview of the QM Plan

Requirement 1: 1915(c) waiver application Appendix H assurances for MFP participants

The QM system at a minimum addresses:

- Health and safety issues of consumers receiving HCBS services
- Abuse/neglect/exploitation of consumer
- Consumer access to services
- Plan of care discrepancies
- Availability of services
- Complaints of service delivery
- Training of providers, case mangers and other stakeholders
- Emergency procedures
- Provider qualifications
- Consumer choice

The QM system shall continuously improve quality through the discovery, remediation and system improvement process. Data shall come from a variety of sources, including HCBS provider databases, site reviews, follow-up compliance reviews, complaint investigations, evaluation reports, consumer satisfaction surveys, consumer interviews and consumer records.

There are three components to the QM system: quality control, quality assurance and QI. Each component is responsible for 'discovery, remediation and improvement.'

At a local or direct service level, quality control standards are in place to establish an expectation of 'quality service.' Examples of quality service can range from direct care workers arriving on time to assist participants, to person-centered planning, to completing the level of care assessment in a consistent manner. Persons involved in the care delivery system at a local level are expected to hold themselves accountable for quality service. Local level management is expected to implement an effective quality control plan. An effective plan includes the provision of routine and consistent checks to ensure the integrity, correctness and completeness of the operation, and to identify and address errors and omissions. Quality control procedures are the responsibility of each contractor or operating agency providing services under the MFP demonstration.

Quality assurance is ensured by DSS and its MFP staff in coordination with QA staff of the operating agency or contractor. As indicated in the chart above, MFP QA staff will have a field presence during the demonstration year. The primary responsibility of QA staff in the MFP demonstration is to seek evidence that required quality controls are in place at a service or support delivery level. Data from all QA activities will be compiled by the MFP evaluation staff on a regular basis and presented to the project director. Evaluation staff will analyze the data in coordination with QA staff to determine patterns, trends, problems and issues in service delivery of HCBS services. Opportunities to improve the delivery system through training and technical assistance will be identified through this process. MFP training and technical assistance staff will be responsible for coordinating training opportunities designed to improve performance. Quarterly QA reports will be written and submitted to the DSS Commissioner. The reports will

be shared with the QI Committee and MFP Steering Committee which will make recommendations regarding follow-up to the Commissioner."

The third component of the quality management system is the QI initiative. While the MFP demonstration will provide assurances that controls are functioning at a local level to continually improve performance, quality control and assurance alone cannot address systems-wide problems. MFP provides the opportunity to address weaknesses in the State's HCBS system that impact the delivery of services across all agencies and negatively impact participant satisfaction. Analysis of QA data that points to systems problems require broader policy change and will be referred to the QI initiative. The QI Committee will be comprised of certain HCBS staff from across agencies, selected providers and selected participants. The initial priority focus area for this Committee has already been determined. The QI initiative will work together to improve workforce reliability that impacts all HCBS participants.

Level of Care assessment, service planning and delivery

All consumers have a person-centered, outcome-based service plan of care developed by their team to address all assessed needs and health and safety risk factors of consumers, as well as personal goals. The transition coordinator helps identify and coordinate specialized supports in each of the aforementioned areas (medical, social, housing, educational, etc.) at the request of the participant. Together all individuals involved in the planning form the "team" for the benefit of the participant. Service plans are updated and revised quarterly or as the consumer's needs change. The consumer is informed of their right to change their plan at any time and they acknowledge this by signing a service plan checklist. The case manager will monitor the service plan on a monthly basis to assure that services are delivered in the type, scope, amount, duration and frequency in accordance with the plan. All service plans are reviewed and approved according to the procedures determined by the operating agency. In the case of the new Chronic Care Aging Disability waiver, service plans will be developed by access agencies or by individuals choosing to self-direct, and plans will be reviewed and approved by MFP staff.

On an annual basis, MFP central office staff, in collaboration with operating agencies, will randomly select a representative sample of the plans for QA review. The QA review process includes desk reviews of provider records and onsite reviews. Onsite reviews include a review process. Service plans are monitored to assure that assessed needs are being identified and that the service plans are updated and revised as needed. If systematic inadequacies in service plan development are found through the QA process, training packets are sent out, regional trainings are held, and a report is made to the QA Committee and relevant waiver managers which may recommend further action as described above under the MFP Quality Management Strategy Overview.

The UR nurse in the MFP unit will conduct quarterly interviews with interviews based upon the approved State MFP Quality Management Strategy and after reviewing the UCONN evaluators' consumer satisfaction survey results. Outcomes from the interviews will be incorporated into the Quality Management Strategy in a continuous quality improvement process.

During the service plan development, participants choosing not to self-direct are presented with an option of available providers in their area and are given a choice on which provider they want to use. In addition, a service plan checklist is used by the case manger that identifies that the consumer was presented with choice. The consumer and the case manager sign off on the checklist and it becomes part of the consumer's file. The case manager incorporates and approves the chosen provider into the service plan. As a follow-up, during the QA interview process, consumers are asked if they had a choice of provider and also review files for documentation.

Qualified Providers

On an annual basis MFP will review all HCBS providers, both licensed and non-licensed, to review eligibility criteria. Information will be requested from the provider that documents current compliance with eligibility criteria for each program and each service that the provider is certified/enrolled to provide as listed on the MMIS system. A series of letters shall be sent to each provider requesting that the provider submit information stating how the provider meets eligibility criteria for each HCBS service they are certified/enrolled to provide. If providers do 2not respond to these requests within the timeframe identified in the letter, termination in the Medicaid program will occur. MFP is in the process of developing a QA process that will review all provider agencies in the state once in a three-year period. This file review will include a discovery process to ensure that training and education is provided based on the certification or licensure needed for each provider. After each review, the MFP specialist identifies if any deficiencies are found with providers, MFP specialists will provide and/or coordinate training**.**

State Medicaid Authority

DSS is the Medicaid single State agency. Through his role, the DSS Commissioner sets policy and provides oversight for the demonstration. The Commissioner directly oversees the Medicaid Director who, in turn, supervises the Project Director. Within Medical Care Administration, MFP's responsibility is to:

- Implement a QA plan
- Consult with contractors on QI measures and determination of areas to be reviewed *(For a definition of 'contractor,' please see Section C.2.f below)*
- Monitor the contractor's performance of all contractor responsibilities
- Review and approve proposed corrective action(s) taken by the contractor
- Monitor corrective actions taken by the contractor
- Submit quarterly reports
- Provide quality control and assurance reports which are accessible online by DSS and contractor management staff. The reports include tracking and reporting of quality control activities and tracking of corrective action plans
- Implement a State-approved corrective action plan within the timeframe negotiated with the State
- Provide documentation to MFP Project Director demonstrating that the corrective action is complete and meets State requirements
- Perform continuous workflow analysis to improve performance of contractor functions and report the results of the analysis to the QI Committee
- Provide MFP Project Director with a description of any changes to the workflow for approval prior to implementation

Financial Accountability under the Demonstration
For additional information on billing and reimbursement procedures, see Section D.3. Connecticut's MMIS system will support the demonstration. The purpose of MMIS is to assist workers in these programs with processing and tracking requests for approval of payment.

- The provider samples billing at each facility location during annual review visits. This review includes verification of program documentation each day service is billed
- MFP QA sample audits are conducted on provider billing records based on reports of potential irregularities. The state staff perform site visits including sample audits at all provider service locations. For example, adult care centers and assisted living facilities are provider service locations. Based on the site review documentation, more comprehensive audits may be warranted based on findings.
- The fiscal intermediary only accepts billing for self-directed services if signed by the participant or the participant's legal representative
- MFP requires audit of the fiscal intermediary to meet contract requirements for verification of billing and making payments on behalf of the State for waiver claims on an annual basis. This is part of the State's typical SURS process for HCBS. MFP contract monitoring staff in collaboration with other oversight managers and operating agencies will conduct the site reviews. Depending upon the findings, the fiscal intermediary will receive a rating that may range from an excellent rating to needs improvement warranting corrective action. All information will be analyzed by the MFP quality assurance staff for recommendations relative to systems improvement. Recommendations that support systems improvement will be forwarded to the QI committee for action.
- MFP QA staff review billing submitted by agencies for waiver participant eligibility and authorization for services on a quarterly basis. If irregularities are noted, the provider receives further follow-up, either training or further audit depending upon the irregularities noted.

Requirement 2: 24-hour triage back-up system
As mentioned previously, the 24-hour triage back-up system is a service for MFP participants that assures support back-up for emergency situations. Connecticut will contract the service to Connecticut Community Care Incorporated (CCCI). Through CCCI, a 24-hour answering service will be acquired. The service will determine the urgency of the call. For calls demonstrating urgency, on-call staff will be contacted immediately. If the situation appears to be acute in nature, 911 will be called. If the situation can wait until morning, no staff or emergency back-up will be sent. If the absence of support constitutes a health and safety risk to the participant, CCCI will stabilize the situation by sending emergency back-up staff or otherwise addressing the immediate concern. While there will be some individualization regarding need that may warrant a faster response rate, the standard time frame that emergency back up staff will be sent to the person's home will be 2 hours. Response rates will be documented in the care plan given the nature of anticipated emergencies.

Monitoring

The back-up system will be monitored through data collected on the quarterly Consumer Satisfaction Survey. All reports will be given to the Program Director and MFP QI Committee. Twenty-four-hour triage will be a regular item on the Committee's bi-monthly meeting agenda for review, analysis and possible action. As noted above, MFP program staff follow-up is conducted to determine that persons who called actually received the necessary back-up provider services.

Risk assessment and mitigation process

Process: Each MFP demonstration participant will complete a level of need assessment and a Risk Screening tool regarding his/her skills and circumstances, and review it with his or her team at least annually. The transition coordinator helps identify and coordinate specialized supports in each of the aforementioned areas (medical, social, housing, educational, etc.) at the request of the participant. Together all individuals involved in the planning form the "team" for the benefit of the participant. The tool produces a summary report that identifies all responses that may present a risk to the participant in medical, health, safety, behavioral and natural support areas. The team is required to address how each potential risk is mitigated in the Individual Plan. Included in this response is the use of an emergency back-up plan if the participant is reliant upon a paid or unpaid service to provide for basic health and welfare supports.

Incident reporting and management system

Each of the three operating agencies for the delivery of services under MFP has demanding and prescriptive procedures for incident and management reporting systems. While the procedures and managing systems are different, each has the same objective: to identify, address and seek to prevent instances of abuse, neglect and exploitation. See Appendix M for a listing of all resources on how to report concerns or incidents of abuse, neglect, and exploitation.

By July 2008, MFP will establish a coordinating effort regarding these procedures. Currently there is no method for collecting and analyzing complaints across waiver programs. The MFP demonstration will develop a new system to enable waiver managers and the QI Committee to:

- Analyze the type and number of complaints from a systemic level
- Look for trends by area and provider
- Identify statewide issues
- Develop and implement plans for improvement

B.9 Housing

a. *Describe the State's process for documenting the type of residence in which each participant is living. The process should categorize each setting in which an MFP participant resides by its type of "qualified residence" and by how the State defines the supported housing setting. If appropriate, identify how each setting is regulated: owned or rented by the individual, group home, adult foster care home, assisted living facility, etc.*

Connecticut will use a standard framework for documenting the type of residence in which each participant is living. Transition coordinators will submit transition plans including the choice of housing 30 days prior to transition. Information on the type of qualified residence that the individual chooses must be verified and approved by MFP central office prior to discharge. Approval will be given in writing and will become part of the participant's file. See Appendix N for a description of the State's current housing inventory.

Table 17. Framework for documenting participant's type of residence

Type of Qualified Residence	Number of Each Type of Qualified Residences	State Definition of Housing Settings	Number in? each Setting	Regulations
Home owned or leased by individual or individual's family member		Home leased by individual or family		Lease with landlord
		Home owned by individual		N/A
		Home owned by family		N/A
		Co-op owned by individual		
Apartment with an individual lease, lockable access and egress, and which includes living, sleeping, bathing and cooking areas over which the individual's family has domain and control		Apartment building		Lease with landlord
		Assisted Living		State regulations
		Public Housing units		Public Housing agency
Residence, in a community-based residential setting, in which no more than 4 unrelated individuals reside		Group home		Agency regulations

Process for informing participants about housing options

Connecticut plans to offer participants in MFP the broadest range of qualified housing permissible. Housing options are carefully described in Connecticut's housing guide designed for people transitioning from nursing homes. This resource provides participants with detailed information about the benefits and disadvantages of renting an apartment, home sharing, cooperative housing, subsidized housing, etc. Transition coordinators will discuss all options with participants. Participants will have an understanding that selection of housing can drive transition time. For example, if a participant chooses to live in a West Hartford, Connecticut two-family dwelling and there are none currently available, waiting for that specific housing to become available may take a very long time. Preferences in type of housing and location will be recorded as part of the transition planning process. Every effort will be made to locate housing consistent with the participant's first choice.

b. Describe how the State will assure a sufficient supply of qualified residences to guarantee that each eligible individual or the individual's authorized representative can choose a qualified residence in which the individual will reside. The narrative must:

i. Describe existing or planned inventories and/or needs assessments of accessible and affordable community housing for persons with disabilities/chronic conditions:

Under MFP, five housing coordinators are funded to identify and coordinate housing options for persons moving out of qualified institutions. Funds for the development and maintenance of a housing inventory were appropriated by the Connecticut State legislature to the Department of Economic and Community Development (DECD). The design was under development at the same time as the MFP proposal in 2006. Both proposals were coordinated because both agencies made development of a housing inventory as a goal. A DECD contract was awarded in December of 2006 to Social Serve.com and was piloted in the spring of 2007.

Currently, the inventory includes existing subsidized and Section 8 tenant-based housing, as well as with homes or apartments available through private landlords. The DECD and Connecticut Housing Finance Authority have listed all housing under their authority on the inventory. The State's housing authority within DSS has shared addresses for all Section 8 participating private landlords and placed the inventory on the DSS website to enhance communication.

Housing coordinators will work in partnership with DECD and will gain agreement from private landlords to participate in the inventory. Since maintenance of the inventory is sustained with funding from the State, MFP housing coordinators will fulfill a crucial role in linking landlords to the inventory.

ii. Explain how the State will address any identified housing shortages for persons transitioning under the MFP demonstration grant:

Matching housing preferences with supply

Recorded preferences in geographic area and type of housing will be given to MFP housing coordinators. Housing coordinators will search for housing in the selected geographic area consistent with the participant's preferences. Coordinators will tour viable options to assure accessibility and condition of the property.

Efforts to assure a sufficient supply of qualified residences to guarantee that each eligible individual or the individual's authorized representative can choose a qualified residence are under development in the State of Connecticut.

iii. Address how the State Medicaid Agency and other MFP stakeholders will work with Housing Finance agencies, Public Housing authorities and the various housing programs they fund to meet housing needs:

Workgroups provide forums for the design and development of the operating protocol. Workgroups also provide oversight for the implementation of the various components. The housing workgroup includes members from HUD, the State's Housing Authority, the DECD, the

Connecticut Housing Finance Agency and multiple other stakeholders. The group jointly developed both a short- and long-term housing strategy.

iv. Identify the strategies the State is pursuing to promote availability, affordability or accessibility of housing for MFP participants:

Short-term housing strategy
Note: We have funded the Rental Assistance Program (RAP) subsidies for 2008 within existing resources. We are committed to funding the housing subsidies for the duration of the MFP demonstration.

Affordability: Connecticut plans to provide State-funded housing subsidies to persons transitioning under MFP. Connecticut's practice of prioritizing housing subsidies for those transitioning started in 2002 under the CMS Nursing Facility Transition Grant. Historical trends suggest that 60% of those transitioning will require a subsidy. Funds have been budgeted to support this expense.

Accessibility: While the subsidies are an essential factor in determining the level of choice that people have in affording rent, equally important is funding to provide accessibility modifications. The investment in accessibility modifications increases the inventory of accessible housing. DECD plans to request bond funds in the amount of $1 million dollars. These monies will be coordinated with the rental subsidies for the benefit of those transitioning. Accessibility modifications funded by this resource will not replace modifications permissible under Connecticut's waiver structure. If the person transitioning is eligible for a waiver and the waiver cap for accessibility modifications is adequate to cover the cost of the modification, the waiver will be used. Often, however, costs of the required modifications are in excess of the permissible level. The fund for accessibility modifications supports maximum choice in housing under MFP.

Availability: The new housing registry previously discussed addresses Connecticut's strategy for increasing communication of housing availability. The web based registry provides information on a real time basis regarding availability. Additional information provided on the registry includes: location, accessibility, cost, size, etc. MFP housing coordinators will focus at a local level to identify affordable housing and get the housing listed on the registry.

Connecticut is also in the process of developing relationships with non-profit owners of Section 8 subsidized housing within the State. This element of the strategy focuses on coordinating with owners who have renovated subsidized housing to include assisted living units. Incorporating assisted living units into subsidized senior housing supports the choice of aging in place and also creates additional availability in housing for persons transitioning. MFP plans to include these brand new units as one housing option available for those moving to the community. Additionally, Connecticut plans to encourage more non-profit owners of subsidized housing to renovate and include assisted living as part of the MFP long-term strategy.

Long-term housing strategy
The long-term housing strategy was designed to address shortages in the supply of affordable, accessible housing in Connecticut.

Encourage non-profits to apply for 202 and 811 funding: During the development of this operational protocol, a preliminary action plan was developed to assure that Connecticut fully utilized all 202 and 811 funding available to the State. Successfully executing this strategy is estimated to result in 125 new, affordable, accessible units by 2010. The action plan developed is as follows:

- Outreach to non-profits for the purpose of establishing interest in 202 and 811 housing
- Identify 15 non-profits who are qualified (experience with managing housing) and willing to develop a proposal
- Assist with development of proposals and coordinate with MFP
- Confirm site control
- Assure applications are submitted by June 2008

Develop housing to address high need areas

Connecticut recognizes the need to develop affordable, accessible housing beyond what is possible through 202 and 811. To address this need, the MFP housing workgroup will develop and seek to execute a plan through the identification of available resources. The action plan developed is as follows:

- Analyze inventory of available housing with respect to factors such as size, cost, geographic area, accessibility, public transportation, etc.
- Assess demand for housing in various geographic areas based on preferences of persons transitioning under MFP
- Prioritize areas of the State based on inadequate housing inventory available to meet demand
- Identify number of units needed and type of housing. Type of housing under consideration may include scattered site, duplex, single homes, etc.
- Identify potential resources for acquisition, rehabilitation, new construction, or a combination thereof
- Based on availability of funds, seek housing developers to develop housing according to the plan

B.10 Continuity of Care Post Demonstration

Provide a detailed description of how the following waiver provisions or amendments to the State Plan will be utilized to promote effective outcomes from the demonstration and to ensure continuity of care.

Connecticut plans to continue all qualified services after the demonstration. For those persons transitioned under the MI target population, the new MI waiver will have slots reserved in anticipation of the transition of persons from the MFP demonstration. Likewise, slots will be reserved anticipating persons transitioning from MFP into both the new Chronic Care waiver and the ABI waiver. Slots will be available in the DDS waivers, as well as the Aged and Disabled waivers. Based on the number of slots approved compared to number of slots available to date, there is no need to reserve capacity for the transition of MFP participants. Financial and clinical eligibility criteria of waivers must be met by participants. Connecticut plans to model waiver

eligibility criteria in the demonstration. Only participants meeting waiver criteria will have access to the qualified services. Other persons will be eligible for State Plan services alone.

As part of the Governor's rebalancing initiative, it is anticipated that decisions regarding the pursuit of an HCBS State Plan Option or Personal Care Assistance State Plan Amendment will be made within state fiscal year ending June 2009. If Connecticut submits State Plan Amendments, Connecticut will also submit an amendment to the operating protocol describing the impact of State Plan Amendments on the demonstration. Connecticut will not implement the anticipated expansion of HCBS until CMS approves the amended protocol.

Reserving capacity in years subsequent to MFP

In order to maintain the fiscal integrity of the demonstration, Connecticut plans to target enrollment and the transition of individuals onto the demonstration. For the intended targeting, please refer to Table 1. Benchmark 1: Number of People Transitioned to the Community. The State is committed to funding the number of slots necessary for the MFP demonstration. Note: This is the current targeting methodology. We will continue to investigate ways to maximize targeting at those individuals who would most benefit from this program.

Connecticut has two 1915(c) waivers serving persons with intellectual disabilities. The Individual and Family Support waiver has capacity to serve 5,578 persons over the next five years. With a present enrollment of 3,331, there is no need to amend the waiver to accommodate persons transitioning under MFP. Likewise, the Comprehensive waiver has capacity to serve 5,117 persons, with current utilization of 4,433. There is no anticipated amendment required for this waiver.

The waiver for persons with mental illness is in final design phases within DSS. Connecticut plans to fund 210 persons under the new waiver. One hundred and forty-one slots will be reserved for MFP participants.

The Chronic Care Aging and Disability waiver under development at DSS will provide authority for delivery of MFP-qualified services to elderly and persons with physical disabilities at the Chronic Care Level of care. All slots will be reserved for MFP participants.

Connecticut's approved 1915(c) ABI waiver has capacity to serve 369 persons with acquired brain injury. Currently, 334 persons are served under the waiver. Connecticut plans to reserve additional slots that will be added to this waiver for MFP participants.

Table 11. Anticipated need for reserved slots by target population and year

Number of People transitioned by target population by Calendar Year								
	Elderly	**Physical Disability**		**MI**	**MR**		**Chronic Care**	**Total Reserved**
		PCA	ABI		Ind	Comp		
2008	N/A	N/A	N/A	N/A	N/A	N/A	N/A	0
2009	N/A	5	1	5	N/A	N/A	2	13
2010	N/A	41	10	41	N/A	N/A	14	106
2011	N/A	41	10	41	N/A	N/A	14	106

2012	N/A	54	13	54	N/A	N/A	19	140

N/A ─ Not applicable because participants will either all be on the demonstration or there is sufficient capacity within the waiver to address transitioning individuals from the demonstration.

Note: The waivers that require slots to be reserved will be modified to include the reserved slots. As described in Table 11, amendments will be submitted for the PCA waiver, the ABI waiver, and the MI waiver. The Chronic Care Waiver will be developed to serve persons in the MFP demonstration. All other waivers have sufficient capacity without modification to ensure that MFP participants will have a slot.

C. Organization and Administration

Provide a description of the organizational and structural administration that will be in place to implement, monitor and operate the demonstration.

C.1 Organizational Structure

Provide an organizational chart that describes the entity that is responsible for the management of this grant and how that entity relates to all other departments, agencies and service systems that will provide care and services and have interface with the eligible beneficiaries under this grant. Show specifically the relationship of the organizational structure to the Medicaid Director and Medicaid agency. The organizational chart should clearly show where the MFP project director sits/to whom he/she reports.

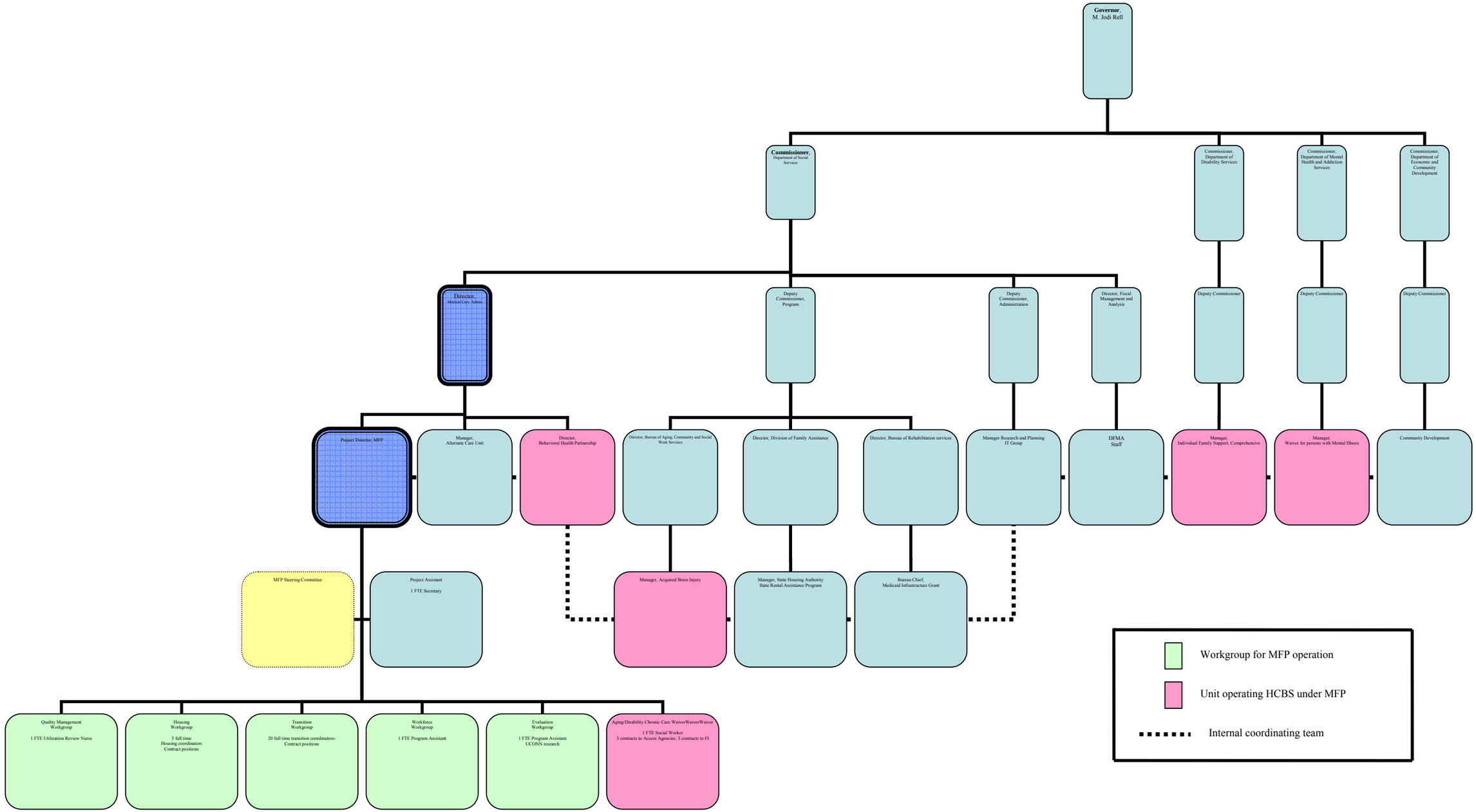
The MFP Rebalancing Demonstration was awarded to the DSS. DSS is the Medicaid single State agency and the largest Department in the State of Connecticut. Within DSS, the MFP Rebalancing Demonstration is part of the Medical Care Administration. The Commissioner of DSS directly oversees the Medical Care Administration, as well as the Bureau of Aging, Community and Social Work Services, the Bureau of Rehabilitation, the Division of Family Assistance and the State Housing Authority. The Director of Medical Care Administration reports directly to the Commissioner and directly supervises the Project Director of the demonstration.

The MFP demonstration is organized as reflected on the Chart 2 below. Workgroups are aligned with benchmarks. MFP staff will support the workgroups by facilitating discussion and ensuring stakeholder input into the development of each key element. The MFP Steering Committee will provide input to the DSS Commissioner in the design, development and implementation of the demonstration.

Qualified demonstration services offered by the MFP demonstration will be operationalized by the unit or division responsible for continuing the services in the community after the first 365 days. Operating units for continuation of waivers are highlighted in pink on the organizational chart. The Project Director serves as full-time staff to the demonstration and will coordinate with the waiver managers. Waiver managers were involved in the development of the MFP proposal and protocol, attend Steering Committee meetings and serve on MFP workgroups. Liaisons from each coordinating agency are appointed to the Steering Committee to assure monthly communication on all aspects of the MFP demonstration. DSS staff assigned to workgroups will be responsible for implementation of all workplans and meeting all objectives.

Additional coordination with units internal to DSS is required for successful implementation of the MFP demonstration. Information technology changes are required to track MFP participants in the eligibility and MMIS systems. Additionally, the financial division is involved on a regular basis to assure appropriate development of cost estimates informing budget projections, as well as MOE documents. Lastly, the MFP Project Director will coordinate with the Division of Family Assistance on issues of eligibility, as well as housing subsidy assistance. Coordination linkages are noted by connection lines across the organizational chart.

Chart 2: Organizational Chart
Money Follows the Person



C.2 Staffing Plan

Provide a staffing plan that includes:

a. A written assurance that the Project Director for the demonstration will be a full-time position and provide the Project Director's resume.

DSS is led by Commissioner Michael P. Starkowski. Commissioner Starkowski, who rose through the ranks over a three-decade public service career, is a leading authority on public financing of health care for children, elders and people with disabilities. Commissioner Starkowski leads the Governor's rebalancing efforts. Under his leadership, funding will be directed to increase and improve home and community-based services, while reducing reliance on institutional care.

David Parrella, Director of Medicaid Administration, provides direct oversight for Connecticut's Money Follows the Person Rebalancing Demonstration. David's leadership and experience with Medicaid policy and the program, both at a state and national level, is invaluable to Connecticut's rebalancing initiatives.

Dawn Lambert serves as the full-time Project Director required for implementation of the demonstration. Prior to serving as Project Director, Dawn was Project Coordinator for the State's Medicaid Infrastructure grant and had administrative oversight of the State's Independent Living Program, Assistive Technology Program and Nursing Facility Transition Program. Dawn is responsible for leading the design, development, implementation and plans for sustaining the MFP demonstration. Dawn's resume was submitted to, and approved by, CMS prior to assuming responsibilities as Project Director.

b-d and g. The number and title of dedicated positions paid for by the grant. Please indicate the key staff assigned to the grant and the percentage of time each individual/position is dedicated to the grant. Please include a brief description of the role/responsibilities of each position. Please list any positions providing in-kind support to the grant. Provide a detailed staffing timeline.

The MFP Rebalancing Demonstration administration includes funding for five additional support positions.

Table 18. MFP Rebalancing Demonstration Administration

Dedicated Positions			
#	**Title**	**% of Time**	**Role/Responsibility**
1	Project Director/Education Consultant I	100	The Project Director is responsible for leading the design, development, implementation and plans for sustaining the CMS MFP demonstration. This position has been filled.
1	Secretary	100	A secretarial position is funded to support the Project Director, the Steering Committee and the workgroup structure. Additional responsibilities include development of a web-based communication plan. This individual will also be primarily responsible for organizing the annual Rebalancing Summit. This position has been filled.
1	Utilization Review Nurse	100	A utilization review nurse is funded to assist with QM during the demonstration and in subsequent years. The utilization review nurse will support the central office QA function and will also serve on the MFP QI Committee. This position will be in place by July 1, 2008.
1	Social Worker	100	A social worker is funded to assist with the new aging and disability 1915(c) waiver under development at the DSS, as well as the self-direction delivery option. This individual will also assist with interagency coordination between waiver managers and the MFP QM plan. Additional responsibilities include serving as a liaison to the Access Agencies and the Fiscal Intermediaries. This position will be hired October 1, 2008.
1	Health Program Assistant/CCT	100	A Health Program assistant is funded to perform data analysis and complete required MFP reports. This individual will support various workgroups, most importantly, the Evaluation Committee. Additional responsibilities include serving as liaison to the University of Connecticut, Center on Aging. This position was posted. The State is awaiting permission to select a successful applicant. The successful applicant will be selected within the next few weeks.
1	Health Program Assistant/CCT	100	This program assistant is funded to provide training and technical assistance for workforce development. The position has been filled.

f. Number of contracted individuals supporting the grant.

Please refer to Section B.5 for a discussion regarding roles and responsibilities of all contractors. Section B.5 also discusses selection criteria, as well as timeline for contract execution. Below is a brief summary of contractual staff involved in MFP.

Note: All contracts are awaiting approval of the final protocol. Once the protocol is approved, the contracts will be finalized and signed within 4 months. Given a June protocol approval, all contracts should be signed and operational by October 2008.

- 10 Contracts for Transition Coordination ─ 20 full-time positions. All Area Agencies on Aging and all Centers for Independent Living will participate in the demonstration by funding full-time transition coordinators. Several joint meetings have been held with all 10 organizations. These costs are supplemental demonstration costs.
- 3 Contracts for Housing Coordination ─ 5 full-time positions. DSS currently has contracts in place with three regional sites for the coordination of mobility counseling activities. DSS plans to competitively bid these activities during the next fiscal year. Because of the regional sites' relationships to the State Housing Authority and familiarity with programs such as Section 8 and Rental Assistance, it was determined that MFP would coordinate activities through these regional sites and join the housing authority next year in the competitive bid process. Five housing coordinators will be hired. Two of the sites will host two coordinators, while the third will host only one. These costs are supplemental demonstration costs.
- 3 Contracts for Care Planning and Assessment (new Chronic Care Aging and Disability waiver) ─ DSS recently completed a competitive bidding process for agencies to provide the assessment and care planning function for Connecticut's Home Care Program for the Elders. There were three successful agencies. The qualifications and duties of care planning and assessment are very similar for the proposed waiver. Therefore, Connecticut will expand contractual responsibilities of the successful agencies to include services under MFP.
- 3 Contracts for Fiscal Intermediaries ─ DDS recently completed a competitive bidding process for agencies to provide services as fiscal intermediaries. There were three successful applicants. The roles and responsibilities expected of the fiscal intermediaries under MFP are very similar to the roles and responsibilities of the fiscal intermediaries under DDS. Therefore, Connecticut will expand contractual responsibilities of the successful agencies to include services for the benefit of MFP participants.
- 1 Contract for Evaluation. The Center on Aging at the University of Connecticut Health Center was selected as the research group to lead MFP evaluation activities. The Center on Aging was selected for many reasons including:
  - Principal Investigator in Connecticut's recent Long-term Care Needs Assessment
  - Principal Investigator over the past seven years for Connecticut's Nursing Home Transition Project
  - Principal Investigator for Connecticut's Real Choice Systems Change Grants including the Medicaid Infrastructure Grant.

  A Memo of Understanding was executed for evaluation activities related to the MFP in November 2007. To date, UCONN has completed the evaluation section of the operating protocol submission.

h. Provide in a timeline format a brief description of staff that have been hired and staff that still need to be hired.

Hired:

March 2007	Project Director
February 2008	Secretary
	Health Program Assistant

Yet to be Hired:

May 2008	Health Program Assistant
	Utilization Review Nurse
October 2008	Social Worker

i. Specify the entity that is responsible for the assessment of performance of the staff involved in the demonstration.

Staff members involved in the demonstration are all employed by the Division of Medical Administration within DSS. Within Medical Administration, the Medicaid Director will assess the performance of the Project Director. The Project Director will assess the performance of subordinate project staff.

C.3 Billing and Reimbursement Procedures

Describe procedures for insuring against duplication and payment for the demonstration and Medicaid programs; and fraud control provisions and monitoring.

Billing and reimbursement will be managed through the systems currently used for waiver and State Plan services. Connecticut DSS and Medical Services Administration have extensive fraud control and financial monitoring systems in place. The current Medicaid MMIS system is set up to deny duplicate claims for waiver and State Plan services that will be utilized under the MFP grant. The Connecticut Medicaid Quality Assurance Unit monitors for fraudulent claims billing. Provider manuals address the requirements for provider documentation. There is no anticipation of change to the current system other than those specified by the grant for reporting purposes.

The State uses the MMIS claims processing system to verify that the participant was Medicaid-eligible on the date of service delivery specified in the request for reimbursement and allows payment only on claims for services provided within the eligibility period.

Prior to processing claims, the automated claims management system edits claims for validity of the information and compliance with business rules for the service/program, and calculates the payment amount and applicable reductions for claims approved for payment. For example, unless the system verifies that a participant's current authorized plan of care contains sufficient units to cover amounts claimed and that an authorized level of care is registered in the claims management system, the claim will be rejected.

Connecticut uses a fiscal review process to ensure that providers for the various Medicaid 1915(c) waivers, State Plan services and other Medicaid services are complying with program requirements. This process was reviewed under the QM Section of this protocol. The methods used in the fiscal review process include examination of financial and service records, as well as plans of care and other records, comparison of provider billings to service delivery, and other supporting documentation.

Current procedures provide for onsite fiscal reviews to examine the provider agency's service delivery and financial records, and verify that all payments are made to the provider agency were supported with documentation. Typically, a one-month sample of the provider's records is

reviewed unless an increase in the review is deemed necessary. Examples of records reviewed include assessment documents, service delivery documents and complaints.

The provider must maintain documentation that supports the claims. If the provider fails to maintain the required documentation, all improper payments are recovered. The State also recovers payments when it verifies the provider was overpaid because of improper billing. The State may take adverse action against the provider's contract or require a corrective action plan for any fiscal review finding.

D. Independent State Evaluations

Connecticut has been continuously evaluating its existing Nursing Facility Transition Program since its inception in October 2001. Throughout this process, the evaluation has focused on the following two primary research questions: "What factors contribute to a successful transition?" and "What factors contribute to the length of time before transition?" The MFP demonstration will incorporate this evaluation because it is a natural extension of the NFTP program and the evaluation methods lend themselves to assessing the effects of the MFP demonstration. The MFP demonstration will broaden the evaluation beyond nursing facility resident transition and include information on ICF-MRs, chronic care hospitals, and IMDs.

In addition to our ongoing evaluation activities focused specifically on the transition experience, the MFP evaluation will assess the long-term care system rebalancing activities that are being undertaken as part of the Connecticut MFP initiative. Those who transition under MFP will have access to an expanded package of community services, compared to what is currently available under either of the existing Medicaid 1915(c) waivers. They will also have more flexibility and choice in how they manage these services. The goal of this portion of the MFP evaluation is to determine the efficacy of this expanded and more flexible service package, in terms of access to care in the community, costs and consumer satisfaction.

D.1 Evaluator

If an evaluator has been identified, name the evaluator and provide a resume of the principle investigator in an indexed appendix. Provide a description of the process that will be used to secure an evaluator if one has not yet been identified. Also provide a description of how the State will assure that the evaluator will possess the necessary expertise to conduct a high quality evaluation. Provide a brief description of the organizational and structural administration that will be in place to implement, monitor and operate the evaluation.

The University of Connecticut Health Center (UCHC), Center on Aging will conduct the evaluation, lead by Principal Investigator (PI) Dr. Julie Robison (PI curriculum vitae is attached in Appendix I). The MFP Project Officer will oversee this evaluation contract. Regular monthly meetings and/or conference calls will occur to ensure that the evaluation is implemented, monitored and operated efficiently and effectively.

The State assures that the evaluator possesses the necessary expertise to conduct a high quality evaluation based on a history of past collaboration. For additional information regarding the background of the evaluation and evaluator, please see Appendix I.

D.2 Evaluation Design

Provide a description of the State's evaluation design. The description should include the following:

a. A discussion of the demonstration hypotheses that will be tested;
b. The outcome measures that will be included to evaluate the impact of the demonstration;
c. The data source that will be utilized;
d. An analysis of the methods used for data collection;
e. The control variables (independent variables) that will be used to measure the actual effects (dependent variables) of the demonstration;
f. The method that will be utilized to isolate the effects of the demonstration from other state initiatives and state characteristics (e.g., per capita income and/or population);
g. Any other information pertinent to the State's evaluative or formative research via the demonstration operations; and
h. Any plans to include interim evaluation findings in the quarterly and annual progress reports (primary emphasis on reports of services being purchased and participant satisfaction).

With the implementation of a 45-day post nursing home admission assessment, we expect that some people will return to the community at that time. They will not be eligible for the MFP service package because they will not meet the six-month stay requirement. This group of nursing home eligible people who return to the community, and who receive Medicaid HCBS under either the Personal Care Assistance waiver or the CT Home Care Program for Elders, will represent one part of a comparison group for the MFP evaluation. The rest of the comparison group will include people in these two waivers who have had a nursing home stay of at least 45 days within the past 12 months. If the comparison group is too small, we will extend that requirement to include people with a 45-day or longer nursing home stay within the past 24 months. Outcomes for this group will be compared to outcomes for those who transition under MFP.

a. A discussion of the demonstration hypotheses of the two comparison groups listed above that will be tested

- Hypothesis 1: The MFP-expanded package of community services, with its increased flexibility and consumer choice, will increase consumer satisfaction and quality of life.
- Hypothesis 2: The MFP-expanded package of community services, with its increased flexibility and consumer choice, will decrease Medicaid costs.
- Hypothesis 3: The MFP-expanded package of community services, with its increased flexibility and consumer choice, will prolong time in the community, post-transition.
- Hypothesis 4: Consumers' demographic characteristics, daily living needs, and community support needs will affect whether or not they achieve a successful transition.

b. The outcome measures that will be included to evaluate the impact of the demonstration

A proposed set of outcome measures has been developed, including many measures that we have collected over the past six years for the NFTP evaluation. These measures are being revised in

order to coordinate with Mathematica Policy Research's national evaluation Quality of Life (QOL) measures and any new QA outcome measures that will also be collected under the MFP initiative.

Current proposed outcome measures are:

- Transition out of the nursing facility
- Time elapsed between enrollment in MFP and transition
- Quality of life indicators including consumers' satisfaction with their current living situation, level of involvement in the community, sufficiency of supports and resources to pay for supports, and how the current living situation compares with previous expectations
- Medicaid long-term care and acute care costs
- HCBS services used post-transition
- Number of months consumer stays in the community residence, post-transition
- Type of post-transition move (another community residence, nursing home/institution, out of state, death)

c. The data source that will be utilized

Information collected from consumers enrolled in MFP and the consumers in the comparison group constitute the primary sources of data. The comparison group includes people currently enrolled in either the PCA or Elder waiver who have a prior nursing home stay of at least 45 days within the last 12 months (or 24 months, if the group is too small for statistical comparisons). The comparison group will continue to enroll people who transition into either waiver after a nursing home stay of less than six months during the MFP project period. Other data sources include information from the transition coordinators, Medicaid cost and claims data supplied by the DSS, and data on nursing facilities compiled in the Connecticut Nursing Facility Registry.

d . An analysis of the methods used for data collection

This proposed data collection plan draws on the existing system of collecting data for our ongoing evaluation of the NFTP, with some modifications. The majority of data is collected via a web-based data entry platform. Because consumers will provide the bulk of the information, data collection instruments are designed as questionnaires, collected at the following time points:

- The transition coordinators at each of the five Independent Living Centers and five Area Agencies on Aging will collect intake data when a person enrolls in the MFP demonstration. This will be done via an in-person or telephone interview.
- The transition coordinators will collect the baseline QOL data for the national evaluation. At this time, they will also collect additional Connecticut-specific QOL and consumer satisfaction data that is not included in the national evaluation tool.
- The transition coordinators will collect data on transition status each quarter after enrollment until six months after transition is complete; also by in-person or telephone interview.

- University of Connecticut Health Center research staff will collect the national and Connecticut-specific QOL and consumer satisfaction data, including questions focused on use of Assistive Technology (AT) at six months, one year and two years post-transition.
- This follow-up data will primarily be collected from MFP and comparison group participants via a telephone interview or self-administered web-based survey interview, with the option of in-person interviews when the telephone is not feasible.

e. The control variables (independent variables) that will be used to measure the actual effects (dependent variables) of the demonstration

The proposed control variables for the MFP evaluation include those variables currently collected under our NFTP evaluation, plus new variables specific to assessing the impact of the expanded package of community services and increased flexibility and choice under the MFP plan.

A. Consumer Demographics

The consumer demographic component provides contact information and descriptive characteristics on each consumer admitted to Connecticut's Nursing Facility Transition Program. Demographic information is collected at the time the consumer applies for services via an intake form. Information continues to be collected during an initial assessment phase, which lasts anywhere from a few days to several weeks.

Consumer intake data (121 variables) encompasses five areas: consumer contact information, consumer demographics, consumer daily livings needs, consumer placement history, and consumer resources needed. Appendix J provides a copy of the Participant Survey which is the intake data collection instrument.

Table 19: Consumer Intake Data Tables

Tables and Description	**# of Variables**
Consumer Contact Information Mailing address, telephone number and other means to contact the consumer once he/she is admitted to the project	32
Consumer Demographics General characteristics of the consumer such as age, gender, race and type of disability	43
Consumer Daily Living Needs Consumer's need for hands-on or cueing assistance to perform activities of daily living and instrumental activities of daily living	26
Consumer Placement History Type of residence and living situation of consumer prior to the current nursing facility placement	9
Consumer Resources Used Type and costs of supports needed by the consumer to transition and function well in the community	11

B. Consumer Transition Status

Descriptive information about the consumer's transition process is recorded quarterly via a Quarterly Transition Progress Report. See Appendix K. This information is collected on both consumers who have transitioned, and on those who are active in the project, but have not transitioned. Transition status data (78 variables) included: consumer transition status, consumer transition timeline and consumer community supports. In addition to the quantitative information, qualitative information is also collected via a Transition Narrative form. The narratives provide the opportunity for transition coordinators to document their perspectives on the transition process for each consumer. While the actual transition and the date of the transition represent dependent variables, many independent variables are collected in the Quarterly Transition Progress Report.

Table 20: Consumer Transition Progress Data Tables

Tables and Description	**# of Variables**
Consumer Transition Status Documents current status of the consumer in terms of progress, barriers and delaying factors. Also identifies consumer's circle of support, project materials utilized by the consumer and the estimated date for transition. *See Table 3 below for the list of transition status options.*	36
Consumer Community Supports Documents the consumer's quarterly needs for community support services.	40

Table 21: Consumer Transition Status Codes and Description

Status Code	Status Description
1	Active
2	Active ─ On Hold
5	Withdrawn by CIL/AAA
6	Withdrew from Project
7	Transitioned to Community
7.1	Transitioned to Community and Still Followed by Transition Coordinator
7.2	Transitioned to Community and Being Followed by Other CIL/AAA Services
7.3	Transitioned to Community and No Longer Being Followed by CIL/AAA
7.4	Transitioned to Community and Returned to Nursing Facility for Short-term Care
7.5	Transitioned to Community and Returned to Nursing Facility ─ Return to Community Undetermined
8	Discharged from Project by Project
9	Transitioned after End of Current Reporting Period
10	New ─ On Wait List or Active after End of Current Reporting Period
11	Deceased
12	Other

C. Consumer Satisfaction Survey

The Consumer Satisfaction Survey is currently mailed twice a year to all consumers who transition from a nursing facility under the project. For the MFP evaluation, the Consumer Satisfaction Survey, adapted to incorporate the national evaluation's QOL questions, will be administered pre-transition and at 6, 12, and 24 months post-transition.

The survey data currently includes 35 variables addressing quality of life, and involvement in community, satisfaction, supports and resources. While most of the QOL and satisfaction measures represent dependent variables, a subset will also be used as independent variables. A copy of the consumer satisfaction data collection instrument is provided in Appendix L. This survey is currently being modified.

Table 22: Consumer Satisfaction Survey Data

Tables and Description	**# of Variables**
Satisfaction with Transition Quality of life indicators such as the consumer's satisfaction with current living situation, level of involvement in the community, sufficiency of supports and resources to pay for supports, and how the current living situation compares with previous expectations.	35
Survey Tracking Fields Designed to record and track surveys that have been sent to and received from transitioned consumers.	7

D. Facility Data

In order to measure outcome and process measures, an additional data set stores descriptive and contact information about Connecticut qualified facilities including nursing facilities (39 variables). This data will also include information on IMDs, ICF-MRs and hospitals.

Table 23: Nursing Facility Data

Tables and Description	**# of Variables**
Connecticut Nursing Facilities Provides basic contact and licensure information such as mailing address and Medicaid certification for all licensed and operating nursing facilities in Connecticut. Information is derived from the Connecticut Nursing Facility Registry.	18
CMS Data Includes number of beds, number of residents and occupancy rates. Information is derived from inspection reports posted on the CMS website.	4
Level of Care and Ownership Includes information about the facility's level of care and type of ownership. Information is derived from the Connecticut Nursing Facility Registry.	6
NFR Data Number of licensed beds, Medicaid rate and Medicaid days as reported by the Connecticut Nursing Facility Registry.	7
Voting Districts Connecticut General Assembly and Congressional Districts where each operating nursing facility resides.	4

E. Public Costs Incurred Before and After Transition; HCBS Services Used

For the Connecticut NFTP evaluation, Medicaid and Medicaid Waiver (home and community-based services) costs for each consumer transitioned to the community are obtained before and after transition by the Connecticut DSS. Key identifiers, such as the consumer's Social Security Number, Medicaid number and name match consumers with their Medicaid cost records. Aggregate costs are then calculated, including the average costs of institutional care and average costs of community-based care for persons transitioned. The HCBS services purchased are clearly delineated. For the MFP evaluation, Medicaid acute care costs will be examined as well. Further, the evaluation will examine administrative costs to operate the HCBS services under the "MFP system" compared to those of the traditional HCBS system, which will be used by those transitioned under the State-funded NFTP. The Medicaid cost measures are dependent variables, but are described here for continuity.

F. Assistive Technology (AT) Data

A series of questions addressing participant's experiences with, need for, and satisfaction with AT have been compiled for the Connecticut MFP evaluation. Specifically, the questions address participants' existing AT and need for specific types of AT at home or at work, sources of information about AT, concerns about AT, satisfaction with and ongoing use of AT, satisfaction with AT providers, and need for further AT training. An additional question assesses how much assistance participants receive from informal sources such as family and friends. These questions will be integrated with the Consumer Satisfaction Survey for the MFP evaluation, in addition to the national evaluation questions and any additional QA data. See the Assistive Technology Survey in Appendix H.

f. The method that will be utilized to isolate the effects of the demonstration from otherSstate initiatives and State characteristics (e.g., per capita income and/or population).

The primary alternative State initiative is the ongoing HCBS waiver system in Connecticut. Participants in the PCA and the Elder waiver whom have had a prior nursing home stay in the past 12 months, will be included in this evaluation as a comparison group. Cost, service use and quality of life data will be compared between these waiver participants and MFP participants to isolate the effects of the demonstration.

g. Any other information pertinent to the State's evaluative or formative research via the demonstration operations.

There is no other pertinent information that has not already been addressed.

h. Any plans to include interim evaluation findings in the quarterly and annual progress reports (primary emphasis on reports of services being purchased and participant satisfaction).

The majority of the MFP evaluation data will be entered directly into a web-based platform. Therefore, cumulative data can be tabulated and included in all reports as they are due.

D.3 Variables

Describe the demographic, health care, and functional outcome variables you propose to collect in the demonstration. Provide a copy in an indexed appendix to the application. Describe the instruments and provide a rationale for their use in the evaluation including reliability, validity and appropriateness for use on the study population.

The variables are also described in more detail in sections D.2.b and D.2.e above. The majority of the quantitative variables proposed come from existing, validated surveys on long-term care. The vast majority of both quantitative and qualitative measures have already been in use in the Connecticut NFTP evaluation for up to six years. They have gone through rigorous pilot testing and refinement over this period. The AT questions are currently being pilot-tested with consumers receiving AT through Connecticut's Tech Act Grant.

D.4 Process Evaluation

Describe how process measures will be evaluated. Include a description of how infrastructure changes will be evaluated as well as any pilot programs.

The MFP process evaluation methods will include review of program workgroup documents, key informant interviews and observation of grant meetings. The process measures will focus on three broad areas ─ achievements, supports, and challenges to implementation, and will focus on processes such as:

- Measuring the increase housing
- Measuring the increase in information to conservators and attorneys about self-direction and choice
- Measuring the increase in successful integration of AT

The Connecticut MFP has a Steering Committee and three workgroups which were defined at the program's onset, each focused on one of the following areas: HCBS, Transition, and Data/Finance. Goals and work plans of each of these groups will be reviewed as they develop and change over the course of the grant. The same process will apply to any additional workgroups that are formed. The evaluation team will review documents such as agendas and meeting minutes in order to describe progress toward the workgroups' goals. Evaluation researchers will conduct annual key informant interviews with representatives of each group, as well as program staff, to identify achievements, supports and challenges to the process. Proposed and achieved changes to Connecticut's long-term care system infrastructure will be documented as they occur.

E. Final Project Budget

Note: All transition counts and budgeted costs are by Calendar Year. While there are no additional transitions beyond 2011, the MFP demonstration will continue through 2012. CMS guidance to date is to include all expenses attributed to 2012 in the 2011 demonstration budget.

1. Projected Estimated Expenditures

Table 24. Total Enrollees by Target Group by Year

Number of People Transitioned by Target Population by Calendar Year									
	Elderly		**Physical Disability**			**MI**	**MR**		**Total**
	HOME Care	Chronic Care Elderly	Chronic Care PD	PCA	ABI		Ind	Comp	
2008	10			6	1	5	1	1	24
2009	85		2	45	10	41	10	10	203
2010	78	4	10	41	10	41	10	10	204
2011	94	10	23	49	13	54	13	13	269
Total	267	14	35	141	34	141	34	34	700
Percentage	38%	2%	5%	20%	5%	20%	5%	5%	100%

Table 25. Service Expenditures by Year (see Appendix C)

Table 26. Administrative Budget

Note: Currently these costs reflect a significant amount of fiscal intermediary cost. However, the specific negotiated amount will change based on an influx of members. Presentation levels are assumed at 100% participation but actual experience could change these results.

MFP General Administrative Budget Years ending December 31, 2007 through 2012					
	2007	**2008**	**2009**	**2010**	**2011 & 2012**
Personnel	67,814	191,090	338,616	361,646	385,171
Benefits	40,128	112,972	200,190	213,805	227,713
Contractual Costs (fiscal intermediary)	-	3,232	61,907	129,252	268,504
Indirect Charges	19,416	101,833	156,000	156,000	156,000
Travel	-	10,000	20,000	20,000	20,000
Supplies	-	1,250	2,500	2,500	2,500
Equipment	3,000	15,000	-		
Other (Training, language line, translation, mail, print materials, forums, Steering Committee)	-	44,000	80,500	73,000	73,000
Total	130,358	479,378	859,714	956,202	1,132,889

Table 27. MFP Evaluation Budget by Calendar Year

	CY 2008		CY 2009	CY 2010	CY2011
	Pre-implementation	May 1 implementation			
Personnel	$18,390	$34,101	$55,510	$57,175	$111,866
Benefits	$5,884	$13,037	$21,092	$22,297	$44,746
Contractual Costs		$15,000	$5,000	$5,000	$5,000
Indirect Charges	$2,221	$2,967	$8,257	$8,257	$19,583
Travel	$300	$500	$8,000	$6,000	$8,000
Supplies	$100	$1,500	$1,516	$646	$2,180
Equipment		$6,000			$8,000
Other			$625	$625	$625
Total	$26,895	$73,105	$100,000	$100,000	$200,000

Rebalancing Fund
To calculate the rebalancing fund, the State first calculated the costs under MFP and the federal share of the MFP. See Tables 28 and 29. The State then calculated the rebalancing fund. See Table 30.

Rebalancing Fund = (1 - Enhanced FMAP) x (Qualified HCBS Expenditures + Demo Services Expenditures)

Table 28: Qualifying Gross Medicaid Expenditures (same as Table 2: Benchmark 2)

Qualifying Gross Medicaid Expenditures to Rebalance Connecticut's Long Term Care						
	Qualified MFP Expenses	Demonstration MFP Expenses	Supplemental Demonstration MFP Expenses	Total MFP Expenses	Other HCBS Expenses	Total Expenses
2008	215,803	37,960	599,440	853,203	815,493,359	816,346,563
2009	4,302,577	230,372	1,525,705	6,058,654	837,943,213	844,001,867
2010	8,982,740	230,912	1,593,941	10,807,593	877,084,320	887,891,913
2011 & 2012	19,699,633	386,763	1,669,426	21,755,822	1,872,687,056	1,894,442,878
Total	33,200,753	886,007	5,388,513	39,475,273	4,403,207,949	4,442,683,221

Table 29: Federal Share to be Counted against MFP Grant

Federal Share - Qualifying Gross Medicaid Expenditures to Rebalance Connecticut's Long Term Care						
	Qualified MFP Expenses	Demonstration MFP Expenses	Supplemental Demonstration MFP Expenses	Total MFP Expenses	Other HCBS Expenses	Total Expenses
2008	161,853	28470	299720	490,043	398,949,122	490,043
2009	3,226,933	172,779	762,853	4,162,564	418,971,607	423,134,171
2010	6,737,055	173,184	796,971	7,707,210	438,542,160	446,249,370
2011 & 2012	14,774,724	290,073	834,713	15,899,510	936,343,528	952,243,038
Total	24,900,565	664,505	2,694,256	28,259,326	2,192,806,417	2,221,065,743

Table 30: Rebalancing Fund Total

Rebalancing Fund			
	Qualified MFP Expenses	Demonstration MFP Expenses	Sub total
2008	53,951	9,490	0
2009	1,075,644	57,593	1,133,237
2010	2,245,685	57,728	2,303,413
2011 & 2012	4,924,908	96,691	5,021,599
Total	8,300,188	221,502	8,458,249

This is not the same formula used for the Rebalancing Funding in Appendix C. The Appendix C formula subtracts supplemental costs and evaluation costs from the total.

Crosswalk

CROSSWALK BETWEEN STATE SERVICE CODES AND TYPE OF MFP SERVICES
FOR MFP FINANCIAL REPORTING FORMS A AND B

Connecticut

Instructions:
1. Include codes for all services approved in your MFP Operational Protocol
2. Use a single line for each service code
3. Add lines to each type of service if necessary
4. Update and submit this crosswalk with each MFP Services File your state submits

Type of Service by Category	State Service Code	Label for State Service Code	Other Data Elements Used to Identify Service (e.g., Provider ID or Place of Service)
State Plan Services			
Clinic Services			
	H2000	Comprehensive multidisciplinary evaluation	
	Q0086	Physical therapy eval/treatment, per visit	
	S5105	Day care services, center-based; services not included in program fee, per diem	
	S9446	Patient education, not otherwise classified, non-physician provider, group, per session	
	T1024	Eval and treatment by an integrated, specialty team contracted to provide coordinated care to multiple or severely handicapped children, per encounter	
	T1025	Intensive, extended multidisciplinary services provided in a clinic setting to children with complex medical, physical, mental and psychosocial impairment, per diem	
	V5010	Assessment for hearing aid	
	90801	Psychiatric diagnostic interview examination	
	90804	Individual Psychotherapy- Office or other Outpatient (20-30 min)	
	90805	Individual Psychotherapy-Office or other Outpatient (20-30 min) with medical evaluation and management services	

Type of Service by Category	State Service Code	Label for State Service Code	Other Data Elements Used to Identify Service (e.g., Provider ID or Place of Service)
	90806	Individual Psychotherapy-Office or other Outpatient (45-50 min)	
	90807	Individual Psychotherapy-Office or other Outpatient (45-50 min) with medical evaluation and management services	
	90808	Individual Psychotherapy-Office or other Outpatient (75-80 min)	
	90809	Individual Psychotherapy-Office or other Outpatient (75-80 min) with medical evaluation and management services	
	90846	Family Psychotherapy (without the patient present)	
	90847	Family Psychotherapy (conjoint psychotherapy) with patient present	
	90853	Group psychotherapy (other than of a multiple-family group)	
	90857	Interactive group psychotherapy	
	92506	Eval of speech, language, voice, communication, auditory processing and/or aural rehab. status	
	92507	Eval.of speech, language, voice, communication, auditory processing disorder (includes aural rehab); individual	
	92541	Spontaneous nystagmus test, including gaze and fixation nystagmus with recording	
	92553	Pure tone audiometry (threshold); air and bone	
	92555	Speech audiometry threshold	
	92556	Speech audiometry threshold; with speech recognition	
	92557	Comprehensive audiometry threshold eval and speech recognition	
		92553 and 92556 combined	
	92565	Stenger test, pure tone	
	92567	Tympanometry (Impedance testing)	
	92568	Acoustic reflex testing	
	92569	Acoustic reflex decay test	
	92577	Stenger test, speech	
	92582	Conditioning play audiometry	
	92583	Select picture and audiometry	
	92585	Auditory evoked potentials for evoked response audiometry and/or	
		testing of the central nervous system, comprehensive	

Type of Service by Category	State Service Code	Label for State Service Code	Other Data Elements Used to Identify Service (e.g., Provider ID or Place of Service)
	92586	Auditory evoked potentials for evoked response audiometry and/or	
		testing of the central nervous system, limited	
	92587	Evoked otoacoustic emissions; limited (single stimulus level, either	
		transient or distortion products)	
	92588	Evoked otoacoustic emissions; comprehensive or diagnostic eval	
		(comparison of transient and/or distortion product otoacoustic	
		emissions at multiple levels and frequencies)	
	94664	Demonstration and/or eval of patient utilization of an aerosol generator	
		nebulizer, metered dose inhaler or IPPB device	
	96117	Neuropsychological testing battery (EG, Halstead-Reitan, Luria, WAIS-R)	
		with interpretation and report, per hour	
	97139	Unlisted therapeutic procedure (Specify)	
	99205	Office or other outpatient visit, 60 minutes, new patient	
	99213	Office or other outpatient visit for the evaluation and management of an established patient, which requires at least two of these three components: expanded problem focused history; expanded problem focused examination; medical decision making of low complexity. (Typically 15 minutes face-to-face)	
	99214	Office or other outpatient visit for the evaluation and management of an established patient, which requires at least two of these three components: detailed history; detailed examination; medical decision making of moderate complexity (Typically 25 minutes face-to-face)	
	99215	Office or other outpatient visit for the evaluation and management of an established patient, which requires at least two of these three components: comprehensive history; comprehensive examination; medical decision making of high complexity (Typically 40 minutes face-to-face)	
	H0015	Intensive Outpatient-Substance Dependence*	
	H2013	Psychiatric health facility service, per diem	
	M0064	Brief office visit for sole purpose of monitoring or changing drug prescriptions used	
		in treatment of mental psychoneurotic and personality disorders	
	S9480	Intensive outpatient psychiatric services, per diem	
	T1015	Clinic visit/encounter, All-Inclusive	
	90801	Psychiatric diagnostic interview examination	
	90802	Interactive Psychiatric Diagnostic Interview	
	90804	Individual Psychotherapy- Office or other Outpatient (20-30 min)	
	90805	Individual Psychotherapy-Office or other Outpatient (20-30 min) with medical evaluation and management services	

Type of Service by Category	State Service Code	Label for State Service Code	Other Data Elements Used to Identify Service (e.g., Provider ID or Place of Service)
	90806	Individual Psychotherapy-Office or other Outpatient (45-50 min)	
	90807	Individual Psychotherapy-Office or other Outpatient (45-50 min) with medical evaluation and management services	
	90808	Individual Psychotherapy-Office or other Outpatient (75-80 min)	
	90809	Individual Psychotherapy-Office or other Outpatient (75-80 min) with medical evaluation and management services	
	90810	Interactive Individual Psychotherapy-Office or other Outpatient (20-30 min)	
	90811	Interactive Individual Psychotherapy-Office or other Outpatient (20-30 min) with medical evaluation and management services	
	90812	Interactive Individual Psychotherapy-Office or other Outpatient (45-50 min)	
	90813	Interactive Individual Psychotherapy-Office or other Outpatient (45-50 min) with medical evaluation and management services	
	90814	Interactive Individual Psychotherapy-Office or other Outpatient (75-80 min)	
	90815	Interactive Individual Psychotherapy-Office or other Outpatient (75-80 min) with medical evaluation and management services	
	90846	Family Psychotherapy (without the patient present)	
	90847	Family Psychotherapy (conjoint psychotherapy) with patient present	
	90853	Group psychotherapy (other than of a multiple-family group)	
	90862	Pharmacologic management, including prescription, use, and review of medication	
		with no more than minimal medical psychotherapy.	
	96100	Psychological testing (includes psycho diagnostic assessment of personality,	
		psychopathology, emotionality, intellectual abilities, EG, WAIS-R, Rorschach,MMPI)	
		with interpretation and report, per hour.	
	96110	Developmental testing, limited (EG, developmental screening test II, early language	
		milestone screen) with interpretation and report.	
	96117	Neuropsychological testing battery (EG, Halstead-Reitan, Luria, WAIS-R) with	
		interpretation and report, per hour.	
	H0014	Alcohol and/or drug services; ambulatory detoxification	
Targeted Case Management for Long Term Care			
DMR	9780Z	DMR State Case Management	
DMHAS	T2023	DMH/TCM Performing Provider, State or Private Agency	
PACE (Program for All Inclusive Care for the Elderly)			

Type of Service by Category	State Service Code	Label for State Service Code	Other Data Elements Used to Identify Service (e.g., Provider ID or Place of Service)
Rehabilitation Services			
Home Health Services			
	580/S9123	Nursing care, in the home by an RN, per hour	
	580/T1002	RN Services, up to 15 minutes	
	580/S9123 TT	Nursing care in Home, by RN, individual service provided to more than one patient in same setting	
	580/T1002 TT	RN Services, individual service provided to more than one patient in same setting (must bill with S9123, TT)	
	580/S9124	Nursing Care, in the home by an LPN, per hour	
	580 T1003	LPN/LVN services, up to 15 min. (must bill with S9124)	
	580/S9124 TT	Nursing care in Home, by LPN, individual service provided to more than one patient in same setting	
	580 T1003 TT	LPN/LVN services, up to 15 minutes, individual service provided to more than one patient in same setting	
	580 S9123 TG	Nursing Care in Home by RN, Complex/high tech level of care	
	580 S9123 TG TT	Nursing Care in Home by RN, Complex/high tech level of care	
		Individ. Service provided to more than one patient in same setting	
	580 S9124 TG TE	Nursing Care in Home by RN, Complex/high tech level of care	
	580 S9124 TG TE TT	Nursing care in Home, by RN,complex/high level of care, individual service provided to more than one patient in same setting	
	580 S9123 TH	Nursing Care in Home by RN, OB/prenatal or postpartum	
	580 T1002 TH	RN services, up to 15 min., OB/prenatal or postpartum (must bill with S9123, TH)	
	580 S9123 TH TT	Nursing care in Home, by RN,OB/prenatal or postpartum, individual service provided to more than one patient in same setting	
	580 S9124 TH	Nursing Care in Home by LPN, OB/prenatal or postpartum	
	580 T1003 TH	LPN/LVN services, up to 15 min. OB/prenatal or postpartum (must bill with S9124, TH)	
	580 S9124 TH TT	Nursing care in Home, by LPN,OB/prenatal or postpartum, individual service provided to more than one patient in same setting	
	580 T1003 TH TT	LPN/LVN services, more than one patient. OB/prenatal or postpartum (must bill with S9124, TH)	
	580 T1001 TD	Nursing Assessment/Evaluation, RN	
	580 T1002	RN services, up to 15 minutes (must be billed with T1001, TD)	
	570 T1004	Services of a qualified nursing aide, up to 15 minutes	
	424	Physical Therapy Evaluation	

Type of Service by Category	State Service Code	Label for State Service Code	Other Data Elements Used to Identify Service (e.g., Provider ID or Place of Service)
	421	Physical Therapy	
	434	Occupational Therapy Evaluation	
	431	Occupational Therapy	
	444	Speech Pathology Evaluation	
	441	Speech Pathology	
	97001	Physical therapy evaluation	
	97002	Physical therapy re-evaluation	
	97003	Occupational therapy evaluation	
	97004	Occupational therapy re-evaluation	
Hospice			
Personal Care Services			
Optional Medicaid Plan Services			
Waiver Services			
Case Management			
ABI	1530P	Case-Management	
CHCP	1286 Z	Care Management Services - Activities Related to Implementation,	
		Coordination, & Monitoring Plan of Care	
CHCP	1288 Z	Initial Assessment - Written Eval. Of Indiv. Medical, Psychological	
		& Economic Status, Degree of Functional Impairment Related to	
		Service Needs	
CHCP		Re-Evaluation of Client - Status Review	
CHCP	1292 Z	In Hospital Status Review	
CHCP	1293 Z	Nursing Home Status Review	
CHCP	1294 Z	Financial Review by Access Agency	
CHCP	1295 Z	Claims Processing Fee - Self-Directed Care Client	

Type of Service by Category	State Service Code	Label for State Service Code	Other Data Elements Used to Identify Service (e.g., Provider ID or Place of Service)
Homemaker Services			
ABI	1542 P	Homemaker Services (agency)	
ABI	1542 P	Homemaker Services (private)	
CHCP	1214 Z	Homemaker Service - Agency - Per 1/4 Hour	
Personal Care			
DMR	T 1019	Personal Care Services	
ABI	1554 P	Personal Care Assistant (private only)	
PCA	1520P	Personal Care Assistant (private onlu)	
Adult Day Health			
CHCP	1200 Z	Adult Day Health - Full Day - Non-Medical Model Provider	
CHCP	1201 Z	Adult Day Health - Full Day - Approved Medical Model Provider	
CHCP	1202 Z	Adult Day Health - Half Day - Less Than or Equal to 4 hours	
Habilitation			
DMR	97535	Self Care/home Management Training	
ABI	1546 P	Independent Living Skill Development (Indiv.)	
ABI	1548 P	Cognitive/Behavioral Programs	
a. Residential Habilitation			
DMR	T 2016	Residential Habilitation (SL)	

Type of Service by Category	State Service Code	Label for State Service Code	Other Data Elements Used to Identify Service (e.g., Provider ID or Place of Service)
b. Day Habilitation			
DMR	T 2021	Group Day - Day Support Option (DSO)	
DMR	T 2021	Group Day - Shelter Workshop (SHE)	
DMR	T 2021 B	Group Day - SHE w/B	
DMR	97537	Individualized Day	
DMR	Group Day Procedure Code + "Sup"	Intensive Staffing Support (Group Day & Respite Only)	
c. Education			
Expanded Habilitation Services			
a. Prevocational Services			
ABI	1560 P	Pre-Vocational Services	
b. Supported Employment			
DMR	T 2019	Supported Employment Individual	
DMR	T 2019	Supported Employment Group	
DMR	T 2019 B	Supported Employment Group w/B	
ABI	1572 P	Supported Employment	
c. Education			
Respite Care			
ABI	1562 P	Respite Care	
CHCP	1226 Z	Respite Care In The Home - Companion - Per 1/4 Hour	
CHCP	1228 Z	Respite Care In The Home - Homemaker - Per 1/4 Hour	
CHCP	1230 Z	Respite Care -Home Health Aide - Per Hour	
CHCP	1232 Z	Respite Care In The Home - Other - Per Hour	
CHCP	1234 Z	Respite Care - Rest Home with Nursing Supervision - Per Day	

Type of Service by Category	State Service Code	Label for State Service Code	Other Data Elements Used to Identify Service (e.g., Provider ID or Place of Service)
CHCP	1236 Z	Respite Care - Chronic Convalescent Nursing Facility - Per Day	
CHCP	1240 Z	Respite Care - Licensed Home for the Aged - Per Day	
CHCP	1244 Z	Respite Care - Out of the Home - Per Hour - Other	
DMR	S 5151	Respite Individual (in home) Daily	
DMR	S 5150	Respite Individual (in home) Hourly	
DMR	S 5151	Respite Individual (out of home) Daily	
DMR	S 5150	Respite Individual (out of home) Hourly	
DMR	S 5151	Respite Group (in/out of home) Daily	
DMR	S 5150	Respite Group (in/out of home) Hourly	
Day Treatment			
ABI	H 2036	Substance Abuse Program (daily)	
ABI	H 2035	Substance Abuse Program (hourly)	
Partial Hospitalization			
Psychosocial Rehabilitation			

Type of Service by Category	State Service Code	Label for State Service Code	Other Data Elements Used to Identify Service (e.g., Provider ID or Place of Service)
Clinic Services			
Live-In Caregiver			
Capitated Payments for Long Term Care Services			
Other			
PCA	1556P	Personal Emergency Response System (one time installation)	
PCA	1557P	Personal Service Emergency Response System (monthly service – one way)	
ABI	1532 P	Chore (Agency)	
ABI	1532 P	Chore (Private)	
ABI	1534 P	Community Living Support Services (CLSS)	
ABI	1536 P	Companion Services (Agency)	
ABI	1536 P	Companion Services (Private)	
ABI	1538 P	Environmental Accessibility Adaptations	
ABI	1550 P	Home Delivered Meals (single)	
ABI	1551 P	Home-Delivered Meals (double meal)	
ABI	1556 P	Personal Emergency Response System (PERS)	
ABI	1557 P	Personal Emergency Response System (monthly service)	
ABI	1564 P	Specialized Medical Equipment & Supplies	

Type of Service by Category	State Service Code	Label for State Service Code	Other Data Elements Used to Identify Service (e.g., Provider ID or Place of Service)
ABI	T 1013	Sign Language or Oral Interpretive Services	
ABI	1574 P	Transportation (Public)	
ABI	1575 P	Transportation (Mileage-Private)	
ABI	1578 P	Vehicle Modification	
ABI	1580 P	Transitional Living Services	
CHCP	1206 Z	Chore Service - Agency - Per 1/4 Hour	
CHCP	1208Z	Chore Service - Highly Skilled - Per Hour	
CHCP	1209 Z	Minor Home Modification	
CHCP	1210 Z	Companion Service - Agency - Per 1/4 Hour	
CHCP	1218 Z	Meal Service - Single Hot Meal	
CHCP	1220 Z	Meal Service - Double (One Hot & One Cold) Per Double Meal	
CHCP	1221 Z	Kosher Meals - Double	
CHCP	1222 Z	PERS Service Installation	
CHCP	1223 Z	Two-Way PERS System On-Going Service	
CHCP	1262 Z	Social Transportation - Taxi - Per Trip	
CHCP	1264 Z	Social Transportation - Livery- Per Trip	
CHCP	1266 Z	Social Transportation - Invalid Coach- Per Trip	
CHCP	1247 Z	Mental Health Counseling - Individual - Provided in Client's Home	
CHCP	1256 Z	Mental Health Counseling - Individual - 45-50 Min. - Out of Home	
CHCP	1260 Z	Elderly Foster Care - Service Does Not Include Room and Board	
Assisted Living	1430 Z	Occasional Personal Services - Per Day	
Assisted Living	1431 Z	Limited Personal Services - Per Day	
Assisted Living	1432 Z	Moderate Personal Services - Per Day	
Assisted Living	1433 Z	Extensive Personal Services - Per Day	
Assisted Living	1434 Z	Core Assisted Living Services - Per Day	
DMR	S 5135	Adult Companion	
DMR	1222 Z	PERS Service Installation	
DMR	1223 Z	PERS System (2 way)	
DMR	S 0215	Transportation	

Type of Service by Category	State Service Code	Label for State Service Code	Other Data Elements Used to Identify Service (e.g., Provider ID or Place of Service)
DMR	S 0215	Transportation - one way trip	
DMR	T 2029	Specialized Medical Equipment	
DMR	H 2019	Consultative Services - Behavioral	
DMR	S 9482	Consultative Services - Counseling	
DMR	S 9470	Nutrition	
DMR	T 1013	Interpreter Services	
DMR	T 2040	Family & Individual Consultation & support (FICS)	
DMR	DSS Codes	Assisted Living Com Waiver only	
DMR	1430 Z	Level I	
DMR	1431 Z	Level 2	
DMR	1432 Z	Level 3	
DMR	1433 Z	Level 4	
DMR	1434 Z	Core Services	
DMR	T 2025	Individual Directed Goods & Services - Comp Waiver only	

2. Budget Narrative

a) MFP General Administrative

a. Personnel.
Personnel costs include salary for a Project Director, Secretary, 2 Health Program Assistants/CCT, a Utilization Review Nurse and a Social Worker. Additional detail for these 6 FTE can be found above in C.2 Staffing plan.

b. Fringe benefits.
The Fringe benefit rates for each year are 59.12% and are noted above in Table 26.

c. Contractual costs, including consultant contracts.
Contractual Contracts include the Fiscal Intermediary contracts and are noted above in Table 26.

d. Indirect Charges, by federal regulation.
Indirect charges have been set at 26,000 per employee for a full year's employment. The costs are prorated for partial year employment and are noted above in Table 26.

e. Travel
Travel costs cover travel to local, state, and regional MFP-related meetings, presentations, and data collection for the state evaluation. Travel costs are noted above in Table 26

f. Supplies
Costs for supplies built in for each year include paper, printing, telephone, postage and other miscellaneous supplies. See Table 26.

g. Equipment
The cost of one new computer per employee is built in the budget for Year 1. See Table 26.

h. Other costs include training, language line, translation, mail, print materials, forums, and Steering Committee support. See Table 26.

b) MFP Evaluation

The evaluation budget covers the following costs for the entire MFP program period, from the pre-implementation period of July 2007 to February 2008, to the end of the project in December 2011. If the program dates change, the budget will shift accordingly.

a. Personnel.
Personnel costs include salary for the Principal Investigator, Dr. Julie Robison, for between 20% and 25% FTE; two research assistants, one for between 9% and 35% FTE and the other between 15% and 20% FTE; and a data manager/analyst for between 5% and 10% FTE. FTE percentages vary across the years of the evaluation as the tasks change. Three percent salary increases are built in annually.

b. Fringe benefits.

The fringe benefit rates for each year through 2011 of the University of Connecticut's Health Center have been predicted and are as follows: 2008 — .32, 2009 — .38, 2010 — .39, 2011 — .40.

c. Contractual costs, including consultant contracts.
Consultant contracts will be issued each year for web-based data entry design and management.

d. Indirect charges, by federal regulation.
Indirect charges have been set at 9%, which are in line with other existing contracts between the UCHC Center on Aging and the Connecticut DSS.

e. Travel.
Travel costs cover travel to local, state, and regional MFP-related meetings, presentations, and data collection for the State evaluation. They do not include travel costs for conducting the National Evaluator's in-person interviews.

f. Supplies.
Costs for supplies built in for each year include paper, printing, telephone, postage and other miscellaneous supplies.

g. Equipment.
The cost of one new computer is included in the budget for Year 1. The Center on Aging has adequate desktop computer availability, but will need to purchase a laptop computer for offsite MFP data collection.

h. Other costs.
Other costs include incentives to key informants or other data sources that will provide data for the process evaluation.

3. Required Budget Request Forms

The operational protocol should be submitted with a final budget. Below are links to the required forms to include with the protocol:

- http://www.whitehouse.gov/omb/grants/sf424.pdf (Application for Federal Assistance SF-424)
- http://www.whitehouse.gov/omb/grants/sf424a.pdf (Budget Information Sheets)
- http://www.whitehouse.gov/omb/grants/sf424b.pdf (Assurances-Non Construction SF-424B)
- http://www.cms.hhs.gov/states/letters/certns.pdf (Additional Assurances)
- http://www.whitehouse.gov/omb/grants/sflll.pdf (Disclosures for Lobbying Activities)

Connecticut contacted the CMS Project Officer, Kate King, on April 30, 2008, to discuss submission of the budget documents. A copy of the SF424a is attached and identifies projected MFP Demonstration expenditures throughout the remainder of this grant period. The SF424, Application for Federal Assistance, is on file with CMS and will be updated when requested by Ms. King. The other two documents are also on file with CMS and will be updated or resubmitted at the request of CMS.

MFP DEMONSTRATION GRANT SUPPLEMENTAL BUDGET REQUEST INFORMATION

STATE NAME: Connecticut AWARD NO. (Grant#): 1LICMS300142

SECTION A - BUDGET SUMMARY						
Grant Program: MFP Demonstration (a)	Federal Domestic Assistance Number (b)	Estimated Unobligated Funds		New or Revised Budget		
		Federal (c)	State Match (d)	Federal (e)	State Match (f)	Total (g)
CY 2007 AWARD	93-779	$1,166,240	$1,166,240			$2,332,479
CY 2008 REQUEST				$872,140	$655,927	$1,528,067
Total						$3,860,547

SECTION B - BUDGET CATEGORIES					
			CY 08 Federal Funds	CY 08 State Funds	Total
Object Class Categories	(1)	(2)	(3)	(4)	(5)
a. Personnel			$100,530	$90,560	$191,090
b. Fringe Benefits			$56,486	$56,486	$112,972
c. Travel			$5,000	$5,000	$10,000
d. Equipment			$97,500	$17,500	$115,000
e. Supplies			$625	$625	$1,250
f. Contractual			$51,616	$51,616	$103,232
g. Construction					
h. Service Dollars			$490,043	$363,161	$853,203
i. Total Direct Charges *(sum of a-h)*			$801,800	$584,948	$1,386,748
j. Indirect Charges			$72,917	$72,917	$145,833
k. TOTALS *(sum of i and j)*			**$874,716**	$657,864	$1,532,581