

Provider Agency – Frequently Asked Questions (FAQ) about the
Mental Health Waiver Program

What are the eligibility requirements for people who wish to enroll in the Mental Health Waiver program?

Please visit: <http://www.ct.gov/dmhas/lib/dmhas/oaswise/eligibilityrequirements.pdf>

What are the requirements for agencies that wish become Mental Health Waiver service providers?

Please visit: <http://www.ct.gov/dmhas/lib/dmhas/oaswise/waiverapplication.pdf>

What is the connection between the Mental Health Waiver and Money Follows the Person (MFP).

MFP is a new program operated by the Department of Social Services (DSS) that will help people residing in nursing homes return to community living. MFP focuses on elderly adults who have been in nursing homes for more than 6 months, and on individuals with one of several disabilities, including psychiatric conditions. MFP is expected to start in the fall 2008, and will serve approximately 700 people during the next five years. An important requirement of MFP is that people who enter this program must transition to other waiver programs within one year. DSS and DMHAS have been working collaboratively to ensure that MFP and the Mental Health Waiver are aligned to facilitate these transitions. For more information about MFP please visit:

How does a provider receive reimbursement for authorized Mental Health Waiver services that have been delivered to a waiver participant?

The provider submits a standard Medicaid claim (using HCPC codes that are assigned to waiver services). The claim must be sent to the Fiscal Intermediary (FI) designated by DMHAS and DSS.

What state and federal compliance requirements must the provider meet?

If your agency bills and collects more than \$5 million from Medicaid per year, you are required to establish a set of written procedures and policies to support the detection and prevention of fraud, abuse and waste. This is commonly called a Compliance Program. Since 1997 the Office of the Inspector General (OIG) strongly encouraged health care entities to establish a Compliance Plan voluntarily. The passage of the Deficit Reduction Act (DRA) in 2006 mandated such programs. For more information see Department of Social Services' website at www.ctdssmap.com. Select "publications", bulletin # PB07-41. Select

“provider type”, “all”. If you have questions, please call Carol Ferro at (860) 418-6800.

Are service providers permitted to charge enrolled Mental Health Waiver participants for wavier services?

No. Reimbursement for services rendered is made by Medicaid through the Fiscal Intermediary. This reimbursement fee is considered full payment. The service provider is not permitted to charge or receive payment from a waiver participant for any waiver services.

Is there a limit on the cost of services that can be provided to an applicant or participant in the Mental Health Waiver?

Yes. This upper limit is called the “Individual Cap.” The Departments will refuse to admit to the waiver any otherwise eligible individual when the Departments reasonably expect that the cost of the home and community-based services furnished to that individual would exceed 125% of the average institutional cost for persons targeted to receive care under this waiver.

What happens if the cost of services exceeds the individual cap?

Applicants or participants whose health and safety needs cannot be reasonably assured at their current level of assessed care and with the support of home and community based services within the Waiver will not be enrolled (or disenrolled if a current participant) in the Waiver. DMHAS and DSS will determine if the cost of the Waiver services necessary to ensure the participant’s health and safety does not exceed the cost limit established by the state. In the event that an individual's Recovery Plan cannot be approved because it exceeds the individual cap, the Departments shall work with the individual and other members of the person-centered team to determine if revisions can be made that will provide appropriate services at the dollar amount available. If the DMHAS Community Support Clinician determines that an applicant's need is more extensive than the services in the Waiver are able to support, the DMHAS Community Support Clinician will inform the applicant that their health and safety can not be assured. The plan may be resubmitted in the future if the total average cost of program participation has decreased sufficiently or the needs of the individual are reduced to a sufficient degree. In the event that the Applicant is denied enrollment or a current participant’s services are being reduced or terminated, the applicant or participant will receive a Medicaid Notice of Action (NOA) regarding their right to a fair hearing in accordance with the rules of the Medicaid program.

What happens if there is a change in the person’s condition that causes a temporary need for additional services in excess of the individual cap?

The DMHAS Community Support Clinician may convene a Recovery Plan Team Meeting in the event of an increased need for service by a Waiver participant. If the team review determines a need for increased intensity of services, the DMHAS Waiver Program Manager and DSS may approve a time limited increase (less than 90 days) in the intensity of services. If it is determined at the time of the meeting or at the end of 90 days that the participant has an extended need for increased intensity of services, the individual is re-assessed by DMHAS Community Support Clinician and transitioned to a nursing facility or inpatient hospital if the health and safety of the participant can not be assured.

How will waiver participants be selected?

Entrance into the Waiver is on a first come-first served basis for those who meet eligibility criteria. The exception to this first come-first served policy is those individuals who meet these criteria and participants in the State's Money Follows the Person (MFP) initiative. Fifteen slots is reserved for people coming from MFP in Waiver Year 1, 41 slots in Year 2 and 44 slots the final year of this Waiver.

Entry into the Waiver is offered to individuals based on their date of application for the Waiver. Individuals who are referred in excess of the allocated Waiver capacity within any given year are placed on a waiting list.

Are there a minimum number of Mental Health Waiver services the applicant must need to qualify for acceptance?

Yes. The individual must need at least two waiver services provided each month to qualify for acceptance.

Who will perform the initial evaluation of the level of care needed by Mental Health Waiver applicants?

A Registered Nurse will perform the Nursing Facility Level of Care evaluation. Determination whether the individual meets the Criteria for Serious Mental Illness is performed by a licensed mental health professional.

Who will perform re-evaluations of the level of care needed by Mental Health Waiver participants, and how often will this be done?

A DMHAS Community Support Clinician will perform the re-evaluation in consultation with a DMHAS R.N. on an annual basis or more frequently if necessary.

What is done if an applicant or a participant has limited English proficiency?

Potential and active Waiver participants with limited fluency in English will have access to services without undue hardship. Information regarding the Waiver and the Request for Waiver Services is available in Spanish. DMHAS Community Support Clinicians is required to make arrangements to provide interpretation or translation services to potential and active waiver participants who need them. No person is denied access to the Waiver on the basis of English proficiency.

Will the Departments conduct criminal history or background checks on individuals who provide Mental Health Waiver services?

Yes. DSS and DMHAS will require any person serving as a household employee (i.e., Recovery Assistant) to a participant in the Waiver to submit to a State of Connecticut criminal background check.

Will the State make payments to relatives or legal guardians for Mental Health Waiver services provided?

No.

What process is use by the State to assure that any willing and qualified provider becomes enrolled to offer Mental Health Waiver services?

Open enrollment is applied to all providers of Waiver services. As the operating agency for this waiver, DMHAS is developing a provider enrollment and certification process. This process includes a communications strategy: 1) to describe the purpose of the waiver, services to be covered, and expectations for the performance of those services, 2) to promote awareness among potential providers regarding the open enrollment opportunity, 3) to share details about how to apply, and, 4) to specify provider certification requirements. Any provider applicant who submits proper documentation of qualifications to perform a particular waiver service is enrolled and certified to perform that service.

Who has responsibility for developing the Recovery Plan?

DMHAS will use a person-centered approach in which the participant plays a significant role in development of the Recovery Plan. The participant is assisted by the DMHAS Community Support Clinician.

The Recovery Plan will outline in writing the services that is provided to the participant to meet his/her identified needs, taking into account the individual's strengths, capacities, preferences, and desired outcomes.

What will the Recovery Plan contain?

The Recovery Plan will contain many details about the assessment and include the specific services to be provided and the frequency of services. The plan will identify all services and supports needed by the individual including services included in the Medicaid state plan as well as services offered by other state agencies, general community resources, and natural supports. It will also identify (when applicable) the specific organization that is requested to offer more formal treatment and support services. Each service proposed in the Recovery Plan will identify the reason for selecting the service, the expected goal and the timeframe for which the service is needed.

How will the cost of provider services be estimated and monitored?

After the Recovery Plan has been developed, the DMHAS Community Support Clinician will prepare the cost sheet. The cost sheet will also be completed when the Recovery Plan is significantly revised. The DMHAS Community Support Clinician will explain the cost sheet to the participant and/or representative at each review of the Recovery Plan, which occurs every 3 months.

What will happen if the provider exceeds cost by delivering more services than are authorized on the Cost Sheet?

If the provider believes that the participant's needs have changed and that services should be increased, this request must be made to the DMHAS Community Support Clinician prior to the delivery of the services. The DMHAS Community Support Clinician will amend the cost sheet, if necessary. Limits specified on the Cost Sheet are monitored by the Fiscal Intermediary. Service claims submitted for payment in excess of authorized costs is denied.

How will the health and safety of consumers be protected?

Information and training is provided every participant to prepare him/her for playing a greater role in the support and Recovery Planning and delivery process. The information and training will cover health and safety factors, emergency back-up planning, and risk identification, assessment, and management. If the consumer's mental condition decompensates, family members and other supports is provided with information (in accordance with the participant's wishes) and training and encouraged to engage with the consumer in the Recovery Planning process. Emergency back-up plans and risk identification and management is included in the consumer's Recovery Plan. Emergency back-up plans is defined and planned for on an individual basis, and may include an assessment of critical services and a back-up strategy for each identified critical service. Back-up may include:

- a) Consumer back-up incorporated into the Recovery Plan;
- b) Informal back-up (e.g., family, friends, neighbors);

- c) Enrolled Medicaid provider network and the local mental health provider offering clinical and rehabilitative services to the participant;
- d) System level/local emergency response and crisis response including the statewide network of DMHAS crisis teams.

How will consumers be assisted in the selection of qualified providers?

During the development of the Recovery Plan, consumers will select providers from a list prepared by the DMHAS Community Support Clinician. DMHAS will maintain the list of waiver providers according to geographic areas within the state, and the list may vary by geographic area. The DMHAS Community Support Clinician will describe the services available from providers on the list. Consumers will choose providers from the list.

What is the process for approval of the Recovery Plan?

All Recovery Plans is reviewed by the DMHAS Waiver Program Manager and DSS. Review of the Recovery Plan is based on the following:

- o Completeness of plan which includes all necessary services (waiver and non-waiver services) being listed in terms of amount, frequency, duration and planned provider(s), including assurances of the consumers' freedom of choice of waiver and non-waiver providers;
- o Consistency of the plan with assessment information regarding consumers' needs; and
- o Presence of appropriate signatures.

DMHAS and DSS will review the Recovery Plan within 10 business days after the consumer approves and signs the Recovery Plan. Upon this review DMHAS and DSS will approve, pend or deny the Recovery Plan. DMHAS and DSS will determine if the cost of the Waiver services necessary to ensure the participant's health and safety does not exceed the cost limit established by the state.

If DMHAS and DSS approve the Recovery Plan the participant is notified and offered enrollment into the Waiver. If the Recovery Plan is pended, DMHAS and DSS will request additional information regarding the participant's need. DMHAS and DSS may also make recommendations to the Recovery Planning Team and the participant regarding changes to services and service budgets. Applicants or participants whose health and safety needs cannot be reasonably assured at their current level of assessed care and home and community based services within the Waiver will not be enrolled (or disenrolled if a current participant) in the Waiver.

In the event that the Applicant is denied enrollment or a current participant's services are being reduced or terminated, the applicant or participant will receive a Medicaid Notice of Action (NOA) regarding their right to a fair hearing in accordance with the rules of the Medicaid program.

How often will the Recovery Plan be reviewed and updated?

The plan is reviewed every three months or more frequently, if necessary.

How will the Recovery Plan be implemented?

Once the participant is enrolled in the Waiver, the DMHAS Community Support Clinician will arrange a Recovery Plan Implementation Meeting. The Support Coordinator will contact the participant, and any organizations that are identified in the Recovery Plan to discuss implementation. Prior to this meeting the DMHAS Support Coordinator will make the referrals and engage these organizations to participate in the Implementation Meeting. The purpose of this Implementation Meeting is to have the participant meet the relevant organization's representative and to coordinate initial appointments to commence service delivery.

How will implementation of the Recovery Plan be monitored?

The purpose of monitoring is to ensure that waiver services are furnished in accordance with the Recovery Plan, meet the participant's needs and achieve their intended outcomes. Monitoring will also be conducted to identify any problems related to the participant's health and welfare that may require action.

The DMHAS Community Support Clinician is responsible for monitoring the Recovery Plan quarterly or more frequently if needed. The frequency with which monitoring is performed may vary based on risk factors that are identified during the assessment and Recovery Plan development process and during subsequent reviews. The DMHAS Community Support Clinician will use interviews (e.g., with principal clinician), chart reviews and other data to determine whether:

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

Proposed changes to a consumer's Recovery Plan is submitted through the Community Support Clinician to the DMHAS Waiver Program Manager and DSS. Updates to the Recovery Plan will undergo the same review process as described above.

What recourse will applicants for enrollment or existing participants have if they are denied care or terminated from the waiver?

Applicants for and participants under this Waiver may request and receive a fair hearing in accordance with the DSS' Medical Assistance Program. Applicants will receive a copy of the DSS W-1035, Freedom of Choice/Hearing Notification Form, during the first visit with the DMHAS Community Support Clinician. Participants are eligible for Fair Hearings in the following circumstances:

- Participant was not offered the choice of home and community services as an alternative to institutional care
- DSS does not reach a determination of financial eligibility within standards of promptness
- DSS denies the application for any reasons other than limitations on the number of individuals that can be served and/or funding limitations as established under this Waiver.
- DSS denies the application for the individual not meeting the level of care or other eligibility criteria
- DSS disapproves the individual's Recovery Plan.
- DSS denies or terminates a service of the individual's choice.
- DSS denies or terminates a payment to a provider of the individual's choice; or
- DSS discharges an individual from this Waiver.

In accordance with Connecticut Medicaid rules, a Notice of Action (NOA) is sent to a Waiver participant when any service is denied, reduced, suspended or terminated. The NOA and Freedom of Choice/Fair Hearing Notification is provided in Spanish to support providing persons with LEP or non-English proficiency.

During the enrollment process participants is informed of their rights and provided information about the Fair Hearing and Grievance processes. At that time, participants is informed that, if they file a grievance or appeal, services will continue while the grievance or appeal is under consideration.

What recourse does the participant have if he/she has a grievance or wishes to lodge a complaint?

DMHAS requires each agency participating in the Waiver to have a complaints and grievances process and to inform each person seeking or receiving services about how to use the process. The DMHAS Complaint, Grievance and Appeal system is available to anyone receiving DMHAS services (upon approval of the waiver, this would include waiver participants) regardless of whether the service is State-funded or State-operated. Additionally, participants is informed that the DSS Fair Hearing process is available to them at any time, and that the provider

or DMHAS operated complaint and grievance process need not be completed for them to request a Fair Hearing.

As a general principle, DMHAS will encourage the handling of complaints and grievances at the level closest to the service recipient, in other words, in the program or facility where the service is located. In addition, DMHAS policy will focus on the mediation and settlement of grievances as soon as possible after they arise. However, when a grievance cannot be resolved to the satisfaction of the person raising the concern, a process is in place for appealing a grievance finding to the Office of the Commissioner at DMHAS. A grievance-appeal will set into motion a time-critical sequence of events involving examination of the grievance conclusion to determine whether the agency-level decision on the grievance is supported or overturned. Waiver recipients will also have recourse to the DSS Fair Hearing process, as well as rights to judicial relief as specified in Chapter 54 of Connecticut General Statutes.

Does the waiver program allow the use of seclusion or restraint?

No. All programs participating in the waiver, whether under contract or operated directly by DMHAS are prohibited from using restraints and seclusion.