

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.

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

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

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 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.

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 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 sufficient (eligibility based on Section 8 rules and based on need)
- Establish a separate pool of funds to provide accessibility in affordable housing above and beyond that which is allowable within cost caps
- Establish flexible budget for participants to purchase transitional supports not currently available under the Medicaid system
- Develop and implement training opportunities to support staff development
- Implement housing strategy
- 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 to enhance global budgeting for individuals in long-term care

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 participants²:

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

Objective 5: Decrease the number of inappropriate hospital discharges to nursing facilities³:

- 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 institution⁴:

- 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

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.

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.

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
 - 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?

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 lose 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.

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.

The next week Alma was visited by a social worker from Connecticut Community Care Incorporated (CCCI) who completed her assessment for community supports. 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.

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.

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. 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 continued to receive services under the new Chronic Care waiver.

Transition of Mentally Ill Population

Greg sat in his room, staring at the letter that had just arrived from the Department of Social Services (DSS), wondering if this was his chance to finally start his life over again. Greg was 20 and living at Smithville, an Institute for Mental Disease. He had been there for a year. Despite all that had happened to him over the past six years, he still had never given up on his goal of attending college. The letter provided the phone number to the MFP program office for more information. He decided to wait until morning to call the phone number.

The following morning, Greg called the MFP program office. He learned that the State of Connecticut was funding a demonstration called Money Follows the Person. After a brief discussion, Greg was told that he may be eligible for the demonstration. The counselor on the phone suggested that he should review an application package and, if he was still interested, he should apply to the program. The final determination for eligibility would be made by DSS after confirming that he had been institutionalized for at least six months and that he was eligible for Medicaid. Greg thought to himself, '...Institutionalized for six months? How about five years?'

The past five years had been a nightmare. It all started when he was 14 and his Mom discovered the cocaine in his room. He always felt his parents were strict. Too strict. His sister was still in high school at time...his perfect sister. She always fit in and was really popular. Greg had no friends. For the most part, he hung out with his sister and her friends. The drugs were a secret until his Mom discovered them. She took them and required that he would start counseling immediately.

He attended counseling sessions over the next few months. But, he also continued to use drugs. Gradually, he sensed his own loss of control over the situation. One day, his Mom started asking questions. Greg admitted that he was still using and he admitted that he needed help. Greg's Mom was certain that the kids at the public school were part of the problem. Greg actually agreed. He didn't like the school he was at. The decision was made to explore private schools.

Things quickly began to spin out of control for Greg. Following the private school he went back to public school. From public school he went to a private school with a rehabilitation program, to a residential program specializing in eating disorders, to a clinic placement and, finally, to yet another residential school – all between the ages of 14 and 16.

Along the way Greg continued to use drugs. Through counseling he recalled suppressed memories of sexual abuse he experienced in the first grade and, as a result, attempted suicide twice and developed an eating disorder. Greg engaged in self-mutilation and blamed his Mother for contributing to his problems.

Greg stayed at the residential school for two years. He liked the school and the guys for the most part. The first year things seemed to get worse weekly. His flashbacks became worse as he remembered more and more of that year in first grade. The second year things seemed to be getting marginally better. He was awarded his high school diploma, but Greg was still not fully in recovery. Greg's parents' resources had become depleted. Greg's school and treatment had

cost hundreds of thousands of dollars. Now that Greg had turned 18, he was no longer eligible for the little insurance that was left.

Reluctantly, Greg's mother discussed finances with Greg. They could no longer afford to pay for private school. There was no money left. Greg's only options were publicly-funded programs. Greg needed to apply for public benefits.

The paperwork for Supplemental Security Income (SSI) and Medicaid was difficult. Greg did not want to receive SSI. He felt like a failure. To make matters worse, Greg couldn't stay at the school. Once again the search for an appropriate placement started.

Neither Greg nor his Mom liked any of the choices. The schools and clinics he had lived at over the past three years looked like the Hyatt compared to the treatment centers he now saw. Reluctantly, he entered Smithville. There was no choice.

This letter that Greg had just received from the DSS seemed to indicate that he had a choice about where he lived for the first time in years. Greg waited anxiously for the application packet to arrive. He didn't have to wait long. Just four days after his discussion with the MFP program office, the application arrived in the mail. He quickly completed the application and returned to the address on the letter. Approximately four weeks later, Greg received a letter confirming that he was eligible for the MFP demonstration. The letter stated that his transition coordinator's name was Victor and that he would be receiving a call within three days. The letter was accompanied by a package of materials including a transition guide, a self-assessment tool, and a description of Greg's rights and responsibilities as an MFP participant. It was only two days later when Victor called asking if he could arrange a time to meet Greg. They scheduled a date for May 5.

Greg wanted to be prepared for the meeting on the 5th. He read the information packet materials twice and completed the self-assessment. When Victor arrived, Greg was anxious to hear what he had to say.

Victor brought a package of materials that he and Greg reviewed during the first meeting. The package included a housing guide, medical release forms, and informed consent documentation. Victor reviewed all of the information with Greg. Greg was reminded of his rights and responsibilities under the program. Victor told Greg that they would work together with a team to create a transition plan based on what Greg wanted. They reviewed the self-assessment that Greg had completed. They also talked for a long time about Greg's past and how he came to live at Smithville. He learned how much Greg wanted to go to college. His 'dream school' was the University of Connecticut (UCONN). Greg felt like Victor really listened and truly cared. Victor asked if Greg had any friends or family members that he would like to include in the planning process. Greg said that he did not. Before Victor left that first day, he asked Greg to sign the informed consent and releases for medical records. Greg was also given his first homework assignment. Greg's homework was to collect all of his documents such as his social security card and his birth certificate. Victor left that day focused on helping Greg realize his dream to attend college.

A week later, Victor returned to visit Greg and to review some of his medical records. During the visit, Victor talked a little bit about colleges and housing. He also discussed the other members of the transition team that he planned to bring along on his next visit. Members included a social worker from the Department of Mental Health and Addiction Services (DMHAS) who would be responsible for helping Greg develop his care plan in the community, and a counselor from the Bureau of Rehabilitation Services (BRS) who could talk to Greg about college.

On May 19, two weeks after Victor's initial visit, he returned with the DMHAS social worker and the BRS counselor. The visit felt a little overwhelming to Greg. Victor was talking about a transition plan, DMHAS was talking about the care plan, and BRS was talking about his vocational plan. Greg mentioned this to the agencies involved. It was agreed that there would be one plan, 'Greg's plan,' and that the agencies could address their roles as well as Greg's role in implementing the plan. With a little help from Greg, the agencies coordinated their efforts.

During the following week, DMHAS, BRS and Victor met to align assessments. They agreed to avoid duplicative questions and share information so that Greg wasn't answering the same question three times. They compiled one joint assessment and decided to administer it together. Some questions had already been answered by Greg's self-assessment. They decided to acknowledge that he had already answered the questions and just confirm the response.

Greg's assessment was scheduled for June 4. It took about 90 minutes. Much of the time was focused on what Greg wanted to do with his life and what he felt he needed in terms of support and education. While Greg had not looked forward to the meeting, he enjoyed the discussion. Greg told the team that he wanted to be a doctor. The BRS counselor reminded Greg that if he wanted to become a doctor, his grades in undergraduate school would need to be excellent. Greg was very convincing about his readiness to accept the challenges of both college and his recovery from trauma and additions. Greg's counselor at Smithville supported Greg's readiness. She felt that with the right supports, Greg could do anything that he wanted to do.

Victor returned with the BRS counselor on June 11. They asked Greg if he would like to visit the UCONN Storrs campus. Greg mentioned that he would love to. The field trip was arranged for June 16.

Greg left the UCONN campus that day even more convinced that he wanted to attend the school. The BRS counselor assisted Greg with completing the application process and with the various financial forms required. As Greg had indicated, his grades in high school were excellent despite his experiences of the past few years. Greg remained optimistic about the outcome despite the fact that he was applying very late for fall admission. The back-up plan was for Greg to attend Manchester Community College (MCC). Paperwork for admission to MCC was completed.

The planning for Greg's discharge from Smithville continued during the month of July. Greg hoped to attend UCONN and live on campus. The back-up plan, however, was for Greg to attend MCC and live in an apartment near Storrs, with support from BRS. DMHAS contacted the local mental health authority in Manchester to begin coordinating the range of supports Greg would need upon transition.

On August 1, Greg received the letter he had dreamed for. He had been accepted to UCONN. He called Victor immediately to let him know. Within a few hours, Victor arrived at Smithville to celebrate with Greg.

The next month was very busy. Greg wanted to self-direct his own care which meant interviewing and hiring staff. Everyone involved in the transition helped him. He selected and enrolled in four classes and BRS arranged for housing on campus. While it is unusual, given the range of supports and services that Greg was going to need outside of Smithfield, it was decided that he would get a single room. While there were concerns about going from five years of support and supervision in institutions to a university campus, Greg really wanted to try it and everyone wanted to see him be successful.

Greg's care plan included peer support. The person he selected was named Ron. Ron wasn't much older than Greg and had attended UCONN. Ron took Greg to the mental health clinic on campus and introduced him to the counselors there. Ron was the one who went with Greg to help him move into the dormitory the day of discharge and who checked in with him every morning. Victor made sure that Greg had all of his medication before he left Smithville and that the doctor's appointment was all set in the community. Ron offered to take Greg to his first appointment.

DMHAS continued to monitor the situation mostly through phone contact or by setting up meetings off campus. Victor also set up meetings to check in on Greg. Greg completed his surveys on time and reported high satisfaction despite the fact that UCONN was tougher than he had anticipated. At the end of the demonstration year, Greg's supports continued under the new 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	9	5	1	5	1	1	2	24
2009	77	41	10	41	10	10	14	203
2010	78	41	10	41	10	10	14	204
2011	103	54	13	54	13	13	19	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 \$3.7 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	274,139	39,400	598,000	911,539	675,346,098	676,257,637
2009	5,255,742	242,552	1,513,525	7,011,818	714,008,730	721,020,548
2010	8,982,740	243,152	1,581,701	10,807,593	749,183,749	759,991,342
2011 & 2012	17,114,309	402,903	1,653,286	19,170,499	1,603,918,528	1,623,089,027
Total	31,626,930	928,007	5,346,513	37,901,449	3,742,457,105	3,780,358,554

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 1% increase in the shift to the community. Estimating a 2% 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

