

## 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
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 7. 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 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, 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.

- 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.*

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. 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.

- 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.

- 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. 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 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.

- 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.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 Statute 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.

### **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 responsibilities.*

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**

<b>MFP Rebalancing Steering Committee</b>	
<b>Member</b>	<b>Representation</b>
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
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
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).

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.

***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 waiver.

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 366<sup>th</sup> 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
<b>Qualified Services</b>						
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
Services in Waivers for MFP Participants in Year 2						
Personal Care		X	X	X	X	
Chore Services	X			X	X	
Homemaker	X			X	X	
Case Management	X			X	X	X <sup>5</sup>
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
Substance Abuse						
Consultative Services	X			X	X	

<sup>5</sup> 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
Interpreter		X				
Vehicle Adaptations		X		X	X	
Independent Broker		X		X	X	
Intensive Staffing Support		X				
Cognitive Behavioral Services						
Assertive Community Treatment						X
Community Support Program				X		X
Recovery Assistant						X
Short-term Supervision and Support						X
<b>Demonstration Services</b>						
One-time Transitional Costs	X	X	X	X	X	X
Accessibility Modifications	X	X	X	X	X	X
<b>Supplemental Services</b>						
Housing Coordination	X	X	X	X	X	X
Transition Coordination	X	X	X	X	X	X

 **New services developed under MFP**

***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**

	<b>Department</b>	<b>Contractor</b>	<b>Individual Qualifications</b>
Elderly	Department of Social Services oversees contractor  <i>(Chronic Care or Aging waivers)</i>	<b>‘3 Access Agencies’</b> Connecticut Community Care, Incorporated; Agency on the Aging of South Central Connecticut; Southwestern Connecticut Area Agency on Aging	Care Manager

	<b>Department</b>	<b>Contractor</b>	<b>Individual Qualifications</b>
Physical/ABI	Department of Social Services  <i>(ABI and PCA waiver)</i>		Social Worker
Mental Illness	Department of Mental Health and Addiction Services  <i>(Mental Illness waiver)</i>		Social Worker
Intellectual Disability	Department of Developmental Disabilities  <i>(Comprehensive waiver; Individual and Family Support waiver)</i>		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 in July 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.<sup>6</sup>
- **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.<sup>7</sup>
- **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

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<sup>6</sup> Qualifications for case manager positions are the same as under the Chronic Care waiver.

<sup>7</sup> Qualifications for case manager positions are the same as under the Chronic Care 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.<sup>8</sup> 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.<sup>9</sup>

### **Fiscal Intermediaries**

See Section B.7.

### **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

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<sup>8</sup> 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.

<sup>9</sup> 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.

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		
<b>2008</b>	N/A	N/A	N/A	N/A	N/A	N/A	N/A	0
<b>2009</b>	N/A	5	1	5	N/A	N/A	2	13
<b>2010</b>	N/A	41	10	41	N/A	N/A	14	106
<b>2011</b>	N/A	41	10	41	N/A	N/A	14	106
<b>2012</b>	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.

**Demonstration Services**

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	\$1,000,000
One-time Transitional Costs	\$420,000
24/7 Emergency Back-up Triage System	\$200,000

**Accessibility Modification Funds**

Any modification expenses 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 and assisted living apartments 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 an institutional or another provider-operated living arrangement, to a living arrangement in a private residence where the person is directly responsible for his or her own living expenses. 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; food, 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.

**Table 13: Budget for Supplemental Services**

	5-Year Total
Housing Coordination	\$1,159,424
Transition Coordination	\$4,886,470

**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 in July 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 in July 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
Pre-transition Consulting Specialization	CILs or AAA	CILs or AAA	CILs or AAA	CILs or AAA	DMHAS Social Worker	DDS Social Worker
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. <sup>10</sup>	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. <sup>11</sup>	Sunset Shores of 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. Transportation*
- ii. Direct service workers*
- iii. Repair and replacement for durable medical and other equipment (and provision of load equipment while repairs are made); and*

<sup>10</sup> These fiscal intermediaries will serve as the FIs for the self-direction under the One-time Transitional Fund services.

<sup>11</sup> These fiscal intermediaries will serve as the FIs for the self-direction under the One-time Transitional Fund services.

- 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.*

### **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:

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- 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 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.

An Agreement for Self-Directed Supports can be terminated 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.

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. A limited number of slots in the elder waiver allow consumers to self-direct using the PCA model. 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 15. Self-direction options under the existing system and the MFP demonstration**

	Elder		Chronic Care Aging/Disabled Waiver		Physical		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
<b>Existing</b>	No	No	No	No	Yes	No	Yes	Yes	No	No
<b>MFP</b>	Yes <sup>12</sup>	Yes <sup>13</sup>	Yes	Yes	Yes <sup>14</sup>	Yes <sup>15</sup>	Yes	Yes	Yes	Yes

<sup>12</sup>Persons in the elderly and physical disability target populations will be served in the existing waivers with self-direction opportunities as noted under "existing waivers." All persons in the target populations will have opportunities for budget authority under the one-time transitional fund demonstration service.

<sup>13</sup> Ibid.

*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

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<sup>14</sup> Ibid.

<sup>15</sup> Ibid.

*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 manage 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 waiver 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**

<b>Overview and Assurances of MFP Quality Management Strategy</b>					
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; 10% 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; 10 % of case plans per year

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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

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

## **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 managers 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 10% 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.

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 manager 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 not 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 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
- MFP QA staff review billing submitted by agencies for waiver participant eligibility and authorization for services on a quarterly basis

**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.

***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.