

ABI Waiver II Advisory Committee

MEETING MINUTES

Thursday, September 10, 2015

11:00 AM in Room 2A of the LOB

The following committee members were present:

Billye Simmers, Bill Eller, Barbara Nadeau, Julie Peters, Kathy Bruni, Rep. Catherine Abercrombie, Rep. Craig Miner, Dianne Whipple (serving as interim DMHAS designee), Heather Marquis, Elaine Burns, and Mary Waitt.

Kate McEvoy attended as an invited guest.

The meeting was called to order at AM by Chairman, Rep. Catherine Abercrombie who welcomed the members.

After introductions, she moved to the first item on the agenda to adopt the minutes from the December 11, 2014 meeting. She clarified that the report to the legislature from the committee were not part of the minutes, but a separate document. A motion was made and seconded to adopt the minutes. There was discussion about the correctness of the minutes, but no changes to them were offered. The December 11 meeting minutes were accepted by voice vote with one opposed.

Next, the chair asked for a motion to approve the minutes from the March 19, 2015 meeting. A motion was made and seconded. There was no discussion, and the minutes were accepted by voice vote.

Representative Abercrombie moved on to the second agenda item which included updates on the status of ABI Waiver II, beginning with the slots reserved for Department of Mental Health and Addiction Services (DMHAS) clients.

Dianne Whipple of DMHAS said that, of the 50 reserve capacity slots, there are currently 21 clients active on ABI Waiver II with 8 clients in the final stages of their plan and hiring staff. There are an additional 18 applications in process, which brings the

total to 47. They are confident that they will utilize all 50 reserve capacity slots this year.

In the discussion following this update, it was noted that all DMHAS clients entering the Waiver go onto Waiver II. The list of people waiting to get on the Waiver is fluid and fluctuates for a variety of reasons. Those receiving DMHAS transition services had to be approved for the ABI Waiver in order to qualify for transition services. Twelve people who applied for the Waiver were denied services, and there was no appeal filed. The people being served in the community that were transitioning to the ABI Waiver have all been moved onto the Waiver.

The lack of reduction in the waiting list was mentioned by some. It was expected that opening Waiver II and moving 50 DMHAS clients from the waiting list would help move non-DMHAS clients onto the Waiver more quickly. However, the waitlist has not been reduced, and may have gotten longer.

Rep. Miner noted that the process is far more complicated than just filling out a form. He called for additional data in the future to give a better idea of how people are coming off the waitlist, including when evaluations have been done for all that are eligible to be evaluated. Also, he asked when we would know if there would be any unfilled slots.

Dianne Whipple said that the list is extremely fluid so it would be hard to say, but she does believe that all 50 slots will be filled. She also said that the money has to transition into the Waiver through transition and attrition, etc. There is not a pot of money available not being utilized for these 50 slots. She stated that all cases and numbers were reviewed in a conference call every two weeks.

Elaine Burns asked for a breakdown of the numbers of people on the wait list and in the community who are now receiving services on the ABI II Waiver.

Dianne Whipple explained that at one time DMHAS was funding 35 clients that were on the ABI waitlist through transition services. All of these had to be approved for a slot on the ABI Waiver in order to be eligible for transition services. When Waiver I closed, DMHAS was able to get money to fund these transitions until a slot opened up and some waited 5-6 years.

Rep. Miner suggested we compare the data that was given to the committee previously regarding a breakdown of the waiting list with an updated breakdown. He also noted that the total population of people waiting for the Waiver continues to grow. He said that when we get the numbers as slots are filled, we may feel that the wait list is still too long and the legislature may want to try to get money for more slots.

It was asked that DSS provide the committee periodic, comprehensive reports on the transition to getting people into Waiver II. He asked, specifically, for the numbers transitioning onto the Waivers, the numbers on the waitlist, how they are transitioning and a projection as to where things will be in two years.

Kathy Bruni of the Department of Social Services then gave an update as to the non-DMHAS slots. She stated that 23 non-DMHAS clients are either active or pending. Sixteen new slots have been assigned that were available under waiver II. Twelve attrition slots are allocated each year and we have filled 7 this year. We anticipate that we will fill the other five this year. Whenever an application is received, the date of the

application holds. DSS has to determine if there is evidence of a brain injury (generally determined via neuropsychological exam), along with functional eligibility and Medicaid eligibility. This means that there are people who have applied, but are still being screened to be determined eligible for the waiting list. Some people had made it onto the waitlist before people who were still in the screening process, but had earlier application dates. DSS was trying to honor those application dates. Additionally, the volume of referrals is increasing significantly. While the average in new applications was 15 per month for the last quarter, 31 were received in June alone. Prior to FY 15, only 3-4 per month were received.

She stated that there were 24 on the waitlist who appeared to be eligible at the time of the meeting. There are about another 80 that are in the pending status.

Doreen Scolnic noted that with advances in medicine, we can expect the increase in applications to increase. Billye Simmers agreed, noting that DPH reported 1,300 TBIs annually.

Heather Marquis asked the committee to consider that people that do not meet the cost cap are not included in the waitlist.

Kathy Bruni said that she can report on both the number of applications received, and the number deemed eligible on the waitlist. She can also breakdown those numbers by DMHAS and non-DMHAS clients. In response to a question from Rep. Miner, Ms. Bruni said that going back to report on the same data for the past two years would be difficult as that is prior to the information being moved to her unit and data base. She said that she can look at the reports given to CMS as to the number of clients served and expenditures by year. It was decided that an update on the information listed above would be made available to the group about two weeks prior to the next meeting. There was also a request made for information on where people are in the process once they have applied at each update.

A general timeline of how long it takes for someone to go from submitting an application to going onto the Waiver. Ms. Bruni said that DSS is asking for a neuropsychological evaluation to be included with the application, then DSS goes into the level of care determination, and then DSS looks at the Medicaid Status. She said that the people that would be put into the next slots applied in July of 2013. Once a slot is given to a client, there are a variety of reasons for a delay in actually receiving services on the Waiver, ranging from difficulty in getting the right provider mix together, to difficulty getting the neuropsychological exam done on time, to not receiving requested information for the Medicaid eligibility determination, and many other reasons. Ideally it would take 60 days for someone who is determined eligible for the Waiver to get onto the Waiver, but 90 days may be more realistic.

In the past, there were four units processing Medicaid eligibility determinations for both nursing home care and for home and community based services. While the process is similar, an important difference is that someone in a nursing home is receiving care while awaiting determination, but home and community based services cannot begin until Medicaid eligibility is determined. The Department carved out one unit of about 35 staff dedicated to processing the applications for the home and community based services. A fast track approach has been developed for Waiver applications. The challenge is getting the required documentation in to process eligibility.

It was explained that the fast track program is a pilot in the Connecticut Home Care Program for Elders, and pertains only to the Medicaid eligibility portion of the process. It is a screening tool comprised of a series of criteria applied to the Medicaid application. Generally, that means there are no transfers, trusts, or applied income and the asset limit (which could be for a couple) is below \$23,000. This pilot could potentially be used in other Waivers, but it just started July 1st.

Kate McEvoy, Medicaid Director from the Department of Social Services spoke to the group regarding assessment and case management in Danbury. She stated that DSS has been working to improve timeliness rates for determinations for people with Waiver applications and for those in nursing facilities. She believed that a joint presentation with Mark Shock, Eligibility Policy Director, and Kathy Bruni may be helpful to the committee, and would help show improvements in both financial and functional eligibility determination processes. There is now a dedicated Long Term Services and Supports (LTSS) application that refines what is being requested for that application. It is accompanied by a Q and A form that explains in lay terms what is being asked for and what supporting documentation is needed. Getting comprehensive substantiating documentation for the application is often the greatest challenge for families. Some protocols have been changed as well. For instance, while a look-back is still done to determine the financial activity over a period of years, it is now being done in a snapshot fashion, instead of requiring 3 or 5 years. She credited Kathy Bruni for the tremendous improvement in the timeliness of the application process. She also said that there is now a Home and Community Based Service (HCBS) Unit for the first time, dedicated to Waiver applications, contributing to the improved times.

Ms. McEvoy also discussed the way Waivers were historically structured in DSS. There used to be some Waivers controlled by the Alternate Care Unit, and others were administered in another unit focused on aging. The Alternate Care Unit is now called the Home and Community Based Services Unit. The name change reflects the state-wide, Governor-led rebalancing plan to enable people to remain in or re-integrate into the community. Now all Waivers are administered from this HCBS unit. This helps to have consistent administration of all the Waivers as well as consistent CMS compliance. The special circumstances and needs of individual Waivers is still emphasized.

DSS also examined their staffing capability. Ms. McEvoy expressed the Department's gratitude to the Administration and legislature for funding additional eligibility staff. However, she noted that there are still areas within the Department struggling with staffing capabilities. One of these is social work. The social workers working with individuals on the Waiver were pulled in many directions, and were also handling Elderly Protective Services cases, which have sadly had an enormous increase. As there are statutory requirements for the time in which elder abuse, neglect and exploitation cases are responded to, the Department wanted to ensure that the assessment, re-assessment and family meetings could still happen in a timely manner. In the Danbury area, in particular, there was additional strain due to medical leave and other absences and there was not adequate staffing. In order to ensure appropriate staffing, DSS engaged Connecticut Community Care, an expert care management agency which the Department has very successfully used for years for care management in the Home Care Program for Elders. Connecticut Community Care augmented staffing in the Danbury area to ensure adequate supports for people. In addition to the staffing needs in Danbury, there is a federal emphasis from CMS on conflict free care management. Conflict free care management means that the best practice is to have an independent agency perform the assessment and development of

a care plan for Waiver services in partnership with the client and his or her circle of support, as opposed to having a service provider perform that function.

There has been a strong, positive effect of using this approach in Danbury, as it relieved some of the staffing challenges. It is the Department's intention to issue a Request for Proposal (RFP) for an independent entity or entities to perform coordination, assessment, care plan development and modification of the care plan. Providers would be involved in the care plan, but the plan would not be driven by them as, while they are committed and upstanding, they necessarily have a financial interest in the amount of care provided. Applicants will have to demonstrate the qualifications, credentials and motivation to support individuals with acquired brain injury. The RFP will not be for general care management. There will be a fully vetted RFP process that neither Kate McEvoy nor Kathy Bruni will be involved in.

It was asked if the neuropsychologist would still be involved in the development of a care plan. Kathy Bruni explained that the care manager would do an assessment to include information from the providers including input from the neuropsychologist. The extreme value of the input of the neuropsychologist remains, but care management will be the lead in the care plan and will be the team lead. The neuropsychologist will still be a part of the meetings and make recommendations to the care manager.

Concern was expressed over the loss of the strong personal relationship that clients and families have with their current teams, as well as where the care management will be located and when the transition will take place.

Kate McEvoy said that a transition plan would be developed, to include the input of the committee, which would articulate the means by which the ABI social worker would meet with the family and new care management agency.

She stated that the RFP process typically takes 8-10 weeks internally and that once the RFP is issued, DSS will not be able to discuss the application. Once selections have been made, there will likely be a 3-4 month process of entering into contracts. They have no preconceived notions of who will apply or be selected. She noted that the Home Care for Elders program has had several agencies operating on a regional basis. While there is no way to know if an agency will apply to provide for the entire state, or if various agencies will apply for regional service, it is a requirement that there be local presence.

Kathy Bruni said that current plans will not change because of the change in care management. Plans are reassessed monthly or quarterly and again annually. At those points, the new care management will be doing the reassessment. The current process is not going to change.

Heather Marquis noted that one thing she sees in her agency at times is that a care plan is changed without the agency's knowledge. She gave the example of a recent meeting with a social worker in which a service was eliminated dating back to May, without notification to the agency. She said that there has to be a way going forward to guard against an agency having to pay back thousands of dollars for something like that. Some agencies are going under from situations like these. Care management should understand that clerical errors and expired service plans are very difficult to get addressed.

Rep. Abercrombie asked how it is determined if an individual will get a monthly reassessment or quarterly. Kathy Bruni replied that it depends on the stability of the plan. For someone new to the Waiver, a monthly meeting is likely to be needed. For some people, the plan stabilizes and you can go to quarterly assessments, and others may need to continue monthly.

Rep. Abercrombie also asked if a person already has the report from the neuropsychologist when they apply for Medicaid. Kathy Bruni replied that families are told when the contact DSS for the waiver that they will need to have the neuropsychological evaluation and the time frame within which they must do that.

Julie Peters expressed her concern that care managers are experienced with brain injury. She also expressed the need for the understanding of the development of the care plans and why a service is needed. She stated that she likes the idea of conflict free care management, but that it must be provided with an understanding of this population and the services required.

Kate McEvoy said that goal setting will be a very important piece in care management. It is the right of people to set goals and track the progress being made.

Barbara Nadeau asked if it will be required that the team leader of the new care management will be required to be at the level of social worker. Kathy Bruni stated that clinical criteria are being developed.

Ms. Nadeau also asked if the transition to the new care management agency will happen all at once, or will it be a slow transition over time. Kathy Bruni said that it would likely be a combination of both depending on when reassessments and meetings are scheduled.

Elaine Burns asked if the information given at this meeting could go out to committee members, as well as survivors and families in writing. Rep. Miner reminded the group that there is generally a "blackout" period during an RFP to avoid giving any advantage to an applicant. Elaine said that even just a bulletin to the community and more information to the committee would be helpful.

George Chamberlain, a manager of the HCBS Unit, was brought in to discuss how to better share information. He said that DSS systems do not always have the capacity to capture data as well as some other units, as it is such an emerging and quickly growing section. They are currently working on putting that kind of data together into a dashboard to more readily share it with others. This will help them internally what some of the bottlenecks are and how to fix them. He noted that some of the improvements that have been made to the application process have actually created a higher number of applications. DSS is looking for dedicated website space for this information and a vehicle for information to be located for the community to look at.

Bill Eller recommended that DSS consider having an open public forum prior to the RFP process for families.

In answer to a question from Mr. Eller, Kate McEvoy stated that the case managers would be dedicated to the brain injury waivers.

Rep. Abercrombie announced the next meeting would be on November 19th from 11-1. The following meeting should be prior to the start of the next session, and another after session in May.

Possible future agenda items mentioned were:

- A presentation on CMS final rules and setting requirements
- A presentation on eligibility by Marc Shock

Elaine Burns said that she believed that the change in care management services was huge and that we should focus on that in November.

Kathy Bruni said there would be a provider forum in November, and Elaine asked that there be a survivor and family forum.

Bill Eller asked if there may be an educational carve-out at the meetings. Perhaps prior to the November 19th meeting, there could be a seminar of some sort to go over things they need an understanding of.

Public Comment:

Alan Cosberg commented that it is critical that case managers have expertise with brain injury. He also wanted to know what role the neuropsychologist will have in care planning. He said that clearly articulated goals are needed in the transition. He was surprised that survivor input was not considered in putting together an RFP for care management.

Craig Sears said that he felt that he was told that ABI Waiver I would not be changed, but it has been amended. Rep. Miner said that he would have to be excruciatingly careful when saying that things would not change. The federal government changes requirements that the state must comply with.

Sandra Cossette shared her story of the car accident that left her with severe injuries, including brain injury and a subsequent opiate addiction, incarceration, and recovery through the ABI Waiver and Independent Living Solutions.

Lillian (unintelligible) with Independent Living Solutions spoke about the individuals with brain injury and the serious difficulty they are facing at home. She asked the committee to think about these individuals through all the discussions about staff and paperwork, etc., and remember why the Waiver was created in the first place.

A motion was duly made and seconded to adjourn the meeting.

Kristen Traini
Committee Clerk