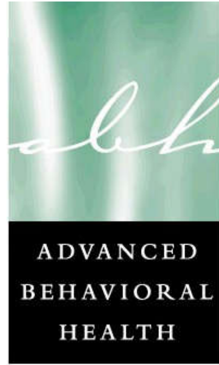

State of Connecticut
Department of Mental Health and Addiction Services

Mental Health Home and Community Based Services Waiver Program

Money Follows the Person (MFP)/Mental Health Waiver

PROVIDER MANUAL

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Dear Provider:

Thank you for becoming a Participating Provider! The Departments of Social Services (DSS) and Mental Health and Addiction Services (DMHAS), and Advanced Behavioral Health, Inc. (ABH®), are pleased to welcome you to the Mental Health Waiver Program (MH Waiver Program).

Your organization, as a provider of services in the MH Waiver Program, is a valuable part of this statewide and federal initiative to assist adults with mental health disorders to live in the community. Your agency is partnering with the State to integrate a recovery orientation in the treatment of mental health disorders. DMHAS defines recovery as:
“A process of restoring or developing a positive and meaningful sense of identity apart from one's condition and then rebuilding one's life despite, or within the limitations imposed by that condition.”

This Provider Manual answers questions you may have about procedures, policies and other facts related to your provision of covered services to Waiver Participants.

The Provider Manual supplements the Provider Agreement and provides additional terms and conditions regarding your provision of covered services to Waiver Participants.

Nothing in this Provider Manual shall be construed as creating any relationship between you and ABH® other than that of independent entities contracting with each other solely to provide the services described in the Provider Agreement.

Updates to any part of this Provider Manual may be made at any time, so you should not assume that the Provider Manual remains current because you have not received a replacement manual. As described in your Provider Agreement, ABH® may give notice of such updates in a variety of ways, depending on the nature of the update, including issuance of a new manual, a letter, a provider alert, a provider newsletter or by posting to ABH®’s website.

Should there be any questions or comments please call us anytime at 860-704-6211.

We look forward to a dynamic and rewarding relationship as we focus on the delivery of the highest quality services to the MH Waiver Participants.

Mental Health Waiver Overview, Relationship of the Parties and the Guiding Principles of Services

The waiver program, authorized in §1915(c) of the Social Security Act, permits the State to furnish an array of home and community-based services to assist Medicaid beneficiaries to live in the community and to avoid institutional care. The State has broad discretion in designing its waiver program to address the needs of the waiver's target population. Waiver services complement and/or supplement services available to participants through the Medicaid State plan and other federal, state and local public programs as well as natural supports that families and communities provide. Connecticut Department of Mental Health and Addiction Services (DMHAS) with oversight by the Department of Social Services (DSS), Connecticut's Single State Agency for Medicaid will administer the Mental Health Waiver (MH Waiver) program and the Money Follows the Person (MFP) program. The MH Waiver authorized in Section 1915(c) of the Social Security Act permits the Secretary of the U.S. Department of Health and Human Services to set aside Medicaid regulations and to allow funding to provide a variety of home and community based services (excluding room and board) to individuals with serious mental illness who would otherwise require nursing home care. This MH Waiver enables Medicaid to cover the cost of services designed to assist Participants in acquiring, retaining, and improving the self-help, socialization, and adaptive skills necessary to reside successfully in home and community based settings. MFP/MH Waiver Services are available to adults with serious mental illness that are being discharged or diverted from nursing home care and are receiving Connecticut Medicaid benefits.

DMHAS and DSS provides the protocols and procedures implemented by Advanced Behavioral Health (ABH) which is contracted to provide Fiscal Intermediary (FI) functions such as serving as the Connecticut Medicaid Billing Provider for MFP/MH Waiver Services, quality management and credentialing. The FI does not provide any MFP/MH Waiver Services directly.

As the administrator, DMHAS requires that services are offered and provided with a recovery orientation. The recovery orientation focuses on:

- Rehabilitation services being provided in the participant's home and in other community settings;
- Attention being paid to the participant's psychiatric and medical needs;
- Whole person wellness and recovery from mental illness;
- Development of an individualized "Recovery Plan"; and
- Incorporating peer support services provided by people trained and certified in rehabilitative care who have first-hand experience with recovery from mental illness.

Each person enrolled in the waiver will participate in a Person-Centered Planning process which leads to the development of an individualized Recovery Plan. The Recovery Plan developed collaboratively with the participant, a DMHAS Support

Coordinator, and a Transitional Case Manager from the Local Mental Health Authority includes one or more of the following: ***Rehabilitative Services**, **Support Services*** and other ***Ancillary services.***

Rehabilitative Services:

- **Assisted Living Services -** Personal care and services, homemaker, chore, attendant care, companion services, medication oversight (to the extent permitted under State law), therapeutic social and recreational programming, provided in a home-like environment in a licensed (where applicable) community care facility, provided to residents of the facility.
- **Community Support Program (CSP)** – a flexible, team-based approach to community rehabilitation.
- **Peer Support** – a "step-down" and follow-up to ACT or CSP provided by a trained and certified peer specialist (i.e., a person who understands mental illness and recovery from his/her own personal experience).
- **Supported Employment** – an effective array of mental health supports designed to help participants find and sustain competitive employment.

Support Services:

- **Recovery Assistant** – homemaker, companion, personal care, and in-home respite services designed to help a participant maintain his/her own home.
- **Transitional Case Management** – services provided during the weeks prior to, and immediately following discharge from a nursing home, to help locate and set up a suitable apartment or other living arrangement.
- **Brief Episode Stabilization**- services used to stabilize an individual following discharge from an institutional setting or to avert admission to this level of care
- **Adult Day Health**- medical or non-medical day program

Other Ancillary Services:

- **Specialized Medical Equipment -** specialized medical equipment and supplies include: devices, controls, or appliances specified in the service plan that enable participants to increase their ability to perform activities of daily living.
- **Personal Emergency Response System -** an electronic device which enables waiver participants to secure help in an emergency.
- **Home Accessibility Adaptations -** those physical adaptations to the private residence of the participant or the participant's family, required by the service plan, that are necessary to ensure the health, welfare and safety of the participant or that enable the participant to function with greater independence in the home.
- **Chore Service-** specialized cleaning services
- **Home Delivered Meals-** dietician approved meals delivered to client home
- **Non-medical Transportation-** transportation offered to gain access to community services, activities and resources as specified in the service plan**.**

Contact Information

Ann Marie Luongo	WISE Program Manager	860-704-6211	aluongo@abhct.com
Cathy Parente	Claims Coordinator	860-704-6201	cparente@abhct.com
Lori-Lynn French	Quality Assurance Supervisor	860-704-6177	lfrench@abhct.com
Chastity Holloway	Program Specialist	860-638-5341	cholloway@abhct.com
Chasaree Dow	Quality Assurance Assistant	860-704-6186	cdow@abhct.com

Call ABH 1-860-638-5309

For questions regarding:

- Provider Enrollment, Credentialing and Billing;
- Self-Directed Recovery Assistant Employer and Employee procedures

Call DMHAS at 1-866- 548-0265

For questions regarding:

- Participant Eligibility; Participant Recovery Plan;
- DMHAS policies

Resources are available on line at www.abhct.com and www.ct.gov/dmhas/wise.

Credentialing

Every participating provider must be credentialed and contracted through ABH prior to providing services to any MFP/MH Waiver participant.

The following accurately completed documents are required for an application to be considered complete: the ABH credentialing application, the DSS Performing Provider Agreement, the selected service application, and the ABH Provider Agreement for Money Follows the Person/Mental Health Waiver Services.

In order to become a participating provider follow these steps:

1. Review the MH Waiver Service Requirements in the Credentialing application which can be found on line at www.abhct.com or www.ct.gov/dmhas/site/default.asp to determine which services you would like to provide.
2. Complete the ABH Credentialing Application, and the selected service application.
3. Return the completed ABH Credentialing application, and the selected service application to ABH. Once the applications have been approved, ABH will provide documentation to the Provider so that the DXC application can be completed if applicable.

Within ten days of receiving the complete applications, ABH will issue written communication of determination. If approved, within a reasonable period of time, provider will receive an executed ABH Provider Agreement, and be
enrolled in the Provider Network Directory.

Requirements

All Services require the following:

- W-9
- ABH Certification and Authorization
- DSS Performing Provider Agreement
- ABH Provider Agreement for MFP/MH Waiver Service Program.
- General liability and professional liability naming Advanced Behavioral Health, 213 Court Street, Middletown, CT 06457 as an additional insured with coverage that shall be no less than $1 million per occurrence, and $3 million aggregate per year.

In addition to the five general requirements listed above each specific service have unique credentialing requirements which are listed below as are each service's
definition and payment polices.

Assisted Living Services Agency

Definition: Personal care and services, homemaker, chore, attendant care, companion services, medication oversight (to the extent permitted under State law), therapeutic social and recreational programming, provided in a home-like environment in a licensed (where applicable) community care facility, provided to residents of the facility. This service includes 24 hour on site response staff to meet scheduled or unpredictable needs in a way that promotes maximum dignity and independence, and to provide supervision, safety and security. Other individuals or agencies may also furnish care directly, or under arrangement with the community care facility, but the care provided by these other entities supplements that provided by the community care facility and does not supplant it.

Personalized care is furnished to individuals who reside in their own living units (which may include dually occupied units when both occupants consent to the arrangement) which includes kitchenette and living rooms and which contain bedrooms and toilet facilities. The participant has a right to privacy. Each living unit is separate and distinct from each other. The facility must have a central dining room, living room or parlor, and common activity center(s)(which may also serve as living rooms or dining rooms). The participant retains the right to assume risk, tempered only by the individual's ability to assume responsibility for that risk. Care must be furnished in a way which fosters the independence of each consumer. Routines of care provision and service delivery must be participant-driven to the maximum extent possible, and treat each person with

dignity and respect.

Recovery plans will be developed based on the individual's service needs. There are four levels of service provided in assisted living facilities based on the consumer's combined needs for personal care and nursing services. The four levels are occasional, which is 1-3.75 hours per week of service, limited which is 4-8.75 hours per week of service, moderate which is 9-14.75 hours per week of service and extensive which is 15-25 hours per week of service. Level of service assigned depends upon the volume and extent of services needed by each individual and is not a limitation of service.

Payment Policies for Assisted Living include:
Coverage of Assisted Living Services shall be subject to the following limitations:

1. Assisted Living Services are subject to service volume (service level per week) and duration (number of months or specified service end date) limits established in the waiver Recovery Plan approved by DMHAS and DSS. The departments or their designee will enact these limits;
2. A claim for reimbursement may be submitted for the qualifying waiver services activities of only one staff member providing Assisted Living Services to a participant during a specific time period (i.e., billable unit of time);
3. The department shall not pay for:
    a. Programs, services or components of services that are of an unproven, experimental, cosmetic or research nature;
    b. Programs, services or components of services that do not relate to the participant’s diagnosis, symptoms, functional limitations or medical history;
    c. Programs, services or components of services that are not included in the fee established by the department;

The following activities are Not Billable, but have been factored into payment rates:
Payment is not made for 24 hour skilled care. Federal financial participation is not available for room and board, items of comfort or convenience, or the costs of facility maintenance, upkeep and improvement.

Unique ALSA Credentialing Requirements:
Must be licensed by the Department of Public Health as an Assisted Living Service. Assisted Living services are provided under the waiver statewide in Private Assisted Living Facilities under CGS 17b-365 and in 17 state funded congregate and 4 HUD facilities under CGS 8-206e(e).

Community Support Program

Definition: Community Support Program (CSP) consist of mental health and substance abuse rehabilitation services and supports necessary to assist the individual in achieving

and maintaining the highest degree of independent functioning. The service utilizes a team approach to provide intensive, rehabilitative community support, crisis intervention, group and individual psycho-education, and skill building for activities of daily living.
CSP includes a comprehensive array of rehabilitation services most of which are provided in non-office settings by a mobile team. Services are focused on skill building with a goal of maximizing independence. Community-based treatment enables the team to become intimately familiar with the participant's surroundings, strengths and challenges, and to assist the participant in learning skills applicable to his/her living environment. The team services and interventions are highly individualized and tailored to the needs and preferences of the individual.

CSP Covered Services of at least 15-minutes duration provided to the participant by a direct-care staff member of the CSP team in the participant's home and in other community settings include:

1. Rehabilitation assessment and development of the rehabilitation plan;
2. Re-evaluation and adjustment of the rehabilitation plan;
3. Crisis response services either face-to-face or telephonic;
4. Psycho-education services for rehabilitation from psychiatric or substance abuse disorders;
5. Clarification of goals and motivational support for pursuing goals related to employment, education, community involvement, and use of natural supports. *(**NOTE:** Documentation shall be maintained in the file of each participant receiving work or education-related services that such services are not available under a program funded under section 110 of the Rehabilitation Act of 1973 or the Individuals with Disabilities Education Act (20 U.S.C. 1401 et seq.)*
6. Residential supports, such as motivating the participant to find and lease an apartment, and assistance with tenancy issues and problems;
7. Skill building and support for Activities of Daily Living, including:
    a. Teaching, coaching and assisting with daily living and self-care skills such as the use of transportation, nutrition, meal planning and preparation, housekeeping and basic household tasks, dressing, personal grooming and hygiene, management of financial resources, shopping, use of leisure time, interpersonal communication, personal safety, child care and parenting, basic first aid, and problem solving;
    b. Other skill development activities directed at reducing disability, restoring participant functioning and achieving independent participation in social, interpersonal, family, or community activities and full community re-integration and independence as identified in the waiver Recovery Plan;
    c. Teaching of recovery skills in order to prevent relapse such as symptom recognition, coping with symptoms, emotional management, relaxation skills, self-administration and appropriate use of medications, and preparation of illnesses related advance directives;

   d. Development of self-advocacy skills for the purpose of accessing natural supports, self-help, and other advocacy resources; and
   e. Health and wellness education.
8. Education, support, and consultation to family members (and significant others) of the participant, provided these activities are directed exclusively toward the rehabilitation treatment of the participant;
9. Participation in waiver Recovery Plan development and quarterly Recovery Plan update meetings, if requested by the DMHAS Support Coordinator;
10. Travel to an appointment with a participant or family member when the CSP provider is also engaged in a qualifying waiver service activity; and
11. Group treatment, involving not more than four persons receiving care, focusing on any of the activities listed in items #4 through #7 above.

Unique CSP Credentialing Requirements:
To be approved as a Community Support Program (CSP) provider the agency must maintain accreditation from either The Joint Commission (TJC), the Commission of Accreditation of Rehabilitation facilities (CARF) or other accrediting body approved by DMHAS or be in an active process of becoming accredited.

A CSP provider must meet State of Connecticut certification standards to provide CSP services as defined by the Department of Mental Health and Addiction Services (DMHAS). An agency site visit is necessary to meet this requirement.

The supervisor must be a licensed or licensed-eligible clinician. CSP staff shall hold either a bachelor’s degree in a behavioral health-related specialty (may include special education or rehabilitation) OR have two years’ experience in the provision of mental health services (may include special education and/or services to persons with developmental disabilities) OR be a Certified Peer Specialist.

Verification of qualifications occurs at the time of Network enrollment and at three year recertification intervals.

Payment Policies for CSP services include:
1. CSP services are subject to service volume (number of ¼ hours service units per day and/or week) and duration (number of months or specified service end date) limits established in the waiver Recovery Plan approved by DMHAS and DSS. The departments or their designee will enact these limits;
2. CSP services shall be based on the waiver Recovery Plan and shall be performed by or under the supervision of a licensed clinician employed by or under contract to the provider;
3. A claim for reimbursement may be submitted for the qualifying waiver services activities of only one direct-care member of a CSP team for services to a participant during a specific time period (i.e., billable unit of time);

4. With the allowable exception of a transition period to CSP (up to 30-days), CSP services cannot be provided concurrently with residential care;
5. CSP services must exclude services that are duplicative of Supported Employment services; and
6. The department shall not pay for:
    a. Psychiatric evaluation and treatment, medication management, individual, group and family psychotherapy;
    b. Time spent by the provider solely for the purpose of transporting participants;
    c. Programs, services or components of services that are of an unproven, experimental, cosmetic or research nature;
    d. Programs, services or components of services that do not relate to the participant's diagnosis, symptoms, functional limitations or medical history;
    e. Programs, services or components of services that are not included in the fee established by the department;
    f. Services or components of services provided solely for social, recreational, educational or vocational purposes; and
    g. Costs associated with room and board for participants.

7. The following activities are **Not Billable**, but have been factored into payment rates:
    a. Day-to-day monitoring regarding the participants health and welfare and problem solving to address concerns;
    b. Communication and coordination with the DMHAS Support Coordinator, and with other service providers to relay information germane to the participant's needs and continued recovery;
    c. Telephone contact with the department or its designated agent for the purpose of requesting or reviewing authorization of services;
    d. Completion of progress notes or billing documentation;
    e. Individual or group supervision, routine case reviews and rounds, ad hoc consultation with supervisors and discussion or consultation among CSP team members, including for the purpose of treatment planning;
    f. Time spent performing routine services such as cleaning, cooking, shopping, or child care designed to provide relief or respite for the family;
    g. No shows, missed or cancelled appointments, and visits to the participant when the participant is unavailable;
    h. CSP services of less than fifteen minutes duration for recovery procedures whose billing codes are defined in 15-minute increments; and
    i. Time spent engaged in activities required by a credentialing, certification or oversight entity such as gathering and submitting care plan, service data or other information.

Peer Support

Definition: Peer Support is available as a step-down from more intensive waiver services such as Community Support Program (CSP), when a CSP level of care is no longer needed. Peer support includes face-to-face interactions that are designed to promote ongoing engagement of persons covered under the waiver in addressing residual problems resulting from psychiatric and substance use disorders, and promoting the individuals strengths and abilities to continue improving socialization, recovery, self-advocacy, development of natural supports, and maintenance of community living skills. Peer support also includes communication and coordination with behavioral health services providers and others in support of the participant.

Peer Support Covered services of at least 15-minutes duration provided face-to-face with the participant in his/her home and in other community settings. These services include:

1. Coaching and support related to:
    a. Continued use of recovery skills;
    b. Involvement in community activities and positive relationships with family and friends;
    c. Attention to personal hygiene and appropriated dress;
    d. Involvement in vocational, volunteer or educational activities;
    e. Follow through on personal obligations and commitments;
    f. Self-advocacy during self-help, peer support and community meetings;
    g. Self-advocacy during meetings with providers to facilitate linkage, communication and improved continuity of care;
    h. Development of natural supports;
    i. Filing complaints and follow-up with proposed resolution as needed, finding resources;
2. Assisting with avoidance of:
    a. Behaviors that might lead to a psychiatric crisis;
    b. Risky behaviors (e.g., unprotected sex, smoking/excessive use of tobacco products, unsafe driving/driving without seatbelt, unsafe relationships, criminal activities);
    c. Substance abuse;
    d. Overspending;
    e. Unnecessary conflict;
3. Mentoring and advice to facilitate development of effective decision making and problem solving skills;
4. Participation in waiver Recovery Plan development and quarterly Recovery Plan update meetings, if requested by the DMHAS Support Coordinator; and
5. Travel with the participant when the Peer Support provider is also engaged in a qualifying waiver service activity.

Unique Peer Support Credentialing Requirements: To be approved as a Peer Support provider the agency must maintain accreditation from either Commission on Accreditation of Rehabilitation Facilities (CARF), The Joint Commission (TJC), International Center for Clubhouse Development (ICCD) , Medicare certified or other accrediting body approved by DMHAS. DMHAS contracted providers may be reviewed for consideration.

The supervisor must be a licensed or licensed-eligible clinician. Peer Supports must provide proof of successful attendance at a DMHAS approved training program and certification by Advocacy Unlimited.

Verification of qualifications occurs at the time of Network enrollment and at two years recertification intervals.

Payment Policies for Peer Support Services include:
Coverage of Peer Support services shall be subject to the following limitations:

1. Peer Support services are subject to service volume (number of ¼ hours service units per day and/or week) and duration (number of months or specified service end date) limits established in the waiver Recovery Plan approved by DMHAS and DSS. The departments or their designee will enact these limits;
2. Peer Support services shall be based on the waiver Recovery Plan and shall be performed by or under the supervision of a licensed clinician employed by or under contract to the provider;
3. Individuals receiving Community Support Program (CSP), both of which have a peer support component, are excluded from waiver Peer Support services, except during a brief transition phase (not to exceed 30 days) between CSP and Peer Support;
4. With the allowable exception of a transition period to Peer Support services (up to 30-days), Peer Support services cannot be provided concurrently with residential care;
5. Peer Support services must exclude services that are duplicative of Supported Employment services;
6. A claim for reimbursement may be submitted for the qualifying waiver services activities of only one staff member providing Peer Support services to a participant during a specific time period (i.e., billable unit of time);
7. The department shall not pay for:
    a. Time spent by the provider solely for the purpose of transporting participants;
    b. Programs, services or components of services that are of an unproven, experimental, cosmetic or research nature;

c. Programs, services or components of services that do not relate to the participant's diagnosis, symptoms, functional limitations or medical history;
d. Programs, services or components of services that are not included in the fee established by the department; and
e. Services or components of services provided solely for social, recreational, educational or vocational purposes; and
f. Costs associated with room and board for participants.

The following activities are **Not Billable**, but have been factored into payment rates:

a. Day-to-day monitoring regarding the participants health and welfare and problem solving to address concerns;
b. Communication and coordination with the DMHAS Support Coordinator, and with other service providers to relay information germane to the participant's needs and continued recovery;
c. Telephone contact with the participant;
d. Telephone contact with the department or its designated agent for the purpose of requesting or reviewing authorization of services;
e. Completion of progress notes or billing documentation;
f. Individual or group supervision, routine case reviews and rounds, ad hoc consultation with supervisors and discussion or consultation among recovery team members, including for the purpose of treatment planning;
g. No shows, missed or cancelled appointments, and visits to the participant when the participant is unavailable;
h. Peer Support services of less than fifteen minutes duration for procedures whose billing codes are defined in 15-minute increments; and
i. Time spent engaged in activities required by a credentialing or oversight entity such as gathering and submitting care plan or service

Recovery Assistant

Definition: The Recovery Assistant provides a flexible range of face-to-face supportive assistance in accordance with a Recovery Plan that enables a participant to maintain a home/apartment, encourages the use of existing natural supports, and fosters involvement in social and community activities. These services will be provided up to seven days a week, including holiday and could occur outside the traditional business hours.

Service activities include: performing household tasks, providing instructive assistance or cuing to prompt the participant to carry out tasks (e.g., meal preparation; routine household chores, cleaning, laundry, shopping, and bill-paying; and participation in social and recreational activities), and providing supportive companionship. The

Recovery Assistant may also provide instruction or cuing to prompt the participant to dress appropriately and perform basic hygiene functions; supportive assistance and supervision of the participant, and short-term relief in the home for a participant who is unable to care for himself/herself when the primary caregiver is absent or in need of relief. Recovery Assistant services may be provided by an agency staff person or an individual under contract with a Waiver participant as a self-directed Recovery Assistant.

Recovery Assistant **Covered Services** of at least 15-minutes duration provided to the participant in his/her home and in other community settings include:

1. Performing the following tasks if the participant (by reason of physical or psychiatric disability) is unable to perform them, or assisting, or cueing the participant to perform them:
    a. Meal planning and preparation, shopping, housekeeping (e.g., changing linens, washing dishes, vacuuming/dusting, laundry, mending clothing repairs), basic household tasks (e.g., regulating home temperature, storing food appropriately, resolving issues about bill paying).
    b. Dressing, personal grooming and hygiene (e.g., bathing, dressing, and oral care).
    c. Appropriate use of emergency medical services.
2. Assisting or cueing the participant to perform or become engaged in:
    a. Family, social, and recreational activities.
    b. Appropriate use of natural community supports (e.g., social clubs, faith-based supports).
    c. Appropriate use of routine medical/dental services.
    d. Use of medications as prescribed, including self-administration of medications.
    e. Healthy habits (e.g., healthy diet, exercise, and behaviors designed to alleviate stress).
    f. Fulfillment of personal commitments, and adherence to scheduled appointments/meetings (e.g., clinical, vocational, educational, and judicial/court).
3. Assisting or cueing the participant to avoid:
    a. Risky behaviors (e.g., unprotected sex, smoking/excessive use of tobacco products, unsafe driving/driving without seatbelt, unsafe relationships, criminal activities).
    b. Substance abuse.
    c. Overspending.
    d. Unnecessary conflicts.
4. Supportive and problem solving-oriented discussions with the participant.
5. Establishing and maintaining a helpful, supportive, companionship relationship with the participant that involves such activities as:
    a. Escorting the participant to necessary medical, dental, or personal business appointments;
    b. Reading to or for the participant;

    c. Engaging in or discussing recreational, hobby, or sport-related activities;
6. Other activities directed at reducing disability, restoring participant functioning and achieving independent participation in social, interpersonal, family, or community activities and full community re-integration and independence;
7. Participation in waiver Recovery Plan development and quarterly Recovery Plan update meetings, if requested by the DMHAS Support Coordinator; and
8. Travel with a participant when the Recovery Assistant is also engaged in a qualifying waiver service activity.

Unique Agency Recovery Assistant Credentialing Requirements: Provider agency must have been in business at least one year at time of application, and have been actively providing licensed, in-home, community-based services. ABH must be able to conduct a site visit of agency prior to start of services in order to evaluate agency operations.

Certificate: Commission on Accreditation of Rehabilitation Facilities (CARF), The Joint Commission (TJC), The Community Health Accreditation Program (CHAP), Accreditation Commission for Health Care (ACHC), Medicare Certification or other accrediting body approved by DMHAS, or is in an active process of becoming accredited. Has a license issued from the Department of Consumer Protection as a Homemaker and Companion agency and must maintain DMHAS Certification to provide Recovery Assistant Services.

RA staff must be supervised by a licensed or licensed-eligible clinician. The RA must complete the DMHAS Recovery Assistant Training and pass the RA exam.
A Recovery Assistant must:

- Be at least 18 yrs old;
- Possess at least a high school diploma or GED;
- Be registered with the Department of Mental Health and Addiction Services (DMHAS) as having completed an approved Recovery Assistant training program and meet any continuing education and/or training requirements set by DMHAS. Training programs to meet staff certification requirements will address the applicant's abilities to:
    - Follow instructions given by the participant or the participant's conservator;
    - Report changes in the participant's condition or needs;
    - Maintain confidentiality;
    - Meet the participant's needs as delineated in the waiver Recovery Plan;
    - Implement cognitive and behavioral strategies;
    - Function as a member of an interdisciplinary team;
    - Respond to fire and emergency situations;
    - Accept supervision in a manner prescribed by the department or its designated agent;
    - Maintain accurate, complete and timely records that meet Medicaid requirements;
    - Use crisis intervention and de-escalation techniques; and

- Provide services in a respectful, culturally competent manner.

A mandatory one day training period with an 80% or higher exam score is required for Recovery Assistants prior to approval. Trainings are scheduled by DMHAS and ABH at convenient times and locations to ensure statewide access. A schedule for available training sessions is posted on the ABH website, www.abhct.com.

Recertification is required every two years. To be recertified, 6 hours of continuing education a year in the following areas must be documented:

- Health and Safety in the home environment
- Verbal De-escalation
- Trauma Informed Recovery
- Life Skills- Listening, Coaching, Assisting
- Recovery in Mental Health
- Mental Illness
- Boundaries and Ethics (completed within the first 6 months after training)
- Interpersonal Communication
- Coping skills/problem solving
- Cognitive Functioning

A State of Connecticut Police Background check must be conducted within six months of applying for the position. Individuals who had the following convictions can be denied by DMHAS and DSS for employment as a Recovery Assistant:

> *Felony, as defined in Section 53a-25 of the Connecticut General Statutes; larceny under Sections 53a-119, 53a-122, 53a-123 and 53a-124 of the Connecticut General Statutes; or a violation under Section 53a-290 to 53a-295, inclusive of the Connecticut General Statutes; involving vendor fraud, section 53-20 of the Connecticut General Statutes involving cruelty to persons; sections 53a-70, 53a-70a, 53a-70b, or 53a-73a of the Connecticut General Statutes involving sexual assault, section 53a-59 of the Connecticut General Statutes involving assault, section 53a-59a of the Connecticut General Statutes involving assault of the elderly, blind, disabled, pregnant or mentally retarded persons and section 53a-320 to 53a-323, inclusive, of the Connecticut General Statutes involving abuse of the elderly, blind, disabled, pregnant or mentally retarded persons.*

Verification of qualifications occurs at the time of Network enrollment and at two year recertification intervals.

If the agency's policy allows staff to transport Participants, the agency shall maintain in effect and submit evidence of automobile insurance coverage when the agency staff transports the Participant. The agency must ensure that a current driver license is held by the person transporting the Participant. This may be demonstrated by submitting the agency's relevant policies.

In light of the fact that the agency staff performing recovery assistant services may choose to work as a self-directed recovery assistant, the agency must provide proof that they have a policy statement that addresses conflicts of interest that may arise from this situation. The statement may be required to be produced during a site visit or file audit
Payment Policies for Recovery Assistant services:

1. Recovery Assistant services are subject to service volume (number of ¼ hours service units per day and/or week) and duration (number of months or specified service end date) limits established in the waiver Recovery Plan approved by DMHAS and DSS. The departments or their designee will enact these limits;
2. Recovery Assistant services shall be based on the waiver Recovery Plan;
3. A claim for reimbursement may be submitted for the qualifying waiver services activities of only one Recovery Assistant for services to a participant during a specific time period (i.e., billable unit of time);
4. Individuals receiving residential rehabilitation services paid for by Medicaid in a group home are excluded from Recovery Assistant services, except during a brief transition phase to a lower level of care (not to exceed 30 days);
5. The following activities are **Not Billable**:
    a. Time spent by the provider solely for the purpose of transporting participants;
    b. Programs, services or components of services that are of an unproven, experimental, cosmetic or research nature;
    c. Programs, services or components of services that do not relate to the participant's diagnosis, symptoms, functional limitations or medical history;
    d. Programs, services or components of services that are not included in the fee established by the department;
    e. Services or components of services provided solely for educational or vocational purposes;
    f. Waiver services provided by a relative of the participant; and
    g. Costs associated with room and board for participants.

6. The following activities are **Not Billable**, but have been factored into payment rates:
    a. Day-to-day monitoring regarding the participants health and welfare and problem solving to address concerns;
    b. Communication and coordination with the DMHAS Support Coordinator, and with other service providers to relay information germane to the participant's needs and continued recovery;
    c. Telephone contact with the participant;
    d. Telephone contact with the department or its designated agent for the purpose of requesting or reviewing authorization of services;
    e. Completion of progress notes or billing documentation;

f. Individual or group supervision, routine case reviews and rounds, ad hoc consultation with supervisors and discussion or consultation among recovery team members, including for the purpose of treatment planning;
g. No shows, missed or cancelled appointments, and visits to the participant when the participant is unavailable;
h. Recovery Assistant services of less than fifteen minutes duration for recovery procedures whose billing codes are defined in 15-minute increments; and
i. Time spent engaged in activities required by a credentialing, certification or oversight entity such as gathering and submitting care plan, service data or other information.

Brief Episode Stabilization:

Definition: This service may be used to stabilize an individual following discharge from an institutional setting or to avert admission to this level of care. The service utilizes brief, concentrated interventions directed to stabilize psychiatric conditions, behavioral and situational problems and to prevent escalation of psychiatric symptoms, and wherever possible to avoid the need for hospitalization or other more restrictive placement. Services and interventions are highly individualized and tailored to the needs and preferences of the participant, with the goal of maximizing independence and supporting recovery.

Brief Episode Stabilization services are provided to restore a participant's ability to manage his or her illness and their ability to utilize treatment. These services are designed to restore prior functional level and reduce the likelihood of crisis recurrence. Interventions include practical problem-solving advice and assistance designed to address and remediate the antecedent causes of an emerging psychiatric or behavioral crisis; or to manage stressors related to exacerbation of ongoing medical conditions. Services would take place in the participant's home or in other community (non-residential) settings. This intervention typically takes place in 4 to 8 hour blocks of time, and might last up to 24 or 48 hours. If the individual cannot be stabilized within this time period, a more intensive intervention is usually needed.

Brief Episode Stabilization is subject to service volume (number of ¼ hours service units per day and/or week) and duration (number of months or specified service end date) limits established in the waiver Recovery Plan approved by DMHAS and DSS

Unique Brief Episode Stabilization Credentialing Requirements

Certificate: Commission on Accreditation of Rehabilitation Facilities (CARF), The Joint Commission (TJC), Commission on Accreditation or other accrediting body approved by DMHAS, or is a DMHAS designated Local Mental Health Authority (LMHA) or contracted

affiliate of an LMHA, or certified Waiver service provider.

Other Standards: The supervisor must be a licensed or licensed-eligible clinician. Brief Episode Stabilization staff shall have two years' experience in the provision of mental health services (may include special education and/or services to persons with developmental disabilities) The agency must meet the State of Connecticut certification standards to provide Brief Episode Stabilization services defined by the Department of Mental Health and Addiction Services

Agency based: A Brief Episode Stabilization staff member shall:

- Be at least 18 yrs old;
- Possess at least a high school diploma or GED; and
- Two years' experience in the provision of mental health services

Training requirement: Training programs will address abilities to:

- Follow instructions given by the participant or the participant's conservator;
- Report changes in the participant's condition or needs;
- Maintain confidentiality;
- Meet the participant's needs as delineated in the waiver Recovery Plan;
- Implement cognitive and behavioral strategies;
- Function as a member of an interdisciplinary team;
- Respond to fire and emergency situations;
- Accept supervision in a manner prescribed by the department or its designated agent;
- Maintain accurate, complete and timely records that meet Medicaid requirements;
- Use crisis intervention and de-escalation techniques;
- Provide services in a respectful, culturally competent manner; and
- Use effective and evidence-based Brief Episode Stabilization practices.

Payment policies for Brief Episode Stabilization services:
Brief Episode Stabilization services of at least 15-minutes duration provided to the participant in his/her home and in other community settings. These services include:

1. Brief Episode Stabilization services are subject to service volume (number of ¼ hours service units per day and/or week) and duration (number of months or specified service end date) limits established in the waiver Recovery Plan approved by DMHAS and DSS.
2. Brief Episode Stabilization services shall be based on the waiver Recovery Plan and shall be performed by or under the supervision of a licensed clinician employed by or under contract to the provider;
3. A claim for reimbursement may be submitted for the qualifying waiver services activities of only one staff member providing Brief Episode Stabilization services to a participant during a specific time period (i.e., billable unit of time);

1. Observation, evaluation and monitoring in order to reduce the participant’s risk of harm to self or others, and to determine whether additional supports are necessary;
2. Practical problem-solving advice and assistance designed to address and remediate the antecedent causes of an emerging psychiatric or behavioral crisis;
3. Crisis intervention and supportive counseling designed to stabilize functioning, reduce stress, calm the participant and prevent further deterioration;
4. Communication with supervisory staff to report the participant’s condition and whether any additional assistance is needed;
5. Participation in waiver Recovery Plan development and quarterly Recovery Plan update meetings, if requested by the DMHAS Support Coordinator; and
6. Travel with a participant when the Brief Episode Stabilization provider is also engaged in a qualifying waiver service activity.

The following activities are not billable, but have been factored into payment rates:

1. Communication and coordination with the DMHAS Support Coordinator, and with other service providers to relay information germane to the participant’s needs and continued recovery;
2. Telephone contact with the participant;
3. Telephone contact with the department or its designated agent for the purpose of requesting or reviewing authorization;
4. Completion of progress notes or billing documentation;
5. Individual or group supervision, routine case reviews and rounds, ad hoc consultation with supervisors and discussion or consultation among team members, including for the purpose of treatment planning;
6. No shows, missed or cancelled appointments, and visits to the participant when the participant is unavailable;
7. Brief Episode Stabilization services of less than fifteen minutes duration for procedures whose billing codes are defined in 15-minute increments; and
8. Time spent engaged in activities required by a credentialing, certification or oversight entity such as gathering and submitting care plan or service data or other information.

Supported Employment

Definition: Supported Employment Services consist of intensive, ongoing supports that enable participants, for whom competitive employment at or above the minimum wage is unlikely absent the provision of supports, and who, because of their disabilities, need supports to perform in a regular work setting. Supported employment may include assisting the participant to locate a job or develop a job on behalf of the participant.

Supported employment is conducted in a variety of settings; particularly work sites where persons with disabilities are employed. Supported employment includes activities needed to sustain paid work by participants, including supervision and training. When supported employment services are provided at a work site where persons without disabilities are employed, payment is made only for the adaptation, supervision and training required by participants receiving waiver services as a result of their disabilities but does not include payment for the supervisory activities rendered as a normal part of the business setting.

Supported Employment **Covered Services** of at least 15-minutes duration provided to the participant face-to-face or telephonically in the participant's home, employment location, or other community settings include:

1. Training, skill building and support to assist the participant with managing his/her symptoms or other manifestations of disability in the workplace or job interview;
2. Assessment of the participant's:
    a. Individualized career development goals and employment ideas/preferences; and
    b. Work related skills and vocational functioning;
3. Assistance in developing and periodically evaluating the individualized employment services component of the participant's waiver Recovery Plan.
4. Support and guidance through the process of obtaining and maintaining employment, including:
    a. Teaching strategies to explore career development, write a resume, conduct job networking, pursue job leads, complete job applications, obtain interviews, and succeed in obtaining and maintaining employment;
    b. Training and skill building regarding proper work habits, and appropriate interactions with coworkers and the public;
    c. Advocating for the participant with potential and current employers; and
    d. Assisting with and reinforcing work-related problem solving skills;
5. Reinforcement of recovery skills designed to promote job retention and success in the workplace, including:
    a. Healthy habits (e.g., healthy diet, exercise, medication management and behaviors designed to alleviate stress);
    b. Fulfillment of personal and work-related commitments (e.g., adherence to the work schedule, avoidance of unnecessary tardiness and absences from work); and
    c. Identification and use of natural supports;
6. Assistance to support self-employment, including:
    a. Aiding the participant to identify potential business opportunities;
    b. Assisting in the development of a business plan, including potential sources of business financing and other assistance in developing and launching a business;

   c. Identification of the supports that are necessary in order for the participant to operate the business; and
   d. Ongoing assistance, counseling and guidance once the business has been launched.
7. Participation in waiver Recovery Plan development and quarterly Recovery Plan update meetings, if requested by the DMHAS Support Coordinator; and
8. Travel with a participant when the Supported Employment provider is also engaged in a qualifying waiver service activity.

Unique Supported Employment Service Credentialing Requirements: To be approved to provide Supported Employment services, the agency must maintain DMHAS Supported Employment standards and must maintain accreditation from either the Commission on Accreditation of Rehabilitation Facilities (CARF),The Joint Commission (TJC) or other accrediting body approved by DMHAS.

A Supported Employment staff member must:

- Be at least 18 yrs old;
- Possess at least a high school diploma or GED; and

Training programs to meet staff requirements will address abilities to:

- Follow instructions given by the participant or the participant's conservator;
- Report changes in the participant's condition or needs;
- Maintain confidentiality;
- Meet the participant's needs as delineated in the waiver Recovery Plan;
- Implement cognitive and behavioral strategies;
- Function as a member of an interdisciplinary team;
- Respond to fire and emergency situations;
- Accept supervision in a manner prescribed by the department or its designated agent;
- Maintain accurate, complete and timely records that meet Medicaid requirements;
- Use crisis intervention and de-escalation techniques;
- Provide services in a respectful, culturally competent manner; and
- Use effective and evidence-based Supported Employment practices.

Payment Policies for Supported Employment services:

1. Supported Employment services are subject to service volume (number of ¼ hours service units per day and/or week) and duration (number of months or specified service end date) limits established in the waiver Recovery Plan approved by DMHAS and DSS. The departments or their designee will enact these limits;
2. Supported Employment services shall be based on the waiver Recovery Plan;
3. Documentation shall be maintained in the file of each participant receiving Supported Employment that the service is not available under a program funded

under section 110 of the Rehabilitation Act of 1973 or the Individuals with Disabilities Education Act (20 U.S.C. 1401 et seq.);

4. Supported Employment must exclude services that are duplicative of the following psychosocial rehabilitation services:, Community Support Program, and Peer Support;
5. A claim for reimbursement may be submitted for the qualifying waiver services activities of only one staff member providing Supported Employment services to a participant during a specific time period (i.e., billable unit of time);
6. The following items are **Not Billable**:
    a. Costs associated with starting up or operating a business;
    b. Sheltered work or any other similar types of vocational services furnished in specialized facilities;
    c. Incentive payments made to an employer to encourage or subsidize the employer's participation in a supported employment program;
    d. Payments passed through to participants in supported employment programs;
    e. Training not directly related to an individual's supported employment program;
    f. Programs, services or components of services that are intended solely to prepare individuals for paid or unpaid employment or for vocational equipment and uniforms;
    g. Time spent by the provider solely for the purpose of transporting participants;
    h. Programs, services or components of services that are of an unproven, experimental, cosmetic or research nature;
    i. Programs, services or components of services that do not relate to the participant's diagnosis, symptoms, functional limitations or medical history;(programs, services or components of services that are not included in the fee established by the department;
    j. Services or components of services provided solely for social, recreational, educational or vocational purposes; and
    k. Costs associated with room and board for participants.

7. The following activities are **Not Billable**, but have been factored into payment rates:
    a. Day-to-day monitoring regarding the participants health and welfare and problem solving to address concerns;
    b. Communication and coordination with the DMHAS Support Coordinator, and with other service providers to relay information germane to the participant's needs and continued recovery;
    c. Telephone contact with the department or its designated agent for the purpose of requesting or reviewing authorization of services;
    d. Completion of progress notes or billing documentation;

e. Individual or group supervision, routine case reviews and rounds, ad hoc consultation with supervisors and discussion or consultation among recovery team members, including for the purpose of treatment planning;
f. No shows, missed or cancelled appointments, and visits to the participant when the participant is unavailable;
g. Supportive Employment services of less than fifteen minutes duration for recovery procedures whose billing codes are defined in 15-minute increments;
h. Time spent engaged in activities required by a credentialing, certification or oversight entity such as gathering and submitting care plan and service data or other information

Transitional Case Management

Definition: Services provided to persons residing in institutional settings prior to their transition to the waiver to prepare them for discharge, or during the adjustment period immediately following discharge from an institution to stabilize them in a community setting, and to assist them with other aspects of the transition to community life by helping them 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 state shall claim the cost of case management services provided to institutionalized persons prior to their transition to the waiver for a period not to exceed 180 days. The state shall claim the cost of case management services provided to institutionalized persons after their transition to the waiver for a period not to exceed 120 days.

Transitional case management **Covered Services** of at least 15-minutes duration include:

1. Referral and related activities to help an participant obtain needed services, including activities that help link eligible individuals with medical, social, educational providers or other programs and services that are capable of providing needed services, such as making referrals to providers for needed services and scheduling appointments for the individual;
2. Monitoring and follow-up activities, including activities and contacts that are necessary to ensure the waiver Recovery Plan is effectively implemented and adequately addresses the needs of the eligible individual, and which may be with the individual, family members, providers, or other entities and conducted as frequently as necessary to help determine such matters as:
    a. Whether services are being furnished in accordance with an individual's Recovery Plan;
    b. Whether the services in the Recovery Plan are adequate; and
    c. Whether there are changes in the needs or status of the eligible individual, and if so, making necessary adjustments in the Recovery Plan and service arrangements with providers.

3. Face-to-face, telephonic and other contacts with the participant to assist preparation for discharge from an institutional setting and adjustment to community life immediately following discharge;
4. Contacts with landlords and vendors designed to locate and secure suitable housing, and make preparations necessary for the arrival of the participant, including such items as assuring:
    a. A lease is signed and a security deposit is made, if needed;
    b. Utilities or service access is obtained (telephone, electricity, heating and water);
    c. Essential home/apartment furnishings are obtained and in place;
    d. Other basic essentials are obtained and are in place, including window coverings, food preparation items, bed and bath linens, and personal care items;
5. Introducing the participant to other professionals or paraprofessionals involved in the waiver Recovery Plan;
6. Providing information, education and training for the participant regarding:
    a. Household budget, living costs, and lease and utility arrangements;
    b. Security features and the safe operation of appliances in the home, and
    c. Availability and how to access Community resources;
7. Assisting with or making arrangement for setting up the new home, including procuring, moving, and arranging furnishings, appliances, and other household items;
8. Supervised visits with the participant to the participant's home, or to locate a suitable home during the transition from an institutional setting;
9. Participation in waiver Recovery Plan development and quarterly Recovery Plan update meetings, if requested by the DMHAS Support Coordinator; and
10. Travel with a participant or family member(s) when the Transitional Case Manager is also engaged in a qualifying waiver service activity.

Unique Transitional Case Management Credentialing Requirements: To be approved as a Transitional Case Management provider, the agency must maintain accreditation from either the Commission on Accreditation of Rehabilitation Facilities (CARF), The Joint Commission (TJC) or other accrediting body approved by DMHAS. Must be a fully credentialed provider of Community Support wavier service.

The supervisor must be a licensed or licensed-eligible clinician. Transitional Case Management staff shall hold either a bachelor's degree in a behavioral health-related specialty (may include special education or rehabilitation) OR have two years' experience in the provision of mental health services (may include special education and/or services to persons with developmental disabilities) OR be a Certified Peer Specialist. Staff is required to meet any other certification standards defined by the Department of Mental Health and Addiction Services.

A Transitional Case Manager must:

- Be at least 18 yrs old;
- Possess at least a high school diploma or GED; and

Training programs to meet staff requirements will address abilities to:

- Follow instructions given by the participant or the participant's conservator;
- Report changes in the participant's condition or needs;
- Maintain confidentiality;
- Meet the participant's needs as delineated in the waiver Recovery Plan;
- Implement cognitive and behavioral strategies;
- Function as a member of an interdisciplinary team;
- Respond to fire and emergency situations;
- Accept supervision in a manner prescribed by the department or designated agent;
- Maintain accurate, complete and timely records that meet Medicaid requirements;
- Use crisis intervention and de-escalation techniques;
- Provide services in a respectful, culturally competent manner; and
- Use effective Transitional Case Management practices.

Payment Policies for Transitional Case Management services:

1. Transitional Case Management services are limited to a period of 180 days of initial enrollment and two hundred (100) ¼ hour service units (25 hours);
2. For services provided during a brief institutionalization following enrollment onto the wavier services are limited to a period of 120 days and one hundred (100) ¼ hour service units during a single episode of care;
3. Additional limitations on the volume and duration of these services may be specified in the waiver Recovery Plan approved by DMHAS and DSS. The departments or their designee will enact these limits;
4. Transitional Case Management services shall be based on the waiver Recovery Plan and shall be performed by or under the supervision of a licensed clinician employed by or under contract to the provider;
5. A claim for reimbursement may be submitted for the qualifying waiver services activities of only one staff member providing Transitional Case Management services to a participant during a specific time period (i.e., billable unit of time);
6. The department shall not pay for:
    a. Transitional Case Management while the participant is receiving Medicaid funded Targeted Case Management services;
    b. Time spent by the provider solely for the purpose of transporting participants;
    c. Programs, services or components of services that are of an unproven, experimental, cosmetic or research nature;
    d. Programs, services or components of services that do not relate to the participant's diagnosis, symptoms, functional limitations or medical history;

e. Programs, services or components of services that are not included in the fee established by the department;
f. Services or components of services provided solely for social, recreational, educational or vocational purposes; and
g. Costs associated with room and board for participants.

7. With the allowable exception of a transition period (up to 30-days), individuals receiving residential rehabilitation services paid for by Medicaid in a group home are excluded from Transitional Case Management.
6. The following activities are **Not Billable**, but have been factored into payment rates:
   a. Day-to-day monitoring regarding the participants health and welfare and problem solving to address concerns;
   b. Communication and coordination with the DMHAS Support Coordinator, and with other service providers to relay information germane to the participant's needs and continued recovery;
   c. Telephone contact with the department or its designated agent for the purpose of requesting or reviewing authorization;
   d. Completion of progress notes or billing documentation;
   e. Individual or group supervision, routine case reviews and rounds, ad hoc consultation with supervisors and discussion or consultation among recovery team members, including for the purpose of treatment planning;
   f. No shows, missed or cancelled appointments, and visits to the participant when the participant is unavailable;
   g. Transitional Case Management services of less than fifteen minutes duration for recovery procedures whose billing codes are defined in 15-minute increments; and
   h. Time spent engaged in activities required by a credentialing, certification or oversight entity such as gathering and submitting care plan or service data or other information.

Adult Day Health

Definition

This service is provided 4 or more hours per day for one or more days per week. Programming shall encompass both health and social services needed to ensure the optimal functioning of the participant. A program nurse shall be available on site for not less than 50% of each operating day.

Provider Qualifications/Conditions for Participation

Certificate: Must be certified by the Connecticut Association of Adult Day Centers Incorporated, its successor agency or a department designee.

Other Standards: A full-time program administrator, nursing consultation during the full operating day by a RN licensed in the State of Connecticut, and the direct care staff –to-client ratio shall be a minimum of one to seven. Volunteers may be included in the ratio only when they conform to the same standards and requirements as paid staff. Credentialed facilities shall be in compliance with all applicable requirements in order to continue providing services to waiver clients. The failure to comply with any applicable requirements shall be grounds for the termination of its credential and participation as a waiver service provider.

Entity Responsible for Verification: DMHAS/ABH
Frequency of Verification: Upon enrollment and reenrollment

Covered services

Nursing consultation, social work, nutritionally balanced meals, personal care, recreational therapy and transportation. The program nurse is responsible for administering medications as needed and assuring that the client's nursing services are coordinated with other services provided in the day health center and in the community.

There are three levels of service provided in adult day health based on the consumer's needs. The three levels:

1. Full Day, Approved Medical Model
2. Full Day, Non- Medical Model
3. Half Day

Level of service assigned depends upon the volume and extent of services needed by each individual and is not a limitation of service. Care must be furnished in a way which fosters the independence of each consumer. Routines of care provision and service delivery must be participant-driven to the maximum extent possible, and treat each person with dignity and respect.

Limitations

Coverage of Adult Day Health services shall be subject to the following limitations

1. Services are subject to the authorized level in the waiver recovery plan approved by DMHAS and DSS.
2. For clients receiving assisted living services, adult day services are included as part of the monthly rate. A separate reimbursement for this service is not authorized. The assisted living service agency may arrange for adult day services and reimburse the provider from their daily rate.
3. The department shall not pay for:
    a. Programs, services or components of services that are of an unproven, experimental, cosmetic or research nature;
    b. Programs, services or components of services that do not relate to the client's diagnosis, symptoms, functional limitations, or medical history;
    c. Programs, services or components of services that are not included in the fee established by the department

Non-billable Activities

Payment for adult day services shall include the costs of transportation, meals and all other required services. Any claims for these services shall be denied.

Notification of Agency Updates and Changes

Provider must notify ABH in writing within five (5) business days after learning of any of the following:

- Any significant changes from all the information provided in the Credentialing Application;
- Any significant changes from the information provided in the DSS Performing Provider Agreement;
- Any action taken to restrict, suspend or revoke Provider's license or certification or any member of Provider's staff license or certification;
- Any civil or criminal claim against Provider or any member of Provider's staff and all relevant information (other than privileged information absent an appropriate waiver) concerning such claim requested by ABH, and by separate notification, the final disposition thereof, provided that the provisions of this Section shall apply except as limited by law and except to the extent compliance therewith may adversely affect Provider's or Provider's staff's insurance coverage;
- The amendment or termination of any insurance policy required hereunder; Provider agrees that ABH will not approve payment for Services delivered on and after the insurance expiration date;
- Any criminal action, administrative proceedings or professional disciplinary actions against Provider or any member of its staff;
- Any written complaint from any Participant's under the MFP/MH Waiver with respect to the quality or accessibility of Provider's services or the performance of the Provider or any of its staff;
- Any sanction(s) by, or loss of the right to participate in, the Medicare or Medicaid program.

Failure to notify ABH of any changes or updates may affect the agency's credentialing status.

Claims Submittal and Processing Procedures

General Requirements

The minimum general requirements for reimbursement of services include the following:

- The Provider shall be reimbursed at the rate in the DSS Fee Schedule for each covered service, or at the billed rate, whichever is lower.
- The Provider shall be reimbursed for authorized services only.

Participant Eligibility

MH Waiver Participants must be eligible for Medicaid services at the time of service. Typical reasons why a person may be denied enrollment onto the Waiver are:

- The individual's income or assets exceed the waiver limit.
- The person does not meet the Nursing Facility level of care requirement.
- The individual does not have and/or does not qualify for Medicaid.
- The person's service needs exceed the covered waiver service limits.
- The individual does not need waiver services covered by the waiver.
- There is no available waiver opening.

Claim Filing

- Claims that include all required data elements must be submitted electronically via the WISE Online System or the DXC Portal depending on the service provided.
- A separate claim must be submitted for each Participant;
- Exact dates of services are required on each claim;
- Services will be billed in quarter-hour unit; Provider should round direct service time to the nearest 15 minute increment;
- Provider will not be reimbursed for unauthorized or excluded services and will not be reimbursed for missed or cancelled appointments;
- The CT General Statue Sec.38a-477 defines a **Clean Claim** as a claim that does not contain a defect requiring the payer to investigate prior to adjudication;
- Clean claims submitted to ABH, Inc will be processed and paid within thirty (30) days of receipt. Providers will receive notification of specific claim errors and will have the opportunity to resubmit corrected claims within forty-five (45) days of notification. All claims for services rendered will be considered **timely** when submitted within 60 days of the date of service. Claims not submitted within the above time frames will be denied reimbursement. Please refer to "WISE Billing Guide" at the ABH website.
- Please refer to DXC policies regarding claims submitted directly to the DSS portal for payment.

Dispute Resolution of Claims

For Claims submitted to ABH, Inc for payment: If a payment is reduced or denied ABH will include an explanation for the reduction or denial of such payment, a Provider may appeal any such reduction or denial in accordance with the "*Payment Dispute Resolution* "policy outlined below:

Payment Dispute Resolution: Upon ABH's determination that a Provider and/or Recovery Assistant employee submitted a Claim Form and/or a time sheet for which payment must be reduced or denied, ABH shall:

- Notify the Provider and/or the Self- Directed Employer and the Recovery Assistant employee in writing of the reason(s) for payment reduction or denial;
- As requested by the Provider, the Self- Directed Employer and/or the Recovery Assistant employee, provide reasonable telephone assistance and training regarding the reason(s) for non-payment stated in the written notification and resolve such non-payment; and
- Permit the Provider to file a written appeal with ABH. ABH shall resolve the appeal in accordance with the DMHAS Guiding Documents. ABH may request an opinion of DSS if the reason for payment reduction or denial is related to Medicaid requirements or requirements under the MFP/MH Waiver program.

For claims submitted directly to the DSS Portal for payment, please see DXC policy regarding claim dispute resolution.

Provider Appeals Process

An administrative denial is issued when there has been a failure to follow protocol for administrative procedures. For example, the requested service falls outside of those covered by the MH Waiver Program, or services rendered exceed the authorized limits. Advanced Behavioral Health, Inc. (ABH) will only issue denials for claims and not for authorization request, since those requests are approved or denied by the WISE Community Support Clinicians (CSC) only. If your denial is due to an authorization issue, please contact the assigned CSC prior to requesting an appeal. If you are having difficulty contacting the CSC, please contact the appropriate supervisor as appeals are time limited.

The first level appeals process can be initiated by submitting a Reconsideration/Appeal Request form to ABH. For all claims submitted to ABH, the appeal must be made within thirty (30) calendar days of the receipt of the denial (EOB). Appeals submitted after this deadline will not be considered for review.

The appeal should contain additional information, or should demonstrate "good cause" for the non-compliance with the required administrative procedure.

ABH will render a written appeal decision within fifteen (15) calendar days of receipt of the appeal. If the denial is overturned, ABH will reprocess the claim for the next payment cycle. In those cases where the denial is upheld, the notification will contain instructions as to how to proceed with a second level appeal.

Second level appeal requests are made directly to DMHAS/DSS, and need to be submitted to DMHAS/DSS within fifteen (15) calendar days of receiving notice that the denial has been upheld at the first level. The appeal must be accompanied by information

necessary and sufficient to render a decision. In those cases where DMHAS/DSS elects to overturn the administrative denial, ABH will be instructed to reprocess the claim. In those cases where the denial is upheld on second level, the appeals process will be considered concluded.

Please refer to DXC policy for information regarding appeal process for claims denied by DXC.

Participant Rights and their Fair Hearing, Complaint, Grievance and Grievance-Appeal Processes

Participant's Rights: A Participant has the right to refuse procedures, medicines, or courses of treatment. A Participant has the right to participate in decision-making regarding his or her care. If the Participant refuses care, the Provider shall inform the Participant of the consequences of the noncompliance with the recommended course of care and seek to resolve the disagreement with the Participant and/or the Participant's family or other person acting on behalf of the Participant. The resolution of the disagreement shall include but not be limited to helping the Participant explore the services of other providers.

Participants Fair Hearing, Complaint, Grievance and Grievance- Appeal Processes: A Participant who is denied enrollment in the MH Waiver program or has been denied new or additional waiver services will receive written notification describing the reason for the denial and a notice of the right to request a DSS Fair Hearing. DSS makes the final administrative Medicaid Waiver eligibility decision.
The participant has the following options to request a DSS Fair Hearing and to file a complaint or grievance and a grievance appeal.

1. DSS Fair Hearing- Participants are informed that the DSS Fair Hearing process is available to them at any time.

2. The participant may follow the agency's complaint and grievance procedure. Each agency in the MH Waiver is required to have a complaints and grievances process and to inform each person seeking or receiving services about how to use the process.

3. The DMHAS Complaint, Grievance and Appeal system is available to anyone receiving DMHAS services regardless of whether the service is State-funded or State-operated. DMHAS will encourage the handling of complaints and grievances at the level closest to the service recipient. DMHAS will focus on the mediation and settlement of grievances as soon as possible. However, when a grievance cannot be resolved to the satisfaction of the person raising the

concern, a process is in place for appealing a grievance finding to the Office of the Commissioner at DMHAS. A grievance-appeal will set into motion a time-critical sequence of events involving examination of the grievance conclusion to determine whether the agency-level decision on the grievance is supported or overturned.

ABH Quality Management (QM) Program

In addition to contract, regulatory and accreditation requirements, the Quality Management plan includes activities that aim to identify potential opportunities for quality improvement, address barriers, and develop interventions to positively impact on the quality and effectiveness of services.

As part of the Quality Management plan, providers are expected to actively participate in quality measurement activities including, but not limited to, providing participant data on a regular schedule or as indicated by ABH; responding to satisfaction surveys; reporting critical incidents; participating in the resolution of Participant complaints and grievances; facilitating site and chart reviews; and helping to maintain open lines of communication to ensure timely resolution of identified concerns.

Outlier data and reports are generated and reviewed with DMHAS and DSS. Each provider is given the opportunity to discuss the unique nature of the providers' participant population and to work collaboratively with ABH and the Departments to improve performance.

If there are recurring issues or frequent sources of complaints from providers, Participants and/or Self- Directed Recovery Assistants, ABH will conduct an investigation and report findings to the Departments.

Providers are expected to provide ABH with copies of records, policies and procedures, state licensing reviews, accreditation surveys, and all documentation as is necessary for ABH to investigate specific quality indicators. The provider is responsible for the cost of

copies, postage or fax services and is expected to provide documents in a timely manner.

ABH will provide any information and profiling data used to evaluate the providers performance and shall make available on a periodic basis and upon request of the provider the information, profiling data and analysis used to evaluate provider performance. Any issues arising out of the reports are discussed with the provider on an as needed basis, or in a meeting coordinated with the Provider Relations department.

Provider Performance Measures

ABH serves as the liaison among participating providers, waiver participants and governing agencies to assess and monitor the progress and ongoing effectiveness of the waiver services. There are general Provider Performance Measures that are monitored for all waiver services and additional measures monitored only for specific waiver service.

Domain	Outcome	Benchmark	Services Measured	How It Will Be Measured
Satisfaction	Client's overall satisfaction	80%	ALL	Satisfaction survey completed by clients
	CSC Evaluation of Performance	80%	ALL	Survey of Community Support Clinicians
	CSC's overall satisfaction	80%	ALL	Survey of Community Support Clinicians
Documentation	Monthly Notes	95%	ALL	Monthly Progress Notes received by 10th day of following month
	Billing Accuracy	80%	ALL	Quarterly audit of Encounter Notes
	Review of Monthly PNs for accuracy	80%	ALL	Quarterly audit of Monthly Progress Notes
Fidelity	CSP Provided in Community	70%	CSP	Claims submitted in previous month
	Recovery Assistant Post Training	6 hours	RA	Review of RA logs every 2 years when agency is credentialed

A. Satisfaction

1. **Client overall satisfaction**

- *Purpose*: To measure client satisfaction with the WISE services he or she is receiving
    - *Measured*: Satisfaction Surveys are sent directly to clients every 6 months based on enrollment date. Providers must receive ≥ 80% satisfaction score.

2. **Community Support Clinician (CSC) Evaluation of Performance**
    - *Purpose*: The CSC's evaluation of the provider ability to perform WISE services which may include, but are not limited to, such areas as adherence to the recovery plan, communication, client stability and independence, agency flexibility and availability.
        - *Measured*: Survey sent to the CSC's at least annually. Providers must receive ≥ 80% satisfaction score.
3. **Community Support Clinician (CSC) overall satisfaction**
    - *Purpose*: The CSC's overall satisfaction with services provided to WISE clients
        - *Measured*: Survey sent to the CSC's at least annually. Providers must receive ≥ 80% satisfaction score.

B. Documentation

1. **Monthly Notes**
    - *Purpose*: Monthly Progress Notes (PNs) for all WISE services must be received by ABH by the 10th day following the end of a month. *Note: A Progress Note is required for any month that falls in an open authorization, even if services were not provided.*
        - *Measured*: The number of Monthly PNs received by ABH for all open authorizations. ABH must receive ≥ 95% of Monthly Progress Notes for open authorizations.
2. **Billing Accuracy**
    - *Purpose*: To ensure that: (a) necessary documentation is being maintained, (b) WISE services are being provided appropriately, and (c) units on submitted claims match documentation.
        - *Measured*: Quarterly comparison of Encounter Notes with submitted claims. Notes will be requested for a randomly selected time period. Providers must score ≥ 80% on note accuracy
3. **Review of Monthly Progress Notes (PNs) for Accuracy**
    - *Purpose*: To ensure Monthly Progress Notes contain all required elements and meet quality standards
        - *Measured*: Monthly PNs reviewed for necessary information (e.g., client name, level of assistance, etc.) and quality of the content in the note. Providers must score ≥ 80% on note accuracy

C. Fidelity

1. **Community Support Program (CSP) Provided in Community Setting**
    - *Purpose*: The majority of CSP services are expected to be provided in the client's home or other community setting.
        - *Measured*: Review of claims submitted for Place of Service (POS) code. Provider must provide $\geq$ 70% of CSP services in a home or community setting.
2. **Recovery Assistant (RA) Post Training**
    - *Purpose*: Each Recovery Assistant is required to complete at least 6 hours of Post-Training each year based on the date certified as an RA.
        - *Measured*: Agencies must maintain detailed record/log of applicable Post-Training that is completed by each RA. This record/log is reviewed every 2 years when the agency is Re-Credentialed as an RA Provider.

Failure to Meet Performance Measures

When calculating the provider's compliance and achievement of a Performance Measure, a Performance Measure will not be rounded. If the provider fails to meet a performance measure ABH shall provide written notification of such failure to the provider except where the failure was due to ABH's failure to provide timely information needed to meet the Performance Measure or for reasons beyond the control of the provider. Within fifteen (15) business days of the date of ABH's notification of failure to meet a Performance Measure, the provider shall submit to ABH for review and approval, a corrective action plan to avoid reoccurrence of non-compliance and a timetable for implementation of the corrective action plan. Any modification to the corrective action plan shall also be subject to review and approval by ABH. ABH can delay a payment for failure to submit a corrective action plan. ABH has the sole authority for determining whether the provider has met, exceeded, or fallen below any or all of the requirements established in each Performance Measure. ABH shall notify the provider when a Performance Measure has returned to acceptable levels as determined by ABH.

Any provider that fails to meet a Performance Measure will receive a report at the end of the calendar Quarter specifying the expected benchmark and the month(s) in which the provider fell below the given benchmark. Continued failure to meet Performance Measures will result in remedial measures such as assistance from ABH staff and the provider being required to submit a Corrective Action Plan to ABH.

Critical Incident Reporting

Critical incidents are defined as incidents that may have a serious or potential serious impact on Waiver Participants, staff, facilities, funded agencies, or the public or may bring about adverse publicity. The requirement to report a critical incident will apply under the following circumstances: the incident involves a Waiver client and/or

occurred within a DMHAS operated facility or an agency or individual serving a Waiver recipient.

Examples of CI include but is not limited to:

- death;
- suicide (including attempts);
- threats to self or others;
- abuse/neglect/exploitation of client;
- missing persons;
- involvement of emergency services/law enforcement (EMTs/Fire/Police);
- criminal activity (perpetrator/victim/witness, etc.);
- incarceration
- falls (even if client refuses medical treatment)
- ANY unplanned medical treatment (ED visits, inpatient treatment, SNF stays – both medical & psych)
- medication errors (wrong meds, not taking meds, out of meds, etc.)
- property damage
- unusual client behavior (suddenly manic? paranoid? selling all their possessions? etc.)

Critical Incident Forms should be submitted to ABH within one business day, and can be faxed to 860-920-4456 or securely emailed to mhwcriticalincident@abhct.com.

Abuse and Neglect

For persons aged 60 or older, Section 17b-451 of the Connecticut General Statutes requires medical professionals, social workers, police officers, clergy, and nursing home staff to report to the Department of Social Services any knowledge or suspicion of abuse, neglect, exploitation, or abandonment. In addition, friends, neighbors, family members, and acquaintances who suspect an elderly person is being abused, neglected, or exploited may call the closest office of the Department of Social Services.

Record Keeping and Documentation

Provider agrees to maintain adequate records for all Services rendered to Participant's in accordance with the standards developed and required by any agency or funding source involved with the MFP/MH Waiver.

Records shall be stored in a locked file cabinet on the premises of the Provider.

Subject to applicable state and federal privacy and confidentiality requirements, Provider agrees to make such records available to any other agency or funding source involved with the MFP/MH Waiver upon request so that such records may be reviewed for any proper purposes related to the MFP/MH Waiver including but not necessarily limited to: billing and payment purposes; to determine the content of the records in order to determine that the quality of Services rendered was acceptable; grievance or corrective action procedures or guidelines, or for any other lawful purpose.

The Provider, for purposes of audit or investigation, shall provide ABH and/or DMHAS/DSS or its authorized representative, on site access to all the Provider's materials and information pertinent to the Services provided under this agreement, at any time, until the expiration of three (3) years from the completion date of the agreement.

Record keeping documenting Medicaid billing is required for all Medicaid services providers. As the Recovery Plan and Monthly Progress Notes are now stored in the WISE Online System, the only required documentation providers must maintain is the Individual Encounter Notes. Each specific service may have prescribed documentation required by DSS and DMHAS. Records must be maintained for six years from date of service or for the greater of time required by applicable federal or state law.

Research and Evaluations Protocols

Research and evaluation is a critical component to measuring the progress of participants involved with the Mental Health Waiver Services. The University of Connecticut Research staff will work independently to analyze trends and outcomes. Providers are expected to comply with DMHAS protocols regarding this research.

Provider Meeting

Provider meetings are held quarterly in Middletown. All providers are encouraged to attend. An announcement agenda are sent out prior to the meeting date. Topics covered include: DMHAS updates, census information, billing, policy and procedures, training, billing and other related topics. Provider Meeting slides are presented on the ABH website.