# Application for a §1915 (c) HCBS Waiver

## HCBS Waiver Application Version 3.4

**Submitted by:**

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| State of Connecticut Department of Social Services and Department of Developmental Services |

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|---|---|
| **Submission Date:** | |

| | |
|---|---|
| **CMS Receipt Date** *(CMS Use)* | |

*Provide a brief one-two sentence description of the request (e.g., renewal of waiver, request for new waiver, amendment):*

| **Brief Description:** |
|---|
| Renewal of waiver #0426-IP.01 (IFS) with enhanced supports for individuals with mental retardation and co-occurring severe medical and/or behavioral support needs. |

# Application for a §1915(c) Home and Community-Based Services Waiver

## *PURPOSE OF THE HCBS WAIVER PROGRAM*

The Medicaid Home and Community-Based Services (HCBS) waiver program is authorized in §1915(c) of the Social Security Act. The program permits a State to furnish an array of home and community-based services that assist Medicaid beneficiaries to live in the community and avoid institutionalization. The State has broad discretion to design its waiver program to address the needs of the waiver's target population. Waiver services complement and/or supplement the services that are available to participants through the Medicaid State plan and other federal, state and local public programs as well as the supports that families and communities provide.

The Centers for Medicare & Medicaid Services (CMS) recognizes that the design and operational features of a waiver program will vary depending on the specific needs of the target population, the resources available to the State, service delivery system structure, State goals and objectives, and other factors. A State has the latitude to design a waiver program that is cost-effective and employs a variety of service delivery approaches, including participant direction of services.

# 1. Request Information

**A.** The **State** of **Connecticut** requests approval for a Medicaid home and community-based services (HCBS) waiver under the authority of §1915(c) of the Social Security Act (the Act).

**B. Waiver Title** (*optional*): Individual and Family Supports WaiverSupports Waiver

**C. Type of Request** *(select only one)*:

| | | | |
|---|---|---|---|
| ○ | **New Waiver (3 Years)** | CMS-Assigned Waiver Number (*CMS Use*): | |
| ○ | **New Waiver (3 Years) to Replace Waiver #**<br>CMS-Assigned Waiver Number (*CMS Use*):<br>*Attachment #1 contains the transition plan to the new waiver.* | | |
| ○ | **Renewal (5 Years) of Waiver #** | | |
| ■ | **Amendment to Waiver #** | 0426-IP.01 (IFS) | |

**D. Type of Waiver** *(select only one)*:

| | |
|---|---|
| ○ | **Model Waiver**. In accordance with 42 CFR §441.305(b), the State assures that no more than 200 individuals will be served in this waiver at any one time. |
| ■ | **Regular Waiver**, as provided in 42 CFR §441.305(a) |

**E.1 Proposed Effective Date:** October 01, 2008

**E.2 Approved Effective Date** *(CMS Use):*

**F. Level(s) of Care**. This waiver is requested in order to provide home and community-based waiver services to individuals who, but for the provision of such services, would require the following level(s) of care, the costs of which would be reimbursed under the approved Medicaid State plan *(check each that applies)*:

| | | |
|---|---|---|
| ☐ | Hospital *(select applicable level of care)* | |
| | ○ | Hospital as defined in 42 CFR §440.10. If applicable, specify whether the State additionally limits the waiver to subcategories of the hospital level of care: |
| | ○ | Inpatient psychiatric facility for individuals under age 21 as provided in 42 CFR § 440.160 |
| ☐ | Nursing Facility *(select applicable level of care)* | |
| | ○ | As defined in 42 CFR §440.40 and 42 CFR §440.155. If applicable, specify whether the State additionally limits the waiver to subcategories of the nursing facility level of care: |
| | ○ | Institution for Mental Disease for persons with mental illnesses aged 65 and older as provided in 42 CFR §440.140 |
| ■ | Intermediate Care Facility for the Mentally Retarded (ICF/MR) (as defined in 42 CFR §440.150). If applicable, specify whether the State additionally limits the waiver to subcategories of the ICF/MR facility level of care: | |

**G. Concurrent Operation with Other Programs.** This waiver operates concurrently with another program (or programs) approved under the following authorities *(check the applicable authority or authorities)*:

| | | | | |
|---|---|---|---|---|
| ☐ | Services furnished under the provisions of §1915(a) of the Act and described in Appendix I | | | |
| ☐ | Waiver(s) authorized under §1915(b) of the Act. *Specify the §1915(b) waiver program and indicate whether a §1915(b) waiver application has been submitted or previously approved:* | | | |
| | | | | |
| | Specify the §1915(b) authorities under which this program operates (*check each that applies*): | | | |
| | ☐ | §1915(b)(1) (mandated enrollment to managed care) | ☐ | §1915(b)(3) (employ cost savings to furnish additional services) |
| | ☐ | §1915(b)(2) (central broker) | ☐ | §1915(b)(4) (selective contracting/limit number of providers) |
| | | | | |
| ☐ | A program authorized under §1115 of the Act. *Specify the program:* | | | |
| | | | | |
| ■ | Not applicable | | | |

# 2. Brief Waiver Description

**Brief Waiver Description.** *In one page or less*, briefly describe the purpose of the waiver, including its goals, objectives, organizational structure (e.g., the roles of state, local and other entities), and service delivery methods.

The goals of the Individual and Family Support waiver are to provide flexible and necessary supports and services for children and adults eligible for services through the Department of Developmental Services (DDS) (formerly Department of Mental Retardation) in accordance with Section 17a-212, CT General Statutes who live in a family home or one's own home to live safe and productive lives; to support and encourage consumer-direction to maximize choice, control and efficient use of state and federal resources; and to provide a mechanism to serve an increased number of individuals through individualized and non-licensed service options such as, personal support, adult companion, respite and individualized day supports. This is a supports waiver capped at $58,000 annually with increases when approved by the Legislature. Each individual's prospective budget allocation is determined by the assessed Level of Need (Minimal, Moderate, or Comprehensive). Additional objectives of this waiver renewal application are to include the results of the Department's CMS Independence Plus Grant through the use of the CT Level of Needs Assessment and Risk Screening Tool and new individual budgeting methodology; and, to make other administrative changes to the application that reflect lessons learned over the past 33 months as the department has fully implemented an individualized and fee for service system.

The Department of Social Services (DSS) is the Single State Medicaid Agency responsible for oversight of the DDS waivers. The Department of Developmental Services is the operating authority through an executed Memorandum of Understanding between the two state departments. Both departments are cabinet level agencies. DDS operates the waiver as a state operated system with state employees delivering targeted case management services, and operational functions carried out either through a central office or through one of three state regional offices. Services are delivered by an array of private service vendors through contracts or through a fee for service system; by DDS directly; and through the use of consumer-direction with waiver participants serving as the employer of record, or through the selection of an Agency with Choice model. DDS utilizes Fiscal Intermediary organizations to support participants who choose consumer-direction and offers support brokers as part of expanded DDS case management services or through the waiver.

# 3. Components of the Waiver Request

The waiver application consists of the following components. *Note: Item 3-E must be completed.*

**A. Waiver Administration and Operation.** **Appendix A** specifies the administrative and operational structure of this waiver.

**B. Participant Access and Eligibility.** **Appendix B** specifies the target group(s) of individuals who are served in this waiver, the number of participants that the State expects to serve during each year that the waiver is in effect, applicable Medicaid eligibility and post-eligibility (if applicable) requirements, and procedures for the evaluation and reevaluation of level of care.

**C. Participant Services.** **Appendix C** specifies the home and community-based waiver services that are furnished through the waiver, including applicable limitations on such services.

**D. Participant-Centered Service Planning and Delivery.** **Appendix D** specifies the procedures and methods that the State uses to develop, implement and monitor the participant-centered service plan (of care).

**E. Participant-Direction of Services.** When the State provides for participant direction of services, **Appendix E** specifies the participant direction opportunities that are offered in the waiver and the supports that are available to participants who direct their services. *(Select one)*:

| | |
|---|---|
| ■ | The waiver provides for participant direction of services. *Appendix E is required.* |
| ○ | Not applicable. The waiver does not provide for participant direction of services. *Appendix E is not completed.* |

**F. Participant Rights.** **Appendix F** specifies how the State informs participants of their Medicaid Fair Hearing rights and other procedures to address participant grievances and complaints.

**G. Participant Safeguards.** **Appendix G** describes the safeguards that the State has established to assure the health and welfare of waiver participants in specified areas.

**H. Quality Management Strategy.** **Appendix H** contains the Quality Management Strategy for this waiver.

**I. Financial Accountability.** **Appendix I** describes the methods by which the State makes payments for waiver services, ensures the integrity of these payments, and complies with applicable federal requirements concerning payments and federal financial participation.

**J. Cost-Neutrality Demonstration.** **Appendix J** contains the State's demonstration that the waiver is cost-neutral.

# 4. Waiver(s) Requested

**A. Comparability.** The State requests a waiver of the requirements contained in §1902(a)(10)(B) of the Act in order to provide the services specified in **Appendix C** that are not otherwise available under the approved Medicaid State plan to individuals who: (a) require the level(s) of care specified in Item 1.F and (b) meet the target group criteria specified in **Appendix B**.

**B. Income and Resources for the Medically Needy.** Indicate whether the State requests a waiver of §1902(a)(10)(C)(i)(III) of the Act in order to use institutional income and resource rules for the medically needy *(select one)*:

| | |
|---|---|
| ○ | Yes |
| ○ | No |
| ■ | Not applicable |

**C. Statewideness.** Indicate whether the State requests a waiver of the statewideness requirements in §1902(a)(1) of the Act *(select one)*:

| | |
|---|---|
| ○ | **Yes** *(complete remainder of item)* |
| ■ | **No** |

If yes, specify the waiver of statewideness that is requested *(check each that applies)*:

| | |
|---|---|
| ☐ | **Geographic Limitation**. A waiver of statewideness is requested in order to furnish services under this waiver only to individuals who reside in the following geographic areas or political subdivisions of the State. S*pecify the areas to which this waiver applies and, as applicable, the phase-in schedule of the waiver by geographic area*: |
| | |
| ☐ | **Limited Implementation of Participant-Direction**. A waiver of statewideness is requested in order to make ***participant direction of services*** as specified in **Appendix E** available only to individuals who reside in the following geographic areas or political subdivisions of the State. Participants who reside in these areas may elect to direct their services as provided by the State or receive comparable services through the service delivery methods that are in effect elsewhere in the State. *Specify the areas of the State affected by this waiver and, as applicable, the phase-in schedule of the waiver by geographic area*: |
| | |

## 5. Assurances

In accordance with 42 CFR §441.302, the State provides the following assurances to CMS:

**A. Health & Welfare:** The State assures that necessary safeguards have been taken to protect the health and welfare of persons receiving services under this waiver. These safeguards include:

1. As specified in **Appendix C**, adequate standards for all types of providers that provide services under this waiver;
2. Assurance that the standards of any State licensure or certification requirements specified in **Appendix C** are met for services or for individuals furnishing services that are provided under the waiver. The State assures that these requirements are met on the date that the services are furnished; and,
3. Assurance that all facilities subject to §1616(e) of the Act where home and community-based waiver services are provided comply with the applicable State standards for board and care facilities as specified in **Appendix C**.

**B. Financial Accountability**. The State assures financial accountability for funds expended for home and community-based services and maintains and makes available to the Department of Health and Human Services (including the Office of the Inspector General), the Comptroller General, or other designees, appropriate financial records documenting the cost of services provided under the waiver. Methods of financial accountability are specified in **Appendix I**.

**C. Evaluation of Need:** The State assures that it provides for an initial evaluation (and periodic reevaluations, at least annually) of the need for a level of care specified for this waiver, when there is a reasonable indication that an individual might need such services in the near future (one month or less) but for the receipt of home and community-based services under this waiver. The procedures for evaluation and reevaluation of level of care are specified in **Appendix B**.

**D. Choice of Alternatives:** The State assures that when an individual is determined to be likely to require the level of care specified for this waiver and is in a target group specified in **Appendix B**, the individual (or, legal representative, if applicable) is:

1. Informed of any feasible alternatives under the waiver; and,
2. Given the choice of either institutional or home and community-based waiver services.

**Appendix B** specifies the procedures that the State employs to ensure that individuals are informed of feasible alternatives under the waiver and given the choice of institutional or home and community-based waiver services.

**E. Average Per Capita Expenditures:** The State assures that, for any year that the waiver is in effect, the average per capita expenditures under the waiver will not exceed 100 percent of the average per capita expenditures that would have been made under the Medicaid State plan for the level(s) of care specified for this waiver had the waiver not been granted. Cost-neutrality is demonstrated in **Appendix J**.

**F. Actual Total Expenditures:** The State assures that the actual total expenditures for home and community-based waiver and other Medicaid services and its claim for FFP in expenditures for the services provided to individuals under the waiver will not, in any year of the waiver period, exceed 100 percent of the amount that would be incurred in the absence of the waiver by the State's Medicaid program for these individuals in the institutional setting(s) specified for this waiver.

**G. Institutionalization Absent Waiver:** The State assures that, absent the waiver, individuals served in the waiver would receive the appropriate type of Medicaid-funded institutional care for the level of care specified for this waiver.

**H. Reporting:** The State assures that annually it will provide CMS with information concerning the impact of the waiver on the type, amount and cost of services provided under the Medicaid State plan and on the health and welfare of waiver participants. This information will be consistent with a data collection plan designed by CMS.

**I. Habilitation Services**. The State assures that prevocational, educational, or supported employment services, or a combination of these services, if provided as habilitation services under the waiver are: (1) not otherwise available to the individual through a local educational agency under the Individuals with Disabilities Education Improvement Act of 2004 (IDEA) or the Rehabilitation Act of 1973; and, (2) furnished as part of expanded habilitation services.

**J. Services for Individuals with Chronic Mental Illness.** The State assures that federal financial participation (FFP) will not be claimed in expenditures for waiver services including, but not limited to, day treatment or partial hospitalization, psychosocial rehabilitation services, and clinic services provided as home and community-based services to individuals with chronic mental illnesses if these individuals, in the absence of a waiver, would be placed in an IMD and are: (1) age 22 to 64; (2) age 65 and older and the State has not included the optional Medicaid benefit cited in 42 CFR §440.140; or (3) under age 21 when the State has not included the optional Medicaid benefit cited in 42 CFR §440.160.

## 6. Additional Requirements

*Note: Item 6-I must be completed.*

**A. Service Plan**. In accordance with 42 CFR §441.301(b)(1)(i), a participant-centered service plan (of care) is developed for each participant employing the procedures specified in **Appendix D**. All waiver services are furnished pursuant to the service plan. The service plan describes: (a) the waiver services that are furnished to the participant, their projected amount, frequency and duration and the type of provider that furnishes each service and (b) the other services (regardless of funding source, including State plan services) and informal supports that complement waiver services in meeting the needs of the participant. The service plan is subject to the approval of the Medicaid agency. Federal financial

participation (FFP) is not claimed for waiver services furnished prior to the development of the service plan or for services that are not included in the service plan.

**B. Inpatients.** In accordance with 42 CFR §441.301(b)(1)(ii), waiver services are not furnished to individuals who are in-patients of a hospital, nursing facility or ICF/MR.

**C. Room and Board**. In accordance with 42 CFR §441.310(a)(2), FFP is not claimed for the cost of room and board except when: (a) provided as part of respite services in a facility approved by the State that is not a private residence or (b) claimed as a portion of the rent and food that may be reasonably attributed to an unrelated caregiver who resides in the same household as the participant, as provided in **Appendix I**.

**D. Access to Services.** The State does not limit or restrict participant access to waiver services except as provided in **Appendix C**.

**E. Free Choice of Provider.** In accordance with 42 CFR §431.51, a participant may select any willing and qualified provider to furnish waiver services included in the service plan unless the State has received approval to limit the number of providers under the provisions of §1915(b) or another provision of the Act.

**F. FFP Limitation**. In accordance with 42 CFR §433 Subpart D, FFP is not claimed for services when another third-party (e.g., another third party health insurer or other federal or state program) is legally liable and responsible for the provision and payment of the service. FFP also may not be claimed for services that are available without charge, or as free care to the community. Services will not be considered to be without charge, or free care, when (1) the provider establishes a fee schedule for each service available and (2) collects insurance information from all those served (Medicaid, and non-Medicaid), and bills other legally liable third party insurers. Alternatively, if a provider certifies that a particular legally liable third party insurer does not pay for the service(s), the provider may not generate further bills for that insurer for that annual period.

**G. Fair Hearing:** The State provides the opportunity to request a Fair Hearing under 42 CFR §431 Subpart E, to individuals: (a) who are not given the choice of home and community-based waiver services as an alternative to institutional level of care specified for this waiver; (b) who are denied the service(s) of their choice or the provider(s) of their choice; or (c) whose services are denied, suspended, reduced or terminated. **Appendix F** specifies the State's procedures to provide individuals the opportunity to request a Fair Hearing, including providing notice of action as required in 42 CFR §431.210.

**H. Quality Management.** The State operates a formal, comprehensive system to ensure that the waiver meets the assurances and other requirements contained in this application. Through an ongoing process of discovery, remediation and improvement, the State assures the health and welfare of participants by monitoring: (a) level of care determinations; (b) individual plans and services delivery; (c) provider qualifications; (d) participant health and welfare; (e) financial oversight and (f) administrative oversight of the waiver. The State further assures that all problems identified through its discovery processes are addressed in an appropriate and timely manner, consistent with the severity and nature of the problem. During the period that the waiver is in effect, the State will implement the Quality Management Strategy specified in **Appendix H**.

**I. Public Input.** Describe how the State secures public input into the development of the waiver:

DDS convenes the following routine meetings where public input is provided on a routine and targeted basis: Family Forums in each of the three Regions on a quarterly basis; Provider Leadership Forums in each of the three Regions on a quarterly basis; and Provider Trades Association meetings with the Commissioner on a bi-monthly basis. Additional public input is gained through targeted information and discussion tables at meetings and events held throughout the state such as self-advocacy supported employment events, provider conferences and cultural events, through publication and solicitation of input requests through the stakeholder mailing *Direct to Families*; through posting on the DDS web site; through publication in the CT Law Journal; and through a

legislative public hearing.

**J. Notice to Tribal Governments**. The State assures that it has notified in writing all federally-recognized Tribal Governments that maintain a primary office and/or majority population within the State of the State's intent to submit a Medicaid waiver request or renewal request to CMS at least 60 days before the anticipated submission date as provided by Presidential Executive Order 13175 of November 6, 2000. Evidence of the applicable notice is available through the Medicaid Agency.

**K. Limited English Proficient Persons**. The State assures that it provides meaningful access to waiver services by Limited English Proficient persons in accordance with: (a) Presidential Executive Order 13166 of August 11, 2000 (65 FR 50121) and (b) Department of Health and Human Services "Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons" (68 FR 47311 - August 8, 2003). **Appendix B** describes how the State assures meaningful access to waiver services by Limited English Proficient persons.

## 7. Contact Person(s)

**A.** The Medicaid agency representative with whom CMS should communicate regarding the waiver is:

| | |
|---|---|
| **First Name:** | Kathy |
| **Last Name** | Bruni |
| **Title:** | Social Services Medical Administrative Program Manager |
| **Agency:** | Department of Social Services |
| **Address 1:** | 25 Sigourney Street |
| **Address 2:** | |
| **City** | Hartford |
| **State** | CT |
| **Zip Code** | 06106 |
| **Telephone:** | 1-860-424-5177 |
| **E-mail** | kathy.a.bruni@ct.gov |
| **Fax Number** | 1-860-424-4963 |

**B.** If applicable, the State operating agency representative with whom CMS should communicate regarding the waiver is:

| | |
|---|---|
| **First Name:** | Deborah |
| **Last Name** | Duval |
| **Title:** | Mental Retardation Program Manager |
| **Agency:** | Department of Developmental Services |
| **Address 1:** | 460 Capitol Avenue |
| **Address 2** | |
| **City** | Hartford |
| **State** | CT |
| **Zip Code** | 06106 |

| | |
|---|---|
| **Telephone:** | 1-860-418-6149 |
| **E-mail** | deborah.duval@ct.gov |
| **Fax Number** | 1-860-418-6001 |

# 8. Authorizing Signature

This document, together with Appendices A through J, constitutes the State's request for a waiver under §1915(c) of the Social Security Act. The State assures that all materials referenced in this waiver application (including standards, licensure and certification requirements) are ***readily*** available in print or electronic form upon request to CMS through the Medicaid agency or, if applicable, from the operating agency specified in Appendix A. Any proposed changes to the waiver will be submitted by the Medicaid agency to CMS in the form of waiver amendments.

Upon approval by CMS, the waiver application serves as the State's authority to provide home and community-based waiver services to the specified target groups. The State attests that it will abide by all provisions of the approved waiver and will continuously operate the waiver in accordance with the assurances specified in Section 5 and the additional requirements specified in Section 6 of the request.

**Signature:** _____ **Date:**

State Medicaid Director or Designee

| | |
|---|---|
| **First Name:** | David |
| **Last Name** | Parella |
| **Title:** | Medical Care Administration Director |
| **Agency:** | Department of Social Services |
| **Address 1:** | 25 Sigourney Street |
| **Address 2:** | |
| **City** | Hartford |
| **State** | CT |
| **Zip Code** | 06106 |
| **Telephone:** | 1-860-424-5116 |
| **E-mail** | David.parella@ct.gov |
| **Fax Number** | |

## Attachment #1: Transition Plan

Specify the transition plan for the waiver:

The only immediate change in this amendment application that impacts a current participant is the deletion of the service Independent Habilitation and change in provider qualifications for Supported Living. The intent of these two services will be delivered in one service named Individualized Home Supports. The transition will require changes in the MMIS system and new service authorizations for the participant's chosen vendors. DDS will notify service vendors and participants of this change within 30 days of the waiver renewal date and provide new service authorizations.

The amendment application contains some new services as well. Participants will receive a fact sheet describing the new services at the time of his/her next Individual Planning meeting and may choose to change services at that time. Information regarding the new service options will be available through the DDS case manager, Regional Offices and on the DDS web site. Participants may notify DDS that he/she wishes to change service selections prior to the next scheduled meeting if desired. In those cases, DDS will schedule a team meeting within 30 days to review the new service options and develop a new Plan of Care if desired.

The amendment application also contains new funding methodologies for individual service budgets. Current authorized services will remain unchanged through this renewal application. Requests for new services by current participants received after the renewal date of this waiver will be subject to the requirements outlined in this application.

# Appendix A: Waiver Administration and Operation

**1. State Line of Authority for Waiver Operation.** Specify the state line of authority for the operation of the waiver *(select one)*:

| | |
|---|---|
| ○ | The waiver is operated by the State Medicaid agency. Specify the Medicaid agency division/unit that has line authority for the operation of the waiver program (*select one; do not complete Item A-2*): |
| | ○ The Medical Assistance Unit *(name of unit)*: |
| | ○ Another division/unit within the State Medicaid agency that is separate from the Medical Assistance Unit (name of division/unit) |
| ■ | The waiver is operated by **Department of Developmental Services** a separate agency of the State that is not a division/unit of the Medicaid agency. In accordance with 42 CFR §431.10, the Medicaid agency exercises administrative discretion in the administration and supervision of the waiver and issues policies, rules and regulations related to the waiver. The interagency agreement or memorandum of understanding that sets forth the authority and arrangements for this policy is available through the Medicaid agency to CMS upon request. *Complete item A-2.* |

**2. Medicaid Agency Oversight of Operating Agency Performance.** When the waiver is not operated by the Medicaid agency, specify the methods that the Medicaid agency uses to ensure that the operating agency performs its assigned waiver operational and administrative functions in accordance with waiver requirements. Also specify the frequency of Medicaid agency assessment of operating agency performance:

The Department of Social Services (DSS) and Department of Developmental Services (DDS) utilize a Memorandum of Understanding to identify assigned waiver operational and administrative functions in accordance with waiver requirements. DSS is the single state Medicaid agency responsible for the overall administration of the HCBS Waiver and assuring that federal reporting and procedural requirements are satisfied. In carrying out these responsibilities, DSS performs the following functions:

1. Coordinates communication with federal officials concerning the waiver;
   Specifies and approves policies and procedures and consults with DDS in the implementation of such policies and procedures, that are necessary and appropriate for the administration and operation of the waiver in accordance with federal regulations and guidance;

2. Monitors waiver operations for compliance with federal regulations including, but not limited to, the areas of waiver eligibility determinations, service quality systems, plans of care, qualification of providers, and fiscal controls and accountability;

3. Determines Medicaid eligibility for potential waiver recipients/enrollee;

4. Establishes, in consultation and cooperation with DDS, the rates of reimbursement for services provided under the waiver;

5. Assists with the billing process for waiver services, completes billing process and claims for FFP for such services;

6. Prepares and submits, with assistance from DDS, all reports required by CMS or other federal agencies regarding the waiver; and,

7. Administers the hearing process through which an individual may request a reconsideration of any decisions that affect eligibility or the denial of waiver services as provided under federal law.

As the operating agency, DDS is responsible for the following components of the program:

1. Conducts initial assessments and required re-assessments of potential waiver enrollees/recipients using uniform assessment instrument(s), documentation and procedure to establish whether an individual meets all eligibility criteria including that set forth as part of the evaluation and criteria in 42 CFR Sec. 441.302;

2. Documents individual plans of care for waiver recipients in format(s) approved by DSS, which set forth: (1) individual service needs, (2) waiver services necessary to meet such needs, (3) the authorized service provider(s), and (4) the amount of waiver services authorized for the individual;

3. Establishes and maintains quality assurance and improvement systems designed to assure the ongoing recruitment of qualified providers of waiver services and documents adherence to all applicable state and federal laws and regulations pertaining to health and welfare consistent with the assurance made in the approved waiver application(s);

4. Develops and amends as necessary, training materials, activities, and initiatives sufficient to provide relevant DMR staff, waiver recipients, and potential waiver recipients, information and instruction related to participation in the waiver program;

5. Maintains and enhances, as necessary, a billing system which:

    a. Identifies the source documents that providers use to verify service delivery in accordance with individual plans of care;
    b. Assures that the data elements required by CMS for Federal Financial Participation (FFP) are collected and maintained at the time of service delivery;
    c. Provides computerized billing system(s) with audit capacity to identify problems and permit timely resolution; and
    d. Issues complete and accurate billing information and data to DSS in accordance with the schedules mutually established by the departments;

6. Maintains service delivery records in sufficient detail to assure that waiver services provided were authorized by individual plans of care and delivered by qualified providers in accordance with the waiver(s);

7. Provides ongoing support and performs periodic audit and assessment of providers of waiver services;

8. Establishes and maintains a person-centered component to the evaluation and improvement activities associated with waiver services;

9. Establishes, maintains and documents the delivery of “case management” and “broker” services as indicated in the individual plan of care;

10. Establishes and maintains a system that provides for continuous monitoring of the provision of waiver services to assure compliance with applicable health and welfare standards and evaluates individual outcomes and satisfaction;

11. Approves the waiver services and settings in which such services are provided;

12. Provides payment for such services from the annual budget allocation to DDS;

13. Assists DSS in establishing and maintaining rates of reimbursement for waiver services;

14, Assists DSS in the preparation of all waiver-related reports and communications with CMS; and,

15. Consults with DSS regarding all waiver-related activities and initiatives including, but not limited to, waiver applications and waiver amendments.

DSS receives quarterly reports from DDS as outlined in Appendix H (Quality Management) and meets with DDS on a quarterly basis to review key operating agency activities. DSS meets with DDS on an as needed basis to review individual or systemic issues as they arise. DSS prepares the annual 372 reports

**3. Use of Contracted Entities.** Specify whether contracted entities perform waiver operational and administrative functions on behalf of the Medicaid agency and/or the waiver operating agency (if applicable) (s*elect one)*:

| | |
|---|---|
| ■ | **Yes.** Contracted entities perform waiver operational and administrative functions on behalf of the Medicaid agency and/or the operating agency (if applicable). Specify the types of contracted entities and briefly describe the functions that they perform. *Complete Items A-5 and A-6.* |
| | MMIS system operated through a contract between DSS and EDS. DDS contracts with Fiscal Intermediaries to support individuals who serve as the employer of record, and to process invoices and makes payment for services for DDS. |
| ○ | **No**. Contracted entities do not perform waiver operational and administrative functions on behalf of the Medicaid agency and/or the operating agency (if applicable). |

**4. Role of Local/Regional Non-State Entities**. Indicate whether local or regional non-state entities perform waiver operational and administrative functions and, if so, specify the type of entity *(check each that applies)*:

| | |
|---|---|
| ☐ | **Local/Regional non-state public agencies** conduct waiver operational and administrative functions at the local or regional level. There is an **interagency agreement or memorandum of understanding** between the Medicaid agency and/or the operating agency (when authorized by the Medicaid agency) and each local/regional non-state agency that sets forth the responsibilities and performance requirements of the local/regional agency. The interagency agreement or memorandum of understanding is available through the Medicaid agency or the operating agency (if applicable). *Specify the nature of these agencies and complete items A-5 and A-6:* |
| | |
| ☐ | **Local/Regional non-governmental non-state entities** conduct waiver operational and administrative functions at the local or regional level. There is a **contract** between the Medicaid agency and/or the operating agency (when authorized by the Medicaid agency) and each local/regional non-state entity that sets forth the responsibilities and performance requirements of the local/regional entity. The contract(s) under which private entities conduct waiver operational functions are available to CMS upon request through the Medicaid agency or the operating agency (if applicable). *Specify the nature of these entities and complete items A-5 and A-6*: |
| | |
| ■ | **Not applicable** – Local/regional non-state agencies do not perform waiver operational and administrative functions. |

**5. Responsibility for Assessment of Performance of Contracted and/or Local/Regional Non-State Entities.** Specify the state agency or agencies responsible for assessing the performance of contracted and/or local/regional non-state entities in conducting waiver operational and administrative functions:

Department of Developmental Services

**6. Assessment Methods and Frequency.** Describe the methods that are used to assess the performance of contracted and/or local/regional non-state entities to ensure that they perform assigned waiver operational and administrative functions in accordance with waiver requirements. Also specify how frequently the performance of contracted and/or local/regional non-state entities is assessed:

1. The DDS fiscal intermediaries (V/FEA) are monitored by DDS per the terms of the contract. This includes quarterly meeting with DDS, maintenance of a complaint log by DDS, an audit of the organization as a whole by a licensed independent certified public account and submitted to the Department annually, with agreed upon procedures for the management of the DDS funds under the control of the V/FEA.
2. V/FEA is subject to audit by the Department, agents of the Department, and the State of Connecticut's Auditors of Public Accounts. Records must be made available in CT for the audit.
3. A copy of the most recent financial statement, with an opinion letter from a CPA with a CT license or by a CPA in the state the vendor performs it business in, is required as a part to the RFP proposal.
4. V/FEA must submit a cost report as requested for rate analysis.

**7. Distribution of Waiver Operational and Administrative Functions.** In the following table, specify the entity or entities that have responsibility for conducting each of the waiver operational and administrative functions listed (*check each that applies*):

In accordance with 42 CFR §431.10, when the Medicaid agency does not directly conduct a function, it supervises the performance of the function and establishes and/or approves policies that affect the function.

| Function | Medicaid Agency | Other State Operating Agency | Contracted Entity | Local Non-State Entity |
|---|---|---|---|---|
| Disseminate information concerning the waiver to potential enrollees | ■ | ■ | ☐ | ☐ |
| Assist individuals in waiver enrollment | ■ | ■ | ☐ | ☐ |
| Manage waiver enrollment against approved limits | ■ | ■ | ☐ | ☐ |
| Monitor waiver expenditures against approved levels | ■ | ■ | ■ | ☐ |
| Conduct level of care evaluation activities | ☐ | ■ | ☐ | ☐ |
| Review participant service plans to ensure that waiver requirements are met | ■ | ■ | ☐ | ☐ |
| Perform prior authorization of waiver services | ☐ | ■ | ☐ | ☐ |
| Conduct utilization management functions | ☐ | ■ | ☐ | ☐ |
| Recruit providers | ☐ | ■ | ☐ | ☐ |
| Execute the Medicaid provider agreement | ■ | ☐ | ☐ | ☐ |
| Determine waiver payment amounts or rates | ■ | ■ | ☐ | ☐ |
| Conduct training and technical assistance concerning waiver requirements | ■ | ■ | ■ | ☐ |

# Appendix B: Participant Access and Eligibility

## Appendix B-1: Specification of the Waiver Target Group(s)

**a. Target Group(s)**. Under the waiver of Section 1902(a)(10)(B) of the Act, the State limits waiver services to a group or subgroups of individuals. *In accordance with 42 CFR §441.301(b)(6), select one waiver target group, check each subgroup in the selected target group that may receive services under the waiver, and specify the minimum and maximum (if any) age of individuals served in each subgroup:*

| Select one Waiver Target Group | | Target Group/Subgroup | Minimum Age | Maximum Age | |
|---|---|---|---|---|---|
| | | | | Maximum Age Limit: Through age – | No Maximum Age Limit |
| ○ | **Aged or Disabled, or Both** *(select one)* | | | | |
| | ○ | **Aged or Disabled or Both – General** *(check each that applies)* | | | |
| | ☐ | Aged (age 65 and older) | | | ☐ |
| | ☐ | Disabled (Physical) (under age 65) | | | |
| | ☐ | Disabled (Other) (under age 65) | | | |
| | ○ | **Specific Recognized Subgroups** *(check each that applies)* | | | |
| | ☐ | Brain Injury | | | ☐ |
| | ☐ | HIV/AIDS | | | ☐ |
| | ☐ | Medically Fragile | | | ☐ |
| | ☐ | Technology Dependent | | | ☐ |
| ■ | **Mental Retardation or Developmental Disability, or Both** *(check each that applies)* | | | | |
| | ☐ | Autism | | | ☐ |
| | ■ | Developmental Disability | 18 years | | ■ |
| | ■ | Mental Retardation | 3 years | | ■ |
| ○ | **Mental Illness** *(check each that applies)* | | | | |
| | ☐ | Mental Illness (age 18 and older) | | | ☐ |
| | ☐ | Serious Emotional Disturbance (under age 18) | | | |

**b. Additional Criteria**. The State further specifies its target group(s) as follows:

Mental Retardation as defined by Con Gen Stat Sec 17a-210. Also included are those determined eligible for DDS services as a result of a hearing conducted by DDS according to the Uniform Administrative Procedures Act or administrative determination of the Commissioner.

Developmental Disability as a target group is limited to individuals who are developmentally disabled who currently reside in general NFs, but who have been shown, as a result of the Pre-Admission Screening and Annual Resident Review process mandated by P.L. 100-203 to require active treatment at the level of an ICF/MR.

Additional Criteria to designate the target group is that the person lives in or will live in a residence licensed or certified by the Department of Developmental Services, or lives in his/her own or family home and requires a level of support not available under the DDS IFS Waiver 0426(IP) due to intensive medical, physical, and/or behavioral conditions, and/or

insufficient availability of natural supports, as determined by a DDS Level of Need assessment.

**c. Transition of Individuals Affected by Maximum Age Limitation.** When there is a maximum age limit that applies to individuals who may be served in the waiver, describe the transition planning procedures that are undertaken on behalf of participants affected by the age limit *(select one)*:

| | |
|---|---|
| ■ | Not applicable – There is no maximum age limit |
| ○ | The following transition planning procedures are employed for participants who will reach the waiver's maximum age limit (*specify*): |
| | |

# Appendix B-2: Individual Cost Limit

**a. Individual Cost Limit.** The following individual cost limit applies when determining whether to deny home and community-based services or entrance to the waiver to an otherwise eligible individual *(select one)*:

| | |
|---|---|
| ○ | **No Cost Limit**. The State does not apply an individual cost limit. *Do not complete Item B-2-b or Item B-2-c.* |
| ○ | **Cost Limit in Excess of Institutional Costs.** The State refuses entrance to the waiver to any otherwise eligible individual when the State reasonably expects that the cost of the home and community-based services furnished to that individual would exceed the cost of a level of care specified for the waiver up to an amount specified by the State. *Complete Items B-2-b and B-2-c.* The limit specified by the State is *(select one)*: |
| | ○ [ ] %, a level higher than 100% of the institutional average |
| | ○ Other *(specify)*: |
| ○ | **Institutional Cost Limit**. Pursuant to 42 CFR 441.301(a)(3), the State refuses entrance to the waiver to any otherwise eligible individual when the State reasonably expects that the cost of the home and community-based services furnished to that individual would exceed 100% of the cost of the level of care specified for the waiver. *Complete Items B-2-b and B-2-c.* |
| ■ | **Cost Limit Lower Than Institutional Costs**. The State refuses entrance to the waiver to any otherwise qualified individual when the State reasonably expects that the cost of home and community-based services furnished to that individual would exceed the following amount specified by the State that is less than the cost of a level of care specified for the waiver. *Specify the basis of the limit, including evidence that the limit is sufficient to assure the health and welfare of waiver participants. Complete Items B-2-b and B-2-c.* |
| | The individuals who will be supported by this waiver will be reflective of the current population served by DDS but may have many more natural or informal supports available to them and will be able to take advantage of the flexibility and variety of service options in this waiver to remain in their own or family home. Individuals in this waiver will not require paid 24 hour care or supervision as a waiver service as a result of the natural or informal supports in place or as a result of the individual's level of supervision needs. These factors and the flexibility and variety of waiver services offered will allow individuals to be effectively supported by a waiver with a more limited benefit package. |
| | The cost limit specified by the State is *(select one)*: |
| | ■ The following dollar amount: $ 58,000 |
| | The dollar amount *(select one)*: |
| | ○ Is adjusted each year that the waiver is in effect by applying the following formula: |
| | ○ May be adjusted during the period the waiver is in effect. The State will submit a waiver amendment to CMS to adjust the dollar amount. |
| | ○ The following percentage that is less than 100% of the institutional average: [ ] % |

| | | |
|---|---|---|
| | ○ | Other – *Specify:* |
| | | |

**b. Method of Implementation of the Individual Cost Limit.** When an individual cost limit is specified in Item B-2-a, specify the procedures that are followed to determine in advance of waiver entrance that the individual's health and welfare can be assured within the cost limit:

The team submits a request for services to the Regional Planning and Allocation Team. Based on the findings of the LON Assessment, the PRAT notifies the team of the funding allocations. The team initiates the Individual Planning process in advance of enrollment in a DDS waiver. If the team determines that the initial allocation is insufficient to meet the individual's needs, the team submits a request for utilization review to the PRAT for consideration. The PRAT determines if a higher funding amount is justified. If approved, the participant will complete enrollment in the Comprehensive waiver and the Individual Plan is processed for service authorizations to initiate services. If the PRAT does not approve the higher funding request, the individual is provided opportunity to informally negotiate a resolution and is simultaneously notified of his/her fair hearing rights as a result of being denied enrollment in the DDS Comprehensive waiver.

**c. Participant Safeguards.** When the State specifies an individual cost limit in Item B-2-a and there is a change in the participant's condition or circumstances post-entrance to the waiver that requires the provision of services in an amount that exceeds the cost limit in order to assure the participant's health and welfare, the State has established the following safeguards to avoid an adverse impact on the participant (*check each that applies*):

| | |
|---|---|
| ○ | The participant is referred to another waiver that can accommodate the individual's needs. |
| ■ | Additional services in excess of the individual cost limit may be authorized. Specify the procedures for authorizing additional services, including the amount that may be authorized: |
| | The case manager submits to the PRAT a request for additional services/funding and an updated Level of Need Assessment supporting the request. The PRAT may authorize funding up to the amount associated with the participant's newly determined Level of Need. |
| ○ | Other safeguard(s) *(specify)*: |
| | |

# Appendix B-3: Number of Individuals Served

**a. Unduplicated Number of Participants**. The following table specifies the maximum number of unduplicated participants who are served in each year that the waiver is in effect. The State will submit a waiver amendment to CMS to modify the number of participants specified for any year(s), including when a modification is necessary due to legislative appropriation or another reason. The number of unduplicated participants specified in this table is basis for the cost-neutrality calculations in Appendix J:

| Table: B-3-a | |
|---|---|
| Waiver Year | Unduplicated Number of Participants |
| Year 1 | 4018 |
| Year 2 | 4468 |
| Year 3 | 4838 |
| Year 4 (renewal only) | 5208 |
| Year 5 (renewal only) | 5578 |

**b. Limitation on the Number of Participants Served at Any Point in Time**. Consistent with the unduplicated number of participants specified in Item B-3-a, the State may limit to a lesser number the number of participants who will be served at any point in time during a waiver year. Indicate whether the State limits the number of participants in this way: *(select one)*:

| | |
|---|---|
| ■ | The State does not limit the number of participants that it serves at any point in time during a waiver year. |
| ○ | The State limits the number of participants that it serves at any point in time during a waiver year. The limit that applies to each year of the waiver period is specified in the following table: |

| Table B-3-b | |
|---|---|
| Waiver Year | Maximum Number of Participants Served At Any Point During the Year |
| Year 1 | |
| Year 2 | |
| Year 3 | |
| Year 4 (renewal only) | |
| Year 5 (renewal only) | |

**c. Reserved Waiver Capacity.** The State may reserve a portion of the participant capacity of the waiver for specified purposes (e.g., provide for the community transition of institutionalized persons or furnish waiver services to individuals experiencing a crisis) subject to CMS review and approval. The State *(select one)*:

| | |
|---|---|
| ■ | **Not applicable**. The state does not reserve capacity. |
| ○ | The State reserves capacity for the following purpose(s). For each purpose, describe how the amount of reserved capacity was determined: |
| | |
| | The capacity that the State reserves in each waiver year is specified in the following table: |

**Table B-3-c**

| Waiver Year | Purpose: | Purpose: |
|---|---|---|
| | | |
| | Capacity Reserved | Capacity Reserved |
| Year 1 | | |
| Year 2 | | |
| Year 3 | | |
| Year 4 (renewal only) | | |
| Year 5 (renewal only) | | |

**d. Scheduled Phase-In or Phase-Out**. Within a waiver year, the State may make the number of participants who are served subject to a phase-in or phase-out schedule *(select one):*

| | |
|---|---|
| ■ | The waiver is not subject to a phase-in or a phase-out schedule. |
| ○ | The waiver is subject to a phase-in or phase-out schedule that is included in Attachment #1 to Appendix B-3. This schedule constitutes an ***intra-year*** limitation on the number of participants who are served in the waiver. |

**e. Allocation of Waiver Capacity.** *Select one:*

| | |
|---|---|
| ■ | Waiver capacity is allocated/managed on a statewide basis. |
| ○ | Waiver capacity is allocated to local/regional non-state entities. Specify: (a) the entities to which waiver capacity is allocated; (b) the methodology that is used to allocate capacity and how often the methodology is reevaluated; and, (c) policies for the reallocation of unused capacity among local/regional non-state entities: |
| | |

**f. Selection of Entrants to the Waiver.** Specify the policies that apply to the selection of individuals for entrance to the waiver:

The State DDS uses a priority system to select individuals for entrance to the DDS waivers. The DDS utilizes a Priority Checklist that incorporates findings from the Level of Needs Assessment and Risk

Screening Tool and collects findings on additional questions pertaining to individual and caregiver status. The system assigns the individual to one of three categories, either an Emergency, a Priority 1 or a Planning status as a result of the screening tools. Those identified as an Emergency require services immediately and are given first priority to the appropriate waiver program when slots are available. The Priority 1 group are those individuals identified as needing services within one year. Those with elderly caregivers (age 65 and above) are given priority within the Priority 1 sub-set. Other than individuals with emergency status and those with elderly caregivers, applicants with a Priority 1 status are managed on a first come, first served basis. Individuals who are dissatisfied with their priority assignment (E, P1, or Planning) may request in writing to the Commissioner of DDS a Fair Hearing pursuant to sub-section (e), section 17a-210, C.G.S., and/or, may initiate an informal dispute resolution process, Programmatic Administrative Review (PAR) set forth in DMR Policy 7 (1986). Individuals who request a PAR may also request a Fair Hearing at any time.

**Attachment #1 to Appendix B-3**

**Waiver Phase-In/Phase Out Schedule**

**a.** The waiver is being *(select one)*:

| | |
|---|---|
| ○ | Phased-in |
| ○ | Phased-out |

**b.** **Waiver Years Subject to Phase-In/Phase-Out Schedule** *(check each that applies)*:

| Year One | Year Two | Year Three | Year Four | Your Five |
|---|---|---|---|---|
| ☐ | ☐ | ☐ | ☐ | ☐ |

**c.** **Phase-In/Phase-Out Time Period**. *Complete the following table:*

| | Month | Waiver Year |
|---|---|---|
| Waiver Year: First Calendar Month | | |
| Phase-in/Phase out begins | | |
| Phase-in/Phase out ends | | |

d. **Phase-In or Phase-Out Schedule**. *Complete the following table:*

| **Phase-In or Phase-Out Schedule** | | | |
|---|---|---|---|
| | Waiver Year: | | |
| Month | Base Number of Participants | Change in Number of Participants | Participant Limit |
| | | | |
| | | | |
| | | | |
| | | | |
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| | | | |

# Appendix B-4: Medicaid Eligibility Groups Served in the Waiver

**a. State Classification.** The State is a *(select one)*:

| | |
|---|---|
| ○ | §1634 State |
| ○ | SSI Criteria State |
| ■ | 209(b) State |

**b. Medicaid Eligibility Groups Served in the Waiver.** Individuals who receive services under this waiver are eligible under the following eligibility groups contained in the State plan. The State applies all applicable federal financial participation limits under the plan. *Check all that apply:*

| | | | |
|---|---|---|---|
| ***Eligibility Groups Served in the Waiver (excluding the special home and community-based waiver group under 42 CFR §435.217)*** | | | |
| ☐ | Low income families with children as provided in §1931 of the Act | | |
| ☐ | SSI recipients | | |
| ■ | Aged, blind or disabled in 209(b) states who are eligible under 42 CFR §435.121 | | |
| ■ | Optional State supplement recipients | | |
| ☐ | Optional categorically needy aged and/or disabled individuals who have income at: *(select one)* | | |
| | ○ | 100% of the Federal poverty level (FPL) | |
| | ○ | % | of FPL, which is lower than 100% of FPL |
| ■ | Working individuals with disabilities who buy into Medicaid (BBA working disabled group as provided in §1902(a)(10)(A)(ii)(XIII)) of the Act) | | |
| ■ | Working individuals with disabilities who buy into Medicaid (TWWIIA Basic Coverage Group as provided in §1902(a)(10)(A)(ii)(XV) of the Act) | | |
| ☐ | Working individuals with disabilities who buy into Medicaid (TWWIIA Medical Improvement Coverage Group as provided in §1902(a)(10)(A)(ii)(XVI) of the Act) | | |
| ☐ | Disabled individuals age 18 or younger who would require an institutional level of care (TEFRA 134 eligibility group as provided in §1902(e)(3) of the Act) | | |
| ☐ | Medically needy | | |
| ■ | Other specified groups (include only the statutory/regulatory reference to reflect the additional groups in the State plan that may receive services under this waiver) *specify*: | | |
| | **Persons defined as qualified severely impaired individuals in section 1619(b) and 1905(q) of the Social Security Act** | | |
| ***Special home and community-based waiver group under 42 CFR §435.217)*** *Note: When the special home and community-based waiver group under 42 CFR §435.217 is included, Appendix B-5 must be completed* | | | |
| ○ | **No**. The State does not furnish waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217. Appendix B-5 is not submitted. | | |
| ■ | **Yes**. The State furnishes waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217. *Select one and complete Appendix B-5.* | | |

| | | | | | |
|---|---|---|---|---|---|
| ○ | All individuals in the special home and community-based waiver group under 42 CFR §435.217 | | | | |
| ■ | Only the following groups of individuals in the special home and community-based waiver group under 42 CFR §435.217 *(check each that applies)*: | | | | |
| | ■ | A special income level equal to (select one): | | | |
| | | ■ | 300% of the SSI Federal Benefit Rate (FBR) | | |
| | | ○ | % | of FBR, which is lower than 300% (42 CFR §435.236) | |
| | | ○ | $ | which is lower than 300% | |
| | ■ | Aged, blind and disabled individuals who meet requirements that are more restrictive than the SSI program (42 CFR §435.121) | | | |
| | ☐ | Medically needy without spenddown in States which also provide Medicaid to recipients of SSI (42 CFR §435.320, §435.322 and §435.324) | | | |
| | ☐ | Medically needy without spend down in 209(b) States (42 CFR §435.330) | | | |
| | ☐ | Aged and disabled individuals who have income at: *(select one)* | | | |
| | | ○ | 100% of FPL | | |
| | | ○ | % | of FPL, which is lower than 100% | |
| | ■ | Other specified groups (include only the statutory/regulatory reference to reflect the additional groups in the State plan that may receive services under this waiver) *specify*: | | | |

- **Persons found eligible for Medicaid under provisions of 1902(a)(10)(A)(ii)(XV) of the Social Security Act and persons defined as qualified severely impaired individuals in section 1619(b) and 1905(q) of the Social Security Act: <u>and</u>**
- **<u>Persons found eligible for Medicaid under the provisions of 1902(a)(10)(A)(ii)(XIII), of the Social Security Act.</u>**

# Appendix B-5: Post-Eligibility Treatment of Income

*In accordance with 42 CFR §441.303(e), Appendix B-5 must be completed when the State furnishes waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217, as indicated in Appendix B-4. Post-eligibility applies only to the 42 CFR §435.217 group. A State that uses spousal impoverishment rules under §1924 of the Act to determine the eligibility of individuals with a community spouse may elect to use spousal post-eligibility rules under §1924 of the Act to protect a personal needs allowance for a participant with a community spouse.*

**a. Use of Spousal Impoverishment Rules.** Indicate whether spousal impoverishment rules are used to determine eligibility for the special home and community-based waiver group under 42 CFR §435.217 *(select one)*:

- ■ Spousal impoverishment rules under §1924 of the Act are used to determine the eligibility of individuals with a community spouse for the special home and community-based waiver group. In the case of a participant with a community spouse, the State elects to (*select one*):
  - ■ Use *spousal* post-eligibility rules under §1924 of the Act. *Complete ItemsB-5-b-2 (SSI State and §1634) or B-5-c-2 (209b State) and Item B-5-d.*
  - ○ Use *regular* post-eligibility rules under 42 CFR §435.726 (SSI State and §1634) (*Complete Item B-5-b-1*) or under §435.735 (209b State) (*Complete Item B-5-c-1). Do not complete Item B-5-d.*
- ○ Spousal impoverishment rules under §1924 of the Act are not used to determine eligibility of individuals with a community spouse for the special home and community-based waiver group. The State uses regular post-eligibility rules for individuals with a community spouse. *Complete Item B-5-c-1 (SSI State and §1634) or Item B-5-d-1 (209b State). Do not complete Item B-5-d.*

**NOTE: Items B-5-b-1 and B-5-c-1 are for use by states that do not use spousal eligibility rules or use spousal impoverishment eligibility rules but elect to use regular post-eligibility rules.**

**b-1. Regular Post-Eligibility Treatment of Income: SSI State and §1634 State.** The State uses the post-eligibility rules at 42 CFR §435.726. Payment for home and community-based waiver services is reduced by the amount remaining after deducting the following allowances and expenses from the waiver participant's income:

**i. Allowance for the needs of the waiver participant** (*select one*):

- ○ The following standard included under the State plan *(select one)*
  - ○ SSI standard
  - ○ Optional State supplement standard
  - ○ Medically needy income standard
  - ○ The special income level for institutionalized persons *(select one):*
    - ○ 300% of the SSI Federal Benefit Rate (FBR)
    - ○ % of the FBR, which is less than 300%
    - ○ $ which is less than 300%.
  - ■ 200 % of the Federal poverty level
  - ○ Other (specify):

| | | | |
|---|---|---|---|
| ○ | The following dollar amount: | $ | If this amount changes, this item will be revised. |
| ○ | The following formula is used to determine the needs allowance: | | |

**ii. Allowance for the spouse only** (*select one*):

| | | | |
|---|---|---|---|
| ○ | SSI standard | | |
| ○ | Optional State supplement standard | | |
| ○ | Medically needy income standard | | |
| ○ | The following dollar amount: | $ | If this amount changes, this item will be revised. |
| ○ | The amount is determined using the following formula: | | |
| ○ | Not applicable *(see instructions)* | | |

**iii. Allowance for the family** *(select one)*:

| | | | |
|---|---|---|---|
| ○ | AFDC need standard | | |
| ○ | Medically needy income standard | | |
| ○ | The following dollar amount: | $ | The amount specified cannot exceed the higher of the need standard for a family of the same size used to determine eligibility under the State's approved AFDC plan or the medically needy income standard established under 42 CFR §435.811 for a family of the same size. If this amount changes, this item will be revised. |
| ○ | The amount is determined using the following formula: | | |
| ○ | Other (specify): | | |
| ○ | Not applicable *(see instructions)* | | |

**iv. Amounts for incurred medical or remedial care expenses not subject to payment by a third party, specified in 42 §CFR 435.726:**

a. Health insurance premiums, deductibles and co-insurance charges

b. Necessary medical or remedial care expenses recognized under State law but not covered under the State's Medicaid plan, subject to reasonable limits that the State may establish on the amounts of these expenses. *Select one:*

| | |
|---|---|
| ○ | Not applicable *(see instructions)* |
| ○ | The State does not establish reasonable limits. |
| ○ | The State establishes the following reasonable limits *(specify)*: |

**c-1. Regular Post-Eligibility: 209(b) State**. The State uses more restrictive eligibility requirements than SSI and uses the post-eligibility rules at 42 CFR §435.735. Payment for home and community-based waiver services is reduced by the amount remaining after deducting the following amounts and expenses from the waiver participant's income:

**i. Allowance for the needs of the waiver participant** (*select one*):

- ○ The following standard included under the State plan *(select one)*
  - ○ The following standard under 42 CFR §435.121:
  - ○ Optional State supplement standard
  - ○ Medically needy income standard
  - ○ The special income level for institutionalized persons *(select one)*
    - ○ 300% of the SSI Federal Benefit Rate (FBR)
    - ○ _____ of the FBR, which is less than 300%
    - ○ $ _____ which is less than 300% of the FBR
  - ○ _____ of the Federal poverty level
  - ○ Other (specify):
- ○ The following dollar amount: $ _____ If this amount changes, this item will be revised.
- ○ The following formula is used to determine the needs allowance:

**ii. Allowance for the spouse only** (*select one*):

- ○ The following standard under 42 CFR §435.121
- ○ Optional State supplement standard
- ○ Medically needy income standard
- ○ The following dollar amount: $ _____ If this amount changes, this item will be revised.
- ○ The amount is determined using the following formula:
- ■ Not applicable *(see instructions)*

**iii. Allowance for the family** *(select one)*

- ○ AFDC need standard
- ■ Medically needy income standard

| | |
|---|---|
| ○ | The following dollar amount: $ _____ The amount specified cannot exceed the higher of the need standard for a family of the same size used to determine eligibility under the State's approved AFDC plan or the medically needy income standard established under 42 CFR §435.811 for a family of the same size. If this amount changes, this item will be revised. |
| ○ | The amount is determined using the following formula: |
| | |
| ○ | Other (specify): |
| | |
| ○ | Not applicable *(see instructions)* |

**iv. Amounts for incurred medical or remedial care expenses not subject to payment by a third party, specified in 42 CFR §435.735:**

a. Health insurance premiums, deductibles and co-insurance charges

b. Necessary medical or remedial care expenses recognized under State law but not covered under the State's Medicaid plan, subject to reasonable limits that the State may establish on the amounts of these expenses. *Select one:*

| | |
|---|---|
| ○ | Not applicable *(see instructions)* |
| ○ | The State does not establish reasonable limits. |
| ○ | The State establishes the following reasonable limits *(specify)*: |
| | |

**NOTE: Items B-5-c-2 and B-5-d-2 are for use by states that use spousal impoverishment eligibility rules *and* elect to apply the spousal post eligibility rules.**

**b-2. Regular Post-Eligibility Treatment of Income: SSI State and §1634 state.** The State uses the post-eligibility rules at 42 CFR §435.726 for individuals who do not have a spouse or have a spouse who is not a community spouse as specified in §1924 of the Act. Payment for home and community-based waiver services is reduced by the amount remaining after deducting the following allowances and expenses from the waiver participant's income:

**i. Allowance for the needs of the waiver participant** (*select one*):

- ○ The following standard included under the State plan *(select one)*
  - ○ SSI standard
  - ○ Optional State supplement standard
  - ○ Medically needy income standard
  - ○ The special income level for institutionalized persons *(select one):*
    - ○ 300% of the SSI Federal Benefit Rate (FBR)
    - ○ ____ % of the FBR, which is less than 300%
    - ○ $ ____ which is less than 300%.
  - ○ ____ % of the Federal poverty level
  - ○ Other (specify):
- ○ The following dollar amount: $ ____ If this amount changes, this item will be revised.
- ○ The following formula is used to determine the needs allowance:

**ii. Allowance for the spouse only** (*select one*):

- ○ The state provides an allowance for a spouse who does not meet the definition of a community spouse in §1924 of the Act. Describe the circumstances under which this allowance is provided:

  Specify the amount of the allowance:
  - ○ SSI standard
  - ○ Optional State supplement standard
  - ○ Medically needy income standard
  - ○ The following dollar amount: $ ____ If this amount changes, this item will be revised.
  - ○ The amount is determined using the following formula:
- ○ Not applicable *(see instructions)*

**iii. Allowance for the family** *(select one)*:

| | |
|---|---|
| ○ | AFDC need standard |
| ○ | Medically needy income standard |
| ○ | The following dollar amount: $ ____ The amount specified cannot exceed the higher of the need standard for a family of the same size used to determine eligibility under the State's approved AFDC plan or the medically needy income standard established under 42 CFR §435.811 for a family of the same size. If this amount changes, this item will be revised. |
| ○ | The amount is determined using the following formula: |
| | |
| ○ | Other *(specify)*: |
| | |
| ○ | Not applicable *(see instructions)* |

**iv. Amounts for incurred medical or remedial care expenses not subject to payment by a third party, specified in 42 CFR §435.726:**

a. Health insurance premiums, deductibles and co-insurance charges

b. Necessary medical or remedial care expenses recognized under State law but not covered under the State's Medicaid plan, subject to reasonable limits that the State may establish on the amounts of these expenses. *Select one:*

| | |
|---|---|
| ○ | Not applicable *(see instructions)* |
| ○ | The State does not establish reasonable limits. |
| ○ | The State establishes the following reasonable limits *(specify)*: |
| | |

**c-2. Regular Post-Eligibility: 209(b) State**. The State uses more restrictive eligibility requirements than SSI and uses the post-eligibility rules at 42 CFR §435.735 for individuals who do not have a spouse or have a spouse who is not a community spouse as specified in §1924 of the Act. Payment for home and community-based waiver services is reduced by the amount remaining after deducting the following amounts and expenses from the waiver participant's income:

**i. Allowance for the needs of the waiver participant** (*select one*):

| | | | | |
|---|---|---|---|---|
| ○ | The following standard included under the State plan *(select one)* | | | |
| | ○ | The following standard under 42 CFR §435.121: | | |
| | | | | |
| | ○ | Optional State supplement standard | | |
| | ○ | Medically needy income standard | | |
| | ○ | The special income level for institutionalized persons *(select one)* | | |
| | | ○ | 300% of the SSI Federal Benefit Rate (FBR) | |
| | | ○ | ____ | of the FBR, which is less than 300% |
| | | ○ | $ | which is less than 300% of the FBR |

| | | | |
|---|---|---|---|
| | ■ | 200 % | of the Federal poverty level |
| | ○ | Other (specify): | |
| ○ | The following dollar amount: | $ | If this amount changes, this item will be revised. |
| ○ | The following formula is used to determine the needs allowance: | | |

**ii. Allowance for the spouse only** (*select one*):

| | | | |
|---|---|---|---|
| ○ | The state provides an allowance for a spouse who does not meet the definition of a community spouse in §1924 of the Act. Describe the circumstances under which this allowance is provided: | | |
| | Specify the amount of the allowance: | | |
| | ○ | The following standard under 42 CFR §435.121: | |
| | ○ | Optional State supplement standard | |
| | ○ | Medically needy income standard | |
| | ○ | The following dollar amount: | $ If this amount changes, this item will be revised. |
| | ○ | The amount is determined using the following formula: | |
| ■ | Not applicable *(see instructions)* | | |

**iii. Allowance for the family** *(select one)*

| | | |
|---|---|---|
| ○ | AFDC need standard | |
| ■ | Medically needy income standard | |
| ○ | The following dollar amount: $ | The amount specified cannot exceed the higher of the need standard for a family of the same size used to determine eligibility under the State's approved AFDC plan or the medically needy income standard established under 42 CFR §435.811 for a family of the same size. If this amount changes, this item will be revised. |
| ○ | The amount is determined using the following formula: | |
| ○ | Other (specify): | |

| | |
|---|---|
| ○ | Not applicable *(see instructions)* |

**iv. Amounts for incurred medical or remedial care expenses not subject to payment by a third party, specified in 42 CFR 435.735:**

a. Health insurance premiums, deductibles and co-insurance charges

b. Necessary medical or remedial care expenses recognized under State law but not covered under the State's Medicaid plan, subject to reasonable limits that the State may establish on the amounts of these expenses. *Select one:*

| | |
|---|---|
| ○ | Not applicable *(see instructions)* |
| ■ | The State does not establish reasonable limits. |
| ○ | The State establishes the following reasonable limits *(specify)*: |
| | |

**d. Post-Eligibility Treatment of Income Using Spousal Impoverishment Rules**

The State uses the post-eligibility rules of §1924(d) of the Act (spousal impoverishment protection) to determine the contribution of a participant with a community spouse toward the cost of home and community-based care if it determines the individual's eligibility under §1924 of the Act. There is deducted from the participant's monthly income a personal needs allowance (as specified below), a community spouse's allowance, a family allowance, and an amount for incurred expenses for medical or remedial care.

| | |
|---|---|
| **i. <u>Allowance for the personal needs of the waiver participant</u>** *(select one)***:** | |
| ○ | SSI Standard |
| ○ | Optional State Supplement standard |
| ○ | Medically Needy Income Standard |
| ○ | The special income level for institutionalized persons |
| ■ | 200 % of the Federal Poverty Level |
| ○ | The following dollar amount: $ If this amount changes, this item will be revised |
| ○ | The following formula is used to determine the needs allowance: |
| | |
| ○ | Other (*specify*)**:** |
| | |
| **ii**. If the allowance for the personal needs of a waiver participant with a community spouse is different from the amount used for the individual's maintenance allowance under 42 CFR §435.726 or 42 CFR §435.735, explain why this amount is reasonable to meet the individual's maintenance needs in the community. *Select one:* | |
| ■ | Allowance is the same |
| ○ | Allowance is different. Explanation of difference: |
| | |
| **iii**. Amounts for incurred medical or remedial care expenses not subject to payment by a third party, specified section 1902(r)(1) of the Act: | |
| a. Health insurance premiums, deductibles and co-insurance charges.<br>b. Necessary medical or remedial care expenses recognized under State law but not covered under the State's Medicaid plan, subject to reasonable limits that the State may establish on the amounts of these expenses. *Select one:* | |
| ○ | Not applicable *(see instructions)* |
| ■ | The State does not establish reasonable limits. |
| ○ | The State uses the same reasonable limits as are used for regular (non-spousal) post-eligibility. |

# Appendix B-6: Evaluation/Reevaluation of Level of Care

*As specified in 42 CFR §441.302(c), the State provides for an evaluation (and periodic reevaluations) of the need for the level(s) of care specified for this waiver, when there is a reasonable indication that an individual may need such services in the near future (one month or less), but for the availability of home and community-based waiver services.*

**a. Reasonable Indication of Need for Services.** In order for an individual to be determined to need waiver services, an individual must require: (a) the provision of at least one waiver service, as documented in the service plan, and (b) the provision of waiver services at least monthly or, if the need for services is less than monthly, the participant requires regular monthly monitoring which must be documented in the service plan. Specify the State's policies concerning the reasonable indication of the need for waiver services:

| | | |
|---|---|---|
| **i.** | **Minimum number of services**. The minimum number of waiver services (one or more) that an individual must require in order to be determined to need waiver services is *(insert number):* | |
| | 1 | |
| **ii.** | **Frequency of services**. The State requires *(select one)*: | |
| | O | The provision of waiver services at least monthly |
| | ■ | Monthly monitoring of the individual when services are furnished on a less than monthly basis. If the State also requires a minimum frequency for the provision of waiver services other than monthly (e.g., quarterly), specify the frequency: |
| | | Waiver services shall be provided at least once a year. The Case Manager will provide monitoring to assure health and welfare in the months the service is not provided and record in a monthly case management note in the individual record. |

**b. Responsibility for Performing Evaluations and Reevaluations**. Level of care evaluations and reevaluations are performed (*select one*):

| | |
|---|---|
| O | Directly by the Medicaid agency |
| ■ | By the operating agency specified in Appendix A |
| O | By an entity under contract with the Medicaid agency. *Specify the entity*: |
| | |
| O | Other (*specify*): |
| | |

**c. Qualifications of Individuals Performing Initial Evaluation:** Per 42 CFR §441.303(c)(1), specify the educational/professional qualifications of individuals who perform the initial evaluation of level of care for waiver applicants:

Case managers or CM Supervisors who meet QMRP standards.

**d. Level of Care Criteria.** Fully specify the level of care criteria that are used to evaluate and reevaluate whether an individual needs services through the waiver and that serve as the basis of the State's level of care instrument/tool. Specify the level of care instrument/tool that is employed. State laws, regulations, and policies concerning level of care criteria and the level of care instrument/tool are available to CMS upon request through the Medicaid agency or the operating agency (if applicable), including the instrument/tool utilized.

There is reasonable indication that the person, but for the provision of waiver services would require placement in an ICF/MR.

The person requires assistance due to one or more of the following:
1. Has a physical or medical disability requiring substantial and/or routine assistance as well as habilitative support in performing self-care and daily activities.
2. Has a deficit in self-care and daily living skills requiring habilitative training.
3. Has a maladaptive social and/or interpersonal patterns to the exent that he/she is incapable of conducting self-care or activities of daily living without habilitative training.

This determination is made through a planning and support team process based on comprehensive professional assessments, evaluations, and/or reports that are on file in the Client Record or another identified location.

**e. Level of Care Instrument(s)**. Per 42 CFR §441.303(c)(2), indicate whether the instrument/tool used to evaluate level of care for the waiver differs from the instrument/tool used to evaluate institutional level of care *(select one)*:

| | |
|---|---|
| ■ | The same instrument is used in determining the level of care for the waiver and for institutional care under the State Plan. |
| ○ | A different instrument is used to determine the level of care for the waiver than for institutional care under the State plan. Describe how and why this instrument differs from the form used to evaluate institutional level of care and explain how the outcome of the determination is reliable, valid, and fully comparable. |
| | |

**f. Process for Level of Care Evaluation/Reevaluation.** Per 42 CFR §441.303(c)(1), describe the process for evaluating waiver applicants for their need for the level of care under the waiver. If the reevaluation process differs from the evaluation process, describe the differences:

The DDS case manager on an annual basis completes a review of the record and enters on the Level of Care determination that the participant still meets Level of Care criteria.

**g. Reevaluation Schedule**. Per 42 CFR §441.303(c)(4), reevaluations of the level of care required by a participant are conducted no less frequently than annually according to the following schedule *(select one)*:

| | |
|---|---|
| ○ | Every three months |
| ○ | Every six months |
| ■ | Every twelve months |
| ○ | Other schedule (*specify*): |

| | |
|---|---|
| | |

**h. Qualifications of Individuals Who Perform Reevaluations.** Specify the qualifications of individuals who perform reevaluations *(select one)*:

| | |
|---|---|
| ■ | The qualifications of individuals who perform reevaluations are the same as individuals who perform initial evaluations. |
| ○ | The qualifications are different. The qualifications of individuals who perform reevaluations are *(specify)*: |
| | |

**i. Procedures to Ensure Timely Reevaluations.** Per 42 CFR §441.303(c)(4), specify the procedures that the State employs to ensure timely reevaluations of level of care *(specify)*:

The CT automated consumer information system (CAMRIS) maintains the date of the last Individual Annual Plan review. The Level of Care determination is completed at the time of each review. The case manager and case manager supervisor use this system as a tickler system.

**j. Maintenance of Evaluation/Reevaluation Records.** Per 42 CFR §441.303(c)(3), the State assures that written and/or electronically retrievable documentation of all evaluations and reevaluations are maintained for a minimum period of 3 years as required in 45 CFR §74.53. Specify the location(s) where records of evaluations and reevaluations of level of care are maintained:

All evaluations and re-evaluations are available in the DDS case management record. The initial evaluations are also maintained in the individual's DSS records.

# Appendix B-7: Freedom of Choice

***Freedom of Choice.*** *As provided in 42 CFR §441.302(d), when an individual is determined to be likely to require a level of care for this waiver, the individual or his or her legal representative is:*

*i. informed of any feasible alternatives under the waiver; and*
*ii. given the choice of either institutional or home and community-based services.*

**a. Procedures.** Specify the State's procedures for informing eligible individuals (or their legal representatives) of the feasible alternatives available under the waiver and allowing these individuals to choose either institutional or waiver services. Identify the form(s) that are employed to document freedom of choice. The form or forms are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Individuals seeking services from DDS are notified of the alternatives available under the waiver and are informed of their option to choose institutional or waiver services by the DDS case manager. This decision is documented on Form 222, Service Selection Form. The State provides individuals with the HCBS waiver Fact Sheet, and with the Guide to Understanding the DDS HCBS Waivers for Individuals and Families at the annual planning meeting, and both are available on the DDS web site.

**b. Maintenance of Forms**. Per 45 CFR §74.53, written copies or electronically retrievable facsimiles of Freedom of Choice forms are maintained for a minimum of three years. Specify the locations where copies of these forms are maintained.

DDS case management record and DSS record.

# Appendix B-8: Access to Services by Limited English Proficient Persons

**Access to Services by Limited English Proficient Persons**. Specify the methods that the State uses to provide meaningful access to the waiver by Limited English Proficient persons in accordance with the Department of Health and Human Services "Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons" (68 FR 47311 - August 8, 2003):

The State DDS prepares HCBS waiver informational materials in English and Spanish and posts both to the DDS web site. Additionally, the DDS utilizes a *Language Line* service to ensure that all individuals who call the DDS at the Central Office or Regional locations will have language interpreter service immediately upon the call. DDS policy states that language interpretation service will be provided free of charge at all intake, formal planning meetings, hearings or informal dispute resolution process sessions. Once enrolled in an HCBS waiver, interpreter services are also included as a covered waiver service for other purposes as detailed in the plan.

# Appendix C: Participant Services

## Appendix C-1: Summary of Services Covered

**a. Waiver Services Summary**. Appendix C-3 sets forth the specifications for each service that is offered under this waiver. *List the services that are furnished under the waiver in the following table. If case management is not a service under the waiver, complete items C-1-b and C-1-c:*

| **Statutory Services** *(check each that applies)* | | |
|---|---|---|
| Service | Included | Alternate Service Title (if any) |
| Case Management | ☐ | |
| Homemaker | ☐ | |
| Home Health Aide | ☐ | |
| Personal Care | ☐ | |
| Adult Day Health | ☐ | |
| Habilitation | ☐ | |
| Residential Habilitation | ■ | Individualized Home Supports, Community Training Homes(CTH) |
| Day Habilitation | ■ | Adult Day Health Services, Group and Individualized Day Supports |
| Expanded Habilitation Services as provided in 42 CFR §440.180(c): | | |
| Prevocational Services | ☐ | |
| Supported Employment | ■ | |
| Education | ☐ | |
| Respite | ■ | |
| Day Treatment | ☐ | |
| Partial Hospitalization | ☐ | |
| Psychosocial Rehabilitation | ☐ | |
| Clinic Services | ☐ | |
| Live-in Caregiver (42 CFR §441.303(f)(8)) | ■ | |

| **Other Services** *(select one)* | |
|---|---|
| ○ | Not applicable |
| ● | As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional services not specified in statute *(list each service by title)*: |
| a. | Adult Companion |

| | |
|---|---|
| b. | Clinical Behavioral Support Services |
| c. | Family Training |
| d. | Health Care Coordination |
| e. | Environmental Modifications |
| f. | Independent Support Broker |
| g. | Individualized Day Service |
| h. | Individual Goods and Services |
| i. | Interpreter Services |
| j. | Nutrition |
| k. | Personal Emergency Response System |
| l. | Personal Support |
| m. | Specialized Medical and Therapeutic Equipment and Supplies |
| n. | Transportation |
| o. | Vehicle Modifications |
| | |
| | |

**Extended State Plan Services** *(select one)*

| | |
|---|---|
| ● | Not applicable |
| ○ | The following extended State plan services are provided *(list each extended State plan service by service title)*: |
| a. | |
| b. | |
| c. | |

**Supports for Participant Direction** *(select one)*

| | |
|---|---|
| ● | The waiver provides for participant direction of services as specified in Appendix E. Indicate whether the waiver includes the following supports or other supports for participant direction. |
| ○ | Not applicable |

| Support | Included | Alternate Service Title (if any) |
|---|---|---|
| Information and Assistance in Support of Participant Direction | ■ | Independent Support Broker |
| Financial Management Services | ☐ | |

Other Supports for Participant Direction *(list each support by service title)*:

| | |
|---|---|
| a. | |

| | |
|---|---|
| b. | |
| c. | |

**b. Alternate Provision of Case Management Services to Waiver Participants.** When case management is not a covered waiver service, indicate how case management is furnished to waiver participants *(check each that applies)*:

| | |
|---|---|
| ■ | As a Medicaid State plan service under §1915(g)(1) of the Act (Targeted Case Management). *Complete item C-1-c.* |
| ☐ | As an administrative activity. *Complete item C-1-c.* |
| ☐ | Not applicable – Case management is not furnished as a distinct activity to waiver participants. *Do not complete Item C-1-c.* |

**c. Delivery of Case Management Services.** Specify the entity or entities that conduct case management functions on behalf of waiver participants:

State of CT DDS.

# Appendix C-2: General Service Specifications

**a. Criminal History and/or Background Investigations**. Specify the State's policies concerning the conduct of criminal history and/or background investigations of individuals who provide waiver services *(select one)*:

| | |
|---|---|
| ● | **Yes**. Criminal history and/or background investigations are required. Specify: (a) the types of positions (e.g., personal assistants, attendants) for which such investigations must be conducted; (b) the scope of such investigations (e.g., state, national); and, (c) the process for ensuring that mandatory investigations have been conducted. State laws, regulations and policies referenced in this description are available to CMS upon request through the Medicaid or the operating agency (if applicable): |
| | Direct Support and professional support services under the following service definitions are required to submit to state (CT) only criminal checks. This includes all staff employed under residential habilitation(CTH), individualized home support, group and individualized day services, supported employment, adult companion, personal support, respite, live-in caregiver, adult day health, individual goods and services, independent support brokers, interpreters, and transportation vendors not licensed as a livery service in the state of CT. Criminal background checks for providers of the following services may be required if requested by the individual receiving the supports or their representative: nutrition, clinical behavioral support, and healthcare coordination. Vendors enrolled as PERS, vehicle modifications, environmental modifications, or specialized medical and adaptive equipment are not required to submit to criminal background checks.<br><br>The process for ensuring that mandatory investigations have been completed depends upon the service and the hiring entity. The V/FEA is required to obtain a criminal background check for any service vendor hired through the consumer-directed process prior to processing any employment paperwork or permitting the employee to begin work. DDS conducts annual FI audits for consumer-directed services to ensure that the required criminal background checks are conducted. For DDS delivered services, the HR department is responsible to ensure all employees have successfully completed criminal background checks. For individually enrolled vendors, criminal background checks are required to enroll in the DDS HCBS waiver program and receive a provider agreement. For services operated by larger vendor agencies, the vendor agency agrees to obtain a criminal background check for any individual who provides the specified services as part of the Medicaid Provider Agreement. When an incident involving abuse/neglect or other misconduct by an employee reveals that the employee has a criminal history DDS Policy requires that DDS conducts an inquiry into the vendor agency's compliance with conducting criminal background checks. |
| | **No**. Criminal history and/or background investigations are not required. |

**b. Abuse Registry Screening**. Specify whether the State requires the screening of individuals who provide waiver services through a State-maintained abuse registry *(select one)*:

| | |
|---|---|
| ● | **Yes**. The State maintains an abuse registry and requires the screening of individuals through this registry. Specify: (a) the entity (entities) responsible for maintaining the abuse registry; (b) the types of positions for which abuse registry screenings must be conducted; and, (c) the process for ensuring that mandatory screenings have been conducted. State laws, regulations and policies referenced in this description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable): |

| | |
|---|---|
| | DDS maintains an abuse/neglect registry pursuant to CT General Statutes 17a-247a-17a-247e. All employees of DDS or agencies funded or licensed by DDS who are found guilty of abuse and terminated or separated from employment are subject to inclusion on the registry. The fiscal intermediary is required to ensure the abuse/neglect registry has been checked for all individual employees sought to be hired through consumer-direction. The DDS and private vendor is required to check the registry prior to hiring any employee who will deliver services. The DDS monitors this expectation during annual FI audits and at the vendor level through bi-annual Quality Service Reviews conducted by DDS. |
| ○ | **No**. The State does not conduct abuse registry screening. |

**c. Services in Facilities Subject to §1616(e) of the Social Security Act**. *Select one*:

| | |
|---|---|
| **O** | **No**. Home and community-based services under this waiver are not provided in facilities subject to §1616(e) of the Act. *Do not complete Items C-2-c.i – c.iii.* |
| ● | **Yes**. Home and community-based services are provided in facilities subject to §1616(e) of the Act. The standards that apply to each type of facility where waiver services are provided are available to CMS upon request through the Medicaid agency or the operating agency (if applicable). *Complete Items C-2-c.i –c.iii.* |

**i. Types of Facilities Subject to §1616(e)**. Complete the following table for *each type* of facility subject to §1616(e) of the Act:

| Type of Facility | Waiver Service(s) Provided in Facility | Facility Capacity Limit |
|---|---|---|
| Community Training Home (Adult or Children's Foster Care) | Residential Habilitation | 3 |
| | | |

**ii. Larger Facilities**: In the case of residential facilities subject to §1616(e) that serve four or more individuals unrelated to the proprietor, describe how a home and community character is maintained in these settings.

.

**iii. Scope of Facility Standards**. By type of facility listed in Item C-2-c-i, specify whether the State's standards address the following *(check each that applies)*:

| Standard | Facility Type<br>Community Training Home | Facility Type<br>Community Living Arrangements | Facility Type | Facility Type |
|---|---|---|---|---|
| Admission policies | ■ | ■ | ☐ | ☐ |
| Physical environment | ■ | ■ | ☐ | ☐ |
| Sanitation | ■ | ■ | ☐ | ☐ |
| Safety | ■ | ■ | ☐ | ☐ |
| Staff : resident ratios | ■ | ■ | ☐ | ☐ |
| Staff training and qualifications | ■ | ■ | ☐ | ☐ |
| Staff supervision | ■ | ■ | ☐ | ☐ |
| Resident rights | ■ | ■ | ☐ | ☐ |
| Medication administration | ☐ | ■ | ☐ | ☐ |
| Use of restrictive interventions | ■ | ■ | ☐ | ☐ |
| Incident reporting | ■ | ■ | ☐ | ☐ |
| Provision of or arrangement for necessary health services | ■ | ■ | ☐ | ☐ |

When facility standards do not address one or more of the topics listed, explain why the standard is not included or is not relevant to the facility type or population. Explain how the health and welfare of participants is assured in the standard area(s) not addressed:

The individual's team will review the medication regimen when developing the Individual Plan. The review will be based on anecdotal information, observation, or other method if identified by the team. The medication regimen will be reviewed quarterly with the review of the Individual Plan. The individual's Primary Care Physician will review their current plan of care at their annual physical exam and any subsequent visits.

**d. Provision of Personal Care or Similar Services by Legally Responsible Individuals.** A legally responsible individual is any person who has a duty under State law to care for another person and typically includes: (a) the parent (biological or adoptive) of a minor child or the guardian of a minor child who must provide care to the child or (b) a spouse of a waiver participant. Except at the option of the State and under extraordinary circumstances specified by the State, payment may not be made to a legally responsible individual for the provision of personal care or similar services that the legally responsible individual would ordinarily perform or be responsible to perform on behalf of a waiver participant. *Select one:*

| | |
|---|---|
| ● | **No**. The State does not make payment to legally responsible individuals for furnishing personal care or similar services. |
| ○ | **Yes**. The State makes payment to legally responsible individuals for furnishing personal care or similar services when they are qualified to provide the services. Specify: (a) the legally responsible individuals who may be paid to furnish such services and the services they may provide; (b) State policies that specify the circumstances when payment may be authorized for the provision of ***extraordinary care*** by a legally responsible individual and how the State ensures that the provision of services by a legally responsible individual is in the best interest of the participant; and, (c) the controls that are employed to ensure that payments are made only for services rendered. *Also, specify in Appendix C-3 the personal care or similar services for which payment may be made to legally responsible individuals under the State policies specified here.* |
| | |

**e. Other State Policies Concerning Payment for Waiver Services Furnished by Relatives/Legal Guardians**. Specify State policies concerning making payment to relatives/legal guardians for the provision of waiver services over and above the policies addressed in Item C-2-d. *Select one*:

| | |
|---|---|
| ○ | The State does not make payment to relatives/legal guardians for furnishing waiver services. |
| ● | The State makes payment to relatives/legal guardians under ***specific circumstances*** and only when the relative/guardian is qualified to furnish services. Specify the specific circumstances under which payment is made, the types of relatives/legal guardians to whom payment may be made, and the services for which payment may be made. Specify the controls that are employed to ensure that payments are made only for services rendered. *Also, specify in Appendix C-3 each waiver service for which payment may be made to relatives/legal guardians.* |
| | Requests to permit payment to relatives/legal guardians for furnishing the following waiver services: Individualized Home Supports, Individualized Day Supports, Supported Employment, Respite, Adult Companion, Interpreter Services, Personal Support, Live-in Caregiver, and Transportation are only permitted under consumer directed services, and must be approved by the DDS prior approval committee. This committee ensures that the provision of service is in the best interest of the participant. Additional requirements include the use of a support broker to ensure that the individual has engaged in recruitment activities and that there is a responsible person other than the paid family member, who, in addition to the participant, assumes employer responsibilities. Circumstances where this may be permitted are limited to relatives/legal guardians who possess the medical skills necessary to safely support the individual, or, when the Prior Approval Committee determines that qualified staff are otherwise not available. Payment to family members is only made when the service provided is not a function that a family member would normally provide for the individual without charge as a matter of course in the usual relationship among members of a nuclear family; and, the service would otherwise need to be provided by a qualified provider. |

| | |
|---|---|
| ○ | Relatives/legal guardians may be paid for providing waiver services whenever the relative/legal guardian is qualified to provide services as specified in Appendix C-3. Specify any limitations on the types of relatives/legal guardians who may furnish services. Specify the controls that are employed to ensure that payments are made only for services rendered. *Also, specify in Appendix C-3 each waiver service for which payment may be made to relatives/legal guardians.* |
| | |
| ○ | Other policy. *Specify*: |
| | |

**f. Open Enrollment of Providers**. Specify the processes that are employed to assure that all willing and qualified providers have the opportunity to enroll as waiver service providers as provided in 42 CFR §431.51:

All information regarding requirements for and instructions to enroll as a qualified provider for the DDS HCBS waivers is posted to the DDS web site. DDS completes the evaluation of qualified providers and notifies DSS for final provider enrollment. Any provider of services may submit an application for enrollment to the DDS Operation Center for any service at any time.

# Appendix C-3: Waiver Services Specifications

For each service listed in Appendix C-1, provide the information specified below. State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

| Service Specification | |
|---|---|
| Service Title: | **Individualized Home Supports** (formerly Supported Living or Individual Habilitation) |

*Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:*

| | |
|---|---|
| ○ | Service is included in approved waiver. There is no change in service specifications. |
| ● | Service is included in approved waiver. The service specifications have been modified. |
| ○ | Service is not included in the approved waiver. |

Service Definition (Scope)**:**

This service provides assistance with the acquisition, improvement and/or retention of skills and provides necessary support to achieve personal outcomes that enhance an individual's ability to live in their community as specified in the plan of care. This service includes a combination of habilitative and personal support activities as they would naturally occur during the course of a day. This service is not available for use in licensed settings. The service may be delivered in a personal home (one's own or family home) and in the community. Payments for Individualized Home Support do not include room and board.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

May not be provided at the same time as Group Day, Individualized Day, Supported Employment, Respite, Personal Support, or Adult Companion.

**Provider Specifications**

| Provider Category(s) *(check one or both)***:** | ■ | Individual. List types: | ■ | Agency. List the types of agencies: |
|---|---|---|---|---|
| | Individuals hired by the participant | | DDS Qualified Provider | |
| | | | | |
| | | | | |

| Specify whether the service may be provided by *(check each that applies):* | ☐ | Legally Responsible Person | ■ | Relative/Legal Guardian |
|---|---|---|---|---|

**Provider Qualifications** (*provide the following information for each type of provider*):

| Provider Type: | License *(specify)* | Certificate *(specify)* | Other Standard *(specify)* |
|---|---|---|---|
| Participant Directed Individual | | | Verified by the FI:<br>Prior to Employment<br>• 18 yrs of age<br>• criminal background check<br>• registry check<br>• have ability to communicate effectively with the individual/family<br>• have ability to complete record keeping as required by the employer |

| | | | |
|---|---|---|---|
| | | | Prior to being alone with the Individual:<br>• demonstrate competence in knowledge of DDS policies and procedures: abuse/neglect; incident reporting; client rights and confidentiality; handling fire and other emergencies, prevention of sexual abuse, knowledge of approved and prohibited physical management techniques<br>• demonstrate competence/knowledge in topics required to safely support the individual as described in the Individual Plan<br>• demonstrate competence, skills, abilities, education and/or experience necessary to achieve the specific training outcomes as described in the Individual Plan<br>• ability to participate as a member of the team if requested by the individual<br>• demonstrate understanding of Person Centered Planning<br>• demonstrate competence/knowledge in positive behavioral programming, working with individuals who experience moderate to severe psychological and psychiatric behavioral health needs and ability to properly implement behavioral support plans*<br>• Medication Administration*<br><br>* if required by the individual supported |
| DDS Qualified Provider | | Certified to provide Individualized Home Supports by DDS | Prior to Employment<br>• 18 yrs of age<br>• criminal background check<br>• registry check<br>• have ability to communicate effectively with the ind/family<br>• have ability to complete record keeping as required by the employer<br><br>Prior to being alone with the Individual:<br>• demonstrate competence in knowledge of DDS policies and procedures: abuse/neglect; incident reporting; client rights and |

| | | | |
|---|---|---|---|
| | | | confidentiality; handling fire and other emergencies, prevention of sexual abuse, knowledge of approved and prohibited physical management techniques<br>• demonstrate competence/knowledge in topics required to safely support the individual as described in the Individual Plan<br>• demonstrate competence, skills, abilities, education and/or experience necessary to achieve the specific training outcomes as described in the Individual Plan<br>• ability to participate as a member of the team if requested by the individual<br>• demonstrate understanding of Person Centered Planning<br>• Medication Administration*<br><br>* if required by the individual supported |

**Verification of Provider Qualifications**

| Provider Type: | Entity Responsible for Verification: | Frequency of Verification |
|---|---|---|
| Individual | FI | Prior to Employment |
| | DDS | Annual sample of participant-directed persons |
| DDS Qualified Provider | DDS | Initial and every 2 years certification thereafter |

| Service Delivery Method | | | | |
|---|---|---|---|---|
| **Service Delivery Method** *(check each that applies)*: | ■ | Participant-directed as specified in Appendix E | ■ | Provider managed |

| Service Title: | **Group Day Supports** |
|---|---|
| *Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:* | |
| ● | Service is included in approved waiver. There is no change in service specifications. |
| ○ | Service is included in approved waiver. The service specifications have been modified. |
| ○ | Service is not included in the approved waiver. |

Service Definition (Scope)**:**

Services and supports leading to the acquisition, improvement and/or retention of skills and abilities to prepare an individual for work and/or community participation, or support meaningful socialization, leisure and retirement activities. This service is generally provided by a qualified provider in a facility-based program.

Transportation to and from home is not included as part of this waiver service.

| Specify applicable (if any) limits on the amount, frequency, or duration of this service: | | | | |
|---|---|---|---|---|
| This service is limited to no more than 8 hours per day.<br>May not be provided at the same time as Individualized Day Supports, Supported Employment, Respite, Personal Support, Individualized Home Supports, or Adult Companion. | | | | |
| **Provider Specifications** | | | | |
| Provider Category(s) *(check one or both)*: | ☐ | Individual. List types: | ■ | Agency. List the types of agencies: |
| | | | | DDS Qualified Provider |
| | | | | |
| Specify whether the service may be provided by *(check each that applies):* | ☐ | Legally Responsible Person | ☐ | Relative/Legal Guardian |

**Provider Qualifications** (*provide the following information for each type of provider)*:

| Provider Type: | License *(specify)* | Certificate *(specify)* | Other Standard *(specify)* |
|---|---|---|---|
| DDS Qualified Provider | | Certified to provide Group Day Supports. | Prior to Employment<br>• 18 yrs of age<br>• criminal background check<br>• registry check<br>• have ability to communicate effectively with the individual/family<br>• have ability to complete record keeping as required by the employer<br><br>Prior to being alone with the Individual:<br>• demonstrate competence in knowledge of DDS policies and procedures: abuse/neglect; incident reporting; client rights and confidentiality; handling fire and other emergencies, prevention of sexual abuse, knowledge of approved and prohibited physical management techniques<br>• demonstrate competence/knowledge in topics required to safely support the individual as described in the Individual Plan<br>• demonstrate competence, skills, abilities, education and/or experience necessary to achieve the specific training outcomes as described in the Individual Plan<br>• ability to participate as a member of the circle if requested by the individual<br>• demonstrate understanding of Person Centered Planning<br>• Medication Administration* |

| | | | |
|---|---|---|---|
| | | | * if required by the individual supported |

**Verification of Provider Qualifications**

| Provider Type: | Entity Responsible for Verification: | Frequency of Verification |
|---|---|---|
| DDS Qualified Provider | DDS | Initial and every 2 years certification thereafter |

Service Delivery Method

| | | | | |
|---|---|---|---|---|
| **Service Delivery Method** *(check each that applies)*: | ☐ | Participant-directed as specified in Appendix E | ■ | Provider managed |

| Service Title: | **Individualized Day Support** |
|---|---|

*Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:*

| | |
|---|---|
| ● | Service is included in approved waiver. There is no change in service specifications. |
| ○ | Service is included in approved waiver. The service specifications have been modified. |
| ○ | Service is not included in the approved waiver. |

Service Definition (Scope)**:**

Services and supports provided to individuals tailored to their specific personal outcomes related to the acquisition, improvement and/or retention of skills and abilities to prepare and support an individual for work and/or community participation and/or meaningful retirement activities, or for an individual who has their own business, and could not do so without this direct support. This service is not delivered in or from a facility-based program. This service may be self directed or provided by a qualified provider.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

This service is limited to no more than 8 hours per day.

May not be provided at the same time as Individualized Home Supports, Group Day, Supported Employment, Respite, Personal Support, Adult Companion, Intensive Behavioral In-home Supports.

Provider Specifications

| | | | | |
|---|---|---|---|---|
| Provider Category(s) *(check one or both)*: | ■ | Individual. List types: | ■ | Agency. List the types of agencies: |
| | Individuals hired by the participant | | DDS Qualified Providers | |
| | | | | |

| | | | | |
|---|---|---|---|---|
| Specify whether the service may be provided by *(check each that applies):* | ☐ | Legally Responsible Person | ■ | Relative/Legal Guardian |

Provider Qualifications (*provide the following information for each type of provider)*:

| Provider Type: | License *(specify)* | Certificate *(specify)* | Other Standard *(specify)* |
|---|---|---|---|
| Participant-directed Individual | | | Verified by the FI:<br>Prior to Employment<br>• 18 yrs of age<br>• criminal background check<br>• registry check<br>• have ability to communicate effectively with the individual/family |

| | | | |
|---|---|---|---|
| | | | • have ability to complete record keeping as required by the employer<br><br>Prior to being alone with the Individual:<br>• demonstrate competence in knowledge of DDS policies and procedures: abuse/neglect; incident reporting; client rights and confidentiality; handling fire and other emergencies, prevention of sexual abuse, knowledge of approved and prohibited physical management techniques<br>• demonstrate competence/knowledge in topics required to safely support the individual as described in the Individual Plan<br>• demonstrate competence, skills, abilities, education and/or experience necessary to achieve the specific training outcomes as described in the Individual Plan<br>• ability to participate as a member of the team if requested by the individual<br>• demonstrate understanding of Person Centered Planning<br>• Medication Administration*<br><br>* if required by the individual supported |
| DDS Qualified Provider | | Certified to provide Individualized Day Supports | Prior to Employment<br>• 18 yrs of age<br>• criminal background check<br>• registry check<br>• have ability to communicate effectively with the individual/family<br>• have ability to complete record keeping as required by the employer<br><br>Prior to being alone with the Individual:<br>• demonstrate competence in knowledge of DDS policies and procedures: abuse/neglect; incident reporting; client rights and confidentiality; handling fire and other emergencies, prevention of sexual abuse, knowledge of approved and prohibited physical management techniques |

| | | | |
|---|---|---|---|
| | | | • demonstrate competence/knowledge in topics required to safely support the individual as described in the Individual Plan<br>• demonstrate competence, skills, abilities, education and/or experience necessary to achieve the specific training outcomes as described in the Individual Plan<br>• ability to participate as a member of the circle if requested by the individual<br>• demonstrate understanding of Person Centered Planning<br>• Medication Administration*<br><br>* if required by the individual supported |

**Verification of Provider Qualifications**

| Provider Type: | Entity Responsible for Verification: | Frequency of Verification |
|---|---|---|
| Individual | FI | Prior to Employment |
| | DDS | Annual sample of consumer-directed persons |
| DDS Qualified Provider | DDS | Initial and every 2 years certification thereafter |

| Service Delivery Method | | | | |
|---|---|---|---|---|
| **Service Delivery Method** *(check each that applies)*: | ■ | Participant-directed as specified in Appendix E | ■ | Provider managed |

| Service Title: | **Supported Employment** |
|---|---|
| *Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:* | |
| ○ | Service is included in approved waiver. There is no change in service specifications. |
| ● | Service is included in approved waiver. The service specifications have been modified. |
| ○ | Service is not included in the approved waiver. |

Service Definition (Scope)**:**

Supported Employment consists 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 without 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 adaptations, supervision and training required by participants receiving waiver services as a result of their disabilities but does not include payment for supervisory activities rendered as a normal part of the business setting.

Supported Employment includes:

1. Individual placement: A supported employment placement strategy in which an employment specialist (job coach) places a participant into competitive employment through a job discovery process, provides training and support, and then gradually reduces time and assistance at the worksite. This service option may also include development and on-going support for self-employment by the participant. This assistance consists of: (a) assisting the participant to identify potential business opportunities; (b) assisting the participant 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.
2. Group: A supported employment situation in competitive employment environment in which a group of participants with disabilities are working at a particular work setting. The participants may be disbursed throughout the company and among workers without disabilities or congregated as a group in one part of the business;
3. Mobile Work Crew: A group of participants who perform work in a variety of locations under the supervision of a permanent employment specialist (job coach/supervisor).

FFP will not be claimed for incentive payments, subsidies, or unrelated vocational training expenses such as the following:

1. Incentive payments made to an employer to encourage or subsidize the employer's participation in a supported employment program;
2. Payments that are passed through to users of supported employment programs; or payments for vocational training that is not directly related to a participant's supported employment.

Transportation to and from home is not included as part of this waiver service.

Supported employment services furnished under the waiver are not available under a program funded by either a program funded by either the Rehabilitation Act of 1973 or P.L. 94-142.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

This service is limited to no more than 8 hours per day or 40 hours per week.

May not be provided at the same time as Group Day Supports, Individualized Day Supports, Individualized Home Supports, Respite, Personal Support, Adult Companion, or Intensive Behavioral In-home Supports.

**Provider Specifications**

| Provider Category(s) *(check one or both)*: | ■ | Individual. List types: | ■ | Agency. List the types of agencies: |
|---|---|---|---|---|
| | Individuals hired by the participant | | DDS Qualified Providers | |
| | | | | |
| | | | | |

| Specify whether the service may be provided by *(check each that applies):* | ☐ | Legally Responsible Person | ■ | Relative/Legal Guardian |
|---|---|---|---|---|

**Provider Qualifications** (*provide the following information for each type of provider)*:

| Provider Type: | License *(specify)* | Certificate *(specify)* | Other Standard *(specify)* |
|---|---|---|---|
| Participant-directed Individual | | | Prior to Employment<br>• 21 years of age<br>• criminal background check |

| | | | |
|---|---|---|---|
| | | | • registry check<br>• have ability to communicate effectively with the individual/family<br>• have ability to complete record keeping as required by the employer<br>Prior to being alone with the individual<br>• demonstrate competence in knowledge of DDS policies and procedures: abuse/neglect; incident reporting; human rights and confidentiality; handling fire and other emergencies, prevention of sexual abuse.<br>• demonstrate competence/knowledge in topics required to safely support the individual as described in the Individual Plan<br>• demonstrate competence, skills, abilities, education and/or experience necessary to achieve the specific outcomes as described in the IP<br>• ability to participate as a member of the circle if requested by the individual<br>• Medication Administration*<br>* if required by the individual supported |
| DDS Qualified Provider | | Certified to provide Supported Employment by DDS | Individual staff : Prior to Employment<br>• 21 years of age<br>• criminal background check<br>• registry check<br>• have ability to communicate effectively with the individual/family<br>• have ability to complete record keeping as required by the employer<br>Prior to being alone with the individual<br>• demonstrate competence in knowledge of DDS policies and procedures: abuse/neglect; incident reporting; human rights and confidentiality; handling fire and other emergencies, prevention of sexual abuse.<br>• demonstrate competence, skills, abilities, education and/or experience necessary to achieve the specific outcomes as described in the IP |

| | | | |
|---|---|---|---|
| | | | • ability to participate as a member of the circle if requested by the individual<br>• Medication Administration*<br>* if required by the individual supported |
| | | | |

**Verification of Provider Qualifications**

| Provider Type: | Entity Responsible for Verification: | Frequency of Verification |
|---|---|---|
| Individual | FI | Prior to Employment |
| | DDS | Annual sample of consumer-directed persons |
| DDS Qualified Provider | DDS | Initial and every 2 years certification thereafter |

| Service Delivery Method | | | | |
|---|---|---|---|---|
| **Service Delivery Method** *(check each that applies)*: | ■ | Participant-directed as specified in Appendix E | ■ | Provider managed |

| **Service Title:** | **Residential Habilitation (Community Training Homes)** |
|---|---|

***Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:***

| | |
|---|---|
| ○ | Service is included in approved waiver. There is no change in service specifications. |
| ○ | Service is included in approved waiver. The service specifications have been modified. |
| ● | Service is not included in the approved waiver. |

Service Definition (Scope)**:**

Assist with the acquisition, improvement and /or retention of skills and provide necessary support to achieve personal outcomes that enhance an individual's ability to live in their community as specified in their Individual Plan. This service is specifically designed to result in learned outcomes, but can also include elements of personal support that occur naturally during the course of the day. Examples of the type of support that may occur in these settings include:

- Provision of instruction and training in one or more need areas to enhance the individual's ability to access and use the community;
- Implement strategies to address behavioral, medical or other needs identified in the Individual Plan;
- Implement all therapeutic recommendations including Speech, O.T., P.T., and assist in following special diets and other therapeutic routines;
- Mobility training;
- Adaptive communication training;
- Training or practice in basic consumer skills such as shopping or banking; and,
- Assisting the individual with all personal care activities.

Provision of these services is limited to licensed CLA and CTH settings. Payments for residential habilitation in these settings do not include room and board, the cost of facility maintenance, upkeep or improvement.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

This is an all inclusive support model and cannot be used in combination with Personal Support or Adult

Companion services.

| Provider Specifications | | | | |
|---|---|---|---|---|
| Provider Category(s) *(check one or both)*: | ■ | Individual. List types: | ☐ | Agency. List the types of agencies: |
| | Individuals Licensed as Community Training Home Providers | | | |

| Specify whether the service may be provided by *(check each that applies):* | ☐ | Legally Responsible Person | ☐ | Relative/Legal Guardian |
|---|---|---|---|---|

**Provider Qualifications** (*provide the following information for each type of provider)*:

| Provider Type: | License *(specify)* | Certificate *(specify)* | Other Standard *(specify)* |
|---|---|---|---|
| DDS Licensed CTH Provider | | | Prior to Employment<br>• 18 yrs of age<br>• criminal background check<br>• registry check<br>• have ability to communicate effectively with the individual/family<br>• have ability to complete record keeping as required by the employer<br><br>Prior to being alone with the Individual:<br>• demonstrate competence in knowledge of DDS policies and procedures: abuse/neglect; incident reporting; client rights and confidentiality; handling fire and other emergencies, prevention of sexual abuse, knowledge of approved and prohibited physical management techniques<br>• demonstrate competence/knowledge in topics required to safely support the individual as described in the Individual Plan<br>• demonstrate competence, skills, abilities, education and/or experience necessary to achieve the specific training outcomes as described in the Individual Plan<br>• ability to participate as a member of the circle if requested by the individual<br>• demonstrate understanding of Person Centered Planning |

**Verification of Provider Qualifications**

| Provider Type: | Entity Responsible for Verification: | Frequency of Verification |
|---|---|---|

| | | |
|---|---|---|
| CTH provider | DDS | Initial and every 2 years certification thereafter |

| Service Delivery Method | | | | |
|---|---|---|---|---|
| **Service Delivery Method** *(check each that applies)*: | ☐ | Participant-directed as specified in Appendix E | ■ | Provider managed |

| | |
|---|---|
| Service Title: | **Family Training** |
| *Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:* | |
| ● | Service is included in approved waiver. There is no change in service specifications. |
| ○ | Service is included in approved waiver. The service specifications have been modified. |
| ○ | Service is not included in the approved waiver. |

Service Definition (Scope)**:**

Training and counseling services for the families of individuals served on this waiver. For purposes of this service, "family" is defined as the persons who live with or provide care to a person served on the waiver, and may include a parent, spouse, children, relatives, foster family, or in-laws. "Family" does not include individuals who are employed to care for the consumer. Training includes instruction about treatment regimens and use of equipment specified in the plan of care, and shall include updates as necessary to safely maintain the individual at home. All family training must be included in the individual's written plan of care.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

**Provider Specifications**

| | | | | |
|---|---|---|---|---|
| Provider Category(s) *(check one or both)***:** | ☐ | Individual. List types: | ■ | Agency. List the types of agencies: |
| | | | | DDS |
| | | | | |

| | | | | |
|---|---|---|---|---|
| Specify whether the service may be provided by *(check each that applies):* | ☐ | Legally Responsible Person | ☐ | Relative/Legal Guardian |

**Provider Qualifications** (*provide the following information for each type of provider)*:

| Provider Type: | License *(specify)* | Certificate *(specify)* | Other Standard *(specify)* |
|---|---|---|---|
| **DDS Clinicians listed below**: | | | **All clinicians listed must be employees of DDS and must meet the Dept. of Administrative Services, Bureau of Human Resources Job Specifications** |
| Psychologist | Connecticut General Statutes Chapter 383 | | |
| Special Educators | CGS Title 20 – Licensure | | |
| OT<br>PT | CGS Chapter 368a | | |

| | | | |
|---|---|---|---|
| SP/L<br><br>Dietician<br><br>Behavior Specialist | Department of Public Health<br><br>Dietician/Nutrition Licensure per CGS Chapter 384b | | |

**Verification of Provider Qualifications**

| Provider Type: | Entity Responsible for Verification: | Frequency of Verification |
|---|---|---|
| DDS | DDS | Initial and Annual |

Service Delivery Method

| | | | | |
|---|---|---|---|---|
| **Service Delivery Method** *(check each that applies)*: | ☐ | Participant-directed as specified in Appendix E | ■ | Provider managed |

| | | | | |
|---|---|---|---|---|
| Service Title: | **Respite** | | | |
| *Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:* | | | | |
| ● | Service is included in approved waiver. There is no change in service specifications. | | | |
| ○ | Service is included in approved waiver. The service specifications have been modified. | | | |
| ○ | Service is not included in the approved waiver. | | | |
| Service Definition (Scope)**:** | | | | |
| Services provided to individuals unable to care for themselves; furnished on a short-term basis because of the absence or need for relief of those persons normally providing the care. FFP will not be claimed for the cost of room and board except when provided as part of respite care furnished in a facility approved by the State that is not a private residence. Respite care will be provided in the following location(s):<br>Individual's home or place of residence; DDS certified respite care facility; DDS certified residential camp program. | | | | |
| Specify applicable (if any) limits on the amount, frequency, or duration of this service: | | | | |
| Respite may be provided for up to 30 consecutive days. Respite services beyond 30 consecutive will require approval from DDS.<br>May not be provided at the same time as Group Day, Individualized Day, Supported Employment, Personal Support, Adult Companion, or Individualized Home Supports. | | | | |

| | | | | |
|---|---|---|---|---|
| Provider Category(s) *(check one or both)***:** | ■ | Individual. List types: | ■ | Agency. List the types of agencies: |
| | Individuals hired by the participant | | DDS Qualified Provider | |
| | | | | |
| | | | | |

| Specify whether the service may be provided by *(check each that applies):* | ☐ | Legally Responsible Person | ■ | Relative/Legal Guardian |
|---|---|---|---|---|

**Provider Qualifications** (*provide the following information for each type of provider)*:

| Provider Type: | License *(specify)* | Certificate *(specify)* | Other Standard *(specify)* |
|---|---|---|---|
| Participant-directed Individual | | Enrolled to provide In-Home Respite by DDS | Verified by the FI:<br>Prior to Employment<br>• 18 yrs of age<br>• criminal background check<br>• registry check<br>• have ability to communicate effectively with the individual/family<br>• have ability to complete record keeping as required by the employer<br><br>Prior to being alone with the Individual:<br>• demonstrate competence in knowledge of DDS policies and procedures: abuse/neglect; incident reporting; client rights and confidentiality; handling fire and other emergencies, prevention of sexual abuse, knowledge of approved and prohibited physical management techniques<br>• demonstrate competence/knowledge in topics required to safely support the individual as described in the Individual Plan<br>• demonstrate competence/knowledge in positive behavioral programming, working with individuals who experience moderate to severe psychological and psychiatric behavioral health needs and ability to properly implement behavioral support plans*<br>• Medication Administration*<br>* if required by the individual supported |
| DDS Qualified Provider | | Vendor Certified to provide Respite.<br><br>Facilities and/or entities and individuals certified in accordance with subsection (d) of Section 17a-218, | Individual Qualifications:<br>Prior to Employment<br>• 18 yrs of age<br>• criminal background check<br>• registry check<br>• have ability to communicate effectively with the individual/family<br>• have ability to complete record |

| | | | |
|---|---|---|---|
| | | the regulations promulgated there under, or otherwise certified as a "qualified provider" of respite services by DDS and Reg. Conn. Agencies-DMR Sections 17a-218-8 through 17a-218-17 (The "Respite Regs") | keeping as required by the employer<br><br>Prior to being alone with the Individual:<br>• demonstrate competence in knowledge of DDS policies and procedures: abuse/neglect; incident reporting; client rights and confidentiality; handling fire and other emergencies, prevention of sexual abuse, knowledge of approved and prohibited physical management techniques<br>• demonstrate competence/knowledge in topics required to safely support the individual as described in the Individual Plan<br>• demonstrate competence/knowledge in positive behavioral programming, working with individuals who experience moderate to severe psychological and psychiatric behavioral health needs and ability to properly implement behavioral support plans*<br>• Medication Administration*<br>* if required by the individual supported |

**Verification of Provider Qualifications**

| Provider Type: | Entity Responsible for Verification: | Frequency of Verification |
|---|---|---|
| Individual | FI | Prior to Employment |
| | DDS | Annual sample of consumer-directed persons |
| DDS Qualified Provider | DDS | Initial and every 2 years certification thereafter |

| Service Delivery Method | | | | |
|---|---|---|---|---|
| **Service Delivery Method** *(check each that applies)*: | ■ | Participant-directed as specified in Appendix E | ■ | Provider managed |

| Service Title: | **Live-in Caregiver** |
|---|---|
| *Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:* | |
| ○ | Service is included in approved waiver. There is no change in service specifications. |
| ○ | Service is included in approved waiver. The service specifications have been modified. |
| ● | Service is not included in the approved waiver. |

Service Definition (Scope)**:**

Live-In Caregiver services are provided in a participant's home by a principal care provider (Caregiver) who lives as a house mate with the participant. Live-In Caregiver services are furnished to adults who require someone to assume as-needed responsibility for their physical and social well-being as determined by Individual

Plan process. Caregiver assists in implementing the needed supports as identified in the Plan of Care such as assisting the participant to retain or improve skills related to health, activities of daily living, money management, community mobility, recreation, cooking, shopping, use of community resources, community safety and other adaptive skills needed to live in the community. Community access activities and coordination of transportation services are provided as needed by the principal Caregiver. The payment for the additional costs of rent and food that can be reasonably attributed to an unrelated live-in personal caregiver who resides in the same household as the waiver participant are provided under this service. The live-in caregiver may also provide an authorized waiver service for the participant.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Payment will not be made when the participant lives in the caregiver's home or in a residence that is owned or leased by the provider of Medicaid services.

**Provider Specifications**

| Provider Category(s) *(check one or both)*: | ■ | Individual. List types: | ■ | Agency. List the types of agencies: |
|---|---|---|---|---|
| | Individuals hired by the participant | | DDS Qualified Providers | |
| | | | | |
| | | | | |

| Specify whether the service may be provided by *(check each that applies):* | ☐ | Legally Responsible Person | ■ | Relative/Legal Guardian |
|---|---|---|---|---|

**Provider Qualifications** (*provide the following information for each type of provider)*:

| Provider Type: | License *(specify)* | Certificate *(specify)* | Other Standard *(specify)* |
|---|---|---|---|
| Participant-directed Individual | | | Verified by the FI:<br>Prior to Employment<br>• 18 yrs of age<br>• criminal background check<br>• registry check<br>• have ability to communicate effectively with the individual/family<br>• have ability to complete record keeping as required by the employer<br><br>Prior to being alone with the Individual:<br>• demonstrate competence in knowledge of DDS policies and procedures: abuse/neglect; incident reporting; client rights and confidentiality; handling fire and other emergencies, prevention of sexual abuse, knowledge of approved and prohibited physical management techniques<br>• demonstrate competence/knowledge in topics required safely support the individual as described in the Individual Plan<br>• demonstrate competence, skills, |

| | | | |
|---|---|---|---|
| | | | abilities, education and/or experience necessary to achieve the specific training outcomes as described in the Individual Plan<br>• ability to participate as a member of the team if requested by the individual<br>• demonstrate understanding of Person Centered Planning<br>• Medication Administration*<br>* if required by the individual supported |
| DDS Qualified Provider | | Certified to provide Live-in Caregiver Service. | Individual Support person Prior to Employment<br>• 18 yrs of age<br>• criminal background check<br>• registry check<br>• have ability to communicate effectively with the individual/family<br>• have ability to complete record keeping as required by the employer<br><br>Prior to being alone with the Individual:<br>• demonstrate competence in knowledge of DDS policies and procedures: abuse/neglect; incident reporting; client rights and confidentiality; handling fire and other emergencies, prevention of sexual abuse, knowledge of approved and prohibited physical management techniques<br>• demonstrate competence/knowledge in topics required to safely support the individual as described in the Individual Plan<br>• demonstrate competence, skills, abilities, education and/or experience necessary to achieve the specific training outcomes as described in the Individual Plan<br>• ability to participate as a member of the circle if requested by the individual<br>• demonstrate understanding of Person Centered Planning<br>• Medication Administration*<br>* if required by the individual supported |
| **Verification of Provider Qualifications** | | | |

| Provider Type: | Entity Responsible for Verification: | Frequency of Verification |
|---|---|---|
| Individual | FI | Prior to Employment |
| | DDS | Annual sample of consumer-directed persons |
| DDS Qualified Provider | DDS | Initial and every 2 years certification thereafter |

| Service Delivery Method | | | | |
|---|---|---|---|---|
| **Service Delivery Method** *(check each that applies)*: | ■ | Participant-directed as specified in Appendix E | ■ | Provider managed |

| **Service Title:** | **Adult Companion** |
|---|---|
| ***Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:*** | |
| ● | Service is included in approved waiver. There is no change in service specifications. |
| ○ | Service is included in approved waiver. The service specifications have been modified. |
| ○ | Service is not included in the approved waiver. |

Service Definition (Scope)**:**

Non-medical care, supervision and socialization provided to an adult. Services may include assistance with meals and basic activities of daily living incidental to the support and supervision of the individual. This service is provided to carry out personal outcomes identified in the individual plan that supports an individual to successfully live in his/her own home. This service does not entail hands-on nursing care, except as permitted under the *Nurse Practice Act (CGS 20-101).*

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

›rovided at the same time as Group Day, Individualized Day, Supported Employment, Respite, Individualized Home Support, or Personal Support.

**Provider Specifications**

| Provider Category(s) *(check one or both)***:** | ■ | Individual. List types: | ■ | Agency. List the types of agencies: |
|---|---|---|---|---|
| | Individuals hired by the participant | | DDS Qualified Provider | |
| | | | | |
| | | | | |

| Specify whether the service may be provided by *(check each that applies):* | ☐ | Legally Responsible Person | ■ | Relative/Legal Guardian |
|---|---|---|---|---|

**Provider Qualifications** (*provide the following information for each type of provider)*:

| Provider Type: | License *(specify)* | Certificate *(specify)* | Other Standard *(specify)* |
|---|---|---|---|
| Participant-directed Individual | | | Verified by the FI:<br>Prior to Employment<br>• 18 yrs of age<br>• criminal background check<br>• registry check<br>• have ability to communicate effectively with the individual/family |

| | | | |
|---|---|---|---|
| | | | • have ability to complete record keeping as required by the employer<br><br>Prior to being alone with the Individual:<br>• demonstrate competence in knowledge of DDS policies and procedures: abuse/neglect; incident reporting; client rights and confidentiality; handling fire and other emergencies, prevention of sexual abuse, knowledge of approved and prohibited physical management techniques<br>• demonstrate competence/knowledge in topics required to safely support the individual as described in the Individual Plan<br>• Medication Administration*<br><br>* if required by the individual supported |
| DDS Qualified Provider | | Certified to provide Companion Care. | Prior to Employment<br>• 18 yrs of age<br>• criminal background check<br>• registry check<br>• have ability to communicate effectively with the individual/family<br>• have ability to complete record keeping as required by the employer<br><br>Prior to being alone with the Individual:<br>• demonstrate competence in knowledge of DDS policies and procedures: abuse/neglect; incident reporting; client rights and confidentiality; handling fire and other emergencies, prevention of sexual abuse, knowledge of approved and prohibited physical management techniques<br>• demonstrate competence/knowledge in topics required to safely support the individual as described in the Individual Plan<br>• Medication Administration*<br><br>* if required by the individual supported |

**Verification of Provider Qualifications**

| Provider Type: | Entity Responsible for Verification: | Frequency of Verification |
|---|---|---|

| | | |
|---|---|---|
| Individual | FI | Prior to Employment |
| | DDS | Annual sample of consumer-directed persons |
| DDS Qualified Provider | DDS | Initial and every 2 years certification thereafter |

| Service Delivery Method | | | | |
|---|---|---|---|---|
| **Service Delivery Method** *(check each that applies)*: | ■ | Participant-directed as specified in Appendix E | ■ | Provider managed |

| | |
|---|---|
| Service Title: | **Clinical Behavioral Support Services** (replaces Consultative Therapy) |

*Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:*

| | |
|---|---|
| ○ | Service is included in approved waiver. There is no change in service specifications. |
| ● | Service is included in approved waiver. The service specifications have been modified. |
| ○ | Service is not included in the approved waiver. |

Service Definition (Scope)**:**

Clinical and therapeutic services which are not covered by the Medicaid State Plan, necessary to improve the individual's independence and inclusion in their community. This service is available to individuals who have intellectual disabilities and demonstrate an emotional, behavioral or mental health issue that results in the functional impairment of the individual and substantially interferes with or limits functioning at home or in the community. Professional clinical service to include: 1) Assess and evaluate the behavioral and clinical need(s); 2) Develop a behavioral support plan that includes intervention techniques as well as teaching strategies for increasing new adaptive positive behaviors, and decreasing challenging behaviors addressing these needs in the individual's natural environments; 3) Provide training to the individual's family and the support providers in appropriate implementation of the behavioral support plan and associated documentation; and, 4) Evaluate the effectiveness of the behavioral support plan by monitoring the plan on a monthly basis, and by meeting with the team one month after the implementation of the behavior plan, and in future three month intervals. The service will include any changes to the plan when necessary and the professional(s) shall be available to the team for questions and consultation. The professional(s) shall make recommendations to the Individual Support Team and Case Manager for referrals to community physicians and other clinical professionals that support the recommendations of the assessment findings as appropriate. Use of this service requires the preparation of a formal comprehensive assessment and submission of any restrictive behavioral support program to the DDS Program Review Committee for approval prior to implementation.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

This service is limited to no more than $2,500 per year.

| Provider Specifications | | | | |
|---|---|---|---|---|
| Provider Category(s) *(check one or both)***:** | ■ | Individual. List types: | ☐ | Agency. List the types of agencies: |
| | Psychologists | | | |
| | Behavior Specialist | | | |
| | Licensed Clinical Social Workers | | | |

| | | | | |
|---|---|---|---|---|
| | Professional Counselor | | | |
| Specify whether the service may be provided by *(check each that applies):* | ☐ | Legally Responsible Person | ☐ | Relative/Legal Guardian |

**Provider Qualifications** (*provide the following information for each type of provider)*:

| Provider Type: | License *(specify)* | Certificate *(specify)* | Other Standard *(specify)* |
|---|---|---|---|
| Psychologist | Connecticut General Statutes Chapter 383 | Enrolled to Provide Clinical Behavioral Supports by DDS | **All qualified providers**--Criminal background check if requested by the participant.<br>Registry check if requested by the participant. |
| Professional Counselor | Connecticut General Statutes Chapter 383 c | Enrolled to Provide Clinical Behavioral Supports by DDS | **All qualified providers**--Providers of this service to children must have 3 years of experience in working with children and adolescents with intellectual disabilities. |
| Behavior Specialist | | Enrolled to Provide Clinical Behavioral Supports by DDS | **Behavior Specialist Only**--Masters degree in psychology, special education or applied behavior analysis and course work in human behavior.<br>One year experience working with people with intellectual disabilities. |

**Verification of Provider Qualifications**

| Provider Type: | Entity Responsible for Verification: | Frequency of Verification |
|---|---|---|
| Individual | FI | Prior to Employment for participant-directed service |
| | DDS | Annual sample of consumer-directed persons |
| | DDS | Initially and every two years thereafter |

Service Delivery Method

| | | | | |
|---|---|---|---|---|
| **Service Delivery Method** *(check each that applies)*: | ■ | Participant-directed as specified in Appendix E | ■ | Provider managed |

| Service Title: | **Health Care Coordination** |
|---|---|
| *Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:* | |
| ○ | Service is included in approved waiver. There is no change in service specifications. |
| ○ | Service is included in approved waiver. The service specifications have been modified. |
| ● | Service is not included in the approved waiver. |

Service Definition (Scope)**:**

Consultation and assistance provided to waiver participants and his/her paid and unpaid caregivers to review medical appointment outcomes, clinical assessment and test outcomes, communicate with physicians to ensure care is coordinated between specialties, advise the consumer and non-licensed support staff on health care needs

and instructions, and provide counseling to the consumer regarding personal health care needs and lifestyle practices. This service shall provide the technical guidance necessary to support the participant in managing health care services and supports to improve health outcomes.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

This service is only available to individuals with identified health risks who receive Individualized Supports in their own home.

**Provider Specifications**

| Provider Category(s) *(check one or both)*: | ■ | Individual. List types: | ☐ | Agency. List the types of agencies: |
|---|---|---|---|---|
| | RN | | | |

| Specify whether the service may be provided by *(check each that applies):* | ☐ | Legally Responsible Person | ☐ | Relative/Legal Guardian |
|---|---|---|---|---|

**Provider Qualifications** (*provide the following information for each type of provider)*:

| Provider Type: | License *(specify)* | Certificate *(specify)* | Other Standard *(specify)* |
|---|---|---|---|
| RN | CGS Chapter 368a Department of Public Health | Enrolled as a Provider of Health Care Coordination by DDS | Criminal background check if requested by the participant.<br>Registry check if requested by the participant. |

**Verification of Provider Qualifications**

| Provider Type: | Entity Responsible for Verification: | Frequency of Verification |
|---|---|---|
| Individual | DDS | Initial and every 2 years verification. |

**Service Delivery Method**

| | ■ | Participant-directed as specified in Appendix E | ■ | Provider managed |
|---|---|---|---|---|

| **Service Title:** | **Adult Day Health Services** |
|---|---|

***Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:***

| | |
|---|---|
| **O** | Service is included in approved waiver. There is no change in service specifications. |
| ○ | Service is included in approved waiver. The service specifications have been modified. |
| ■ | Service is not included in the approved waiver. |

Service Definition (Scope)**:**

Adult day health services are provided through a community-based program designed to meet the needs of cognitively and physically impaired adults through a structure, comprehensive program that provides a variety of health, social and related support services including, but not limited to, socialization, supervision and monitoring, personal care and nutrition in a protective setting during any part of a day. There are two different models of adult day health services: the social model and the medical model. Both models shall include the minimum requirements described in Section 17b-342-2(b)(2) of the DSS regulations. In order to qualify as a medical model, adult day health services shall also meet the requirements described in Section 17b-342-2(b)(3) of the DSS regulations.

| Specify applicable (if any) limits on the amount, frequency, or duration of this service: |
|---|
| May not be provided at the same time as Group Day, Supported Employment, Respite, or Personal Support. |

**Provider Specifications**

| Provider Category(s) *(check one or both)*: | ☐ | Individual. List types: | ■ | Agency. List the types of agencies: |
|---|---|---|---|---|
| | | | | DDS Vendor Agencies |

| Specify whether the service may be provided by *(check each that applies):* | ☐ | Legally Responsible Person | ☐ | Relative/Legal Guardian |
|---|---|---|---|---|

**Provider Qualifications** (*provide the following information for each type of provider)*:

| Provider Type: | License *(specify)* | Certificate *(specify)* | Other Standard *(specify)* |
|---|---|---|---|
| Qualified Provider | | Certified to provide Adult Day Health Supports by DDS or DSS | Prior to Employment<br>• 18 yrs of age<br>• criminal background check<br>• registry check<br>• have ability to communicate effectively with the individual/family<br>• have ability to complete record keeping as required by the employer<br>Prior to being alone with the Individual:<br>• demonstrate competence in knowledge of DDS policies and procedures: abuse/neglect; incident reporting; client rights and confidentiality; handling fire and other emergencies, prevention of sexual abuse, knowledge of approved and prohibited physical management techniques<br>• demonstrate competence/knowledge in topics required to safely support the individual as described in the Individual Plan<br>• demonstrate competence, skills, abilities, education and/or experience necessary to achieve the specific training outcomes as described in the Individual Plan<br>• ability to participate as a member of the circle if requested by the individual<br>• demonstrate understanding of Person Centered Planning<br>• Medication Administration*<br>* if required by the individual supported |

**Verification of Provider Qualifications**

| Provider Type: | Entity Responsible for Verification: | Frequency of Verification |
|---|---|---|
| Qualified Provider | DDS or DSS | Initial and every 2 years certification thereafter |

| Service Delivery Method | | | | |
|---|---|---|---|---|
| **Service Delivery Method** *(check each that applies)*: | **O** | Participant-directed as specified in Appendix E | ■ | Provider managed |

| **Service Title:** | **Individual Goods and Services** |
|---|---|

***Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:***

| | |
|---|---|
| ● | Service is included in approved waiver. There is no change in service specifications. |
| ○ | Service is included in approved waiver. The service specifications have been modified. |
| ○ | Service is not included in the approved waiver. |

Service Definition (Scope)**:**

Services, equipment or supplies that will provide direct benefit to the individual and support specific outcomes identified in the Individual Plan. The service, equipment or supply must either reduce the reliance of the individual on other paid supports, be directly related to the health and/or safety of the individual in his/her home or in the community, be habilitative in nature and contribute to a therapeutic goal, enhance the individual's ability to be integrated into the community, or provide resources to expand self-advocacy skills and knowledge, and, the individual has no other funds to purchase the described goods or services. Examples include but are not limited to cleaning services, specialized clothing for work or safety for the individual, public speaking training, and specialized therapies. Experimental and prohibited treatments are excluded.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

This service is only available for individuals who self-direct his/her own supports, and must be pre-approved by DDS and follow DDS Cost Standards. DDS applies consistent guidelines in respect to the appropriateness of the services or items to be approved in this service definition. This service may not duplicate any Medicaid State Plan service.

**Provider Specifications**

| Provider Category(s) *(check one or both)***:** | ■ | Individual. List types: | ■ | Agency. List the types of agencies: |
|---|---|---|---|---|
| | | Individuals hired by the participant | | DDS Qualified Providers |

| Specify whether the service may be provided by *(check each that applies):* | ☐ | Legally Responsible Person | ■ | Relative/Legal Guardian |
|---|---|---|---|---|

**Provider Qualifications** (*provide the following information for each type of provider)*:

| Provider Type: | License *(specify)* | Certificate *(specify)* | Other Standard *(specify)* |
|---|---|---|---|
| Participant-directed Individual | | | Verified by the FI:<br>Prior to Employment<br>• 18 yrs of age<br>• criminal background check<br>• registry check<br>• have ability to communicate effectively with the |

| | | | |
|---|---|---|---|
| | | | individual/family<br>• have ability to complete record keeping as required by the employer<br><br>Prior to being alone with the Individual:<br>• demonstrate competence in knowledge of DDS policies and procedures: abuse/neglect; incident reporting; client rights and confidentiality; handling fire and other emergencies, prevention of sexual abuse, knowledge of approved and prohibited physical management techniques<br>• demonstrate competence/knowledge in topics required to safely support the individual as described in the Individual Plan<br>• demonstrate competence, skills, abilities, education and/or experience necessary to achieve the specific training outcomes as described in the Individual Plan<br>• ability to participate as a member of the circle if requested by the individual<br>• demonstrate understanding of Person Centered Planning<br>• Medication Administration*<br>* if required by the individual supported |
| DDS Qualified Provider | | Certified to provide Individualized Goods and Services | Prior to Employment<br>• 18 yrs of age<br>• criminal background check<br>• registry check<br>• have ability to communicate effectively with the individual/family<br>• have ability to complete record keeping as required by the employer<br><br>Prior to being alone with the Individual:<br>• demonstrate competence in knowledge of DDS policies and procedures: abuse/neglect; incident reporting; client rights and confidentiality; handling fire and other emergencies, prevention of sexual abuse, knowledge of approved and prohibited physical management techniques |

| | | | |
|---|---|---|---|
| | | | • demonstrate competence/knowledge in topics required to safely support the individual as described in the Individual Plan<br>• demonstrate competence, skills, abilities, education and/or experience necessary to achieve the specific training outcomes as described in the Individual Plan<br>• ability to participate as a member of the circle if requested by the individual<br>• demonstrate understanding of Person Centered Planning<br>• Medication Administration*<br><br>* if required by the individual supported |

**Verification of Provider Qualifications**

| Provider Type: | Entity Responsible for Verification: | Frequency of Verification |
|---|---|---|
| Individual | FI | Prior to Employment |
| | DDS | Annual sample of consumer-directed persons |
| DDS Qualified Provider | DDS | Initial and every 2 years certification thereafter |

Service Delivery Method

| | | | | |
|---|---|---|---|---|
| **Service Delivery Method** *(check each that applies)*: | ■ | Participant-directed as specified in Appendix E | ☐ | Provider managed |

| **Service Title:** | **Interpreter** |
|---|---|

***Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:***

| | |
|---|---|
| ● | Service is included in approved waiver. There is no change in service specifications. |
| ○ | Service is included in approved waiver. The service specifications have been modified. |
| ○ | Service is not included in the approved waiver. |

Service Definition (Scope)**:**

Service of an interpreter to provide accurate, effective and impartial communication where the waiver recipient or representative is deaf or hard of hearing or where the individual does not understand spoken English.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

| Provider Specifications | | | | |
|---|---|---|---|---|
| Provider Category(s) *(check one or both)*: | ■ | Individual. List types: | ■ | Agency. List the types of agencies: |
| | Individuals hired by the participant | | DDS Qualified Providers | |
| Specify whether the service may be provided by *(check each that applies):* | ☐ | Legally Responsible Person | ■ | Relative/Legal Guardian |

**Provider Qualifications** (*provide the following information for each type of provider)*:

| Provider Type: | License *(specify)* | Certificate *(specify)* | Other Standard *(specify)* |
|---|---|---|---|
| Participant-directed Individual | | **Sign language interpreter**: Certified by National Assn. Of the Deaf or National registry of Interpreters for the Deaf. Sign language interpreters must be registered with the Commission on the Deaf and Hearing Impaired. | Any other language interpreter: Prior to Employment<br>• 18 yrs of age<br>• criminal background check<br>• registry check<br>• have ability to communicate effectively with the individual/family<br>• be proficient in both languages<br>• be committed to confidentiality<br>• understand cultural nuances and emblems<br>• understands the interpreter's role to provide accurate interpretation |
| DDS Qualified Provider | | Certified to provide Interpreter Services by DDS<br><br>**Sign language interpreter**: Certified by National Assn. Of the Deaf or National registry of Interpreters for the Deaf.<br>Sign language interpreters must be registered with the Commission on the Deaf and Hearing Impaired. | Any other language interpreter: Prior to Employment<br>• 18 yrs of age<br>• criminal background check<br>• registry check<br>• have ability to communicate effectively with the individual/family<br>• be proficient in both languages<br>• be committed to confidentiality<br>• understand cultural nuances and emblems<br>• understands the interpreter's role to provide accurate interpretation |

**Verification of Provider Qualifications**

| Provider Type: | Entity Responsible for Verification: | Frequency of Verification |
|---|---|---|
| Individual | FI | Prior to Employment |
| | DDS | Annual sample of consumer-directed persons |
| DDS Qualified Provider | DDS | Initial and every 2 years certification thereafter |

**Service Delivery Method**

| **Service Delivery Method** *(check each that applies)*: | ■ | Participant-directed as specified in Appendix E | ■ | Provider managed |
|---|---|---|---|---|

| **Service Title:** | **Nutrition (formerly Consultative Services)** |
|---|---|

***Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:***

| | |
|---|---|
| ○ | Service is included in approved waiver. There is no change in service specifications. |
| ● | Service is included in approved waiver. The service specifications have been modified. |
| ○ | Service is not included in the approved waiver. |

Service Definition (Scope)**:**

Clinical assessment and development of special diets, positioning techniques for eating; recommendations for adaptive equipment for eating and counseling for dietary needs related to medical diagnosis for participants and paid support staff.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

This service is limited to 25 hours of service per year.

**Provider Specifications**

| Provider Category(s) *(check one or both)***:** | ■ | Individual. List types: | ☐ | Agency. List the types of agencies: |
|---|---|---|---|---|
| | | Dietician | | |

| Specify whether the service may be provided by *(check each that applies):* | ☐ | Legally Responsible Person | ☐ | Relative/Legal Guardian |
|---|---|---|---|---|

**Provider Qualifications** (*provide the following information for each type of provider)*:

| Provider Type: | License *(specify)* | Certificate *(specify)* | Other Standard *(specify)* |
|---|---|---|---|
| Dietician | Dietitian Licensure per CGS Chapter 384b | Enrolled as a Nutrition Vendor by DDS. | Criminal background check if desired by the participant.<br>Registry check if desired by the participant. |

**Verification of Provider Qualifications**

| Provider Type: | Entity Responsible for Verification: | Frequency of Verification |
|---|---|---|
| Individual | FI | Prior to Employment |
| | DDS | Annual sample of consumer- |

| | | |
|---|---|---|
| | | directed persons |
| DDS Qualified Provider | DDS | Initial and every 2 years certification thereafter |

| Service Delivery Method | | | | |
|---|---|---|---|---|
| **Service Delivery Method** *(check each that applies)*: | ■ | Participant-directed as specified in Appendix E | ■ | Provider managed |

| **Service Title:** | **Personal Emergency Response System** |
|---|---|

***Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:***

| | |
|---|---|
| ● | Service is included in approved waiver. There is no change in service specifications. |
| ○ | Service is included in approved waiver. The service specifications have been modified. |
| ○ | Service is not included in the approved waiver. |

Service Definition (Scope)**:**

PERS is an electronic device which enables certain individuals at high risk of institutionalization to secure help in an emergency. The individual may also wear a portable "help" button to allow for mobility. The system is connected to the person's phone and programmed to signal a response center once a "help" button is activated. The response center is staffed by trained professionals, as specified in Appendix B-2. PERS services are limited to those individuals who live alone, or who are alone for significant parts of the day, and have no regular caregiver for extended periods of time, and who would otherwise require extensive routine supervision.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

,

| Provider Specifications | | | | |
|---|---|---|---|---|
| Provider Category(s) *(check one or both)***:** | ☐ | Individual. List types: | ■ | Agency. List the types of agencies: |
| | | | | DDS Qualified Provider |
| | | | | |

| Specify whether the service may be provided by *(check each that applies):* | ☐ | Legally Responsible Person | ☐ | Relative/Legal Guardian |
|---|---|---|---|---|

**Provider Qualifications** (*provide the following information for each type of provider)*:

| Provider Type: | License *(specify)* | Certificate *(specify)* | Other Standard *(specify)* |
|---|---|---|---|
| DDS Qualified Provider | Regulations of CT. State Agencies 17-134-165 | Enrolled as a PERS Vendor by DDS | Providers Shall:<br>• Provide trained emergency response staff on a 24-hour basis<br>• Have quality control of equipment<br>• Provide service recipient instruction and training<br>• Assure emergency power failure backup and other safety features<br>• Conduct a monthly test of each system to assure proper operation<br>• Recruit and train community-based |

| | | | |
|---|---|---|---|
| | | | responders in service provision<br>Provide an electronic means of activating a response system to emergency medical and psychiatric services, police or social support systems. |

**Verification of Provider Qualifications**

| Provider Type: | Entity Responsible for Verification: | Frequency of Verification |
|---|---|---|
| DDS Qualified Provider | DDS | Initial and every 2 years certification thereafter |

Service Delivery Method

| | | | | |
|---|---|---|---|---|
| **Service Delivery Method** *(check each that applies)*: | ☐ | Participant-directed as specified in Appendix E | ● | Provider managed |

| **Service Title:** | **Personal Support** |
|---|---|

***Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:***

| | |
|---|---|
| ● | Service is included in approved waiver. There is no change in service specifications. |
| ○ | Service is included in approved waiver. The service specifications have been modified. |
| ○ | Service is not included in the approved waiver. |

Service Definition (Scope)**:**

Assistance necessary to meet the individual's day-to-day activity and daily living needs and to reasonably assure adequate support at home and in the community to carry out personal outcomes. Cueing and supervision of activities is included. This service may not be used in place of eligible Medicaid State Plan Home Health Care services. Provision of services is limited to the person's own or family home and/or in their community

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

May not be provided at the same time as Individualized Day Supports, Supported Employment, Respite, Individualized Home Support, Adult Companion, or Community Training Home.

Provider Specifications

| Provider Category(s) *(check one or both)***:** | ■ | Individual. List types: | ■ | Agency. List the types of agencies: |
|---|---|---|---|---|
| | Individuals hired by the participant | | DDS Qualified Provider | |
| | | | | |
| | | | | |

| Specify whether the service may be provided by *(check each that applies):* | ☐ | Legally Responsible Person | ■ | Relative/Legal Guardian |
|---|---|---|---|---|

**Provider Qualifications** (*provide the following information for each type of provider)*:

| Provider Type: | License *(specify)* | Certificate *(specify)* | Other Standard *(specify)* |
|---|---|---|---|
| Participant directed Individual | | | Verified by the FI:<br>Prior to Employment<br>• 18 yrs of age |

| | | | |
|---|---|---|---|
| | | | • criminal background check<br>• registry check<br>• have ability to communicate effectively with the individual/family<br>• have ability to complete record keeping as required by the employer<br><br>Prior to being alone with the Individual:<br>• demonstrate competence in knowledge of DDS policies and procedures: abuse/neglect; incident reporting; client rights and confidentiality; handling fire and other emergencies, prevention of sexual abuse, knowledge of approved and prohibited physical management techniques<br>• demonstrate competence/knowledge in topics required to safely support the individual as described in the Individual Plan<br>• Medication Administration*<br><br>* if required by the individual supported |
| DDS Qualified Provider | | Certified to provide Personal Support | Prior to Employment<br>• 18 yrs of age<br>• criminal background check<br>• registry check<br>• have ability to communicate effectively with the individual/family<br>• have ability to complete record keeping as required by the employer<br><br>Prior to being alone with the Individual:<br>• demonstrate competence in knowledge of DDS policies and procedures: abuse/neglect; incident reporting; client rights and confidentiality; handling fire and other emergencies, prevention of sexual abuse, knowledge of approved and prohibited physical management techniques<br>• demonstrate competence/knowledge in topics required to safely support the individual as described in the Individual Plan<br>• Medication Administration* |

| | | | |
|---|---|---|---|
| | | | * if required by the individual supported |

**Verification of Provider Qualifications**

| Provider Type: | Entity Responsible for Verification: | Frequency of Verification |
|---|---|---|
| Individual | FI | Prior to Employment |
| | DDS | Annual sample of consumer-directed persons |
| DDS Qualified Provider | DDS | Initial and every 2 years certification thereafter |

| Service Delivery Method | | | | |
|---|---|---|---|---|
| **Service Delivery Method** *(check each that applies)*: | ■ | Participant-directed as specified in Appendix E | ■ | Provider managed |

| **Service Title:** | **Specialized Medical Equipment and Supplies** |
|---|---|

***Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:***

| | |
|---|---|
| ● | Service is included in approved waiver. There is no change in service specifications. |
| ○ | Service is included in approved waiver. The service specifications have been modified. |
| ○ | Service is not included in the approved waiver. |

Service Definition (Scope)**:**

Specialized medical equipment and supplies to include devices, controls, or appliances, specified in the plan of care, which enable individuals to increase their abilities to perform activities of daily living, or to perceive, control, or communicate with he environment in which they live.
This service also includes items necessary for life support, ancillary supplies and equipment necessary to the proper functioning of such items, and durable and non-durable medical equipment not available under the Medicaid State plan. Items reimbursed with waiver funds shall be in addition to any medical equipment and supplies furnished under the State plan and shall exclude those items which are not of direct medical or remedial benefit to the individual. All items shall meet applicable standards of manufacture, design and installation .

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Prior approval will be required with documentation by a licensed therapy professional for single items costing more than $750. The benefit package is limited to $5,000 over the period of the waiver per recipient.

| Provider Specifications | | | | |
|---|---|---|---|---|
| Provider Category(s) *(check one or both)***:** | ☐ | Individual. List types: | ■ | Agency. List the types of agencies: |
| | | | | DDS Qualified Providers |
| | | | | |

| Specify whether the service may be provided by *(check each that applies):* | ☐ | Legally Responsible Person | ☐ | Relative/Legal Guardian |
|---|---|---|---|---|

**Provider Qualifications** (*provide the following information for each type of provider)*:

| Provider Type: | License *(specify)* | Certificate *(specify)* | Other Standard *(specify)* |
|---|---|---|---|
| Vendor | Pharmacies: CT Dept. of Consumer Protection Pharmacy Practice Act: Regulations Concerning Practice of Pharmacy Section 20-175-4-6-7. | Enrolled as a vendor of Adaptive equipment by DDS. | Private Vendors: Conn. State Agency Reg. Section 10-102-3(e)(8)<br><br>Dept. of Admin. Services Bureau of Purchasing/Purchasing Manual 11/91<br><br>Direct Purchase Activity No. 8-F (CGS 4a-50 and 4a-52. |

**Verification of Provider Qualifications**

| Provider Type: | Entity Responsible for Verification: | Frequency of Verification |
|---|---|---|
| Vendor | DDS | Initial and every 2 years certification thereafter |

Service Delivery Method

| **Service Delivery Method** *(check each that applies)*: | ■ | Participant-directed as specified in Appendix E | ■ | Provider managed |
|---|---|---|---|---|

| **Service Title:** | **Independent Support Broker** (replaces Family and Individual Consultation and Support) |
|---|---|

***Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:***

| | |
|---|---|
| ● | Service is included in approved waiver. There is no change in service specifications. |
| ○ | Service is included in approved waiver. The service specifications have been modified. |
| ○ | Service is not included in the approved waiver. |

Service Definition (Scope)**:**

Support and Consultation provided to individuals and/or their families to assist them in directing their own plan of individual support. This service is limited to those who direct their own supports. The services included are:

- Assistance with developing a natural community support network
- Assistance with managing the Individual Budget
- Support with and training on how to hire, manage and train staff
- Accessing community activities and services, including helping the individual and family with day to day coordination of needed services.
- Assistance with negotiating rates and reimbursements.
- Developing an emergency back up plan
- Self advocacy training and support

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Provider Specifications

| Provider Category(s) | ■ | Individual. List types: | ■ | Agency. List the types of agencies: |
|---|---|---|---|---|
| | Individual | | DDS Qualified Providers | |

| | | |
|---|---|---|
| *(check one or both)*: | | |
| | | |

| | | | | |
|---|---|---|---|---|
| Specify whether the service may be provided by *(check each that applies):* | ☐ | Legally Responsible Person | O | Relative/Legal Guardian |

**Provider Qualifications** (*provide the following information for each type of provider)*:

| Provider Type: | License *(specify)* | Certificate *(specify)* | Other Standard *(specify)* |
|---|---|---|---|
| Participant-directed Individual | | | Prior to Employment:<br>• 21 yrs of age<br>• criminal background check<br>• registry check<br>• demonstrated ability, experience and/or education to assist the individual and/or family in the specific areas of support as described by the circle in the Individual Plan.<br>• Five years experience in working with people with mental retardation involving participation in an interdisciplinary team process and the development, review and/or implementation of elements in an individual's plan of care.<br>• One year of the General Experience must have involved supervision of direct care staff in OR responsibility for developing, implementing and evaluating individualized supports for people with mental retardation in the areas of behavior, education or rehabilitation.<br>**Substitutions Allowed:** College training in programs related to supporting people with disabilities (social service, education, psychology, rehabilitation etc.) may be substituted for the General Experience on the basis of fifteen (15) semester hours equaling one-half (1/2) year of experience to a maximum of four (4) years.<br>• demonstrate competence in knowledge of DDS policies and procedures: abuse/neglect; incident reporting; human rights and confidentiality; handling fire and other emergencies, prevention of sexual abuse, knowledge of approved and prohibited physical |

| | | | |
|---|---|---|---|
| | | | management techniques<br>• demonstrate understanding of the role of the service, of advocacy, person-centered planning, and community services<br>• demonstrate understanding of individual budgets and DDS fiscal management policies |
| DDS Qualified Providers | | Certified to provide Support Broker Service by DDS | Prior to Employment:<br>• 21 yrs of age<br>• criminal background check<br>• registry check<br>• demonstrated ability, experience and/or education to assist the individual and/or family in the specific areas of support as described by the circle in the Individual Plan.<br>• Five years experience in working with people with mental retardation involving participation in an interdisciplinary team process and the development, review and/or implementation of elements in an individual's plan of care.<br>• One year of the General Experience must have involved supervision of direct care staff in OR responsibility for developing, implementing and evaluating individualized supports for people with mental retardation in the areas of behavior, education or rehabilitation.<br>**Substitutions Allowed:** College training in programs related to supporting people with disabilities (social service, education, psychology, rehabilitation etc.) may be substituted for the General Experience on the basis of fifteen (15) semester hours equaling one-half (1/2) year of experience to a maximum of four (4) years.<br>• demonstrate competence in knowledge of DDS policies and procedures: abuse/neglect; incident reporting; human rights and confidentiality; handling fire and other emergencies, prevention of |

| | | | |
|---|---|---|---|
| | | | sexual abuse, knowledge of approved and prohibited physical management techniques<br>• demonstrate understanding of the role of the service, of advocacy, person-centered planning, and community services<br>• demonstrate understanding of individual budgets and DDS fiscal management policies |

**Verification of Provider Qualifications**

| Provider Type: | Entity Responsible for Verification: | Frequency of Verification |
|---|---|---|
| Individual | FI | Prior to Employment |
| | DDS | Annual sample of consumer-directed persons |
| DDS Qualified Providers | DDS | Initial and every 2 years certification thereafter |

Service Delivery Method

| | | | | |
|---|---|---|---|---|
| **Service Delivery Method** *(check each that applies)*: | ■ | Participant-directed as specified in Appendix E | ■ | Provider managed |

| **Service Title:** | **Transportation** |
|---|---|

***Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:***

| | |
|---|---|
| ● | Service is included in approved waiver. There is no change in service specifications. |
| ○ | Service is included in approved waiver. The service specifications have been modified. |
| ○ | Service is not included in the approved waiver. |

Service Definition (Scope)**:**

Service offered in order to enable individuals served on the waiver to gain access to waiver and other community services, activities and resources, specified by the plan of care. This service is offered in addition to medical transportation required under 42 CFR 431.53 and transportation services under the State plan, defined at 42 CFR 440.170(a) (if applicable), and shall not replace them. Transportation services under the waiver shall be offered in accordance with the individual's plan of care. Whenever possible, family, neighbors, friends, or community agencies which can provide this service without charge will be utilized.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Provider Specifications

| Provider Category(s) *(check one or both)***:** | ■ | Individual. List types: | ■ | Agency. List the types of agencies: |
|---|---|---|---|---|
| | Individuals hired by the participant | | DDS Qualified Providers | |
| | | | | |
| | | | | |

| | | | | |
|---|---|---|---|---|
| Specify whether the service may be provided by *(check each that applies):* | ☐ | Legally Responsible Person | ■ | Relative/Legal Guardian |

**Provider Qualifications** (*provide the following information for each type of provider)*:

| Provider Type: | License *(specify)* | Certificate *(specify)* | Other Standard *(specify)* |
|---|---|---|---|
| Participant-directed Individual | | | Individual Provider: Valid CT driver's license and insured vehicle.<br>Verified by the FI:<br>Prior to Employment<br>• 18 yrs of age<br>• criminal background check<br>• registry check<br>• have ability to communicate effectively with the individual/family<br>• have ability to complete record keeping as required by the employer<br><br>Prior to being alone with the Individual:<br>• demonstrate competence in knowledge of DDS policies and procedures: abuse/neglect; incident reporting; client rights and confidentiality; handling fire and other emergencies, prevention of sexual abuse, knowledge of approved and prohibited physical management techniques |
| DDS Qualified Providers | | Certified to provide Transportation Services | Private Transportation Service: DSS Medicaid Transportation Provider: |

**Verification of Provider Qualifications**

| Provider Type: | Entity Responsible for Verification: | Frequency of Verification |
|---|---|---|
| Individual | FI | Prior to Employment |
| | DDS | Annual sample of consumer-directed persons |
| DDS Qualified Providers | DDS | Initial and every 2 years certification thereafter |

Service Delivery Method

| | | | | |
|---|---|---|---|---|
| **Service Delivery Method** *(check each that applies)*: | ■ | Participant-directed as specified in Appendix E | ■ | Provider managed |

| Service Title: | **Environmental Modifications** |
|---|---|

*Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:*

| | |
|---|---|
| ● | Service is included in approved waiver. There is no change in service specifications. |
| ○ | Service is included in approved waiver. The service specifications have been modified. |
| ○ | Service is not included in the approved waiver. |

Service Definition (Scope)**:**

Those physical adaptations to the home, required by the individual's plan of care, which are necessary to ensure the health, welfare and safety of the individual, or which enable the individual to function with greater independence in the home, and without which, the individual would require institutionalization. Such adaptations may include the installation of ramps and grab-bars, widening of doorways, modification of bathroom facilities, or installation of specialized electric and plumbing systems which are necessary to accommodate the medical equipment and supplies which are necessary for the welfare of the individual. Excluded are those adaptations or improvements to the home that are of general utility, and are not of direct medical or remedial benefit to the individual, such as carpeting, roof repair, central air conditioning, etc. Adaptations which add to the total square footage of the home are excluded from this benefit. All services shall be provided in accordance with applicable State or local building codes.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Maximum benefit over the term of the waiver (5 years) shall not exceed $15,000

**Provider Specifications**

| Provider Category(s) *(check one or both)***:** | ■ | Individual. List types: | ☐ | Agency. List the types of agencies: |
|---|---|---|---|---|
| | | Private Contractors | | |
| | | | | |

| Specify whether the service may be provided by *(check each that applies):* | ☐ | Legally Responsible Person | ☐ | Relative/Legal Guardian |
|---|---|---|---|---|

**Provider Qualifications** (*provide the following information for each type of provider)*:

| Provider Type: | License *(specify)* | Certificate *(specify)* | Other Standard *(specify)* |
|---|---|---|---|
| Private Contractors | Licensed in State of CT for specific service to be rendered, i.e. electrical, plumbing, general contractor. | | NFPA Life Safety Code<br>State Building Code |

**Verification of Provider Qualifications**

| Provider Type: | Entity Responsible for Verification: | Frequency of Verification |
|---|---|---|
| Private Contractors | FI | Initial |
| | DDS | Annual sample of consumer-directed persons |
| | DDS | Initial |

**Service Delivery Method**

| **Service Delivery Method** | ■ | Participant-directed as specified in Appendix E | ■ | Provider managed |
|---|---|---|---|---|

| *(check each that applies)*: | | | | |
|---|---|---|---|---|

| **Service Title:** | **Vehicle Modifications** |
|---|---|

***Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:***

| | |
|---|---|
| ● | Service is included in approved waiver. There is no change in service specifications. |
| ○ | Service is included in approved waiver. The service specifications have been modified. |
| ○ | Service is not included in the approved waiver. |

Service Definition (Scope)**:**

Alterations made to a vehicle which is the individual's primary means of transportation, when such modifications are necessary to improve the individual's independence and inclusion in the community, and to avoid institutionalization. The vehicle may be owned by the individual, a family member with whom the individual lives or has consistent and on-going contact, or a non-relative who provides primary long-term support to the individual and is not a paid provider of such services.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

The benefit package is limited to a maximum of $10,000 within the waiver period per recipient for vehicle modifications. Once this cap is reached, $750 per individual per year may be allowable for repair, replacement or additional modification with prior approval.

**Provider Specifications**

| Provider Category(s) *(check one or both)***:** | ☐ | Individual. List types: | ■ | Agency. List the types of agencies: |
|---|---|---|---|---|
| | | | | DDS Qualified Providers |
| | | | | |
| | | | | |

| Specify whether the service may be provided by *(check each that applies):* | ☐ | Legally Responsible Person | ☐ | Relative/Legal Guardian |
|---|---|---|---|---|

**Provider Qualifications** (*provide the following information for each type of provider)*:

| Provider Type: | License *(specify)* | Certificate *(specify)* | Other Standard *(specify)* |
|---|---|---|---|
| DDS Qualified Provider | | Enrolled to deliver Vehicle Modification Service | CGS 10-102-18(j) and has Dept. of Motor Vehicles Dealer's Registration |

**Verification of Provider Qualifications**

| Provider Type: | Entity Responsible for Verification: | Frequency of Verification |
|---|---|---|
| DDS Qualified Provider | DDS | Initial |

**Service Delivery Method**

| **Service Delivery Method** *(check each that applies)*: | ■ | Participant-directed as specified in Appendix E | ☐ | Provider managed |
|---|---|---|---|---|

## Appendix C-4: Additional Limits on Amount of Waiver Services

**Additional Limits on Amount of Waiver Services**. Indicate whether the waiver employs any of the following additional limits on the amount of waiver services *(check each that applies).*

*When a limit is employed, specify: (a) the waiver services to which the limit applies; (b) the basis of the limit, including its basis in historical expenditure/utilization patterns and, as applicable, the processes and methodologies that are used to determine the amount of the limit to which a participant's services are subject; (c) how the limit will be adjusted over the course of the waiver period; (d) provisions for adjusting or making exceptions to the limit based on participant health and welfare needs or other factors specified by the state; (e) the safeguards that are in effect when the amount of the limit is insufficient to meet a participant's needs; and, (f) how participants are notified of the amount of the limit.*

| | |
|---|---|
| ☐ | **Limit(s) on Set(s) of Services**. There is a limit on the maximum dollar amount of waiver services that is authorized for one or more sets of services offered under the waiver. *Furnish the information specified above.* |
| | |
| ☐ | **Prospective Individual Budget Amount**. There is a limit on the maximum dollar amount of waiver services authorized for each specific participant. *Furnish the information specified above.* |
| | |

| | |
|---|---|
| ■ | **Budget Limits by Level of Support**. Based on an assessment process and/or other factors, participants are assigned to funding levels that are limits on the maximum dollar amount of waiver services. *Furnish the information specified above*. |
| | Each individual receives a budget allocation based on the results of the participant's assessed Level of Need. The Level of Need is determined as a result of the completed CT Level of Need Assessment and Risk Screening Tool (LON). The resulting score of 0-8 is associated with a prospective individual funding amount for vocational related services and home and community services. The LON Assessment and preliminary associated funding levels were developed under the CMS Independence Plus Grant using qualitative and quantitative methodologies. The bulk of the historical financial data used to calculate these rates includes information on individuals who were served on Master Contracts prior to the conversion to the present Fee for Service model. The Department is continuing to analyze the historical funding data and refine the prospective allocation methodology from the present allocation method of categorizing people with an LON of 0,1,or 2 as Minimum with an allocation range up to $27,300; those with an LON scores of 3,4, or 5 as Moderate with an allocation range up to $60,100 and those with LON scores of 6,7, and 8 as Comprehensive with an allocation range up to $92,800 to an allocation amount based on more current use data. People with approved support packages that exceed $58,000 are enrolled in the Comprehensive Waiver. During the period covered by this waiver the analysis of the data will continue and allocations will be modified according to the results of the analyses.<br><br>The DDS Regional Planning and Resource Allocation Team notifies the applicant of the funding limit via letter as described in Appendix D. The budget allocation limits apply to all services with the exception of Specialized Adaptive Equipment, Vehicle Modification and Environmental Modifications, which are not annualized services. Adjustments to the budget allocation limit can be made either as a result of a higher assessed Level of Need leading to an increased LON score, or due to short-term circumstances necessitating an increased amount of services to address short term health and safety needs.<br><br>The state applies legislatively approved COLA's each year the waiver is in effect to these dollar amounts. |
| ☐ | **Other Type of Limit.** The State employs another type of limit. *Describe the limit and furnish the information specified above.* |
| | |
| ☐ | **Not applicable.** The State does not impose a limit on the amount of waiver services except as provided in Appendix C-3. |

# Appendix D: Participant-Centered Planning and Service Delivery

## Appendix D-1: Service Plan Development

| **State Participant-Centered Service Plan Title**: | Individual Plan |
|---|---|

**a**. **Responsibility for Service Plan Development**. Per 42 CFR §441.301(b)(2), specify who is responsible for the development of the service plan and the qualifications of these individuals *(check each that applies)*:

| | |
|---|---|
| ☐ | Registered nurse, licensed to practice in the State |
| ☐ | Licensed practical or vocational nurse, acting within the scope of practice under State law |
| ☐ | Licensed physician (M.D. or D.O) |
| ☐ | Case Manager (qualifications specified in Appendix C-3) |
| ■ | Case Manager (qualifications not specified in Appendix C-3). *Specify qualifications*: |
| | DDS hired and qualified state employee Case Managers. |
| | Social Worker. *Specify qualifications:* |
| | |
| ☐ | Other (*specify the individuals and their qualifications):* |
| | |

**b. Service Plan Development Safeguards.** *Select one:*

| | |
|---|---|
| ● | Entities and/or individuals that have responsibility for service plan development *may not provide* other direct waiver services to the participant. |
| ○ | Entities and/or individuals that have responsibility for service plan development *may provide* other direct waiver services to the participant. The State has established the following safeguards to ensure that service plan development is conducted in the best interests of the participant. *Specify*: |
| | |

**c. Supporting the Participant in Service Plan Development**. Specify: (a) the supports and information that are made available to the participant (and/or family or legal representative, as appropriate) to direct and be actively engaged in the service plan development process and (b) the participant's authority to determine who is included in the process.

The DDS case manager supports the waiver participant and other team members to develop and implement a plan that addresses the individual's needs and preferences. The case manager supports the individual to be actively involved in the planning process and assists the individual to identify members of his or her planning and support team and to invite them to the meeting. The case manager supports the individual to determine the content of the meeting and decide how the meeting will be run and organized. Individuals who are interested in self-directing their supports

are made aware of the opportunity to hire an independent support broker to assist with planning. If selected, the independent support broker would become a member of the person's planning and support team. During the planning meeting the individual and team discuss ways to enhance the individual's future participation in the planning process if needed. The case manager supports the individual and family to review assessments and reports before the meeting. The case manager is responsible to ensure the individual planning meeting is scheduled at a time when the person, his or her family and other team members can attend. The case manager ensures the individual has a choice of supports, service options, and providers and that the plan represents the individual's preferences.

**d. Service Plan Development Process** In four pages or less, describe the process that is used to develop the participant-centered service plan, including: (a) who develops the plan, who participates in the process, and the timing of the plan; (b) the types of assessments that are conducted to support the service plan development process, including securing information about participant needs, preferences and goals, and health status; (c) how the participant is informed of the services that are available under the waiver; (d) how the plan development process ensures that the service plan addresses participant goals, needs (including health care needs), and preferences; (e) how waiver and other services are coordinated; (f) how the plan development process provides for the assignment of responsibilities to implement and monitor the plan; and, (g) how and when the plan is updated, including when the participant's needs change. State laws, regulations, and policies cited that affect the service plan development process are available to CMS upon request through the Medicaid agency or the operating agency (if applicable):

The individual planning process results in the development of a comprehensive Individual Plan, which is the document to guide all supports and services provided to the individual. Individual planning, a form of person-centered planning, is a way to discover the kind of life a person desires, map out a plan for how it may be achieved, and ensure access to needed supports and services. Individual planning is an approach to planning driven by a respect for the individual, a belief in the capacities and gifts of all people, and the conviction that everyone deserves the right to create their own future.

Individual planning supports people to achieve the outcomes of the mission of the Department of Developmental Services, which states that all people should have opportunities to experience:

- Presence and participation in Connecticut town life.
- Opportunities to develop and exercise competence.
- Opportunities to make choices in the pursuit of a personal future.
- Good relationships with family members and friends.
- Respect and dignity

The individual planning process promotes and encourages the person and those people who know and care for him or her to take the lead in directing this process and in planning, choosing, and evaluating supports and services. Individual planning puts the person at the "center" of the plan. Individual planning offers people the opportunities to lead self-determined lifestyles and exercise greater control in their lives.

With individual planning, the person is viewed holistically to develop a plan of supports and services that is meaningful to him or her. Services and supports are identified to meet the person's unique desires and needs, regardless of funding source and may include state plan services, generic resources, and natural support networks.

Individuals meeting the eligibility requirements for this DDS HCBS waiver must initiate a HCBS waiver application at the time of the new resource allocation or requested service notice. To access waiver services, a current Individual Plan, and accompanying Individual Budget, if applicable, must be developed or updated to identify specific needs, preferences and individual outcomes that will be addressed by waiver services. The DDS Individual Plan serves as the Medicaid Plan of Care that supports and prescribes the need for the specific type(s), frequency, amount and/or duration of waiver services. Without a complete plan as described below, Medicaid waiver services cannot be authorized.

Following are the major steps of the Individual Planning process:

**Prepare to plan.**
The case manager develops strategies to assist the person and his or her family to be actively involved in the planning process. The case manager and other team members assemble as much information as possible before the meeting to assist the individual and his or her family to prepare for the meeting. This helps the meeting to be shorter, more focused on decision making, and more efficient. Before the meeting, the case manager or another team member may assist the individual and his or her family to begin to update the Information Profile and the CT Level of Need Assessment and Risk Screening Tool. The case manager may provide a copy of "My Health and Safety Screening" to the individual or his or her family so they may identify health and safety concerns they want to be sure are addressed in the plan. Providers of supports and services share current assessments, reports and evaluations with the case manager at least 14 days prior to the scheduled meeting. The case manager shares the LON and LON Summary Report with team members prior to the planning meeting. It is also helpful before the meeting to ensure that the person and his or her family has a chance to review the information in current Assessments, Reports, and Evaluations that will be discussed at the meeting. Supporting the individual to prepare for the meeting offers an opportunity to express his or her desires or concerns to the case manager or another team member with whom he or she is comfortable and who can assist the individual to share these issues with the larger group. The case manager assists the individual to understand the waiver service options and hiring options that DDS now provides to all consumers and explains the DDS portability process.
There may be circumstances when the individual does not want to discuss something in a meeting. This preference should be respected when possible, however, personal information that affects supports or impacts the individual's health or safety must be addressed. In these circumstances, the topic should be acknowledged and dealt with respectfully and privately outside of the meeting with the person and with others who need to know this information to provide appropriate supports.

During the planning meeting, the individual and his or her planning and support team completes a profile or assessment of the person's current life situation and future vision. The team completes an analysis of the person's preferences, desired outcomes, and support needs. They also review the information profile, personal profile, future vision, current assessments, reports, and evaluations, including the health and safety screening, to identify what is important to include in the plan and identify any additional assessments needed. The sections of the plan completed during this stage of plan development include the:

- Information Profile
- Personal Profile
- Level of Need Assessment and Risk Screening Tool (LON)
- Future Vision
- Assessment Review.

Any dispute with the results of a completed LON may be resolved by requesting that a new LON be completed by a different DDS employee who has the requisite skills and background to coordinate the completion of the assessment. The completion of the LON must include input from the individual, family, personal representatives, friends and service providers who know the person best. If a LON ultimately affects the amount, type or duration of waiver services, the individual and personal representative will be provided Fair Hearing Rights notice.

The action plan includes desired outcomes, needs or issues addressed, actions and steps, responsible person(s), and by when and should consider the individual's choices and preferences.

The section of the plan completed during this stage of plan development includes the:

- Action Plan

The Individual Plan must address each identified risk area that was identified by the LON. If new action is required then the Action Plan must include services or supports that are needed to address an identified risk.

Once the individual and team have completed the action plan, they identify the type of services and supports that will address the Action Plan. Specific agencies and/or individuals who will provide service or support are further identified. The need for a waiver service that addresses specific outcomes included in the Action Plan must be clearly identified and supported by the Individual Plan. The case manager ensures that the individual and his or her family or guardian have sufficient information available to make informed selections of support providers, and information to make informed decisions regarding the degree to which the individual and his or her family or guardian may wish to self-direct services and supports. The section of the plan completed during this stage of plan development includes the:

- Summary of Supports or Services.

During the planning meeting, the individual and planning and support team discuss plans to monitor progress and to evaluate whether the supports are helping the person to reach desired outcomes. At a minimum, the case manager initiates a contact quarterly to evaluate the implementation or satisfaction with the plan, and visits the individual at each service site during the year to review progress on the plan. The team may be assembled to review the Individual Plan any time during the year if the individual experiences a life change, identifies a need to change supports, or requests a review. The section of the plan completed during this stage of plan development includes the:

- Summary of Monitoring and Evaluation of the Plan .
- Once the plan is completed and the individual and planning and support team agree with the plan, the case manager ensures the plan is documented on the appropriate forms.

Each waiver service specifies the experience, background and training requirements for the agency and/or individual providing the support. Services delivered in licensed settings and in facility day programs are governed by regulation and contract requirements. Individual support services require that the planning and support team designates specific training, experience or background requirements for the staff based on the specific needs of the individual. Specific training and/or experience and the timeframe for completion of any training is recorded on the:

- Provider Qualifications and Training Form

Every effort should be made to arrange for needed supports and to implement the plan as soon as possible after the final approval is obtained as outlined above

The role of the DDS case manager in individual planning is to support the person and other team members to develop and implement a plan that addresses the individual's needs. Case managers support individuals to be actively involved in the planning process. They are responsible for ensuring that individual planning meetings are scheduled at times when the person, his or her family and other team members can attend. The case manager is responsible for facilitating the annual individual planning meeting unless the individual requests another team member to facilitate the meeting. The case manager ensures the meeting is facilitated in line with the individual planning process and encompasses input across services settings.
The case manager ensures the plan is documented on the Individual Plan forms, though other team

members or clerical staff may do the actual transcription of the plan. He or she ensures the plan is distributed to all team members, though this task may also be assumed by another team member or clerical staff.

The case manager is responsible for ensuring the completion of a HCBS waiver application during the initial planning process. The case manager monitors implementation of the plan and ensures supports and services match the individual's needs and preferences. He or she ensures the plan is periodically reviewed and updated based on individual circumstances and regulatory requirements.

Under both DDS waivers, individuals who do, or are considering whether to, self-direct services and supports by hiring staff directly may choose to purchase the Independent Support Broker service with waiver funding. The DDS case manager will inform the individual that this option is available to individuals and families who may wish to pursue self-direction in advance of the Individual Planning meeting. This notice shall be provided as soon as an individual has been awarded waiver funding by the PRAT so there is sufficient time to locate and initiate the Independent Support Broker service provider of the individual's choice prior to the IP meeting..

If requested by the individual, the case manager will submit a request for Independent Support Broker authorization up to 6 hours to be paid by DDS prior to the completion and approval of the Individual Plan and Budget. Payment may be state funded if the person has not yet completed enrollment in a waiver, or waiver funded if the person is already enrolled and is so noted in the IP6 for the purpose of initial individual planning.

Once the Individual Plan has been completed, Independent Support Broker may continue to be a selected service if the individual self-directs services, and chooses to retain the Independent Support Broker service as part of his/her individual budget. In those cases, the DDS case manager continues to carry out TCM activities on behalf of the individual.

The individual and his or her family members should be comfortable with the people who help to develop the Individual Plan and should consider inviting a balance of people who can contribute to planning, including friends, family, support providers, professional staff. The individual should be supported to include people in the planning and support team who:

- Care about the individual and see him or her in a positive light;
- Recognize the individual's strengths and take the time to listen to him or her; and,
- Can make a commitment of time and energy to help the individual to develop, carry out, review and update the plan.

At the very minimum, all planning and support teams shall include the individual who is receiving supports, his or her guardian if applicable, his or her case manager, and persons whom the individual requests to be involved in the individual planning process. Planning and support teams for individuals who receive residential, employment, or day support should include support staffs that know the individual best. Depending upon the individual's specific needs, health providers, allied health providers, and professionals who provide supports and services to the individual should be involved in the individual planning process and may be in attendance at the individual planning meeting.

Every effort will be made to schedule the planning meeting at times and locations that will facilitate participation by the individual and his or her family, guardian, advocate or other legal representative, as applicable. The case manager will ensure that the individual and/or the person's family are contacted to schedule the meeting at their convenience.

If the person, family, or guardian refuses to participate in the Individual Plan meeting, the case manager shall document his or her attempt(s) to invite participation and the responses to those attempts in the individual record and in the Individual Plan, Section 5 - Summary of Representation, Participation, and Plan Monitoring. In these situations, the case manager shall pursue other ways to involve the individual, family, or guardian in the planning process outside of the meeting.

**e. Risk Assessment and Mitigation.** Specify how potential risks to the participant are assessed during the service plan development process and how strategies to mitigate risk are incorporated into the service plan, subject to participant needs and preferences. In addition, describe how the service plan development process addresses backup plans and the arrangements that are used for backup.

Each waiver participant has a Level of Need Assessment and Risk Screening Tool competed regarding his/her skills and circumstances, and reviewed with the Team at least on an annual basis. This tool produces a Summary report that identifies all responses that may present a risk to the participant in medical, health, safety, behavioral and natural support areas. The team is required to address how each potential risk is mitigated in the Individual Plan. Included in this response is the use of an emergency back up plan if the participant is reliant upon a paid or unpaid service to provide for basic health and welfare supports.

**f. Informed Choice of Providers.** Describe how participants are assisted in obtaining information about and selecting from among qualified providers of the waiver services in the service plan.

All waiver participants are provided with a complete listing of all waiver service providers at the time of the Individual Plan and provider selection process by the DDS case manager. This list of providers is also available on the DDS website. DDS case managers will accompany potential and current waiver participants to different service provider locations if desired to assist in the selection process. As DDS further develops the Quality Service Review data, that information will also be made available and posted on line to assist waiver recipients in choosing service providers.

**g. Process for Making Service Plan Subject to the Approval of the Medicaid Agency**. Describe the process by which the service plan is made subject to the approval of the Medicaid agency in accordance with 42 CFR §441.301(b)(1)(i):

DDS authorizes the Individual Plan under the Memorandum of Understanding agreement subject to quarterly retrospective reviews of a sample of 10-15 Individual Plans each quarter by DSS. DDS also prepares quarterly reports of Individual Plan quality reviews by DDS case management supervisors, the DDS Medicaid Operations Unit and DDS Quality Service Review results for review and comment by the DSS oversight unit.

**h. Service Plan Review and Update**. The service plan is subject to at least annual periodic review and update to assess the appropriateness and adequacy of the services as participant needs change. *Specify the minimum schedule for the review and update of the service plan:*

| | |
|---|---|
| ○ | Every three months or more frequently when necessary |
| ○ | Every six months or more frequently when necessary |
| ● | Every twelve months or more frequently when necessary |
| ○ | Other schedule (*specify*): |
| | |

**i. Maintenance of Service Plan Forms**. Written copies or electronic facsimiles of service plans are maintained for a minimum period of 3 years as required by 45 CFR §74.53. Service plans are maintained by the following *(check each that applies)*:

| | |
|---|---|
| ☐ | Medicaid agency |
| ☐ | Operating agency |
| ■ | Case manager |
| ☐ | Other (*specify):* |
| | |

## Appendix D-2: Service Plan Implementation and Monitoring

**a. Service Plan Implementation and Monitoring**. Specify: (a) the entity (entities) responsible for monitoring the implementation of the service plan and participant health and welfare; (b) the monitoring and follow-up method(s) that are used; and, (c) the frequency with which monitoring is performed.

The DDS case manager is responsible to monitor the implementation of the Individual Plan. This is accomplished by: case manager reviews the Individual Plan, vendor quarterly reports and reviews progress on the plan during reviews at each service site; review of the Fiscal Intermediary monthly and quarterly expenditure reports for individuals who choose participant-direction; and; quarterly contacts through the Targeted Case Management service requirements. DDS also reviews service plan implementation through Quality Service Review process detailed in Appendix H. Regional and State Quality Review staff review the implementation of a service plan during each quality service review activity to evaluate a significant sample size on an annual basis.

**b. Monitoring Safeguards.** *Select one:*

| | |
|---|---|
| ● | Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare *may not provide* other direct waiver services to the participant. |
| ○ | Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare *may provide* other direct waiver services to the participant. The State has established the following safeguards to ensure that monitoring is conducted in the best interests of the participant. *Specify*: |
| | |

# Appendix E: Participant Direction of Services

[NOTE: *Complete Appendix E only when the waiver provides for one or both of the participant direction opportunities specified below.*]

**Applicability** *(select one)*:

| | |
|---|---|
| ● | **Yes.** This waiver provides participant direction opportunities. Complete the remainder of the Appendix. |
| ○ | **No.** This waiver does not provide participant direction opportunities. Do not complete the remainder of the Appendix. |

*CMS urges states to afford all waiver participants the opportunity to direct their services. Participant direction of services includes the participant exercising decision-making authority over workers who provide services, a participant-managed budget or both. CMS will confer the Independence Plus designation when the waiver evidences a strong commitment to participant direction. Indicate whether Independence Plus designation is requested (select one):*

| | |
|---|---|
| ○ | **Yes.** The State requests that this waiver be considered for Independence Plus designation. |
| ● | **No.** Independence Plus designation is not requested. |

## Appendix E-1: Overview

**a. Description of Participant Direction.** In no more than two pages, provide an overview of the opportunities for participant direction in the waiver, including: (a) the nature of the opportunities afforded to participants; (b) how participants may take advantage of these opportunities; (c) the entities that support individuals who direct their services and the supports that they provide; and, (d) other relevant information about the waiver's approach to participant direction.

The CT Department of Developmental Services (DDS) will provide consumer-directed options for participants who choose to direct the development of their Individual Plans and to have choice and control over the selection and management of waiver services. Individuals may choose to have either or both employer authority and budget authority.

The Individual Planning process is designed to promote and encourage the individual and those people who know and care about him or her to take the lead in directing the process and in planning, choosing, and managing supports and services to the extent they desire. The development of the Individual Plan is participant led. During the planning process services and supports are identified to meet the person's unique desires and needs, regardless of funding source and may include state plan services, generic resources, and natural support networks. At the time of the planning process, the individual's case manager ensures the person and his or her family or personal representative have sufficient information available to make informed choices about the degree to which they wish to self-direct supports and services. The case manager also ensures the individual and his or her family or personal representative have information to make informed selections of qualified waiver providers. This information is presented in three Consumer Guidebooks: Understanding the HCBS waivers; Your Hiring Choices; and Making Good choices about your DDS Supports and Services. Case managers also notify individuals about their ability to change providers when they are not satisfied with a provider's performance.

Self-direction is included in the Comprehensive Waiver to the extent the individual and/or family wishes to directly manage services and supports. Individuals may self-direct some or all of their

waiver services identified in the Individual Plan. They may choose to self-direct workers and professionals who provide the following services: Individualized Home Support, Personal Support, Adult Companion Services, Respite care, Supported Employment Services, Individualized Day Support, Transportation, Clinical Behavioral Support, Live-in Caregiver, Individual Goods and Services, Nutrition, Independent Support Broker, and Interpreter Services.

Individuals who self-direct may choose to be the direct employer of the workers who provide waiver services, or may select an Agency with Choice. The Agency with Choice is the employer of record for employees hired to provide waiver services for the individual, however the individual maintains the ability to select and supervise those workers. The individual may refer staff to the Agency with Choice for employment. In both arrangements, the individual and/or family have responsibility for managing the services they choose to direct.

Individuals who self-direct and hire their own workers have the authority to recruit and hire staff, verify staff qualifications, obtain and review criminal background checks, determine staff duties, set staff wages and benefits within established guidelines, schedule staff, provide training and supervision, approve time sheets, evaluate staff performance, and terminate staff employment.

Individuals who self direct by hiring their own staff will have a DDS case manager or, a specialized case manager (Support Broker), to assist them to direct their plan of individual support. In addition to case management activities, the Support Brokers assist individuals to access community and natural supports and advocate for the development of new community supports as needed. They assist individuals to monitor and manage the Individual Budgets. Brokers may provide support and training on how to hire, manage and train staff and to negotiate with service providers. They assist individuals to develop an emergency back up plan and may assist individuals to access self-advocacy training and support.

Another option for those who self-direct is to have a DDS case manager and an Independent Support Broker through the waiver service. This waiver service provides support and consultation to individuals and/or their families to assist them in directing their own plan of individual support. This service may be self-directed or provided by a qualified agency and is available to those who direct their own supports and hire their own staff. The services included in Independent Support Broker service are:

- Assistance with developing a natural community support network
- Assistance with managing the Individual Budget
- Support with and training on how to hire, manage and train staff
- Accessing community activities and services, including helping the individual and family with day-to-day coordination of needed services.
- Developing an emergency back up plan
- Self advocacy training and support

The services of a Vendor Fiscal Employer Agent (VFEA) are required for individuals who self-direct their services and supports. The VFEA assists the individual and/or family or personal representative to manage and distribute funds contained in the individual budget including, but not limited to, the facilitation of employment of service workers by the individual or family, including federal, state and local tax withholding/payments, processing payroll or making payments for goods and services and unemployment compensation fees, wage settlements, fiscal accounting and expenditure reports, support to enter into provider agreements on behalf of the Medicaid agency, and providing information and training materials to assist in employment and training of workers. This service is required to be utilized by individuals and families who choose to hire their own staff and self-direct some or all of the waiver services in their Individual Plan. The service will be delivered as an administrative cost and is not included in individual budgets.

**b. Participant Direction Opportunities**. Specify the participant direction opportunities that are available in the waiver. *Select one:*

| | |
|---|---|
| ○ | **Participant – Employer Authority**. As specified in ***Appendix E-2, Item a,*** the participant (or the participant's representative) has decision-making authority over workers who provide waiver services. The participant may function as the common law employer or the co-employer of workers. Supports and protections are available for participants who exercise this authority. |
| ○ | **Participant – Budget Authority.** As specified in ***Appendix E-2, Item b***, the participant (or the participant's representative) has decision-making authority over a budget for waiver services. Supports and protections are available for participants who have authority over a budget. |
| ● | **Both Authorities.** The waiver provides for both participant direction opportunities as specified in ***Appendix E-2***. Supports and protections are available for participants who exercise these authorities. |

**c. Availability of Participant Direction by Type of Living Arrangement.** *Check each that applies:*

| | |
|---|---|
| ■ | Participant direction opportunities are available to participants who live in their own private residence or the home of a family member. |
| ■ | Participant direction opportunities are available to individuals who reside in other living arrangements where services (regardless of funding source) are furnished to fewer than four persons unrelated to the proprietor. |
| ☐ | The participant direction opportunities are available to persons in the following other living arrangements *(specify)*: |
| | |

**d. Election of Participant Direction**. Election of participant direction is subject to the following policy (*select one):*

| | |
|---|---|
| ○ | Waiver is designed to support only individuals who want to direct their services. |
| ● | The waiver is designed to afford every participant (or the participant's representative) the opportunity to elect to direct waiver services. Alternate service delivery methods are available for participants who decide not to direct their services. |
| ○ | The waiver is designed to offer participants (or their representatives) the opportunity to direct some or all of their services, subject to the following criteria specified by the State. Alternate service delivery methods are available for participants who decide not to direct their services or do not meet the criteria. *Specify the criteria*: |
| | |

**e. Information Furnished to Participant.** Specify: (a) the information about participant direction opportunities (e.g., the benefits of participant direction, participant responsibilities, and potential liabilities) that is provided to the participant (or the participant's representative) to inform decision-making concerning the election of participant direction; (b) the entity or entities responsible for furnishing this information; and, (c) how and when this information is provided on a timely basis.

The case manager provides information about options to self-direct to the participants and their families at the time of the Individual Planning meeting and at any time the individual expresses an interest in self-direction. (This includes a Family Manual on Self-Direction and Your Hiring Choices http://www.dmr.state.ct.us/HCBS/DMRbook2ENG.pdf, and informational fact sheets).

The VFEA (fiscal intermediary) has responsibility to provide fact sheets to individuals who are referred to them who choose to self-direct. Fact sheets include information about criminal background checks, abuse/neglect registry checks, employer responsibilities, hiring and managing your own supports, employee safety: workers compensation and liability insurance. The VFEA ensures that individual provider qualifications and training requirements are met prior to employment and the appropriate forms to document that training are completed.

**f. Participant Direction by a Representative.** Specify the State's policy concerning the direction of waiver services by a representative *(select one)*:

| | | |
|---|---|---|
| ○ | | The State does not provide for the direction of waiver services by a representative. |
| ● | | The State provides for the direction of waiver services by a representative. Specify the representatives who may direct waiver services: *(check each that applies)*: |
| | ■ | Waiver services may be directed by a legal representative of the participant. |

| | | |
|---|---|---|
| | ■ | Waiver services may be directed by a legal representative of the participant. |
| [redacted] | ■ | The state's practice is to allow participants the opportunity to self direct waiver services with the assistance they need by allowing family members, advocates, or a representative of the participant's choosing, to assist with the responsibilities of self-direction. A representative does not have to be a legal representative. The representative assumes responsibilities for the Agreement For Self Directed Supports, which is reviewed with the representative and the participant, and signs the Agreement. The participant can also be the sponsoring person. The Agreement for Self Directed Supports includes the identification of areas of responsibility where the responsible person will require assistance. Any assistance needed as indicated in the agreement must be addressed in the participant's Individual Plan. |

**g. [redacted]ipant-Directed Services**. Specify the participant direction opportunity (or opportunities) a[redacted]ble for each waiver service that is specified as participant-directed in Appendix C-3. *(Check the o[redacted]unity or opportunities available for each service)*:

| Participant-Directed Waiver Service | Employer Authority | Budget Authority |
|---|---|---|
| Individualized Home Supports | ■ | ■ |
| Personal Support | ■ | ■ |
| Adult Companion | ■ | ■ |
| Respite | ■ | ■ |
| Supported Employment | ■ | ■ |
| Individualized Day Supports | ■ | ■ |
| Transportation | ■ | ■ |
| Clinical Behavioral Supports | ■ | ■ |
| Healthcare Coordination | ■ | ■ |
| Interpreter | ■ | ■ |
| Independent Support Broker | ■ | ■ |
| Individual Directed Goods and Services | ■ | ■ |
| Nutrition | ■ | ■ |
| Live-in Caregiver | ■ | ■ |

**h. Financial Management Services.** Except in certain circumstances, financial management services are mandatory and integral to participant direction. A governmental entity and/or another third-party entity must perform necessary financial transactions on behalf of the waiver participant. *Select one:*

| | | |
|---|---|---|
| ● | **Yes**. Financial Management Services are furnished through a third party entity. *(Complete item E-1-i)*. Specify whether governmental and/or private entities furnish these services. *Check each that applies:* | |
| | ☐ | Governmental entities |
| | ■ | Private entities |

| | |
|---|---|
| ○ | **No**. Financial Management Services are not furnished. Standard Medicaid payment mechanisms are used. *Do not complete Item E-1-i.* |

**i. Provision of Financial Management Services.** Financial management services (FMS) may be furnished as a waiver service or as an administrative activity. S*elect one*:

| | | |
|---|---|---|
| ○ | FMS are covered as the waiver service entitled as specified in Appendix C-3. | |
| ● | FMS are provided as an administrative activity. *Provide the following information:* | |
| | **i.** | **Types of Entities**: Specify the types of entities that furnish FMS and the method of procuring these services: |
| | | VFEAs are procured through a competitive RFP process. Private not for profit and for profit corporations and LLC's furnish these services. CT DDS pays the VFEAs directly per the contract. Participants who self direct must use a VFEA under contract with the state. CT requires the re-bidding of VFEA contracts every three years. |
| | **ii.** | **Payment for FMS**. Specify how FMS entities are compensated for the administrative activities that they perform: |
| | | Payment through a contract with the DDS as a result of an awarded RFP. |
| | **iii.** | **Scope of FMS**. Specify the scope of the supports that FMS entities provide *(check each that applies):* |
| | | *Supports furnished when the participant is the employer of direct support workers:* |
| | | ■ Assist participant in verifying support worker citizenship status |
| | | ■ Collect and process timesheets of support workers |
| | | ■ Process payroll, withholding, filing and payment of applicable federal, state and local employment-related taxes and insurance |
| | | ■ Other *(specify):* |
| | | Verify training requirements of direct support workers are completed. |
| | | *Supports furnished when the participant exercises budget authority:* |
| | | ■ Maintain a separate account for each participant's participant-directed budget |
| | | ■ Track and report participant funds, disbursements and the balance of participant funds |
| | | ■ Process and pay invoices for goods and services approved in the service plan |
| | | ■ Provide participant with periodic reports of expenditures and the status of the participant-directed budget |
| | | ☐ Other services and supports *(specify)*: |
| | | |
| | | *Additional functions/activities:* |
| | | ■ Execute and hold Medicaid provider agreements as authorized under a written agreement with the Medicaid agency |

| | | |
|---|---|---|
| | ■ | Receive and disburse funds for the payment of participant-directed services under an agreement with the Medicaid agency or operating agency |
| | ■ | Provide other entities specified by the State with periodic reports of expenditures and the status of the participant-directed budget |
| | ■ | Other *(specify):* |
| | | VFEAs provide an enrollment packet to each individual to whom it provides fiscal intermediary services under their state contract. The enrollment packet includes the State's forms and information (employee application, fact sheet on employer liability and safety, Criminal Background and Abuse/Neglect Registry checks, Individual Provider Medicaid agreement, employee and Vendor Agreement forms, Individual Provider Training Verification Record and training materials).<br>VFEAs meet with each participant who is hiring individual providers to review all of the State and Federal employer requirements.<br>VFEAs secure Workers Compensation Policies for each participant employer with employees who work 26 or more hours per week and for employers and employees who choose to have Worker's Compensation Insurance for employees who work fewer than 26 hours per week. The Contractor is responsible for filing Criminal History Background Check, Abuse/Neglect Registry Check, driver's license checks, Workers Compensation Policies, and training verification records along with all state and federal employee and employer forms. |
| **iv.** | **Oversight of FMS Entities.** Specify the methods that are employed to: (a) monitor and assess the performance of FMS entities, including ensuring the integrity of the financial transactions that they perform; (b) the entity (or entities) responsible for this monitoring; and, (c) how frequently performance is assessed. | |
| | The state conducts an annual performance review of VFEAs. VFEAs are responsible for providing the state with an independent annual audit of its organization and the state funds and expenditures under the agent's control according to procedures dictated by the CT DDS audit unit (VFEA contract template Part 3). In addition, quarterly statements of expenditures against individual budgets are sent to the individual and the regional office. These statements are reviewed on a periodic basis by regional administration staff and the individual's case manager, DDS support broker or the Independent Support Broker. In addition to the quarterly statements an annual expenditure report is submitted for each participant that is reviewed by the state and either accepted or sent back for clarification or changes. | |

**j. Information and Assistance in Support of Participant Direction.** In addition to financial management services, participant direction is facilitated when information and assistance are available to support participants in managing their services. These supports may be furnished by one or more entities, provided that there is no duplication. Specify the payment authority (or authorities) under which these supports are furnished and, where required, provide the additional information requested *(check each that applies)*:

| | |
|---|---|
| ■ | **Case Management Activity**. Information and assistance in support of participant direction are furnished as an element of Medicaid case management services. *Specify in detail the information and assistance that are furnished through case management for each participant direction opportunity under the waiver:* |
| | The role of the DDS case manager (TCM) in individual planning is to support the person and other team members to develop and implement a plan that addresses the individual's needs and preferences. Case managers support individuals to be actively involved in the planning process. Case managers share information about choice of qualified providers and self-directed options at the time of the planning meeting and upon request. Case managers assist the person to develop an individual budget and assist with arranging supports ands services as described in the plan. They also assist the individual to monitor services and make changes as needed. Case managers share information regarding the ability to change providers when individuals are dissatisfied with performance.<br><br>As described in Section E.1.a, individuals who self direct by hiring their own staff will have case manager or a specialized case manager, called a DDS support broker, to assist them to direct their plan of individual support. In addition to case management (TCM) activities, the DMR Support Brokers assist individuals to hire, train and manage the support staff, negotiate provider rates, develop and manage the individual budget , develop emergency back up plans, and provide support and training to access and develop self-advocacy skills. These additional duties are considered outside the scope of the TCM service so the time/costs are not included in the rate setting methodology for TCM.<br><br>Another option for those who self-direct is to have a DDS case manager (TCM) and independent support brokerage through the option of Independent Support Broker under the waiver. This waiver service noted below provides support and consultation to individuals and/or their families to assist them in directing their own plan of individual support. This service may be self-directed or provided by a qualified agency and is available to those who direct their own supports and hire their own staff. The services included are :<br>• Assistance with developing a natural community support network<br>• Assistance with managing the Individual Budget<br>• Support with and training on how to hire, manage and train staff<br>• Assistance with negotiating rates and reimbursements.<br>• Collaborates with DDS CM and either participates in participant's planning meetings or is made aware of the participant's individual plan and goals from both the participant and case manager.<br>• Accessing community activities and services, including helping the individual and family with day-to-day coordination of needed services.<br>• Developing an emergency back up plan<br>• Self advocacy training and support |
| ■ | **Waiver Service Coverage**. Information and assistance in support of participant direction are provided through the waiver service coverage (s) specified in Appendix C-3 entitled: **Independent Support Broker** |

| | |
|---|---|
| ☐ | **Administrative Activity**. Information and assistance in support of participant direction are furnished as an administrative activity. *Specify: (a) the types of entities that furnish these supports; (b) how the supports are procured and compensated; (c) describe in detail the supports that are furnished for each participant direction opportunity under the waiver; (d) the methods and frequency of assessing the performance of the entities that furnish these supports; and, (e) the entity or entities responsible for assessing performance:* |
| | |

**k. Independent Advocacy** *(select one)*.

| | |
|---|---|
| ● | **Yes.** Independent advocacy is available to participants who direct their services. *Describe the nature of this independent advocacy and how participants may access this advocacy*: |
| | Independent Advocacy is available to participants through the Office of the Ombudsperson for Developmental Services as well as through the use of an Independent Support Broker. |
| ○ | **No.** Arrangements have not been made for independent advocacy. |

**l. Voluntary Termination of Participant Direction.** Describe how the State accommodates a participant who voluntarily terminates participant direction in order to receive services through an alternate service delivery method, including how the State assures continuity of services and participant health and welfare during the transition from participant direction:

Individuals may through the Individual Plan process request the termination of self-direction and his or her Self Directed Support Agreement and Individualized Budgets.
An individual/family may decide to terminate the Self Directed Support Agreement and Individualized budget and choose an alternative support service. The case manager, support broker or regional designee discusses with the individual/family all the available options and resources available, updates the individual plan, and begins the process of referral to those options. Once the new option has been identified and secured, the case manager, support broker or regional designee will fill out the form for termination of the individual budget. The form is sent within 10 business days to the VFEA, Resource Administrator, or regional designee, and the regional fiscal office representative.

**m. Involuntary Termination of Participant Direction**. Specify the circumstances when the State will involuntarily terminate the use of participant direction and require the participant to receive provider-managed services instead, including how continuity of services and participant health and welfare is assured during the transition.

Each individual who self-directs by hiring his or her own workers has an Agreement for Self Directed Supports describing the expectations of participation. Termination of the participant's self-direction opportunity may be made when a participant or representative cannot adhere to the terms of the Agreement for Self Directed Supports: Key terms are:

1. To participate in the development and implementation of the Individual Planning Process.
2. Funds received under this agreement can only be used for items, goods, supports, or services identified in the service recipient's individual plan and authorized individual budget.
3. To actively participate in the selection and ongoing monitoring of supports and services
4. To understand that no one can be both a paid employee and the employer of record.
5. To authorize payments for services provided only to the recipient according to the individual plan and budget.
6. To enter into an agreement with the provider agency/agencies or individual support

worker(s) hired. The agreement is outlined in the Individual Family Agreements with Vendors and Employees and identifies the type and amount of supports and services that will be provided.

7. To submit timesheets, receipts, invoices, expenditure reports, or other documentation on the required forms to the fiscal intermediary on a monthly basis or within the agreed upon timeframe.
8. To review the VFEA expenditures reports on a quarterly basis and notify the case manager, broker and VFEA of any questions or changes.
9. To follow the DDS Cost Standards and Costs Guidelines for all services and supports purchased with the DDS allocation.
10. To get prior authorization from the DDS to purchase supports, services, or goods from a party that is related to the individual through family, marriage, or business association.
11. To seek and negotiate reasonable fees for services and reasonable costs for items, goods, or equipment, and to obtain three bids for purchases of items, equipment, or home modifications over $2,500.
12. Any special equipment, furnishings, or items purchased under the agreement are the property of the service recipient and will be transferred to the individual's new place of residence or day program or be returned to the state when the item is no longer needed..
13. To participate in the department's quality review process.
14. To use qualified vendors enrolled by DDS.
15. To ensure that each employee has read the required training materials and completed any individual specific training in the Individual Plan prior to working with the person.
16. To offer employment to any new employee on a conditional basis until the Criminal History Background Check, Driver's License Check, and DDS Abuse Registry Check has been completed. Anyone on the DDS Abuse Registry cannot be employed to provide support to the individual.
17. To notify the case manager/broker when the individual is no longer able to meet the responsibilities for self directed services.

The individual acknowledges that the authorization and payment for services that are not rendered could subject him/her to Medicaid fraud charges under state and federal law. Breach of any of the above requirements with or without intent may disqualify the individual from self-directing-services.

An Agreement for Self -Directed Supports can be terminated if the participant does not comply with the agreed upon requirements. The DDS case manager would coordinate the transition of services and assist the individual to choose a qualified provider to replace the directly hired staff.

**n. Goals for Participant Direction**. In the following table, provide the State's goals for each year that the waiver is in effect for the unduplicated number of waiver participants who are expected to elect each applicable participant direction opportunity. Annually, the State will report to CMS the number of participants who elect to direct their waiver services.

**Table E-1-n**

| | **Employer Authority Only** | **Budget Authority Only or Budget Authority in Combination with Employer Authority** |
|---|---|---|
| **Waiver Year** | **Number of Participants** | **Number of Participants** |
| **Year 1** | 120 | 400 |
| **Year 2** | 134 | 450 |
| **Year 3** | 145 | 450 |
| **Year 4 (renewal only)** | 156 | 520 |
| **Year 5 (renewal only)** | 170 | 560 |

# Appendix E-2: Opportunities for Participant-Direction

**a. Participant – Employer Authority** *(Complete when the waiver offers the employer authority opportunity as indicated in Item E-1-b)*

**i. Participant Employer Status**. Specify the participant's employer status under the waiver. *Check each that applies:*

| | |
|---|---|
| ■ | **Participant/Co-Employer**. The participant (or the participant's representative) functions as the co-employer (managing employer) of workers who provide waiver services. An agency is the common law employer of participant-selected/recruited staff and performs necessary payroll and human resources functions. Supports are available to assist the participant in conducting employer-related functions. *Specify the types of agencies (a.k.a., "agencies with choice") that serve as co-employers of participant-selected staff; the standards and qualifications the State requires of such entities and the safeguards in place to ensure that individuals maintain control and oversight of the employee.:* |
| | Agencies with Choice are permitted and encouraged. DDS requires specific assurances to enroll and be designated as an Agency with Choice organization through the submission of policies and procedures that support the control and oversight by the participants over the employees, and requires periodic participation in DDS sponsored training and events in consumer-direction. |
| ■ | **Participant/Common Law Employer**. The participant (or the participant's representative) is the common law employer of workers who provide waiver services. An IRS-approved Fiscal/Employer Agent functions as the participant's agent in performing payroll and other employer responsibilities that are required by federal and state law. Supports are available to assist the participant in conducting employer-related functions. |

**ii. Participant Decision Making Authority.** The participant (or the participant's representative) has decision making authority over workers who provide waiver services. *Check the decision making authorities that participants exercise*:

| | |
|---|---|
| ■ | Recruit staff |
| ■ | Refer staff to agency for hiring (co-employer) |
| ■ | Select staff from worker registry |
| ■ | Hire staff (common law employer) |
| ■ | Verify staff qualifications |
| ■ | Obtain criminal history and/or background investigation of staff. Specify how the costs of such investigations are compensated: |
| | Costs are covered in the individual budget provided for the participant by DDS. |
| ■ | Specify additional staff qualifications based on participant needs and preferences so long as such qualifications are consistent with the qualifications specified in Appendix C-3. |
| ■ | Determine staff duties consistent with the service specifications in Appendix C-3. |
| ■ | Determine staff wages and benefits subject to applicable State limits |
| ■ | Schedule staff |
| ■ | Orient and instruct-staff in duties |
| ■ | Supervise staff |
| ■ | Evaluate staff performance |
| ■ | Verify time worked by staff and approve time sheets |

| | |
|---|---|
| ■ | Discharge staff (common law employer) |
| ☐ | Discharge staff from providing services (co-employer) |
| ■ | Other *(specify)*: |
| | Discharge staff from employment with the participant but not the agency at large (co-employer) |

**b. Participant – Budget Authority** *(Complete when the waiver offers the budget authority opportunity as indicated in Item E-1-b)*

**i. Participant Decision Making Authority.** When the participant has budget authority, indicate the decision-making authority that the participant may exercise over the budget. *Check all that apply***:**

| | |
|---|---|
| ■ | Reallocate funds among services included in the budget |
| ■ | Determine the amount paid for services within the State's established limits |
| ■ | Substitute service providers |
| ■ | Schedule the provision of services |
| ■ | Specify additional service provider qualifications consistent with the qualifications specified in Appendix C-3 |
| ■ | Specify how services are provided, consistent with the service specifications contained in Appendix C-3 |
| ■ | Identify service providers and refer for provider enrollment |
| ■ | Authorize payment for waiver goods and services |
| ■ | Review and approve provider invoices for services rendered |
| □ | Other *(specify):* |
| | |

**ii. Participant-Directed Budget**. Describe in detail the method(s) that are used to establish the amount of the participant-directed budget for waiver goods and services over which the participant has authority, including how the method makes use of reliable cost estimating information and is applied consistently to each participant. Information about these method(s) must be made publicly available.

Initial funding range provided by the Regional Planning and Resource Allocation Team based on Level of Need Assessment. Within that allocation individuals design an Individual Budget to support the outcomes identified in the Individual Plan. The resource allocation ranges derived from analysis of past utilization and costs for services used by like individuals based on assessed level of need as described in Appendix B of this application. The participant can direct the entire budget for waiver goods and services as the participant chooses. Information regarding this process is available to the public on the DDS website and in the "Guide for Consumers and their Families".

**iii. Informing Participant of Budget Amount**. Describe how the State informs each participant of the amount of the participant-directed budget and the procedures by which the participant may request an adjustment in the budget amount.

The Regional Planning and Resource Allocation Team (PRAT) provides the individual with the resource allocation based on their assessed Level of Need in writing. Following the development of the Individual Plan, the individual may request additional funding based on identified needs. The request is reviewed by the regional PRAT, or may go to a regional or state level utilization review process depending upon the amount of funding requested beyond the initial funding rage. Any denial of service/funding levels is communicated in writing by the Central Office Waiver Policy Unit and includes the formal notice and requests for a Fair Hearing. This same process applies any time an individual requests an increase in approved funding levels.

**iv. Participant Exercise of Budget Flexibility**. *Select one:*

| | |
|---|---|
| ● | The participant has the authority to modify the services included in the participant-directed budget without prior approval. Specify how changes in the participant-directed budget are documented, including updating the service plan. When prior review of changes is required in certain circumstances, describe the circumstances and specify the entity that reviews the proposed change: |
| | Amendments are changes in the budget that add additional funds for new waiver services or additional waiver services and require a modification to the Individual Plan. Amendments follow Procedure No**.** I.C.2.PR.007, Individual Support Budget Authorization Process.<br>Adjustments are changes to existing Individual Budgets in amount or type of waiver service without a change in funding:<br>The individual/family and case manager or support broker discuss the need for a change in the type or amount of a particular support or service that does not increase the total budget. When this change is within existing line items or results in a new line item without a change in the authorized allocation, a revision to individual the individual budget is required to effect the change. Individuals who are self-directing and have an Individual Budgets may shift funds among waiver services authorized in their budgets up to the designated amount identified in policy without a change in the Individual Plan. When changes exceed the designated amount found in policy or include a new waiver service a change in the Individual Plan is required. The case manager reviews the proposed changes with the Planning and Service Team. When the Planning and Service Team is in agreement with the changes, the case manager has the option of updating the IP and all relative sections, completing an IP 12, Periodic Review Form, or developing a new plan. An IP 6 and a Waiver Form 223 are required and the case manager supervisor is required to authorize the change.. |
| ○ | Modifications to the participant-directed budget must be preceded by a change in the service plan. |

**v. Expenditure Safeguards.** Describe the safeguards that have been established for the timely prevention of the premature depletion of the participant-directed budget or to address potential service delivery problems that may be associated with budget underutilization and the entity (or entities) responsible for implementing these safeguards:

The VFEA monitors expenditures and alerts the waiver participant and Department's support broker/case manger of any variance in line items prior to payment that exceed the quarterly budgeted amount for the specific line item where the variance occurred.

The VFEA has a system to verify that the service or support or product billed is in the authorized Individual Budget prior to making payment. The VFEA is responsible to cover out of its' own funds any payments that exceed what the state has authorized in the Individual Budget.

Monthly and Quarterly Utilization Reports:

Each region has a regional contact person to whom the VFEA sends the Quarterly Utilization Reports. Each region has an internal system for distribution and review of these reports. In addition to the quarterly expenditure report the participant and the case manager also receive a monthly expenditure report. The reports are due the 25th day of the following month. The DDS case manager/broker monitors the monthly expenditure reports, and is responsible to review the expenditure reports against the approved individual plan and budget on at least a quarterly

basis to monitor for under/over utilization. The region administrator reviews the quarterly reports for utilization and follows up with the case manager/broker when there are significant gaps in service.

# Appendix F: Participant Rights

## Appendix F-1: Opportunity to Request a Fair Hearing

*The State provides an opportunity to request a Fair Hearing under42 CFR Part 431, Subpart E to individuals: (a) who are not given the choice of home and community-based services as an alternative to the institutional care specified in Item 1-F of the request; (b) are denied the service(s) of their choice or the provider(s) of their choice; or, (c) whose services are denied, suspended, reduced or terminated. The State provides notice of action as required in 42 CFR §431.210.*

**Procedures for Offering Opportunity to Request a Fair Hearing.** Describe how the individual (or his/her legal representative) is informed of the opportunity to request a fair hearing under 42 CFR Part 431, Subpart E. Specify the notice(s) that are used to offer individuals the opportunity to request a Fair Hearing. State laws, regulations, policies and notices referenced in the description are available to CMS upon request through the operating or Medicaid agency.

Participants are informed of the Fair Hearing process at the Individual Plan meeting, in the Consumer and Family Guide to the HCBS Waivers, and in all correspondence related to the HCBS waiver program related to resource allocation and access to the HCBS waiver program by DDS . Any time access to a HCBS waiver or services are denied, reduced or terminated, the participant and legal representative are notified by the DDS Waiver Policy Unit through the Notice of Denial of Home and Community Based Services Waiver Services, and each notice includes a Department of Social Services (DSS) Request for an Administrative Hearing for the DDS HCBS Waiver Program form.

# Appendix F-2: Additional Dispute Resolution Process

**a. Availability of Additional Dispute Resolution Process**. Indicate whether the State operates another dispute resolution process that offers participants the opportunity to appeal decisions that adversely affect their services while preserving their right to a Fair Hearing. *Select one*:

| | |
|---|---|
| ● | **Yes**. The State operates an additional dispute resolution process *(complete Item b)* |
| ○ | **No**. This Appendix does not apply (*do not complete Item b)* |

**b. Description of Additional Dispute Resolution Process**. Describe the additional dispute resolution process, including: (a) the State agency that operates the process; (b) the nature of the process (i.e., procedures and timeframes), including the types of disputes addressed through the process; and, (c) how the right to a Medicaid Fair Hearing is preserved when a participant elects to make use of the process: State laws, regulations, and policies referenced in the description are available to CMS upon request through the operating or Medicaid agency.

Individual Plans and budgets that exceed the resources allocated to the individual by PRAT or Individual Budget limits based on the Level of Need Assessment and additional information as presented by the support team proceed through utilization review (UR). Each waiver specifies circumstances where services can exceed established Level of Need limits.

**Review Process and Timelines**

Individual Plans and budgets are reviewed to evaluate the amount, type, frequency, and intensity of services directly related to health and safety needs of the individual, and desired outcomes based on the individual's preferences and needs as described below:

Requests for resource allocations exceeding original allocation or Individual Budget limit provided by the Regional PRAT are made to the PRAT. PRAT has up to 10 business days to issue a decision on the request.

The Regional Director or designee is required to review and approve PRAT decisions that exceed PRAT approval limits and will do so within 5 business days.

Regional Directors may provide immediate temporary approval for requests to address immediate threats to the individual's health and/or safety.

The PRAT notifies the case manager of the UR decision within 12 business days of the submission. The case manager will contact the individual and personal representative by phone to inform them of the decision within 3 business days. If the request has been denied by UR, the individual and personal representative will be offered the following options:

- revise the service plan to fall within the original resource allocation;
- request an informal negotiation with DDS to determine if a compromise can be reached; or,
- request that the decision be forwarded to the Central Office Waiver Policy Unit for formal action and Medicaid Fair Hearing rights if the UR denial is upheld.

The individual and his or her personal/legal representative may request a review of any decision to which he/she/they claim to be aggrieved by the next level review authority (Regional Director, Utilization Review Committee). Such reviews will be completed within the timelines described above.

The telephone contact and outcome of the discussion will be documented in the case manager's running case notes in the individual's master record. If the individual requests an opportunity to further discuss and negotiate the region's decision, the case manager will notify his/her supervisor and the region will designate an administrator from a different regional Division to meet with the individual and family or other support persons within 10 business days. The outcome of this meeting will either be an agreement on a service package, or continued disagreement and submission of the proposed plan to the DDS CO Waiver Policy Unit for a final determination. The outcome of the

meeting will be documented by the regional administrator in a letter to the individual and family immediately following the meeting, with a copy to the case manager and the PRAT.
If the individual and personal representative request that the decision be reviewed by the Central Office Waiver Policy Unit, the complete packet will be forwarded to the Unit within 3 business days of that decision by the PRAT.

For determinations of the CO Waiver Policy Unit that constitute a denial of or reduction in a waiver service, the CO Waiver Policy Unit will provide information and forms to initiate an administrative hearing through the Department of Social Services.

DDS maintains an additional informal dispute resolution process, the Programmatic Administrative Review. This informal dispute resolution is available to individuals supported by DDS for any service oriented decision regardless of HCBS waiver status. DDS also operates an Administrative Hearing process for decisions regarding placement on the DDS Waiting List for services that may affect potential waiver participants.

# Appendix F-3: State Grievance/Complaint System

**a. Operation of Grievance/Complaint System**. *Select one:*

| | |
|---|---|
| ● | **Yes.** The State operates a grievance/complaint system that affords participants the opportunity to register grievances or complaints concerning the provision of services under this waiver *(complete the remaining items)*. |
| ○ | **No.** This Appendix does not apply (*do not complete the remaining items*) |

**b. Operational Responsibility.** Specify the State agency that is responsible for the operation of the grievance/complaint system:

DDS and the Independent Office of the Ombudsperson for Developmental Services.

**c. Description of System**. Describe the grievance/complaint system, including: (a) the types of grievances/complaints that participants may register; (b) the process and timelines for addressing grievances/complaints; and, (c) the mechanisms that are used to resolve grievances/complaints. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Grievances and complaints may be recorded by phone, letter, fax or in person to the DDS Commissioner or Regional Director. The complaint or grievance is entered into a data tracking system and assigned by the Commissioner or Regional Director for follow-up and resolution. The Independent Office of the Ombudsperson may also receive grievances or complaints and investigates accordingly. The Independent Office of the Ombudsperson reports to the Council on Mental Retardation at each meeting, and prepares an Annual Report.

# Appendix G: Participant Safeguards

## Appendix G-1: Response to Critical Events or Incidents

**a. State Critical Event or Incident Reporting Requirements**. Specify the types of critical events or incidents (including alleged abuse, neglect and exploitation) that the State requires to be reported for review and follow-up action by an appropriate authority, the individuals and/or entities that are required to report such events and incidents, and the timelines for reporting. State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Abuse/Neglect Reporting (Who Reports, Timeframe for Reporting)

Who Reports (Policy No. I.F.PO.001: Policy Statement)

Any employee of DDS or a Provider Agency must immediately intervene on the individual's behalf in any abuse/neglect situation and shall immediately report the incident.

Timeframe for reporting (Procedure Nos. I.F.PR.001 D.2:Reporting and Notification; and PR.001a D.3; PR.005 D.: Implementation)

A verbal report must be made immediately to the appropriate agency (OPA, DCF, DSS) and a subsequent written report by the individual witnessing the abuse/neglect incident. The verbal report is transcribed by the receiving agency and is forwarded to DDS Division of Investigations via fax or secure electronic transmission.

Supervisors must notify State Police in cases involving observed/suspected assault or sexual abuse cases in DDS Operated facilities or local police in similar cases involving Private Agencies.

Regional Directors/Private Agency Administrators must ensure the Regional abuse/neglect liaison is notified within 72 hours of the incident.

Critical Incident Types (Who Reports, Timeframe for Reporting)

Critical Incident Types (Procedure No. I.D.PR.009 C. Definitions) in DDS or Private Agency Operated Settings.

1. Deaths
2. Severe Injury
3. Vehicle accident involving moderate or severe injury
4. Missing Person
5. Fire requiring emergency response and/or involving a severe injury
6. Police Arrest
7. Victim of Aggravated Assault or Forcible Rape

Who Reports (Procedure No. I.D.PR.009 B.: Applicability)

Staff of all DDS operated, funded or licensed facilities and programs.

Timeframe for Reporting (Procedure No. I.D.PR.009 D.1.a-b Implementation)

During Normal Business Hours: Immediately report the incident to the individual's family and/or guardian and appropriate DDS regional director or designee via telephone. An Incident Report form shall be faxed to the DDS Regional Director's Office. The form should be forwarded to the appropriate DDS Region in the usual process within five business days.

After Normal Business Hours: Immediately report the incident to the individual's family

and/or guardian and appropriate DDS on-call manager. An Incident Report form shall be faxed to the DDS on-call manager the next business day. The form should be forwarded to the appropriate DDS Region in the usual process within five business days.

Critical Incident Types (Procedure No. I.D.PR.009a C. . Definitions) in Own/Family Home and Receive DDS Funded Services) if service is located in individual's own or family home.

1. Deaths
2. Use of restraint
3. Severe Injury
4. Fire requiring emergency response and/or involving a severe injury
5. Hospital admission
6. Missing Person
7. Police Arrest
8. Victim of theft or larceny
9. Victim of Aggravated Assault or Forcible Rape
10. Vehicle accident involving moderate or severe injury.

Who Reports ((Procedure No. I.D.PR.009a B: Applicability)

Applies to all staff employed directly by the individual, individual's family or provider agency to provide services and supports to the applicable individuals.

Time Frames for Reporting (Procedure No. I.D.PR.009a D. Implementation)

Immediately notify the individual's family and the individual's DMR case manager or broker. If not available, leave a voice mail message regarding the incident. Complete an Incident Report form. Send or bring the completed form to the employer (individual, family or private agency) who shall keep the original and send the remaining copies to the DMR Regional Director or designee's office immediately or the next working day following the incident.

Situations of exploitation are reported as a Special Concern using the same form and procedure as Abuse /Neglect reporting.

Non-critical incidents are recorded on the DDS Form 255 and submitted to DDS within five (5) business days for entry into CAMRIS. Non-critical incidents include restraint, injury, unusual behavioral incidents and medication errors.

**b. Participant Training and Education.** Describe how training and/or information is provided to participants (and/or families or legal representatives, as appropriate) concerning protections from abuse, neglect, and exploitation, including how participants (and/or families or legal representatives, as appropriate) can notify appropriate authorities or entities when the participant may have experienced abuse, neglect or exploitation.

Describe Abuse/Neglect Training (Policy No. I.F.PO.001 D.1 Abuse and Neglect; Procedure No. I.F.PR001 D.1 Abuse/Neglect Prevention, Notification, Resolution and Follow-Up).
The department has produced and made available on its website family fact sheets on abuse/neglect reporting http://www.dmr.state.ct.us/publications/centralofc/fact_sheets/ifs_abuneg_fam.htm, and those are provided during the annual plan meeting. During the Individual Plan meeting a review of a participant's individual needs is conducted to identify methods of prevention if appropriate.
People who direct their own supports receive additional materials to train his/her staff on abuse and

ıeglect policies and reporting

**c. Responsibility for Review of and Response to Critical Events or Incidents**. Specify the entity (or entities) that receives reports of critical events or incidents specified in item G-1-a, the methods that are employed to evaluate such reports, and the processes and time-frames for responding to critical events or incidents, including conducting investigations.

Abuse/Neglect Incidents

The following agencies receive reports of abuse/neglect (Procedure No. I.F.PR.001 D.2 Reporting and Notification and PR.005 D. Implementation):

- Office of Protection and Advocacy OPA (if the individual is between 18-59 years of age)
- Dept. of Children and Families DCF (if the individual is under 18 years of age)
- Dept. of Social Services DSS (if the individual is 60 years of age or over)
- Dept. of Public Health DPH (if a medical facility or provider is licensed by DPH) In this case the appropriate agency above would also be notified.
- DDS Division of Investigations receive reports of all abuse/neglect involving persons served by DDS

Methods for evaluating reports (Procedure No. I.F.PR.005 D.2 Investigation Assignment and D.3. Investigations)

The OPA designates the agency assigned to conduct the primary investigation.. OPA investigates all incidents of abuse and neglect that are alleged to have occurred in a private home. OPA may direct DDS to implement an Immediate Protective Services Plan when an allegation is made. This plan is developed, implemented and monitored by the Case Manager, the Abuse and Neglect Liaison and OPA for participants who live in a family home or their own home while the investigation is conducted. OPA may choose to investigate any other allegation. DCF, DSS and DPH conduct investigations per statutory charge. DDS and Private agencies are also responsible for investigating reports involving the individuals they are responsible for serving. The DDS Division of Investigations (DOI) reviews the completion of all investigations, and selects cases to directly investigate in private operated services after consultation with OPA. The investigation into any allegation of abuse or neglect that is determined to have the potential to lead to a recommendation to place an employee on the DDS Abuse Neglect Registry will be monitored by the DDS Division of Investigations and will have a shortened timeline for completion of the investigation. All investigations completed by DDS and private agencies are to be submitted to OPA for review within 90 days of the allegation.

Based on the investigations the allegation (s) are either substantiated or not substantiated. Recommendations for follow up actions are generated (for substantiated cases, and in some cases, unsubstantiated cases) by the investigator and /or during the review process by DDS or DOI..

Within 7 days of the review of the recommendations of the completed abuse or neglect investigation, a written response shall be requested of the provider. A written response is due from the provider within 30 days of the request date.

Procedures are in place to address situations in which the written response is not submitted within the required timeframe (a compliance plan will then be required)

A standard tracking system is used to track responses to the recommendations and will be monitored by the Regional Quality Improvement Director or designee. Monthly reports on recommendations tracking will be generated and reviewed by the regional quality and abuse/neglect investigations staff

Critical Incidents

The following agencies receive reports of critical incidents (Procedure No. I.D.PR.009 D.1. Implementation)

DDS receives all reports of Critical Incidents. Deaths are also to the OCME if considered sudden and/or unexpected. A DDS Nurse Investigator conducts a Medical Desk Review of all deaths occurring in funded service settings to determine if a more detailed review or investigation is indicated. If no further review is indicated the case is referred to mortality review. If further review is indicated the case is referred to expedited mortality review if systemic issues are identified or suspected. If abuse or neglect is suspected to contribute to the death, the allegation is reported to OPA and is processed through the Abuse/Neglect reporting and investigation system. For mortality review the Regional DDS Health Service Director prepares the family regarding the review process.

Incidents are determined to be "critical" based on meeting the definitional requirements stated on section a under "Critical Incident Types". The participant's team is responsible for assessing and documenting all follow-up regarding the critical incident on the DDS Incident Follow-up Form and submit the document to the DDS Regional Quality Improvement Director or designee within 5 business days. Regional Quality Monitors and Case Managers ensure that action has been taken on all follow up activities.

All incidents are reviewed for trends and discussion by the team every six months. A Program nurse reviews all medication errors on a quarterly basis.

**d. Responsibility for Oversight of Critical Incidents and Events.** Identify the State agency (or agencies) responsible for overseeing the reporting of and response to critical incidents or events that affect waiver participants, how this oversight is conducted, and how frequently.

The Office of Protection and Advocacy is the state agency charged with the responsibility of oversight for Abuse/Neglect for individuals between the ages of 18 and 59, DCF has responsibility for children under the age of 18 and DSS( the state Medicaid Agency) has responsibility for people age 60 and over.. DDS has joint responsibility for Abuse/Neglect reporting as well as Critical Incident Reporting, Investigation and Follow-up. The Office of Protection and Advocacy also monitors the submission of abuse and neglect reporting, investigations and reports.
Critical Incidents are reported using the DDS Incident Reporting Procedure and are stored in the DDS Incident Reporting data system.

# Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions

**a. Use of Restraints or Seclusion *(select one):***

| | |
|---|---|
| ○ | The State does not permit or prohibits the use of restraints or seclusion. Specify the State agency (or agencies) responsible for detecting the unauthorized use of restraints or seclusion and how this oversight is conducted and its frequency: |
| | |
| ● | The use of restraints or seclusion is permitted during the course of the delivery of waiver services. Complete Items G-2-a-i and G-2-a-ii: |

**i. Safeguards Concerning the Use of Restraints or Seclusion.** Specify the safeguards that the State has established concerning the use of each type of restraint (i.e., personal restraints, drugs used as restraints, mechanical restraints or seclusion). State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Reference Incident Reporting Procedure I.D.PR.009,March 13, 2006, and Procedure No. I.D.PR.011 (own and family home) and PRC Procedure I.E. PR.004, June 30, 2005, Regional Human Rights Procedure I. F.PR.006, March 30, 2007, DMR Policy 1 Client Rights, Behavior Support Plans Procedure I. E.PR.002, August 21, 2006, Behavior Modifying Medications Policy I.E.PO.003 and Procedure I.E.PR.003, January 1, 2004

When submitting the proposed use of a physical restraint or seclusion practice documentation must exist that less aversive procedures have been found to be ineffective in addressing the target behavior. If the Interdisciplinary team identifies the need for restraint and/or seclusion the proposed use of the procedure must be reviewed and approved by the regional Program Review Committee, the Human Rights Committee and the Regional Director prior to its implementation. The use of the procedure must be presented within the context of an overall behavior support plan designed to teach adaptive skills and reduce the identified target behavior. There must also be documentation that:

- The proposed procedure is not medically contraindicated by the individual's physician
- Methods for increasing positive behaviors and decreasing undesirable behaviors
- Criteria for ensuring the least restrictive level of aversive intervention is employed
- Required documentation concerning use of restraints or seclusion
- The individual and the individual's family, guardian or advocate are informed of the target behavior, goal of the plan, the adaptive behavior to be taught, the aversive procedure under consideration, the possible side effects of using the procedure, the consequences of not administering the procedure, documentation that less restrictive procedures have been found to be ineffective, expected duration of the plan, the PRC and Human Rights Review Committee processes, and the procedures for appeal as required by Connecticut General Statutes 17a-210.

Procedure No. I.E.PR.004 and Procedure No. I.D.PR.011 (own and family home)– Incident Reporting

All use of restraint or seclusion (physical isolation), both planned and emergency, are required to be reported using the DDS Incident Reporting procedures. Incident reports require the date and time of the incident, the length of time of the restraint or seclusion, the specific restraint type(s) used in the incident, behaviors necessitating the restraint and whether an injury occurred as a result of the restraint or if abuse/neglect was suspected in the restraint application. Some selected restraints may be reported on a monthly basis but individuals are still required to report the total number of restraint applications and the total time in restraint. This data is collected in the DDS Incident Reporting data system and is kept historically.

Within 24 hours of the use of an emergency application of a physical restraint, supervisory or professional staff must examine the participant and report any evidence of trauma to a nurse or physician and report to the Regional DDS Director. Within 3 working days of the incident the team, including a physician, shall review the participant and his/her environment to determine if changes in the plan including the continued use of an emergency restraint or seclusion procedure are required. If the team plans to continue the use of a restraint or seclusion procedure, a behavior support plan must be designed and the approval process be initiated within five days of the team meeting.

- Education and training requirements personnel must meet who are involved with the administration of restraints or seclusion

Only staff with the appropriate training/in-service and experience can be assigned to implement use of restraints or other restrictive procedures.

DDS only allows training on use of restraints to be done via a specific approved training curricula (ID PR.009, Attachment G) which specify particular physical and mechanical restraint techniques and allows only DDS approved mechanical restraints to be used for mechanical restraint procedures (ID PR.009, Attachment I)

Use of behavior modifying medications, defined as any chemical agent used for the direct effect it exerts upon the central nervous system to modify thoughts, feelings, mental activities, mood or performance, require the use in conjunction with a comprehensive behavioral support plan. The behavior modifying medication may only be prescribed for a condition that is diagnosed according to the most current edition of the DSM. Use of the medication may be initiated upon consent of the individual, guardian or conservator, or if the individual does not have the capacity to consent and has no guardian or conservator, with the approval by an emergency Program Review Committee review, pending full review by the DDS PRC and HRC as described above. If the individual, guardian, or conservator does not consent, a physician may order the start of such medication if the physician determines the individual is a danger to him/herself or others. The individual/guardian/conservator is informed of their right to a hearing if this occurs.

Use of a medication on a STAT or at once basis may be used with approval by the DDS PRC and HRC Committees for time-limited purposes and in extraordinary circumstances. Standing orders for the use of chemical restraint are prohibited by DDS policy. The team must review the use of behavior modifying medications on a quarterly basis and be reported to the physician. Medications must be reviewed and re-ordered no more than every 6 months by the physician.

The completion and annual review of the Level of Need and Risk Screening Assessment Tool identifies if an individual has experienced issues in a number of categorical areas relevant to the need for safeguards (critical/serious incidents, medication, risk to self or others, physical

control risks or personal safety). If an issue is identified, an assessment or review must be done as part of the individual planning process. All assessments or reviews must contain specific recommendations for supports or procedures to minimize the risk to the person. All recommended supports and procedures must be referenced in the person's plan. The person's team ensures that recommended supports or procedures are in place, required training is completed and documented and ongoing supervision provided.

**ii. State Oversight Responsibility**. Specify the State agency (or agencies) responsible for overseeing the use of restraints or seclusion and ensuring that State safeguards concerning their use are followed and how such oversight is conducted and its frequency:

All providers are required to report emergency use (use that has not been pre-approved by the Program Review Committee) of restraint and other aversive procedures using the DDS incident reporting procedures. Use of emergency restraints and other aversive procedures must be reviewed by the interdisciplinary team and, if the use of these procedures are planned to continue or if there is an ongoing pattern of use (once per month for three months or three times within a 30 day period) a behavior support plan must be designed including this procedure and the approval process begun.

During quality review visits, waiver participants are interviewed by DDS Quality Review staff. Questions include those that would lead a reviewer to further investigate the possible use of an unauthorized restraint. Case managers are also involved in the monitoring of services and are instructed to closely monitor participants' records who may be at high risk of unauthorized restraint.

The DDS Central Office monitors the use of restraint on an emergency and planned basis, and can initiate an investigation of agency practice or of an individual based on a quarterly analysis of restraint data. Additionally, the DDS Central Office monitors the Regional Operations of the Program Review and Human Rights Review Committees to ensure policies and procedures as described herein are carried out.

**b. Use of Restrictive Interventions**

| | |
|---|---|
| ○ | The State does not permit or prohibits the use of restrictive interventions. Specify the State agency (or agencies) responsible for detecting the unauthorized use of restrictive interventions and how this oversight is conducted and its frequency: |
| | |
| ● | The use of restrictive interventions is permitted during the course of the delivery of waiver services. Complete Items G-2-b-i and G-2-a-ii: |

**i. Safeguards Concerning the Use of Restrictive Interventions.** Specify the safeguards that the State has in effect concerning the use of interventions that restrict participant movement, participant access to other individuals, locations or activities, restrict participant rights or employ aversive methods (not including restraints or seclusion) to modify behavior. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency.

All procedures described above are in place for any restrictive intervention. Use of a mechanical restraint, intrusive device that signals the whereabouts or movements of an individual to ensure the safety of the individual or safety of the community, or a restriction that prevents an individual from having access to specific categories of objects likely to be dangerous for the individual or others, such as knives, lighter fluid, weapons, matches or lighters, must always be reviewed and approved by the DDS Human Rights Committee. The Human Rights Committee is comprised of individuals who are not employees of DDS and provide oversight and advice regarding the rights of DDS service participants. Following the HRC review the Regional Director must also approve the restrictive procedure. The HRC determines the frequency of its review of the procedure and supporting behavior plans. The Department has recently issued a procedure for the extremely limited use of prone restraint.

**ii. State Oversight Responsibility**. Specify the State agency (or agencies) responsible for monitoring and overseeing the use of restrictive interventions and how this oversight is conducted and its frequency:

All providers are required to report emergency use (use that has not been pre-approved by the Program Review Committee) of restraint and other aversive procedures using the DDS incident reporting procedures. Use of emergency restraints and other aversive procedures must be reviewed by the interdisciplinary team and, if the use of these procedures are planned to continue or if there is an ongoing pattern of use (once per month for thee months or three times within a 30 day period) a behavior support plan must be designed including this procedure and the approval process begun.

During quality review visits, waiver participants are interviewed by DDS Quality Review staff. Questions include those that would lead a reviewer to further investigate the possible use of an unauthorized restraint. Case managers are also involved in the monitoring of services and are instructed to closely monitor participants' records who may be at high risk of unauthorized restraint.

The DDS Central Office monitors the use of any restrictive procedure on an emergency and planned basis, and can initiate an investigation of agency practice or of an individual based on a quarterly analysis of restraint data. Additionally, the DDS Central Office monitors the Regional Operations of the Program Review and Human Rights Review Committees to ensure policies and procedures as described herein are carried out.

# Appendix G-3: Medication Management and Administration

*This Appendix must be completed when waiver services are furnished to participants who are served in licensed or unlicensed living arrangements where a provider has round-the-clock responsibility for the health and welfare of residents. The Appendix does not need to be completed when waiver participants are served exclusively in their own personal residences or in the home of a family member.*

**a. Applicability.** Select one:

| | |
|---|---|
| ● | **Yes**. This Appendix applies *(complete the remaining items)*. |
| **O** | **No**. This Appendix is not applicable *(do not complete the remaining items)*. |

**b. Medication Management and Follow-Up**

**i. Responsibility.** Specify the entity (or entities) that have ongoing responsibility for monitoring participant medication regimens, the methods for conducting monitoring, and the frequency of monitoring.

The individual's team will review the medication regimen when developing the Individual Plan. The review will be based on anecdotal information, observation, or other method if identified by the team. The medication regimen will be reviewed quarterly with the review of the Individual Plan. The individual's Primary Care Physician will review their current plan of care at their annual physical exam and any subsequent visits.

**ii. Methods of State Oversight and Follow-Up**. Describe: (a) the method(s) that the State uses to ensure that participant medications are managed appropriately, including: (a) the identification of potentially harmful practices (e.g., the concurrent use of contraindicated medications); (b) the method(s) for following up on potentially harmful practices; and, (c) the State agency (or agencies) that is responsible for follow-up and oversight.

DMR Policy No. I.E.PO.003 and DMR Procedure No. I.E.003 addresses the use of behavior modifying medications and programmatic support. DMR Policy No. I.E.PO.004 and DMR Procedure No. I.E.004 outlines the role of the Program review Committee in the oversight of behavior modifying medications and behavioral support plans. Both of these policy and procedure allows for the use of these medications to be monitored. They are also supported by several DMR Medical Advisories including; 91-2 Unlabeled use of Medication for their Behavior Modifying effects for DMR Clients, 92-2 Monitoring the Use of Psychtropic Medications for DMR Clients, 98-5 Standards for Multiple Psychotropic drug Use, and 2000-2 Monitoring for Abnormal Involuntary Movements (Tardive Dyskinesia Screening). The team has the responsibility to ensure that these policies, procedures and advisories are followed in the CTH setting. The individual's Primary Care Physician will also see the individual annually to evaluate their current treatment plan. The team, with representation from DMR, will also review the plan quarterly when the Individual Plan is being reviewed

**c. Medication Administration by Waiver Providers**

**i. Provider Administration of Medications.** *Select one*:

| | |
|---|---|
| ● | Waiver providers are responsible for the administration of medications to waiver participants who cannot self-administer and/or have responsibility to oversee participant |

| | |
|---|---|
| | self-administration of medications. *(complete the remaining items)* |
| ○ | Not applicable (*do not complete the remaining items*) |

**ii. State Policy.** Summarize the State policies that apply to the administration of medications by waiver providers or waiver provider responsibilities when participants self-administer medications, including (if applicable) policies concerning medication administration by non-medical waiver provider personnel. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Administration of medication by unlicensed staff is provided by Connecticut State Statute Chapter 370 sections 20-14h to 20-14j (An Act Concerning Medication Administration in Department of Mental Retardation Residential Facilities and Programs) along with, Connecticut Agency Regulations Section 17a-210-1 through 17a-210-8 regulations concerning the administration of medications in day and residential programs and facilities operated, licensed or funded by the Department of Mental Retardation. The implementation of the CT agency regulations are set forth in the DMR Medical Advisory #99-3, Interpretive Guidelines for the DMR Regulations Concerning the Administration of Medication by Certified Unlicensed Personnel (Revised #89-1, 93-1, 97-1).

**iii. Medication Error Reporting.** *Select one of the following:*

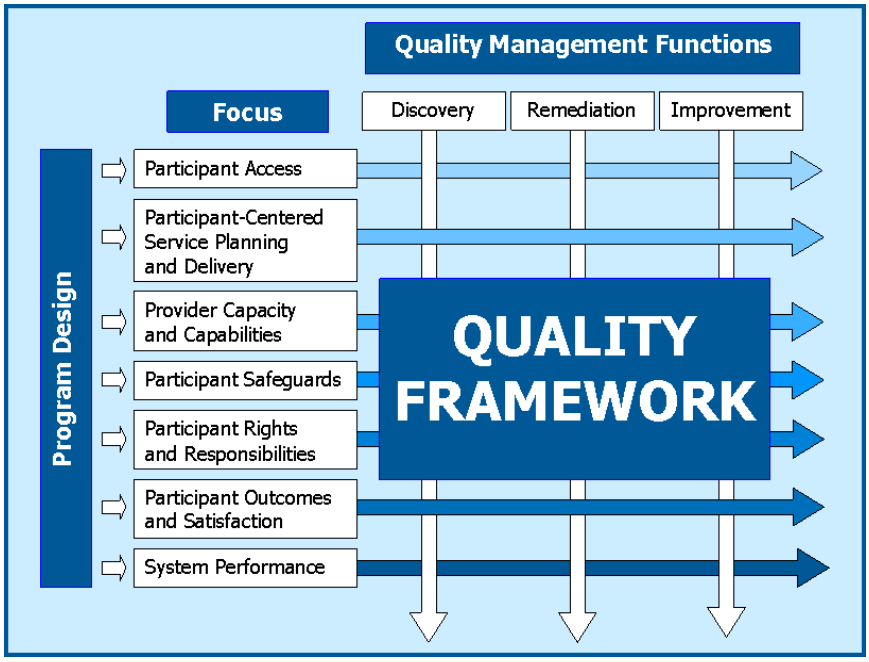
| | |
|---|---|
| ● | Providers that are responsible for medication administration are required to *both* record and report medication errors to a State agency (or agencies). *Complete the following three items:* |
| | (a) Specify State agency (or agencies) to which errors are reported: |
| | Department of Developmental Services |
| | (b) Specify the types of medication errors that providers are required to *record:* |
| | Medication omission, errors involving wrong- client, medication, route, dose, time, and any medication error resulting in the need for medical care |
| | (c) Specify the types of medication errors that providers must *report* to the State: |
| | All medication errors required to be recorded must be reported to DDS. DMR Procedure No. I.D.PR.009 outlines the procedure for incident reporting including medication errors |
| ○ | Providers responsible for medication administration are required to *record* medication errors but make information about medication errors available only when requested by the State. Specify the types of medication errors that providers are required to record: |
| | |

**iv. State Oversight Responsibility.** Specify the State agency (or agencies) responsible for monitoring the performance of waiver providers in the administration of medications to waiver participants and how monitoring is performed and its frequency.

DDS will be responsible for the monitoring of the administration of medication. The team, including DDS representation, implementing the Individual Plan will seek information from the provider concerning the administration of medications. This will include a review of the current medications, compliance of the individual in taking medications, and any identified supports needed. This review will happen quarterly with the review of the Individual Plan.

# Appendix H: Quality Management Strategy

Under §1915(c) of the Social Security Act and 42 CFR §441.302, the approval of an HCBS waiver requires that CMS determine that the State has made satisfactory assurances concerning the protection of participant health and welfare, financial accountability and other elements of waiver operations. Renewal of an existing waiver is contingent upon review by CMS and a finding by CMS that the assurances have been met. By completing the HCBS waiver application, the State specifies how it has designed the waiver's critical processes, structures and operational features in order to meet these assurances.




- Quality Management is a critical operational feature that an organization employs to continually determine whether it operates in accordance with the approved design of its program, meets statutory and regulatory assurances and requirements, achieves desired outcomes, and identifies opportunities for improvement.

CMS recognizes that a state's waiver Quality Management Strategy may vary depending on the nature of the waiver target population, the services offered, and the waiver's relationship to other public programs, and will extend beyond regulatory requirements. However, for the purpose of this application, the State is expected to have, at the minimum, systems in place to measure and improve its own performance in meeting six specific waiver assurances and requirements.

It may be more efficient and effective for a Quality Management Strategy to span multiple waivers and other long-term care services. CMS recognizes the value of this approach and will ask the state to identify other waiver programs and long-term care services that are addressed in the Quality Management Strategy.

Quality management is dynamic and the Quality Management Strategy may, and probably will, change over time. Modifications or updates to the Quality Management Strategy shall be submitted to CMS in conjunction with the annual report required under the provisions of 42 CFR §441.302(h) and at the time of waiver renewal.

## Quality Management Strategy: Minimum Components

The Quality Management Strategy that will be in effect during the period of the waiver is included as Attachment #1 to Appendix H. The Quality Management Strategy should be no more than ten-pages in length. It may reference other documents that provide additional supporting information about specific elements of the Quality Management Strategy. Other documents that are cited must be available to CMS upon request through the Medicaid agency or the operating agency (if appropriate).

In the QMS, a state spells out:

- The evidence based *discovery* activities that will be conducted for each of the six major waiver assurances;
- The *remediation* processes followed when problems are identified in the implementation of each of the assurances;
- The *system improvement* processes followed in response to aggregated, analyzed information collected on each of the assurances;
- The correspondent *roles/responsibilities* of those conducting discovery activities, assessing, remediating and improving system functions around the assurances; and

The process that the state will follow to continuously *assess the effectiveness of the QMS* and revise it as necessary and appropriate.

If the State's Quality Management Strategy is not fully developed at the time the waiver application is submitted, the state may provide a work plan to fully develop its Quality Management Strategy, including the specific tasks that the State plans to undertake during the period that the waiver is in effect, the major milestones associated with these tasks, and the entity (or entities) responsible for the completion of these tasks.

When the Quality Management Strategy spans more than one waiver and/or other types of long-term care services under the Medicaid State plan, specify the control numbers for the other waiver programs and identify the other long-term services that are addressed in the Quality Management Strategy.

**Attachment #1 to Appendix H**

The Quality Management Strategy for the waiver is:

The Connecticut Department of Developmental Services (DDS) as the waiver operating agency is responsible to assure that it meets the federal requirements and expectations for the quality operation of DDS HCBS waiver programs. The Department of Social Services (DSS) monitors the activities of DDS per the Memorandum of Understanding and associated responsibilities per the requirements found in the Administrative Authority assurance. DDS has in place long-standing policy, procedures and practices to assure the health and welfare of individuals supported by the department. The introduction of in-home services and participant-direction has required an expansion of those practices.

DDS has structured its quality management system to systemically address all requirements identified in the Six Assurances and strives to meet the goals of the HCBS Quality Framework. DDS Regional Offices assume the responsibility for overall service access, planning and delivery (Level of Care and Service Planning), and for substantial elements of the quality system through the provision of Targeted Case Management, quality review activities, system safeguards and the maintenance of state administrative functions. DDS central office maintains responsibility for the Division of Investigations, oversight of TCM, Provider Licensure and Certification activities, and for systemic oversight, evaluation and analysis of data related to provider performance, system safeguards, fiscal accountability, administrative authority and quality improvement.

The department developed a data system to support QA/I functions through a CMS Systems Change Grant awarded in 2003. That system, called the Quality Systems Review (QSR), is utilized to automate the monitoring that occurs as a function of the DDS Quality Service Review activities carried out by Central and Regional Quality Review staff and by Case Managers and Case Management Supervisors. Detailed information about the Quality Service Review content can be found at http://www.dmr.state.ct.us/QSR/QSR_BackgroundandTools.pdf. The QSR data system is also used to enter recommendations for corrective action and quality improvement as a result of critical incident reports, Program Review and Human Rights Review Committee recommendations, mortality review recommendations and any other special concern. This soon to be web-based system permits any authorized DDS employee and service providers access to key quality data for individual, provider and systemic quality oversight and improvement. In this manner the department assures follow-up and can evaluate systemic trends. Until the web based QSR is operational it is being implemented manually and with an interim tracking database. DDS maintains a separate LAN linked system to monitor the abuse and neglect incident, investigation and follow-up system, and the CT Automated Consumer Information System (CAMRIS) is the current data system that supports these applications. DDS' long-range work plan is to integrate these systems into one web-based application.

Formal Quality Assurance and Improvement Divisions in the Central and Regional Offices complete field QSR reviews at service locations throughout the year. The Regional Quality Review process completed by each regional office is conducted annually at each day/vocational service location, and for a 10% sample of residential supports delivered in individual participant's personal home. Those reviews include a review of the Level of Care

determination, of the timely development and implementation of the Individual Plan, adherence to department safeguards, verification of documentation to support waiver billing, and consumer satisfaction for a waiver participant served in each location. The Central Office Quality Service Review certification process reviews a stratified sample of participants dependent upon the total number of participants served by each day and vocational service and individual residential provider every two years, and reviews an expanded number of quality indicators in each area of the QSR, and, a 10% sample of all individuals who self-direct services on an annual basis in each region.

Case Managers monitor the service delivery and satisfaction for each participant on a quarterly basis through TCM activities. Case Management Supervisors complete structured record reviews each quarter on 10% of each case manager's case load that includes assessment of compliance to agency policies and procedures related to level of care, service planning and delivery, abuse, neglect and exploitation and consumer rights.

DDS Central Office Medicaid Operations Unit, Waiver Policy Unit, Planning and Evaluation Unit and the Administration Divisions implement additional quality assurance and improvement activities. In addition, DDS established a new Quality Improvement Unit effective October 1,2007. The Single State Medicaid Agency, DSS, further supports the quality management system through its own record audits, review of DDS reports, management of the MMIS system and management of the Fair Hearing process. Those activities are outlined under each of the assurance areas described below.

**1) Level of Care:**

Discovery:

- The Central Office Medicaid Operations Unit verifies that all newly enrolled individuals have a completed Level of Care determination, and that each one makes a choice between ICF/MR and waiver services.
- The Central Office Medicaid Operations Unit conducts a quarterly record audit of 10 records per quarter per Region inclusive of verification of timely and appropriate Level of Care determination.
- The Case Manager Supervisor conducts a review of 10% of each case manager's caseload (4 per case manager) each quarter including a review of Level of Care determination timeliness and appropriate determinations.
- The DSS waiver manager reviews 10 records per quarter to verify that DDS follows policies and procedures regarding Level of Care determinations.
- The DDS regional quality review process includes a verification of Level of Care documentation in the file at service locations.

Remediation:

- The CO Medicaid Operations Unit notifies the Regional Case Management Supervisor of findings from individual initial enrollment reviews and record audits. Corrective actions are completed in the Regional Offices and reported back to the CO Medicaid Operations Unit.
- The Case Manager Supervisor ensures remediation of any individual or case manager specific issues identified in the LOC determination review.
- The Quality Review staff enter findings in a follow-up tracking data base, notify the case manager supervisor of adverse findings, and monitor completion of corrective

action during the subsequent service location review.

**2) Service Planning and Delivery**

- The Region assures the completion of assessments and review of Level of Need and Risk Assessment screenings, and follows a person-centered planning process in assisting individuals and their families/legal representatives in the development of individual plans.
- The Region provides information and support for individuals to self-direct to the extent he/she desires.
- The Region informs the individual and family/legal representative of all qualified providers of services and supports outlined in the individual plan, and provides assistance as requested in the selection of qualified providers.
- The Region monitors the qualifications of direct hire support staff through oversight of the Fiscal Intermediary and vendors.
- The Region assures the case manager/support broker coordinates and monitors the provision/delivery of waiver and non-waiver services and supports;
- The Region assures the case manager/support broker assists individuals in accessing non-waiver services as appropriate.
- The Region follows policies and procedures for the allocation of waiver openings and assigns funding based on Level of Need results.
- The Region conducts Quality Reviews, monitors contract provider performance, and participates in the development of Provider Quality Improvement plans.

<u>Discovery:</u>

- Case Management supervisors review a 10% sample per quarter of each case manager's caseload to review compliance with Individual Plan (IP) policies and procedures. These include reviews to assure the plan addresses all identified needs, preferences and risks; that plans identify generic, state plan and waiver services; that participants were informed of and made choices regarding service delivery methods and service providers; that services are being implemented; and that changes are made to the plan based on participant circumstances.
- Case Managers receive monthly reports from the Fiscal Intermediary regarding services delivered and billed against the approved Individual Plan for monitoring to assure services are delivered as described in the IP and to monitor for over or under utilization.
- Case Managers implement quarterly monitoring of each participant to verify implementation of the Individual Plan through in person or telephone contact and review of each service provider's written report of progress on the specific service.
- Regional and Central Office QSR review activities include indicators to assess all elements of service planning, provider choice and service delivery. All findings are aggregated on individual quality indicators in each area by the DDS Central Office on a quarterly basis for provider, regional and statewide analysis of performance trends.
- The Central Office Medicaid Operations Unit performs 10 record audits in each of the three Regions per quarter inclusive of review of the timely development of the plan, choice of service delivery type and provider, and plan outcomes and prescribed services address participants needs, preferences and risks.
- DSS conducts quarterly record reviews of 10 participants per quarter. Findings are reported back to DDS for corrective action.

Remediation:

- All participant specific findings are entered into the QSR database and communicated to the service provider or case manager as appropriate for corrective action on an individual basis. The CM Supervisor monitors case management follow-up. Regional Quality Review staff monitor individual provider follow-up at the next service location visit.
- Provider systemic findings are presented and monitored for corrective action by the Regional Resource Management Unit during bi-annual performance review meetings.
- DDS system wide data is presented to the Quality Review and Improvement Committee on a quarterly basis. QI plans may be developed that address case management, service providers and system issues depending on the findings.
- DSS meets with DDS managers on a quarterly basis to discuss findings and make recommendations for system improvement.

**3) Provider Capacity and Performance**

- The Central Office Operations Center processes all provider enrollment packages. Service Providers may apply to participate in the DDS waiver program at any time. The initial enrollment process assures that all providers meet waiver requirements for licensure, insurance and certification as appropriate, have policies and procedures in place that reflect understanding and process to meet DDS policy in all areas of provider qualifications, service implementation, participant rights, and participant safeguards and agree to Medicaid requirements. The enrollment package and Medicaid Provider Agreement is maintained in the DDS office.
- The Central Office Operations Center works in conjunction with Regional Resource Management Units to monitor the adequacy of the provider network to assure access to waiver services across the state. When problems with access are noted, the CO Operations Center will work with Regional Offices to develop targeted recruitment and provider development initiatives. This includes targeted recruitment of culturally diverse vendors and recruitment for specific service needs in geographic areas of the state.
- The Fiscal Intermediary is responsible to assure that all provider qualifications for pre-employment and staff training requirements are met when participant's self-direct services and hire their own staff.
- On-going performance of service providers and compliance with waiver provider qualifications and required training is monitored by case managers for individual participants, by the Regional Resource Management Units, by Regional Quality Review staff and by Central Office Quality Review staff as described below.

Discovery:

- Case Managers report to the Regional Resource Management Unit problems with access when participants have difficulty with accessing preferred services or providers in specific areas of the state.
- Case Managers review provider quarterly or bi-annual progress reports, monthly and quarterly Fiscal Intermediary Reports on service utilization, and conduct quarterly contacts through TCM to monitor provider performance on behalf of each participant.
- Regional Quality Reviewers conduct annual visits to all facility based day and vocational service locations as part of a comprehensive system of oversight. Regional

Quality Review staff also conduct a review for a 10% sample of participants who live in their own home and receive in-home supports. This sample is stratified by service provider.

- Regional Resource Management Units collect summary performance data related to contracts, quality reviews, case management oversight, and adherence to policies and procedures related to participant safeguards, and meet with day/vocational and residential service providers two times per year as part of a continuous quality improvement cycle.
- The Central Office Quality Management Division completes certification reviews of all providers specific to each type of service rendered. This review is completed once every two years, using a sampling methodology depending on the number of participants who are supported in each service type.
- The Central Office Quality Management Division certifies all Respite facilities and Community Training homes on an annual basis.
- The Fiscal Intermediary agencies are audited on an annual basis to evaluate compliance with assuring provider qualifications prior to employment and with staff training requirements for participants who self-direct services.

**Remediation**

- Provider performance data is entered into the QSR information system. Providers must enter online plans of correction and improvement as requested in response to individual monitoring by case managers, quality review staff and/or the CO Certification Review. This plan of correction or improvement is accepted by the Regional Resource Manager or the CO Quality Review Team, and monitored either through receipt of documents or by direct evaluation at the next review visit.
- Systemic Provider performance concerns may result in targeted technical assistance provided by the DDS Regional Office.
- DDS has begun the work of establishing QSR benchmarks for each service type reviewed and for the overall review of providers. Once the benchmarks have been finalized failure to meet QSR review benchmarks will result in the provider being placed on probationary status and may lead to loss of certification in one or more service areas.
- Central Office Waiver Policy Unit and Regional Quality Improvement staff prepare summary reports for the Regional Quality Improvement Councils and the state Quality Systems and Improvement Committee of provider performance data and trends for formulation of remediation and/or improvement plans pertaining to specific providers or the system at large.

**4) Safeguards**

Discovery and Remediation:

- The Region operates the Program Review Committee and Human Rights Committee, and monitors compliance with the safeguards established for the use of behavioral medications, restrictive behavioral interventions and other restrictions on the rights of individuals.
- The Region implements Abuse/Neglect and Incident Management systems by monitoring the completion and quality of investigations and implementation of all follow-up recommendations by the private providers.

- The Region monitors Medication Management practices, Nursing Delegation and End of Life decisions according to policies and procedures.
- The Region completes a Mortality Review for all reportable deaths. The Central Office coordinates the Independent Mortality Review Board, a committee comprised medical professionals, MR/DD professionals, and private citizens, that reviews a sample of regional mortality reviews for quality control. The Central Office Director of Health and Clinical Services is a member of the State Fatality Review Board that conducts separate Fatality Reviews of select cases.
- The Central Office Division of Investigations conducts abuse and neglect investigations of all suspicious deaths, completes a medical desk review of all deaths, and directly investigates other selected cases of reported abuse and neglect in the public and private sectors. This Division monitors the completion of reports, coordinates and evaluates the training of investigators in the public and private sectors, and reviews select investigative reports completed by private and public sector investigators.
- The Central Office Division of Quality Management monitors select critical incidents for individual or provider specific follow-up and intervention, and issues Safety Alerts.
- The Central Office Director of Health and Clinical Services holds routine meetings with department wide nursing personnel, serves as a liaison for private sector medical personnel, develops best practice guides and training curriculums, monitors the state-wide medication administration program.

- The Regional QI Division prepares bi-annual summary reports of compliance with and performance in the areas of critical incidents, abuse and neglect investigations, PRC and HRC reviews and Quality Review results for day/vocational and residential providers for review and discussion with the Resource Management Units.
- The Regional QI Division monitors the timely reporting and follow-up of all critical incidents, and completion of and follow-up to abuse and neglect investigation reports.
- The Regional QI Division monitors the completion of Immediate Protective Service Plans as directed by the Office of Protection and Advocacy in response to allegations of abuse or neglect for participants who live in natural homes.
- The Central Office Waiver Policy Unit and Quality Improvement staff prepare quarterly and bi-annual summary reports of critical incidents and abuse and neglect allegations and findings for analysis regarding trends on a regional and statewide basis for review by the Regional Quality Improvement Councils and state Systems Design Committee.
- A new computer application is under development that will allow DDS to do a detailed analysis of reported incidents by person and provider. It is expected that this system will become operational during year 1 of this waiver.
- The Regional Quality Improvement staff prepare quarterly reports on PRC compliance for review by the Regional Quality Improvement Councils and for other key department management staff.

**5) Administrative Authority**

- DSS receives and evaluates DDS summary reports completed by the DDS Medicaid Operations Unit, and summaries prepared by the DDS Waiver Policy Unit for performance reports related to service planning and delivery, provider qualifications, safeguards, fiscal integrity and consumer satisfaction.
- DDS participates in DDS/DSS meetings with key waiver management staff to discuss

performance and operational concerns on a quarterly basis.

- DDS conducts the Fair Hearing process and provides instruction to DDS on the implementation of utilization review criteria.
- DSS conducts 40 individual record reviews per year to evaluate Level of Care and Plan of Care requirements.

**6) Fiscal Integrity**

- The Regional Office samples day/vocational billing at each facility location during bi-annual review visits. This review includes verification of program documentation on each day service is billed.
- The Administration Division conducts sample audits of provider billing records based on reports of potential irregularities.
- The Fiscal Intermediary only accepts billing for self-directed services if signed by the participant or the participant's legal representative.
- The DDS requires audits of the Fiscal Intermediary to meet contract requirements for verification of billing and making payments on behalf of the state for waiver claims on an annual basis.
- DSS reviews billing submitted by DDS via the Department of Administrative Services for waiver participant eligibility and authorization for services on a quarterly basis.

**Quality Improvement**

- The DDS Central Office in conjunction with the Regions develops annual Business Plans designed to assess performance and promote quality improvement. The Department Deputy Commissioner assures the performance of regional administrative processes and identified business objectives to enhance performance on an annual basis in strategic areas depending upon department wide data.
- The Region maintains a Regional Advisory Committee composed of participants, family members and community members. This Council will recommend to the Regional Director strategies to enhance service quality and outcomes for participants specific to the Regional operations or region specific providers.
- The Region Quality Improvement Councils receive all reports referred to above for evaluation and quality improvement recommendations, reporting to the Regional Advisory Committee and submitting recommendations to the state Systems Design Committee.
- The DDS participates in the National Core Indicators project seeking participant and family/guardian feedback on satisfaction related to service access, planning and delivery. The findings are evaluated against past department performance and against other states to inform quality improvement initiatives.
-

**Published Reports**

DDS prepares a number of reports for internal use and analysis and for public review.

**Management Information Report (MIR)**

Prepared quarterly by the DDS Waiver Policy Unit. Includes: demographics; DDS referral and eligibility; service utilization; placement/access to services; waiting list data; waiver enrollment; incident data; abuse/neglect data; worker's compensation data; revenue; referrals to the Abuse/Neglect Registry; and psychiatric hospitalization utilization. Ad hoc reports are prepared and included as available. This report is submitted to the Legislature's Office of Fiscal analysis, disseminated to all DDS staff, and is available to all stakeholders upon request. With the completion of a new web portal, this report will be posted to the web.

**Business Plan Reports**

Annual business plans are developed by each CO Division within the Department in conjunction with regional staff. Goals and objectives are prepared each year to support department goals generated internally or through external direction. Extensive quality improvement information is included in these plans. Quarterly progress reports are prepared and shared with all Divisions, and will be available for review by Quality Committees and Councils.

Individual CLA Licensing Results

Individual Licensing reports are posted to the web. Summary Deficiencies and subsequent follow-up are prepared quarterly for administrative monitoring. Statewide aggregate licensing results prepared annually to identify trends for quality improvement.

Annual QUEST for Excellence Report

Prepared annually by DDS Central Office this report includes summary information pertaining to: Provider Performance; Critical Incidents and Abuse/Neglect Allegations; Mortality Review; Behavior Medication Use; and Audit and Revenue. New focus areas to be included in this report beginning in FY09 include NCI results, Case Management performance, eligibility and access. The report is posted to the web, provided to the State Medicaid Agency (DSS), Legislature, Governor, all Quality Committees and Councils, and is available on request to any stakeholder.

**Annual Mortality Review Report**

Mortality data and analysis is compiled on an annual basis to report causes of death, trends regarding mortality of individuals supported by DDS, and recommendations for systemic DDS and health care system improvement.

The new Quality Service Review data system will provide the capability to prepare detailed summary reports for analysis in the areas of Level of Care determinations, Individual Plan requirements, Provider Performance profiles, compliance with safeguard mechanisms, rights, choice, community connections, health and wellness, safety and satisfaction. The new system will generate findings both in terms of individual personal outcomes and of the provider's effectiveness in supporting those outcomes.

Additional Quality Improvement initiatives include further automation of service utilization reports, web based incident management, further inclusion of individuals and families in design and discovery activities, training in quality improvement planning, and cultural competence initiatives.

# Appendix I: Financial Accountability

## APPENDIX I-1: Financial Integrity and Accountability

**Financial Integrity**. Describe the methods that are employed to ensure the integrity of payments that have been made for waiver services, including: (a) requirements concerning the independent audit of provider agencies; (b) the financial audit program that the state conducts to ensure the integrity of provider billings for Medicaid payment of waiver services, including the methods, scope and frequency of audits; and, (c) the agency (or agencies) responsible for conducting the financial audit program. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

DDS funds all providers of services and supports from State General Funds directly appropriated to the DDS. Payment is made to providers of service through contract payments, or through an approved Fiscal Intermediary per delegated authority from the Medicaid Agency. For HCBS waiver services, DMR serves as the Medicaid Billing Provider and holds Performing Provider Agreements with private providers of service through delegation by the Medicaid Agency (DSS).

For individuals who self-direct services and supports, the Medicaid Agency (DSS) delegates the authority to hold the Performing Provider Agreement(s) and to make provider payments for those services and supports to the Fiscal Management Agency (FI).

DDS submits billing for all HCBS waiver services to the CT Department of Administrative Services, which submits claims to EDS, the approved MMIS. Medicaid payments are made directly back to the CT General Fund. DDS maintains audit responsibility for contracted services and Fiscal Intermediary services. DDS requires annual audited cost reports from contract providers, and independent audits of the Fiscal Intermediary accounting.

(a) Providers of residential and day services under contract with DDS are required to file annually an Operational Plan and Audited Consolidated Operational Report (ACOR). The audited report is in conformance with generally accepted accounting standards.
(b) The ACOR documents are the basis for field audits either by the Department of Social Services or the Department of Developmental Services. DDS Resource Managers review contract compliance on at least a semi-annual basis.
(c) The Department of Social Services (DSS), the Department of Developmental Services and the State Auditor of Public Accounts are responsible for conducting State financial audits per CT Gen Statute 17a-226, 17a-246 and 17b-244.

# APPENDIX I-2: Rates, Billing and Claims

**a. Rate Determination Methods.** In two pages or less, describe the methods that are employed to establish provider payment rates for waiver services and the entity or entities that are responsible for rate determination. Indicate any opportunity for public comment in the process. If different methods are employed for various types of services, the description may group services for which the same method is employed. State laws, regulations, and policies referenced in the description are available upon request to CMS through the Medicaid agency or the operating agency (if applicable).

DDS traditionally paid for services through a provider contract for both day and residential services. Medicaid rates were based on audited cost reports from providers. The costs were divided by the utilization to establish per diem rates.

With the advent of self directed services, DDS has been moving toward a fee for service system with funds paid to providers through fiscal intermediary agencies. The rates paid to providers are developed by the DDS Operations Center. The payment rates are based on a direct wage baseline with adjustments for indirect, supervision and administrative costs. These expenses are based on information drawn from Connecticut Department of Labor wage statistics, salary surveys and audited findings from annual provider fiscal reports.

Data developed by DDS is formatted and sent to the Department of Social Services (the single state Medicaid agency) for review and Medicaid rate approval.

**b. Flow of Billings.** Describe the flow of billings for waiver services, specifying whether provider billings flow directly from providers to the State's claims payment system or whether billings are routed through other intermediary entities. If billings flow through other intermediary entities, specify the entities:

DDS funds all providers of services and supports from State General Funds directly appropriated to the DDS. Payment is made to providers of service through contract payments, or through an approved Fiscal Intermediary per delegated authority from the Medicaid Agency. For HCBS waiver services, DDS serves as the Medicaid Billing Provider and holds Performing Provider Agreements with private providers of service through delegation by the Medicaid Agency (DSS).

For individuals who self-direct services and supports, the Medicaid Agency (DSS) delegates the authority to hold the Performing Provider Agreement(s) and to make provider payments for those services and supports to the Fiscal Management Agency (FI). The DDS private providers bill DDS and DDS provides payment for services in the fee for service system. The DDS providers may choose to bill directly through the MMIS if requested.

**c. Certifying Public Expenditures** *(select one)*:

■ **Yes**. Public agencies directly expend funds for part or all of the cost of waiver services and certify their public expenditures (CPE) in lieu of billing that amount to Medicaid (*check each that applies*):

| | | |
|---|---|---|
| | ■ | **Certified Public Expenditures (CPE) of State Public Agencies**. Specify: (a) the public agency or agencies that certify public expenditures for waiver services; (b) how it is assured that the CPE is based on the total computable costs for waiver services; and, (c) how the State verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51(b). (*Indicate source of revenue for CPEs in Item I-4-a.*) |
| | | (a) The Department of Developmental Services is the state agency which operates the waiver and expenditures come from DDS' annual appropriation.<br>(b) Private Providers of residential and day services under contract with DDS are required to file annually an Operational Plan and Audited Consolidated Operational Report (ACOR). The audited report is in conformance with generally accepted accounting standards. DDS public expenditures are subject to audit by the State Auditor of Public Accounts.<br>(c) All Medicaid rates are reviewed and approved by the Department of Social Services which is the State Single Medicaid Agency. |
| | ☐ | **Certified Public Expenditures (CPE) of Non-State Public Agencies**. Specify: (a) the non-State public agencies that incur certified public expenditures for waiver services; (b) how it is assured that the CPE is based on total computable costs for waiver services; and, (c) how the State verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51(b). (*Indicate source of revenue for CPEs in Item I-4-b.*) |
| | | |
| ○ | **No**. Public agencies do not certify expenditures for waiver services. | |

**d. Billing Validation Process**. Describe the process for validating provider billings to produce the claim for federal financial participation, including the mechanism(s) to assure that all claims for payment are made only: (a) when the individual was eligible for Medicaid waiver payment on the date of service; (b) when the service was included in the participant's approved service plan; and, (c) the services were provided:

a) Eligibility for waiver services is annotated in the DDS CAMRIS computer system. This system generates the attendance documents for Medicaid billing and annotates who is eligible for waiver services on the attendance form. The Department of Administrative Services which completes the data entry for billing is also informed of those eligible for waiver services and has access to the CMARIS system for verification if necessary. (b) The DDS Medicaid Operations unit conducts audits of consumer files and reviews individual plans with Medicaid billing. (c) DDS Quality Monitors receive sample billing records from the DDS Medicaid Operations Unit. The Quality Monitors use the billing records during their program reviews and check provider records against the billing records. Results are reported back to the Medicaid Operations Unit.

**e. Billing and Claims Record Maintenance Requirement.** Records documenting the audit trail of adjudicated claims (including supporting documentation) are maintained by the Medicaid agency, the operating agency (if applicable), and providers of waiver services for a minimum period of 3 years as required in 45 CFR §74.53.

# APPENDIX I-3: Payment

**a. Method of payments — MMIS** *(select one)*:

| | |
|---|---|
| ■ | Payments for all waiver services are made through an approved Medicaid Management Information System (MMIS). |
| ○ | Payments for some, but not all, waiver services are made through an approved MMIS. Specify: (a) the waiver services that are not paid through an approved MMIS; (b) the process for making such payments and the entity that processes payments; (c) how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64. |
| | |
| ○ | Payments for waiver services are not made through an approved MMIS. Specify: (a) the process by which payments are made and the entity that processes payments; (b) how and through which system(s) the payments are processed; (c) how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64: |
| | |
| ○ | Payments for waiver services are made by a managed care entity or entities. The managed care entity is paid a monthly capitated payment per eligible enrollee through an approved MMIS. Describe how payments are made to the managed care entity or entities: |
| | |

**b. Direct payment**. In addition to providing that the Medicaid agency makes payments directly to providers of waiver services, payments for waiver services are made utilizing one or more of the following arrangements (*select at least one*):

| | |
|---|---|
| ■ | The Medicaid agency pays providers through the same fiscal agent used for the rest of the Medicaid program. |
| ☐ | The Medicaid agency pays providers of some or all waiver services through the use of a limited fiscal agent. Specify the limited fiscal agent, the waiver services for which the limited fiscal agent makes payment, the functions that the limited fiscal agent performs in paying waiver claims, and the methods by which the Medicaid agency oversees the operations of the limited fiscal agent: |
| | |
| ☐ | Providers are paid by a managed care entity or entities for services that are included in the State's contract with the entity. Specify how providers are paid for the services (if any) not included in the State's contract with managed care entities. |
| | |

**c. Supplemental or Enhanced Payments.** Section 1902(a)(30) requires that payments for services be consistent with efficiency, economy, and quality of care. Section 1903(a)(1) provides for Federal financial participation to States for expenditures for services under an approved State plan/waiver. Specify whether supplemental or enhanced payments are made. *Select one:*

| | |
|---|---|
| ■ | **No**. The State does not make supplemental or enhanced payments for waiver services. |
| ○ | **Yes**. The State makes supplemental or enhanced payments for waiver services. Describe: (a) the nature of the supplemental or enhanced payments that are made and the waiver services for which these payments are made and (b) the types of providers to which such payments are made. Upon request, the State will furnish CMS with detailed information about the total amount of supplemental or enhanced payments to each provider type in the waiver. |
| | |

**d. Payments to Public Providers.** *Specify whether public providers receive payment for the provision of waiver services.*

| | |
|---|---|
| ■ | **Yes.** Public providers receive payment for waiver services. Specify the types of public providers that receive payment for waiver services and the services that the public providers furnish. *Complete item I-3-e.* |
| | |
| ○ | **No**. Public providers do not receive payment for waiver services. *Do not complete Item I-3-e.* |

**e**. **Amount of Payment to Public Providers**. Specify whether any public provider receives payments (including regular and any supplemental payments) that in the aggregate *exceed* its reasonable costs of providing waiver services and, if so, how the State recoups the excess and returns the Federal share of the excess to CMS on the quarterly expenditure report. *Select one*:

| | |
|---|---|
| ○ | The amount paid to public providers is the same as the amount paid to private providers of the same service. |
| ■ | The amount paid to public providers differs from the amount paid to private providers of the same service. No public provider receives payments that in the aggregate exceed its reasonable costs of providing waiver services. |
| ○ | The amount paid to public providers differs from the amount paid to private providers of the same service. When a public provider receives payments (including regular and any supplemental payments) that in the aggregate exceed the cost of waiver services, the State recoups the excess and returns the federal share of the excess to CMS on the quarterly expenditure report. Describe the recoupment process: |
| | |

**f. Provider Retention of Payments.** Section 1903(a)(1) provides that Federal matching funds are only available for expenditures made by states for services under the approved waiver. *Select one:*

| | |
|---|---|
| ■ | Providers receive and retain 100 percent of the amount claimed to CMS for waiver services. |
| ○ | Providers do not receive and retain 100 percent of the amount claimed to CMS for waiver services. Provide a full description of the billing, claims, or payment processes that result in less than 100% reimbursement of providers. Include: (a) the methodology for reduced or returned payments; (b) a complete listing of types of providers, the amount or percentage of payments that are reduced or returned; and, (c) the disposition and use of the funds retained or returned to the State (i.e., general fund, medical services account, etc.): |
| | |
| ○ | Providers are paid by a managed care entity (or entities) that is paid a monthly capitated payment. Specify whether the monthly capitated payment to managed care entities is reduced or returned in part to the State. |
| | |

**g. Additional Payment Arrangements**

**i. Voluntary Reassignment of Payments to a Governmental Agency.** *Select one:*

| | |
|---|---|
| ○ | **Yes**. Providers may voluntarily reassign their right to direct payments to a governmental agency as provided in 42 CFR §447.10(e). Specify the governmental agency (or agencies) to which reassignment may be made. |
| | |
| ■ | **No**. The State does not provide that providers may voluntarily reassign their right to direct payments to a governmental agency. |

**ii. Organized Health Care Delivery System**. *Select one:*

| | |
|---|---|
| ○ | **Yes**. The waiver provides for the use of Organized Health Care Delivery System arrangements under the provisions of 42 CFR §447.10. Specify the following: (a) the entities that are designated as an OHCDS and how these entities qualify for designation as an OHCDS; (b) the procedures for direct provider enrollment when a provider does not voluntarily agree to contract with a designated OHCDS; (c) the method(s) for assuring that participants have free choice of qualified providers when an OHCDS arrangement is employed, including the selection of providers not affiliated with the OHCDS; (d) the method(s) for assuring that providers that furnish services under contract with an OHCDS meet applicable provider qualifications under the waiver; (e) how it is assured that OHCDS contracts with providers meet applicable requirements; and, (f) how financial accountability is assured when an OHCDS arrangement is used: |
| | |
| ■ | **No**. The State does not employ Organized Health Care Delivery System (OHCDS) arrangements under the provisions of 42 CFR §447.10. |

**iii. Contracts with MCOs, PIHPs or PAHPs.** *Select one:*

| | |
|---|---|
| ○ | The State contracts with a Managed Care Organization(s) (MCOs) and/or prepaid inpatient health plan(s) (PIHP) or prepaid ambulatory health plan(s) (PAHP) under the provisions of §1915(a)(1) of the Act for the delivery of waiver and other services. Participants may *voluntarily* elect to receive *waiver* and other services through such MCOs or prepaid health plans. Contracts with these health plans are on file at the State Medicaid agency. Describe: (a) the MCOs and/or health plans that furnish services under the provisions of §1915(a)(1); (b) the geographic areas served by these plans; (c) the waiver and other services furnished by these plans; and, (d) how payments are made to the health plans. |
| | |
| ○ | This waiver is a part of a concurrent §1915(b)/§1915(c) waiver. Participants are required to obtain *waiver* and other services through a MCO and/or prepaid inpatient health plan (PIHP) or a prepaid ambulatory health plan (PAHP). The §1915(b) waiver specifies the types of health plans that are used and how payments to these plans are made. |
| ■ | The State does not contract with MCOs, PIHPs or PAHPs for the provision of waiver services. |

# APPENDIX I-4: Non-Federal Matching Funds

**a. State Level Source(s) of the Non-Federal Share of Computable Waiver Costs.** Specify the State source or sources of the non-federal share of computable waiver costs. *Check each that applies:*

| | |
|---|---|
| ☐ | **Appropriation of State Tax Revenues to the State Medicaid agency** |
| ■ | **Appropriation of State Tax Revenues to a State Agency other than the Medicaid Agency.** If the source of the non-federal share is appropriations to another state agency (or agencies), specify: (a) the entity or agency receiving appropriated funds and (b) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if the funds are directly expended by public agencies as CPEs, as indicated in Item I-2-c: |
| | (a) The Department of Developmental Services receives a State appropriation and directly expends funds for services provided under this waiver.<br>(b) The Department of Developmental Services expends funds directly as noted in I-2-c. DDS receives a direct appropriation for services provided under this waiver. DDS provides the services directly, by contracting for services or paying for self directed services through a fiscal intermediary. |
| ☐ | **Other State Level Source(s) of Funds.** Specify: (a) the source and nature of funds; (b) the entity or agency that receives the funds; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by public agencies as CPEs, as indicated in Item I-2- c: |
| | |

**b. Local or Other Source(s) of the Non-Federal Share of Computable Waiver Costs.** Specify the source or sources of the non-federal share of computable waiver costs that are not from state sources. *Check each that applies:*

| | |
|---|---|
| ☐ | **Appropriation of Local Revenues.** Specify: (a) the local entity or entities that have the authority to levy taxes or other revenues; (b) the source(s) of revenue; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement (indicate any intervening entities in the transfer process), and/or, indicate if funds are directly expended by public agencies as CPEs, as specified in Item I-2- c: |
| | |
| ☐ | **Other non-State Level Source(s) of Funds.** Specify: (a) the source of funds; (b) the entity or agency receiving funds; and, (c) the mechanism that is used to transfer the funds to the State Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and /or, indicate if funds are directly expended by public agencies as CPEs, as specified in Item I-2- c: |
| | |
| ■ | **Not Applicable**. There are no non-State level sources of funds for the non-federal share. |

**c. Information Concerning Certain Sources of Funds**. Indicate whether any of the funds listed in Items I-4-a or I-4-b that make up the non-federal share of computable waiver costs come from the following sources: (a) provider taxes or fees; (b) provider donations; and/or, (c) federal funds (other than FFP). *Select one:*

| | | |
|---|---|---|
| ■ | None of the specified sources of funds contribute to the non-federal share of computable waiver costs. | |
| ○ | The following source (s) are used. *Check each that applies.* | |
| | ☐ | Provider taxes or fees |
| | ☐ | Provider donations |
| | ☐ | Federal funds (other than FFP) |
| | For each source of funds indicated above, describe the source of the funds in detail: | |
| | | |

# APPENDIX I-5: Exclusion of Medicaid Payment for Room and Board

**a. Services Furnished in Residential Settings**. *Select one:*

| | |
|---|---|
| ○ | No services under this waiver are furnished in residential settings other than the private residence of the individual. (*Do not complete Item I-5-b*). |
| ■ | As specified in Appendix C, the State furnishes waiver services in residential settings other than the personal home of the individual. (*Complete Item I-5-b*) |

**b. Method for Excluding the Cost of Room and Board Furnished in Residential Settings**. The following describes the methodology that the State uses to exclude Medicaid payment for room and board in residential settings:

The state has several mechanisms to ensure that room and board costs are not included in the request for federal reimbursement for residential supports in the HCBS Waiver.

1. Cost standards have been established for individual support agreements that specifically exclude room and board as allowed costs. These agreements are used to fund services which are self directed and provided in the recipient's home.
2. Each region has a program resource allocation team which reviews applications for the HCBS waiver. These teams ensure that appropriate resources are provided and that CMS requirements are met.
3. A costing methodology has been established which specifically excludes room and board expenses from the established rates used to request federal reimbursement.
4. The DDS Central Office Waiver Operations Unit reviews waiver applications before they are processed.
5. Room and board is an audit item for DDS auditors when they review regional programs

# APPENDIX I-6: Payment for Rent and Food Expenses of an Unrelated Live-In Caregiver

**Reimbursement for the Rent and Food Expenses of an Unrelated Live-In Personal Caregiver.**
*Select one:*

| | |
|---|---|
| ■ | **Yes**. Per 42 CFR §441.310(a)(2)(ii), the State will claim FFP for the additional costs of rent and food that can be reasonably attributed to an unrelated live-in personal caregiver who resides in the same household as the waiver participant. The State describes its coverage of live-in caregiver in Appendix C-3 and the costs attributable to rent and food for the live-in caregiver are reflected separately in the computation of factor D (cost of waiver services) in Appendix J. FFP for rent and food for a live-in caregiver will not be claimed when the participant lives in the caregiver's home or in a residence that is owned or leased by the provider of Medicaid services. *The following is an explanation of: (a) the method used to apportion the additional costs of rent and food attributable to the unrelated live-in personal caregiver that are incurred by the individual served on the waiver and (b) the method used to reimburse these costs:* |
| | The DDS completes a rental analysis for each participant and identified the portion of rent that can be attributed to the live-in caregiver. The participant will supply the lease or ownership papers for the home verifying that the participant is the lessee or the owner of the house, and an agreement between the participant and the live-in caregiver outlining the expectation and elements of waiver services to be provided. The rent will be based on the cost of the residence and apportioned to the living space for the caregiver. In most cases this will be an equal split among the residents of the home. Food will be based on USDA rates for annual food costs for state residents. The sponsoring provider agency will submit claims on behalf of the participant to DDS for payment, and transfer the funds to the participant for the specified household costs. |
| ○ | **No.** The State does not reimburse for the rent and food expenses of an unrelated live-in personal caregiver who resides in the same household as the participant. |

# APPENDIX I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing

**a. Co-Payment Requirements**. Specify whether the State imposes a co-payment or similar charge upon waiver participants for waiver services. These charges are calculated per service and have the effect of reducing the total computable claim for federal financial participation. *Select one:*

| | |
|---|---|
| ■ | **No**. The State does not impose a co-payment or similar charge upon participants for waiver services. (*Do not complete the remaining items; proceed to Item I-7-b*). |
| ○ | **Yes**. The State imposes a co-payment or similar charge upon participants for one or more waiver services. (*Complete the remaining items*) |

**i. Co-Pay Arrangement** Specify the types of co-pay arrangements that are imposed on waiver participants *(check each that applies)*:

| ***Charges Associated with the Provision of Waiver Services*** *(if any are checked, complete Items I-7-a-ii through I-7-a-iv):* | |
|---|---|
| ☐ | Nominal deductible |
| ☐ | Coinsurance |
| ☐ | Co-Payment |
| ☐ | Other charge *(specify)*: |
| | |

**ii Participants Subject to Co-pay Charges for Waiver Services**. Specify the groups of waiver participants who are subject to charges for the waiver services specified in Item I-7-a-iii and the groups for whom such charges are excluded

**iii. Amount of Co-Pay Charges for Waiver Services.** In the following table, list the waiver services for which a charge is made, the amount of the charge, and the basis for determining the charge.

| Waiver Service | Amount of Charge | Basis of the Charge |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

**iv. Cumulative Maximum Charges**. Indicate whether there is a cumulative maximum amount for all co-payment charges to a waiver participant *(select one)*:

| | |
|---|---|
| ○ | There is no cumulative maximum for all deductible, coinsurance or co-payment charges to a waiver participant. |
| ○ | There is a cumulative maximum for all deductible, coinsurance or co-payment charges to a waiver participant. Specify the cumulative maximum and the time period to which the maximum applies: |
| | |

**v. Assurance**. The State assures that no provider may deny waiver services to an individual who is eligible for the services on account of the individual's inability to pay a cost-sharing charge for a waiver service.

**b. Other State Requirement for Cost Sharing**. Specify whether the State imposes a premium, enrollment fee or similar cost sharing on waiver participants as provided in 42 CFR §447.50. *Select one:*

| | |
|---|---|
| ■ | **No**. The State does not impose a premium, enrollment fee, or similar cost-sharing arrangement on waiver participants. |
| ○ | **Yes**. The State imposes a premium, enrollment fee or similar cost-sharing arrangement. Describe in detail the cost sharing arrangement, including: (a) the type of cost sharing (e.g., premium, enrollment fee); (b) the amount of charge and how the amount of the charge is related to total gross family income (c) the groups of participants subject to cost-sharing and the groups who are excluded~~;~~ and, (d) the mechanisms for the collection of cost-sharing and reporting the amount collected on the CMS 64: |
| | |

# Appendix J: Cost Neutrality Demonstration

## Appendix J-1: Composite Overview and Demonstration of Cost-Neutrality Formula

**Composite Overview**. Complete the following table for each year of the waiver.

| **Level(s) of Care** *(specify)*: | | | | | | | |
|---|---|---|---|---|---|---|---|
| **Col. 1** | **Col. 2** | **Col. 3** | **Col. 4** | **Col. 5** | **Col. 6** | **Col. 7** | **Col. 8** |
| **Year** | **Factor D** | **Factor D′** | **Total: D+D′** | **Factor G** | **Factor G′** | **Total: G+G′** | **Difference (Column 7 less Column 4)** |
| 1 | $18,166 | $7,084 | $25,250 | $190,960 | $5,923 | $196,883 | $171,633 |
| 2 | $18,747 | $7,297 | $26,043 | $196,689 | $6,101 | $202,789 | $176,746 |
| 3 | $19,275 | $7,515 | $26,791 | $202,589 | $6,284 | $208,873 | $182,083 |
| 4 | $19,986 | $7,741 | $27,727 | $208,667 | $6,472 | $215,139 | $187,413 |
| 5 | $20,639 | $7,973 | $28,612 | $214,927 | $6,666 | $221,594 | $192,982 |

# Appendix J-2 - Derivation of Estimates

**a. Number Of Unduplicated Participants Served**. Enter the total number of unduplicated participants from Item B-3-a who will be served each year that the waiver is in operation. When the waiver serves individuals under more than one level of care, specify the number of unduplicated participants for each level of care:

**Table J-2-a: Unduplicated Participants**

| Waiver Year | Total Unduplicated Number of Participants (From Item B-3-a) | Distribution of Unduplicated Participants by Level of Care (if applicable) | |
|---|---|---|---|
| | | Level of Care: | Level of Care: |
| Year 1 | 4018 | | |
| Year 2 | 4468 | | |
| Year 3 | 4838 | | |
| Year 4 (renewal only) | 5208 | | |
| Year 5 (renewal only) | 5578 | | |

**b. Average Length of Stay**. Describe the basis of the estimate of the average length of stay on the waiver by participants in Item J-2-d.

The average length of stay was calculated by taking the average length of stay for those enrolled in the waiver from 2/1/06 through 1/31/07. The last full year for which we have data. This yielded an average length of stay of 352 days.

**c. Derivation of Estimates for Each Factor**. Provide a narrative description for the derivation of the estimates of the following factors.

**i. Factor D Derivation**. The estimates of Factor D for each waiver year are located in Item J-2-d. The basis for these estimates is as follows:

The estimates of Factor D are based on past utilization of services prorated for estimates of increased enrollment.

**ii. Factor D′ Derivation**. The estimates of Factor D' for each waiver year are included in Item J-1. The basis of these estimates is as follows:

Factor D' was based on the third year of the Comprehensive Waiver as the W-372 report for the first year of the IFS waiver was low due to the large number of people who were enrolled in the last four months of the first year.

**iii. Factor G Derivation**. The estimates of Factor G for each waiver year are included in Item J-1. The basis of these estimates is as follows:

Factor G was based on the W-372 report for the first year of the IFS waiver.

**iv. Factor G′ Derivation**. The estimates of Factor G' for each waiver year are included in Item J-1. The basis of these estimates is as follows:

Factor G' was based on the W-372 report for the first year of the IFS waiver

**d. Estimate of Factor D.** *Select one:* Note: Selection below is new.

| | |
|---|---|
| ⊙ | The waiver does not operate concurrently with a §1915(b) waiver. Complete Item J-2-d-i |
| ○ | The waiver operates concurrently with a §1915(b) waiver. Complete Item J-2-d-ii |

**i. Estimate of Factor D – Non-Concurrent Waiver**. Complete the following table for each waiver year

| **Waiver Year:** Year 1 | | | | | |
|---|---|---|---|---|---|
| **Waiver Service** | Col. 1 | Col. 2 | Col. 3 | Col. 4 | Col. 5 |
| | **Unit** | **# Users** | **Avg. Units Per User** | **Avg. Cost/ Unit** | **Total Cost** |
| Individualized Supports | Per 15 Min | 805 | 1700 | $8.50 | $11,632,250.00 |
| Community Training Home | Per Diem | 40 | 360 | $71.00 | $1,022,400.00 |
| Adult Day Health | Per Diem | 75 | 225 | $59.00 | $995,625.00 |
| Group Day Services | Per diem | 926 | 225 | $68.20 | $14,205,633.75 |
| Supported Employment - Individual | Per 15 min | 662 | 1492 | $12.26 | $12,109,251.04 |
| Supported Employment - Group | Per Diem | 1409 | 225 | $68.20 | $21,621,105.00 |
| Respite less than 24 hrs | Per 15 Min | 43 | 112 | $3.32 | $15,989.12 |
| Respite over night | Per Diem | 59 | 9 | $135.78 | $72,099.18 |
| Adult Companion | Per 15 Min | 31 | 295 | $4.25 | $38,866.25 |
| Clinical Behav Support | Per 15 Min | 61 | 450 | $17.50 | $480,375.00 |
| Live in Caregiver | Per Diem | 10 | 360 | $25.00 | $90,000.00 |
| Environmental Modification | Per Service | 5 | 1 | $8,000.00 | $40,000.00 |
| Family Training | Per Hour | 150 | 4 | $60.00 | $36,000.00 |
| Health Care Coordination | Monthly | 56 | 12 | $170.00 | $114,240.00 |
| Individualized Day Services | Per 15 min | 307 | 3520 | $6.00 | $6,489,120.00 |
| Individual Goods and Services | Per Service | 50 | 1 | $750.00 | $37,500.00 |
| Interpreter Services | Per 15 min | 25 | 96 | $15.00 | $36,000.00 |
| Nutrition | Per 15 min | 12 | 8 | $16.25 | $1,560.00 |
| Personal Emergency Response | Per month | 8 | 12 | $57.00 | $5,472.00 |
| Personal Support | Per 15 min | 363 | 1500 | $6.50 | $3,539,250.00 |
| Specialized Medical and Therapeutic Equipment and Supplies | Per Service | 3 | 1 | $750.00 | $2,250.00 |
| Independent Support Broker | Per 15 Min | 6 | 250 | $12.50 | $18,750.00 |
| Transportation | Per mile | 261 | 1778 | $0.42 | $194,904.36 |
| Transportation | Per Trip | 44 | 153 | $25.00 | $168,300.00 |
| Vehicle Modification | Per Service | 3 | 1 | $7,500.00 | $22,500.00 |
| GRAND TOTAL: | | | | | $72,,989,440.70 |
| TOTAL ESTIMATED UNDUPLICATED PARTICIPANTS (from Table J-2-a) | | | | | 4,018 |
| FACTOR D (Divide grand total by number of participants) | | | | | $18,165.61 |
| AVERAGE LENGTH OF STAY ON THE WAIVER | | | | | 352 |

| **Waiver Year:** Year 2 | | | | | |
|---|---|---|---|---|---|
| **Waiver Service** | Col. 1 | Col. 2 | Col. 3 | Col. 4 | Col. 5 |
| | **Unit** | **# Users** | **Avg. Units Per User** | **Avg. Cost/ Unit** | **Total Cost** |
| Individualized Supports | Per 15 Min | 912 | 1700 | $8.76 | $13,573,752.00 |
| Community Training Home | Per Diem | 43 | 360 | $73.13 | $1,132,052.40 |
| Adult Day Health | Per diem | 80 | 225 | $60.77 | $1,093,860.00 |
| Group Day Services | Per diem | 1034 | 225 | $70.25 | $16,342,731.90 |
| Supported Employment - Individual | Per 15 min | 736 | 1492 | $12.63 | $13,866,738.71 |
| Supported Employment - Group | Per Diem | 1566 | 225 | $70.25 | $24,751,178.10 |
| Respite less than 24 hrs | Per 15 Min | 48 | 112 | $3.42 | $18,383.77 |
| Respite over night | Per Diem | 66 | 9 | $139.85 | $83,072.92 |
| Adult Companion | Per 15 Min | 34 | 295 | $4.38 | $43,906.33 |
| Clinical Behav Support | Per 15 Min | 62 | 450 | $18.03 | $502,897.50 |
| Live in Caregiver | Per Diem | 12 | 360 | $25.75 | $111,240.00 |
| Environmental Modification | Per Service | 5 | 1 | $8,240.00 | $41,200.00 |
| Family Training | Per Hour | 150 | 4 | $61.80 | $37,080.00 |
| Health Care Coordination | Monthly | 63 | 12 | $175.10 | $132,375.60 |
| Individualized Day Services | Per 15 min | 342 | 3520 | $6.18 | $7,428,854.40 |
| Individual Goods and Services | Per Service | 50 | 1 | $772.50 | $38,625.00 |
| Interpreter Services | Per 15 min | 25 | 96 | $15.45 | $37,080.00 |
| Nutrition | Per 15 min | 12 | 8 | $16.74 | $1,606.80 |
| Personal Emergency Response | Per month | 8 | 12 | $58.71 | $5,636.16 |
| Personal Support | Per 15 min | 404 | 1500 | $6.70 | $4,057,170.00 |
| Specialized Medical and Therapeutic Equipment and Supplies | Per Service | 3 | 1 | $772.50 | $2,317.50 |
| Independent Support Broker | Per 15 Min | 6 | 250 | $12.88 | $19,312.50 |
| Transportation | Per mile | 290 | 1778 | $0.43 | $223,057.21 |
| Transportation | Per Trip | 49 | 153 | $25.75 | $193,047.75 |
| Vehicle Modification | Per Service | 3 | 1 | $7,725.00 | $23,175.00 |
| GRAND TOTAL: | | | | | $83,760,351.55 |
| TOTAL ESTIMATED UNDUPLICATED PARTICIPANTS (from Table J-2-a) | | | | | 4,468 |
| FACTOR D (Divide grand total by number of participants) | | | | | $18,746.72 |
| AVERAGE LENGTH OF STAY ON THE WAIVER | | | | | 352 |

| **Waiver Year:** Year 3 | | | | | |
|---|---|---|---|---|---|
| **Waiver Service** | Col. 1 | Col. 2 | Col. 3 | Col. 4 | Col. 5 |
| | **Unit** | **# Users** | **Avg. Units Per User** | **Avg. Cost/ Unit** | **Total Cost** |
| Individualized Supports | Per 15 Min | 1005 | 1700 | $9.02 | $15,410,670.00 |
| Community Training Home | Per Diem | 48 | 360 | $75.32 | $1,301,529.60 |
| Adult Day Health | | 85 | 225 | $62.59 | $1,197,033.75 |
| Group Day Services | Per diem | 1093 | 225 | $72.35 | $17,793,504.98 |
| Supported Employment - Individual | Per 15 min | 797 | 1492 | $13.01 | $15,466,500.65 |
| Supported Employment - Group | Per Diem | 1696 | 225 | $72.35 | $27,610,049.81 |
| Respite less than 24 hrs | Per 15 Min | 52 | 112 | $3.52 | $20,513.22 |
| Respite over night | Per Diem | 71 | 9 | $144.05 | $92,047.31 |
| Adult Companion | Per 15 Min | 37 | 295 | $4.51 | $49,226.65 |
| Clinical Behav Support | Per 15 Min | 63 | 450 | $18.54 | $525,609.00 |
| Live in Caregiver | Per Diem | 15 | 360 | $26.52 | $143,221.50 |
| Environmental Modification | Per Service | 6 | 1 | $8,487.20 | $50,923.20 |
| Family Training | Per Hour | 150 | 4 | $63.65 | $38,192.40 |
| Health Care Coordination | Monthly | 68 | 12 | $180.35 | $147,168.05 |
| Individualized Day Services | Per 15 min | 370 | 3520 | $6.37 | $8,290,296.96 |
| Individual Goods and Services | Per Service | 50 | 1 | $795.68 | $39,783.75 |
| Interpreter Services | Per 15 min | 25 | 96 | $15.91 | $38,192.40 |
| Nutrition | Per 15 min | 12 | 8 | $17.24 | $1,655.00 |
| Personal Emergency Response | Per month | 10 | 12 | $60.47 | $7,256.56 |
| Personal Support | Per 15 min | 437 | 1500 | $6.90 | $4,520,229.68 |
| Specialized Medical and Therapeutic Equipment and Supplies | Per Service | 3 | 1 | $795.68 | $2,387.03 |
| Independent Support Broker | Per 15 Min | 6 | 250 | $13.26 | $19,891.88 |
| Transportation | Per mile | 314 | 1778 | $0.45 | $248,762.63 |
| Transportation | Per Trip | 53 | 153 | $26.52 | $215,070.95 |
| Vehicle Modification | Per Service | 3 | 1 | $7,956.75 | $23,870.25 |
| GRAND TOTAL: | | | | | $93,253,587.20 |
| TOTAL ESTIMATED UNDUPLICATED PARTICIPANTS (from Table J-2-a) | | | | | 4,838 |
| FACTOR D (Divide grand total by number of participants) | | | | | $19,275.24 |
| AVERAGE LENGTH OF STAY ON THE WAIVER | | | | | 352 |

| **Waiver Year:** Year 4 *(renewal only)* | | | | | |
|---|---|---|---|---|---|
| **Waiver Service** | Col. 1 | Col. 2 | Col. 3 | Col. 4 | Col. 5 |
| | **Unit** | **# Users** | **Avg. Units Per User** | **Avg. Cost/ Unit** | **Total Cost** |
| Individualized Supports | Per 15 Min | 1098 | 1700 | $9.29 | $17,340,714.00 |
| Community Training Home | Per Diem | 51 | 360 | $77.58 | $1,424,368.80 |
| Adult Day Health | Per Diem | 90 | 225 | $64.47 | $1,305,517.50 |
| Group Day Services | Per diem | 1208 | 225 | $74.52 | $20,255,618.14 |
| Supported Employment - Individual | Per 15 min | 858 | 1492 | $13.40 | $17,149,768.23 |
| Supported Employment - Group | Per Diem | 1826 | 225 | $74.52 | $30,618,177.76 |
| Respite less than 24 hrs | Per 15 Min | 56 | 112 | $3.63 | $22,753.90 |
| Respite over night | Per Diem | 77 | 9 | $148.37 | $102,820.74 |
| Adult Companion | Per 15 Min | 40 | 295 | $4.65 | $54,870.00 |
| Clinical Behav Support | Per 15 Min | 64 | 450 | $19.10 | $550,080.00 |
| Live in Caregiver | Per Diem | 15 | 360 | $27.32 | $147,518.15 |
| Environmental Modification | Per Service | 6 | 1 | $8,741.82 | $52,450.90 |
| Family Training | Per Hour | 150 | 4 | $65.56 | $39,338.17 |
| Health Care Coordination | Monthly | 73 | 12 | $185.76 | $162,728.90 |
| Individualized Day Services | Per 15 min | 398 | 3520 | $6.56 | $9,190,970.51 |
| Individual Goods and Services | Per Service | 50 | 1 | $819.55 | $40,977.26 |
| Interpreter Services | Per 15 min | 25 | 96 | $16.39 | $39,338.17 |
| Nutrition | Per 15 min | 12 | 8 | $17.76 | $1,704.65 |
| Personal Emergency Response | Per month | 10 | 12 | $62.29 | $7,474.25 |
| Personal Support | Per 15 min | 470 | 1500 | $7.10 | $5,007,421.48 |
| Specialized Medical and Therapeutic Equipment and Supplies | Per Service | 3 | 1 | $819.55 | $2,458.64 |
| Independent Support Broker | Per 15 Min | 9 | 250 | $13.66 | $30,732.95 |
| Transportation | Per mile | 338 | 1778 | $0.46 | $275,809.63 |
| Transportation | Per Trip | 57 | 153 | $27.32 | $238,241.80 |
| Vehicle Modification | Per Service | 3 | 1 | $8,195.45 | $24,586.36 |
| GRAND TOTAL: | | | | | $104,086,440.89 |
| TOTAL ESTIMATED UNDUPLICATED PARTICIPANTS (from Table J-2-a) | | | | | 5,208 |
| FACTOR D (Divide grand total by number of participants) | | | | | $19,985.88 |
| AVERAGE LENGTH OF STAY ON THE WAIVER | | | | | 352 |

| **Waiver Year:** Year 5 *(renewal only)* | | | | | |
|---|---|---|---|---|---|
| **Waiver Service** | Col. 1 | Col. 2 | Col. 3 | Col. 4 | Col. 5 |
| | **Unit** | **# Users** | **Avg. Units Per User** | **Avg. Cost/ Unit** | **Total Cost** |
| Individualized Supports | Per 15 Min | 1192 | 1700 | $9.57 | $19,392,648.00 |
| Community Training Home | Per Diem | 57 | 360 | $79.91 | $1,639,753.20 |
| Adult Day Health | Per Diem | 95 | 225 | $66.40 | $1,419,300.00 |
| Group Day Services | Per diem | 1295 | 225 | $76.76 | $22,365,857.83 |
| Supported Employment - Individual | Per 15 min | 919 | 1492 | $13.80 | $18,920,112.03 |
| Supported Employment - Group | Per Diem | 1956 | 225 | $76.76 | $33,781,944.34 |
| Respite less than 24 hrs | Per 15 Min | 60 | 112 | $3.74 | $25,110.55 |
| Respite over night | Per Diem | 82 | 9 | $152.82 | $112,782.33 |
| Adult Companion | Per 15 Min | 43 | 295 | $4.78 | $60,634.30 |
| Clinical Behav Support | Per 15 Min | 65 | 450 | $19.67 | $575,347.50 |
| Live in Caregiver | Per Diem | 15 | 360 | $28.14 | $151,943.69 |
| Environmental Modification | Per Service | 7 | 1 | $9,004.07 | $63,028.49 |
| Family Training | Per Hour | 150 | 4 | $67.53 | $40,518.32 |
| Health Care Coordination | Monthly | 78 | 12 | $191.34 | $179,090.96 |
| Individualized Day Services | Per 15 min | 427 | 3520 | $6.75 | $10,144,165.88 |
| Individual Goods and Services | Per Service | 50 | 1 | $844.13 | $42,206.58 |
| Interpreter Services | Per 15 min | 25 | 96 | $16.88 | $40,518.32 |
| Nutrition | Per 15 min | 12 | 8 | $18.29 | $1,755.79 |
| Personal Emergency Response | Per month | 12 | 12 | $64.15 | $9,238.18 |
| Personal Support | Per 15 min | 504 | 1500 | $7.32 | $5,530,750.29 |
| Specialized Medical and Therapeutic Equipment and Supplies | Per Service | 3 | 1 | $844.13 | $2,532.39 |
| Independent Support Broker | Per 15 Min | 9 | 250 | $14.07 | $31,654.94 |
| Transportation | Per mile | 362 | 1778 | $0.47 | $304,255.56 |
| Transportation | Per Trip | 61 | 153 | $28.14 | $262,609.34 |
| Vehicle Modification | Per Service | 3 | 1 | $8,441.32 | $25,323.95 |
| GRAND TOTAL: | | | | | $116,123,082.76 |
| TOTAL ESTIMATED UNDUPLICATED PARTICIPANTS (from Table J-2-a) | | | | | 5,578 |
| FACTOR D (Divide grand total by number of participants) | | | | | $20,638.77 |
| AVERAGE LENGTH OF STAY ON THE WAIVER | | | | | 352 |

**ii. Estimate of Factor D – Concurrent §1915(b)/§1915(c) Waivers.** Complete the following table for each waiver year.

| **Waiver Year:** Year 1 | | | | | | |
|---|---|---|---|---|---|---|
| **Waiver Service** | Col. 1 | Col. 2 | Col. 3 | Col. 4 | Col. 5 | Col. 6 |
| | **Check if included in capitation** | **Unit** | **# Users** | **Avg. Units Per User** | **Avg. Cost/ Unit** | **Total Cost** |
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| GRAND TOTAL: | | | | | | |
| Total: Services included in capitation | | | | | | |
| Total: Services not included in capitation | | | | | | |
| TOTAL ESTIMATED UNDUPLICATED PARTICIPANTS (from Table J-2-a) | | | | | | |
| FACTOR D (Divide grand total by number of participants) | | | | | | |
| Services included in capitation | | | | | | |
| Services not included in capitation | | | | | | |
| AVERAGE LENGTH OF STAY ON THE WAIVER | | | | | | |

| **Waiver Year:** Year 2 | | | | | | |
|---|---|---|---|---|---|---|
| **Waiver Service** | Col. 1 | Col. 2 | Col. 3 | Col. 4 | Col. 5 | Col. 6 |
| | **Check if included in capitation** | **Unit** | **# Users** | **Avg. Units Per User** | **Avg. Cost/ Unit** | **Total Cost** |
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| GRAND TOTAL: | | | | | | |
| Total: Services included in capitation | | | | | | |
| Total: Services not included in capitation | | | | | | |
| TOTAL ESTIMATED UNDUPLICATED PARTICIPANTS (from Table J-2-a) | | | | | | |
| FACTOR D (Divide grand total by number of participants) | | | | | | |
| Services included in capitation | | | | | | |
| Services not included in capitation | | | | | | |
| AVERAGE LENGTH OF STAY ON THE WAIVER | | | | | | |

| **Waiver Year:** Year 3 | | | | | | |
|---|---|---|---|---|---|---|
| **Waiver Service** | Col. 1 | Col. 2 | Col. 3 | Col. 4 | Col. 5 | Col. 6 |
| | **Check if included in capitation** | **Unit** | **# Users** | **Avg. Units Per User** | **Avg. Cost/ Unit** | **Total Cost** |
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| GRAND TOTAL: | | | | | | |
| Total: Services included in capitation | | | | | | |
| Total: Services not included in capitation | | | | | | |
| TOTAL ESTIMATED UNDUPLICATED PARTICIPANTS (from Table J-2-a) | | | | | | |
| FACTOR D (Divide grand total by number of participants) | | | | | | |
| Services included in capitation | | | | | | |
| Services not included in capitation | | | | | | |
| AVERAGE LENGTH OF STAY ON THE WAIVER | | | | | | |

| **Waiver Year:** Year 4 (Renewal Only) | | | | | | |
|---|---|---|---|---|---|---|
| **Waiver Service** | Col. 1 | Col. 2 | Col. 3 | Col. 4 | Col. 5 | Col. 6 |
| | **Check if included in capitation** | **Unit** | **# Users** | **Avg. Units Per User** | **Avg. Cost/ Unit** | **Total Cost** |
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| GRAND TOTAL: | | | | | | |
| Total: Services included in capitation | | | | | | |
| Total: Services not included in capitation | | | | | | |
| TOTAL ESTIMATED UNDUPLICATED PARTICIPANTS (from Table J-2-a) | | | | | | |
| FACTOR D (Divide grand total by number of participants) | | | | | | |
| Services included in capitation | | | | | | |
| Services not included in capitation | | | | | | |
| AVERAGE LENGTH OF STAY ON THE WAIVER | | | | | | |

| **Waiver Year:** Year 5 (Renewal Only) | | | | | | |
|---|---|---|---|---|---|---|
| **Waiver Service** | Col. 1 | Col. 2 | Col. 3 | Col. 4 | Col. 5 | Col. 6 |
| | **Check if included in capitation** | **Unit** | **# Users** | **Avg. Units Per User** | **Avg. Cost/ Unit** | **Total Cost** |
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| GRAND TOTAL: | | | | | | |
| Total: Services included in capitation | | | | | | |
| Total: Services not included in capitation | | | | | | |
| TOTAL ESTIMATED UNDUPLICATED PARTICIPANTS (from Table J-2-a) | | | | | | |
| FACTOR D (Divide grand total by number of participants) | | | | | | |
| Services included in capitation | | | | | | |
| Services not included in capitation | | | | | | |
| AVERAGE LENGTH OF STAY ON THE WAIVER | | | | | | |