Request for an Amendment to a §1915(c) Home and Community-Based Services Waiver

1. Request Information

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

B. Program Title:
CT ABI Waiver

C. Waiver Number:CT.0302
Original Base Waiver Number: CT.0302.

D. Amendment Number:

E. Proposed Effective Date: (mm/dd/yy)
07/01/19

Approved Effective Date of Waiver being Amended: 01/01/17

2. Purpose(s) of Amendment

Purpose(s) of the Amendment. Describe the purpose(s) of the amendment:

The following changes are proposed in this amendment:

- Board Certified Behavioral Analyst is being added as a credential to provide cognitive behavioral programming
- Annual training requirements for providers of Independent Living Skills Training have been added
- A new provider credential, Certified Adult Day Health Provider, is being added as a credential to provide ABI Group Day Services
- Credentials to provide ABI Group Day have been expanded to include providers who are not CARF or JAHCO certified
- Durable Medical Equipment and Supplies has been replaced with Assistive Technology which is a more accurate description of the service being provided. Also, medically necessary DME is coverable under the Medicaid state plan

3. Nature of the Amendment

A. Component(s) of the Approved Waiver Affected by the Amendment. This amendment affects the following component(s) of the approved waiver. Revisions to the affected subsection(s) of these component(s) are being submitted concurrently *(check each that applies):*

Component of the Approved Waiver	Subsection(s)
☐ Waiver Application	
☐ Appendix A Waiver Administration and Operation	
☐ Appendix B Participant Access and Eligibility	
☒ Appendix C Participant Services	
☐ Appendix D Participant Centered Service Planning and Delivery	

Component of the Approved Waiver	Subsection(s)
☐ Appendix E Participant Direction of Services	
☐ Appendix F Participant Rights	
☐ Appendix G Participant Safeguards	
☐ Appendix H	
☐ Appendix I Financial Accountability	
☐ Appendix J Cost-Neutrality Demonstration	

B. Nature of the Amendment. Indicate the nature of the changes to the waiver that are proposed in the amendment *(check each that applies):*

- ☐ **Modify target group(s)**
- ☐ **Modify Medicaid eligibility**
- ☐ **Add/delete services**
- ☒ **Revise service specifications**
- ☒ **Revise provider qualifications**
- ☐ **Increase/decrease number of participants**
- ☐ **Revise cost neutrality demonstration**
- ☐ **Add participant-direction of services**
- ☐ **Other**

Specify:

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

1. Request Information (1 of 3)

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. Program Title (*optional - this title will be used to locate this waiver in the finder*):

CT ABI Waiver

C. Type of Request: amendment

Requested Approval Period:*(For new waivers requesting five year approval periods, the waiver must serve individuals who are dually eligible for Medicaid and Medicare.)*

○ **3 years** ◉ **5 years**

Original Base Waiver Number: CT.0302
Draft ID: CT.026.04.01

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

Regular Waiver

E. Proposed Effective Date of Waiver being Amended: 01/01/17
Approved Effective Date of Waiver being Amended: 01/01/17

1. Request Information (2 of 3)

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 age 21 and under as provided in42 CFR §440.160**

☒ **Nursing Facility**

Select applicable level of care

◉ **Nursing Facility 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:

The Waiver Uses NF and ABI/NF
1.-Nursing Facility As defined in 42 CFR §440.40 and 42 CFR §440.155

2.-Acquired Brain Injury Nursing Facility (ABI/NF) - A type of nursing facility that provides specialized programs for persons with acquired brain injury.

○ **Institution for Mental Disease for persons with mental illnesses aged 65 and older as provided in 42 CFR §440.140**

☒ **Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) (as defined in 42 CFR §440.150)**

If applicable, specify whether the state additionally limits the waiver to subcategories of the ICF/IID level of care:

1. Request Information (3 of 3)

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

Select one:

◉ **Not applicable**

○ **Applicable**

Check the applicable authority or authorities:

☐ **Services furnished under the provisions of §1915(a)(1)(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)(2) (central broker)**
- ☐ **§1915(b)(3) (employ cost savings to furnish additional services)**
- ☐ **§1915(b)(4) (selective contracting/limit number of providers)**

☐ **A program operated under §1932(a) of the Act.**
Specify the nature of the state plan benefit and indicate whether the state plan amendment has been submitted or previously approved:

☐ **A program authorized under §1915(i) of the Act.**

☐ **A program authorized under §1915(j) of the Act.**

☐ **A program authorized under §1115 of the Act.**
Specify the program:

H. Dual Eligiblity for Medicaid and Medicare.
Check if applicable:

☒ **This waiver provides services for individuals who are eligible for both Medicare and Medicaid.**

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.

Goals and Objectives
Connecticuts Acquired Brain Injury Waiver (ABI) serves persons who are at least 18 years of age with acquired brain injury who, without such services, would otherwise require placement in one of four types of institutional settings. It is designed to assist participants to relearn, improve or retain the skills needed to support community living. The waiver employs the principles of person-centered planning to develop an adequate, appropriate and cost-effective plan of care from a menu of nineteen home and community-based services to achieve personal outcomes that support the individuals ability to live in his/her community of choice.

Organizational Structure:
The Department of Social Services (DSS), as the state Medicaid Agency pursuant to Connecticut General Statutes (CGS) §17b-1, directly administers the ABI Waiver according to CGS §17b-260a. DSS assures that all individuals receiving waiver services meet the categorically and medically needy eligibility and income/asset requirements. DSS is responsible for calculating the consumers share of liability that can be applied to the cost of waiver services. DSS also informs individuals determined eligible to receive waiver services of their due process rights and gives them the choice of institutional or home and community based services.

Care managers, in consultation with the consumer, their family and care providers (e.g., skilled nursing/ABI facility staff, primary care physicians, and neuropsychologists) develop plans of care to meet an individuals cognitive, physical, and behavioral support needs. Plans are submitted to the department's Home and Community Based Services Unit staff for review of eligibility, service adequacy and responsiveness to the waiver participants needs.

DSS contracts with a fiscal agent to conduct provider recruitment; training; engage in fiscal monitoring; claims processing and reporting; and provider credentialing. Quarterly reports, at a minimum, are submitted to the Department to facilitate State oversight of the waiver program. In addition, routine quality assurance activities through staff meetings, training; case conferences, consumer record maintenance, and staff supervision are components of the Departments oversight of the ABI waiver program.

Service Delivery
ABI Waiver credentialed providers deliver services in the clients home and community. These services are based on the team developed ABI Service plan. The providers collaborate with the consumer and other members of the team to implement strategies to support community living. These include the following:
Provide instruction and training in one or more areas of need to enhance the participants ability to live independently in their own home
Implement strategies to address behavioral, medical or other needs identified in the ABI Service Plan
Provide assistance with personal care or activities of daily living
Support the attainment of vocational skills
Provide training or practice in consumer skills (e.g., banking, budgeting, shopping)

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*):

◉ **Yes. This waiver provides participant direction opportunities.** *Appendix E is required.*

○ **No. This waiver does not provide participant direction opportunities.** *Appendix E is not required.*

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 Improvement Strategy. Appendix H contains the Quality Improvement 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)*:

◉ **Not Applicable**

○ **No**

○ **Yes**

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

◉ **No**

○ **Yes**

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.
Specify 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 Act (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) age 21 and under and 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 frequency 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/IID.

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 §431.151, 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 Improvement. 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 Improvement Strategy specified in **Appendix H.**

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

Print notice was published in the CT Law Journal on August 16,2016 and was also posted on the DSS website. The content of the notice is as follows:
DEPARTMENT of SOCIAL SERVICES

Notice of Intent to Renew the Acquired Brain Injury Waiver

In accordance with the provisions of section 17b-8 of the Connecticut General Statutes, notice is hereby given that the Commissioner of the Department of Social Services (DSS) intends to renew the Acquired Brain Injury Waiver. The current waiver expires on December 31, 2016. There are no changes to eligibility, services or rates. The only changes to this waiver pertain to routine operational issues.

A complete text of the waiver renewal and amendment is available, at no cost, upon request to the Community Options Unit, Department of Social Services, 55 Farmington Ave., Hartford, Connecticut 06105; or via email to shirlee.stoute@ct.gov. It is also available on the Department's website, www.ct.gov/dss, under "Latest News."

Any written comments regarding this waiver renewal and amendment must be submitted by September 22, 2016 to the Department of Social Services, Community Options Unit, 55 Farmington Ave, Hartford, CT 06105; Attention: Kathy Bruni, Director; or via email to kathy.a.bruni@ct.gov.

The two CT tribes were directly notified via email On August 12, 2016. In addition, the waiver was posted on the department's web site on 9/1/16. The link to the posting is as follows:
http://www.ct.gov/dss/cwp/view.asp?Q=585166&A=4125
Two comments were received, both identifying an error in the rate for ILST that the department subsequently corrected. A written response was sent to the commenter.

For the amendment, a notice of intent was posted on the DSS web site on June XX, 2019 at the following link:

Written notice was published in the CT Law Journal on June 18, 2019. The two Connecticut tribes were notified via email on June XX, 2019

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 is 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:

Last Name: Bruni

First Name: Kathy

Title: Director, HCBS Unit

Agency: Connecticut Department of Social Services

Address: 55 Farmington Avenue

Address 2:

City: Hartford

State: **Connecticut**

Zip: 06105

Phone: (860) 424-5177 **Ext:** ☐ **TTY**

Fax: (860) 424-4963

E-mail: kathy.a.bruni@ct.gov

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

Last Name:

First Name:

Title:

Agency:

Address:

Address 2:

City:

State: **Connecticut**

Zip:

Phone: **Ext:** ☐ **TTY**

Fax:

E-mail:

8. Authorizing Signature

This document, together with the attached revisions to the affected components of the waiver, constitutes the state's request to amend its approved waiver under §1915(c) of the Social Security Act. The state affirms that it will abide by all provisions of the waiver, including the provisions of this amendment when approved by CMS. The state further attests that it will continuously operate the waiver in accordance with the assurances specified in Section V and the additional requirements specified in Section VI of the approved waiver. The state certifies that additional proposed revisions to the waiver request will be submitted by the Medicaid agency in the form of additional waiver amendments.

Signature:

State Medicaid Director or Designee

Submission Date:

Note: The Signature and Submission Date fields will be automatically completed when the State Medicaid Director submits the application.

Last Name:

First Name:

Title:

Agency:

Address:

Address 2:

City:

State: **Connecticut**

Zip:

Phone:

Ext: ☐ **TTY**

Fax:

E-mail:

Attachments

Attachment #1: Transition Plan

Check the box next to any of the following changes from the current approved waiver. Check all boxes that apply.

- ☐ **Replacing an approved waiver with this waiver.**
- ☐ **Combining waivers.**
- ☐ **Splitting one waiver into two waivers.**
- ☐ **Eliminating a service.**
- ☐ **Adding or decreasing an individual cost limit pertaining to eligibility.**
- ☐ **Adding or decreasing limits to a service or a set of services, as specified in Appendix C.**
- ☐ **Reducing the unduplicated count of participants (Factor C).**
- ☐ **Adding new, or decreasing, a limitation on the number of participants served at any point in time.**
- ☐ **Making any changes that could result in some participants losing eligibility or being transferred to another waiver under 1915(c) or another Medicaid authority.**
- ☐ **Making any changes that could result in reduced services to participants.**

Specify the transition plan for the waiver:

Attachment #2: Home and Community-Based Settings Waiver Transition Plan

Specify the state's process to bring this waiver into compliance with federal home and community-based (HCB) settings requirements at 42 CFR 441.301(c)(4)-(5), and associated CMS guidance.

Consult with CMS for instructions before completing this item. This field describes the status of a transition process at the point in time of submission. Relevant information in the planning phase will differ from information required to describe attainment of milestones.

To the extent that the state has submitted a statewide HCB settings transition plan to CMS, the description in this field may reference that statewide plan. The narrative in this field must include enough information to demonstrate that this waiver complies with federal HCB settings requirements, including the compliance and transition requirements at 42 CFR 441.301(c)(6), and that this submission is consistent with the portions of the statewide HCB settings transition plan that are germane to this waiver. Quote or summarize germane portions of the statewide HCB settings transition plan as required.

Note that Appendix C-5 HCB Settings describes settings that do not require transition; the settings listed there meet federal HCB setting requirements as of the date of submission. Do not duplicate that information here.

Update this field and Appendix C-5 when submitting a renewal or amendment to this waiver for other purposes. It is not necessary for the state to amend the waiver solely for the purpose of updating this field and Appendix C-5. At the end of the state's HCB settings transition process for this waiver, when all waiver settings meet federal HCB setting requirements, enter "Completed" in this field, and include in Section C-5 the information on all HCB settings in the waiver.

The state assures that the settings transition plan included with this waiver amendment will be subject to any provisions or requirements included in the State's approved Statewide Transition Plan. The State will implement any required changes upon approval of the Statewide Transition Plan and will make conforming changes to its waiver when it submits the next amendment or renewal.

Additional Needed Information (Optional)

Provide additional needed information for the waiver (optional):

The state will assess the settings in which waiver applicants reside for compliance with the new rules as they apply for and are assessed for participation in the waiver. Waiver participants reside in their own homes, apartments or with family members. Under this waiver, participants may also choose to reside in provider owned homes. Prior to an individual accessing any of the services listed below the state will verify that the provider owned or controlled setting comports with CMS home and community based settings requirements through its person centered assessment process. The person centered assessment is completed to determine functional eligibility for the waiver and must be completed prior to waiver services being authorized to begin. If the social worker assesses that the setting is not compliant with the new rules, the social worker will discuss and offer the participant alternative settings that would be compliant. The applicant could choose another setting or remain in their current setting. If they stay in the setting that has been assessed not to be compliant, they would not be approved to receive services under this waiver and would be afforded rights to a fair hearing..

Appendix C: Participant Services

C-1: Summary of Services Covered (1 of 2)

a. Waiver Services Summary. *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:*

Service Type	Service
Statutory Service	Homemaker
Statutory Service	Pre-Vocational Service
Statutory Service	Respite
Statutory Service	Supported Employment
Other Service	ABI Group Day
Other Service	Assistive Technology
Other Service	Chore
Other Service	Cognitive Behavioral Programs
Other Service	Community Living Support Services (CLSS)
Other Service	Companion
Other Service	Environmental Accessibility Adaptation
Other Service	Home-Delivered Meals
Other Service	Independent Living Skills Training
Other Service	Personal Emergency Response Systems (PERS)
Other Service	Substance Abuse Programs
Other Service	Transitional Living Services
Other Service	Transportation
Other Service	Vehicle Modification Services

Appendix C: Participant Services

C-1/C-3: Service Specification

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 Type:

Statutory Service

Service:

Homemaker

Alternate Service Title (if any):

HCBS Taxonomy:

Category 1:

Sub-Category 1:

Category 2:

Sub-Category 2:

Category 3: **Sub-Category 3:**

Service Definition *(Scope)*:

Category 4: **Sub-Category 4:**

Homemaker services consist of general household activities, including meal preparation and routine household chores. Homemaker services are provided by the Department only when the individual regularly responsible for these activities is temporarily absent from the home or unable to manage the home and care for him/herself or others in the home; or, when the waiver participant is unable to (re)learn such skills or does not choose to perform these tasks.

Homemaker services may not be provided by a member of the participants family.

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

A member of the consumers family or the conservator or their family may not provide these services.

Service Delivery Method *(check each that applies)*:

- ☒ **Participant-directed as specified in Appendix E**
- ☒ **Provider managed**

Specify whether the service may be provided by *(check each that applies)*:

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Individual	Private household employee
Agency	Agency provider

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Homemaker

Provider Category:

Individual

Provider Type:

Private household employee

Provider Qualifications

License *(specify)*:

Certificate *(specify)*:

Other Standard *(specify):*

Homemaker service providers are not licensed or regulated.
A homemaker provider shall:
be at least 18 years of age
follow instructions given by the consumer or the consumers conservator
be able to report changes in the consumers condition or needs
maintain confidentiality
have the ability or skills necessary to meet the consumers needs as delineated in the service plan
demonstrate ability to implement cognitive and behavioral strategies

Verification of Provider Qualifications

Entity Responsible for Verification:

Fiscal Intermediary

Frequency of Verification:

At start of services

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Homemaker

Provider Category:

Agency

Provider Type:

Agency provider

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Homemaker service providers are not licensed or regulated.
A homemaker provider shall:
be at least 18 years of age
follow instructions given by the consumer or the consumers conservator
be able to report changes in the consumers condition or needs
maintain confidentiality
have the ability or skills necessary to meet the consumers needs as delineated in the service plan
demonstrate ability to implement cognitive and behavioral strategies

Verification of Provider Qualifications

Entity Responsible for Verification:

Fiscal Intermediary

Frequency of Verification:

At start of services

Appendix C: Participant Services

C-1/C-3: Service Specification

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 Type:

Statutory Service

Service:

Prevocational Services

Alternate Service Title (if any):

Pre-Vocational Service

HCBS Taxonomy:

Category 1:	Sub-Category 1:
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope)*:

Services that provide learning and work experiences, including volunteer work, where the individual can develop general, non-job-task-specific strengths and skills that contribute to employability in paid employment in integrated community settings. Services are expected to occur over a defined period of time and with specific outcomes to be achieved, as determined by the individual and his/her service and supports planning team through an ongoing person-centered planning process. Services are delivered in a participant's home or in a fully integrated work setting based on the participant's needs and preferences. Services are not delivered in facility based, congregate or sheltered work settings where individuals are supervised for the primary purpose of producing goods or performing services.

Individuals receiving prevocational services must have employment-related goals in their person-centered services and supports plan; the general habilitation activities must be designed to support such employment goals. Competitive, integrated employment in the community for which an individual is compensated at or above the minimum wage, but not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by individuals without disabilities is considered to be the optimal outcome of prevocational services.

Prevocational services should enable each individual to attain the highest level of work in the most integrated setting and with the job matched to the individual's interests, strengths, priorities, abilities, and capabilities, while following applicable federal wage guidelines. Services are intended to develop and teach general skills. Examples include, but are not limited to: ability to communicate effectively with supervisors, co-workers and customers; generally accepted community workplace conduct and dress; ability to follow directions; ability to attend to tasks; workplace problem solving skills and strategies; general workplace safety and mobility training.

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

40 hours per week. This service will be limited to two years than may be extended up to a maximum of four years if the participant is demonstrating progress toward achieving their employment goal.
Some waiver participants have been receiving this service for 10, 12 and 14 years. Upon approval of the amendment, each participant's plan will be reviewed as part of their annual reassessment process. The department may approve an additional 2 years of service up to a maximum of an additional four years beyond the services received through December 1, 2015. The determination will be made as part of the ongoing evaluation of the person centered plan and based on whether there is demonstrated progress being made toward vocational goals. Annual redeterminations of eligibility for such services. Once services are discontinued, the participant would be evaluated for other services as part of the person centered planning process. The most likely services to replace the prevocational service would be ABI Group Day or Independent Living Skills Training.

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☒ **Provider managed**

Specify whether the service may be provided by *(check each that applies)*:

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Vocational Agency Provider

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Pre-Vocational Service

Provider Category:

Agency

Provider Type:

Vocational Agency Provider

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Commission on Accreditation of Rehabilitation Facilities (CARF)- Employment Services, or

Other Standard *(specify):*

Meet the State of CT Standard to provide vocational rehabilitation services for the Bureau of Rehabilitative Services, Department of Developmental Services or the Department of Mental Health and Addiction Services. This shal include: A Director of Vocational Services has Commission on Rehabilitation Counselor certification and a minimum of two years experience (experience is defined as a minimum of 1000 documented service hours per year) in providing community based vocational services to persons with disabilities. OR The Director of Vocational Services has a Bachelors degree in a relevant area and a minimum of five years experience (experience is defined as a minimum of 1000 documented service hours per year) in providing community based vocational services to persons with disabilities.

Verification of Provider Qualifications

Entity Responsible for Verification:

Fiscal Intermediary

Frequency of Verification:

At start of services or re-accreditation (every two years).

Appendix C: Participant Services

C-1/C-3: Service Specification

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 Type:

Statutory Service

Service:

Respite

Alternate Service Title (if any):

HCBS Taxonomy:

Category 1: **Sub-Category 1:**

Category 2: **Sub-Category 2:**

Category 3: **Sub-Category 3:**

Service Definition *(Scope)*:

Category 4: **Sub-Category 4:**

Services provided to persons unable to care for themselves, and furnished on a short-term basis only in the individuals home or place of residence, when person performing such services is absent or in need of relief.

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

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☒ **Provider managed**

Specify whether the service may be provided by *(check each that applies)*:

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Individual	Private household employee
Agency	Agency Provider

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Respite

Provider Category:

Individual

Provider Type:

Private household employee

Provider Qualifications

License *(specify)*:

Certificate *(specify):*

Other Standard *(specify):*

Employ staff who:
are at least 18 years of age
demonstrate the ability to maintain a safe and healthy living environment
demonstrate knowledge of basic first aid
demonstrate knowledge of response to fire and emergency situations
demonstrate ability to implement cognitive and behavioral strategies
demonstrate ability to function as a member of an interdisciplinary team.
Must be capable of performing all functions of the primary caregiver in their absence.
Training requirement
Must have completed an approved training program(s) concerning acquired brain injury and person-centered planning, given by a state agency, the states fiduciary, community providers, Brain Injury Association of CT, or an Independent Living Center.

OR meet the qualifications for Independent Living Skills Training and Development.

Verification of Provider Qualifications

Entity Responsible for Verification:

Fiscal Intermediary

Frequency of Verification:

At start of services or at re-accreditation for CARF Providers

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Respite

Provider Category:

Agency

Provider Type:

Agency Provider

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Commission on Accreditation of Rehabilitation Facilities (CARF) Community Support Services,

Other Standard *(specify):*

Employ staff who:
are at least 18 years of age
demonstrate the ability to maintain a safe and healthy living environment
demonstrate knowledge of basic first aid
demonstrate knowledge of response to fire and emergency situations
demonstrate ability to implement cognitive and behavioral strategies
demonstrate ability to function as a member of an interdisciplinary team.
Must be capable of performing all functions of the primary caregiver in their absence.
Training requirement
Must have completed an approved training program(s) concerning acquired brain injury and person-centered planning, given by a state agency, the states fiduciary, community providers, Brain Injury Association of CT, or an Independent Living Center.

Verification of Provider Qualifications

Entity Responsible for Verification:

Fiscal Intermediary

Frequency of Verification:

At start of services or at re-accrediation for CARF Providers

Appendix C: Participant Services

C-1/C-3: Service Specification

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 Type:

Statutory Service

Service:

Supported Employment

Alternate Service Title (if any):

HCBS Taxonomy:

Category 1:	Sub-Category 1:
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**

Service Definition *(Scope)*:

Category 4: **Sub-Category 4:**

Supported Employment -Individual Employment Support services are the ongoing supports to participants who, because of their disabilities, need intensive on-going support to obtain and maintain an individual job in competitive or customized employment, or self-employment, in an integrated work setting in the general workforce for which an individual is compensated at or above the minimum wage, but not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by individuals without disabilities. The outcome of this service is sustained paid employment at or above the minimum wage in an integrated setting in the general workforce, in a job that meets personal and career goals.
Supported employment services can be provided through many different service models. Some of these models can include evidence-based supported employment for individuals with mental illness, or customized employment for individuals with significant disabilities. States may define other models of individualized supported employment that promote community inclusion and integrated employment.
Supported employment individual employment supports may also include support to establish or maintain self-employment, including home-based self-employment. Supported employment services are individualized and may include any combination of the following services: vocational/job-related discovery or assessment, person-centered employment planning, job placement, job development, negotiation with prospective employers, job analysis, job carving, training and systematic instruction, job coaching, benefits support, training and planning, transportation (Transportation to and from the individuals residence and a day habilitation site is included in the rate paid to the provider), asset development and career advancement services, and other workplace support services including services not specifically related to job skill training that enable the waiver participant to be successful in integrating into the job setting.
Documentation is maintained that the service is not available under a program funded under section 110 of the Rehabilitation Act of 1973 or the IDEA (20 U.S.C. 1401 et seq.).
Federal financial participation is not 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 supported employment; or
2. Payments that are passed through to users of supported employment services.

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

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☒ **Provider managed**

Specify whether the service may be provided by *(check each that applies)*:

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Agency Provider

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Supported Employment

Provider Category:

Agency

Provider Type:

Agency Provider

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Commission on Accreditation of Rehabilitation Facilities (CARF) Employment Services

Other Standard *(specify):*

Meet the State of CT Standard to provide vocational rehabilitation services for the Bureau of Rehabilitative Services, Department of Developmental Services or the Department of Mental Health and Addiction Services. This shal include: A Director of Vocational Services has Commission on Rehabilitation Counselor certification and a minimum of two years experience (experience is defined as a minimum of 1000 documented service hours per year) in providing community based vocational services to persons with disabilities. OR The Director of Vocational Services has a Bachelors degree in a relevant area and a minimum of five years experience (experience is defined as a minimum of 1000 documented service hours per year) in providing community based vocational services to persons with disabilities.

Verification of Provider Qualifications

Entity Responsible for Verification:

Fiscal Intermediary

Frequency of Verification:

At start of services or at recertification

Appendix C: Participant Services

C-1/C-3: Service Specification

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 Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

ABI Group Day

HCBS Taxonomy:

Category 1:	Sub-Category 1:
04 Day Services	04070 community integration
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

Services and supports that lead to the acquisition, improvement and/or retention of skills and abilities to prepare an individual for health and wellness, self-care or for work and/or community participation, or support meaningful socialization, leisure activities. This service is provided by a qualified provider in a facility-based program or appropriate community locations. 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.

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☒ **Provider managed**

Specify whether the service may be provided by *(check each that applies)*:

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Rehabilitation Hospital Outpatient Department
Agency	Adult Day Health provider
Agency	Community Integration Agency Provider
Agency	Employment Services/Supports Agency Provider

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: ABI Group Day

Provider Category:

Agency

Provider Type:

Rehabilitation Hospital Outpatient Department

Provider Qualifications

License *(specify):*

Certificate *(specify):*

CARF certification in brain injury and/or Community Support, or
JCAHO accreditation for Behavioral Health Care

Other Standard *(specify):*

Employee staff who:
are at least 18 years old
have a minimum of a Bachelors Degree and one years experience providing services to individuals with brain injuries in the community, and complete training program(s) concerning acquired brain injury and person-centered planning, given by a state agency, the fiduciary, community providers, Brain Injury Association of CT, or Independent Living Center, or have a high school diploma and two years experience providing services to individuals with brain injuries in the community and completed training program(s) concerning acquired brain injury and person-centered planning, given by a state agency, broker agency, community providers, Brain Injury Association of CT, or Independent Living Center
demonstrate ability to function as a member of an interdisciplinary team
have documented experience implementing cognitive/Behavioral interventions developed by a clinician and utilized in community settings
or, meet qualifications for Cognitive/Behavioral Programs

Verification of Provider Qualifications

Entity Responsible for Verification:

Fiscal Intermediary

Frequency of Verification:

At start of services and at recertification/re-accreditation (Every two years)

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: ABI Group Day

Provider Category:

Agency

Provider Type:

Adult Day Health provider

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Peer certified by CT Association of Adult Day Centers. Certification is for 3 years

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

Adult Day Association and Fiscal Intermediary

Frequency of Verification:

At start of services and FI recertifies every two years thereafter

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: ABI Group Day

Provider Category:

Agency

Provider Type:

Community Integration Agency Provider

Provider Qualifications

License *(specify):*

Certificate *(specify):*

CARF certification in brain injury and/or Community Support, or
JCAHO accreditation for Behavioral Health Care

Other Standard *(specify):*

Employee staff who:
are at least 18 years old
have a minimum of a Bachelors Degree and one years experience providing services to individuals with brain injuries in the community, and complete training program(s) concerning acquired brain injury and person-centered planning, given by a state agency, the fiduciary, community providers, Brain Injury Association of CT, or Independent Living Center, or have a high school diploma and two years experience providing services to individuals with brain injuries in the community and completed training program(s) concerning acquired brain injury and person-centered planning, given by a state agency, broker agency, community providers, Brain Injury Association of CT, or Independent Living Center
demonstrate ability to function as a member of an interdisciplinary team
have documented experience implementing cognitive/Behavioral interventions developed by a clinician and utilized in community settings
or, meet qualifications for Cognitive/Behavioral Programs

Verification of Provider Qualifications

Entity Responsible for Verification:

Fiscal intermediary

Frequency of Verification:

At start of services and at recertification/re-accreditation (Every two years)

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: ABI Group Day

Provider Category:

Agency

Provider Type:

Employment Services/Supports Agency Provider

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Commission on Accredidation of Rehabilitation Facilities (CARF) -Employment Services

Other Standard *(specify):*

Meet the State of CT Standard to provide vocational rehabilitation services for the Bureau of Rehabilitative Services, Department of Developmental Services or the Department of Mental Health and Addiction Services.

Verification of Provider Qualifications

Entity Responsible for Verification:

Fiscal Intermediary

Frequency of Verification:

At start of services or at recertification (Every two years)

Appendix C: Participant Services

C-1/C-3: Service Specification

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 Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Assistive Technology

HCBS Taxonomy:

Category 1:	Sub-Category 1:
14 Equipment, Technology, and Modifications	14031 equipment and technology
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

An item, piece of equipment or product system whether acquired commercially, modified or customized, that is used to increase, maintain, monitor or improve functional capabilities of participants to perform Activities of Daily Living or Instrumental Activities of Daily Living. Assistive Technology is a service that directly assists a participant in the selection, acquisition, or use of an assistive technology device.
A.Services consisting of purchasing, leasing, or otherwise providing for the acquisition of assistive technology devices.
B. Services consisting of selecting, designing, fitting, customizing, adapting, applying, maintaining, repairing or replacing assistive technology devices
C. Training or technical assistance for the participant or for the direct benefit of the participant receiving the service and, where appropriate, the family members, guardians, advocates or authorized representatives of participants.

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

Care plans may be developed based on the needs identified in the comprehensive assessment. Costs will be capped at no more than $15,000 over a three year period. Smart phones, tablets or computers whether desk top or lap top shall not be replaced more frequently than every three years

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☒ **Provider managed**

Specify whether the service may be provided by *(check each that applies)*:

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Assistive Technology Equipment Vendors
Agency	Pharmacies
Agency	DME

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Assistive Technology

Provider Category:

Agency

Provider Type:

Assistive Technology Equipment Vendors

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Must meet the State of CT Standard to provide equipment supplies for the Department of Rehabilitation Services, Department of Developmental Services. Medicaid provider status for assistive technology and supplies or agency that obtains Medicaid performing provider status

Verification of Provider Qualifications

Entity Responsible for Verification:

Fiscal Intermediary

Frequency of Verification:

At start of services and recertification every two years.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Assistive Technology

Provider Category:

Agency

Provider Type:

Pharmacies

Provider Qualifications

License *(specify):*

State of CT Dept. of Consumer Protection Pharmacy Practice Act : Regulations Concerning Practice of Pharmacy Section 20-175-4-6-7

Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

Fiscal Intermediary

Frequency of Verification:

At start of services and every two years.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Assistive Technology

Provider Category:

Agency

Provider Type:

DME

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Must meet the State of CT Standard to provide medical equipment supplies for the Department of Rehabilitation Services, Department of Developmental Services or Medicaid have provider status for medical equipment and supplies or agency that obtains Medicaid performing provider status.

Verification of Provider Qualifications

Entity Responsible for Verification:

Fiscal Intermediary

Frequency of Verification:

At start of services and every two years.

Appendix C: Participant Services

C-1/C-3: Service Specification

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 Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Chore

HCBS Taxonomy:

Category 1:	Sub-Category 1:

Category 2:	Sub-Category 2:

Category 3:	Sub-Category 3:

Service Definition *(Scope):*

Category 4:	Sub-Category 4:

Services needed to maintain the consumers home in a clean, sanitary and safe condition. This service includes heavy household chores, such as washing floors, windows, walls, and moving heavy items of furniture in order to provide safe access and egress.

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

Chore services are provided only when neither the individual, nor anyone else in the household, is capable of performing or financially providing for them, or where no other third party is capable for their provision. ABI Waiver funds shall not be used if the service may be provided free of charge through friends, relatives, caregiver or community agencies. In the case of rental property, any service that is the responsibility of the landlord or his or her designee shall not be paid from ABI waiver funds; a copy of the lease agreement shall be reviewed before this service is authorized.

Service Delivery Method *(check each that applies)*:

☒ **Participant-directed as specified in Appendix E**

☒ **Provider managed**

Specify whether the service may be provided by *(check each that applies)*:

☐ **Legally Responsible Person**

☐ **Relative**

☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Individual	Self employed private provider
Agency	Private or non-profit agencies

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Chore

Provider Category:

Individual

Provider Type:

Self employed private provider

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Chore service providers are not licensed or regulated. Services shall not be provided by any person who is a relative of the participant, is the participants conservator, or is a member of the conservators family.
A chore service provider shall:
Be at least 18 years of age and be able to physically perform the service required.
Be able to follow instructions given by the consumer or the consumers conservator.
Be able to report changes in the consumers condition or needs.
Maintain confidentiality.
Have the ability or skills necessary to meet the consumers needs as delineated in the service plan.

Verification of Provider Qualifications

Entity Responsible for Verification:

Fiscal Intermediary

Frequency of Verification:

At start of services and recertification every 2 years

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Chore

Provider Category:

Agency

Provider Type:

Private or non-profit agencies

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Chore service providers are not licensed or regulated. Services shall not be provided by any person who is a relative of the participant, is the participants conservator, or is a member of the conservators family.
A chore service provider shall:
Be at least 18 years of age and be able to physically perform the service required.
Be able to follow instructions given by the consumer or the consumers conservator.
Be able to report changes in the consumers condition or needs.
Maintain confidentiality.
Have the ability or skills necessary to meet the consumers needs as delineated in the service plan.

Verification of Provider Qualifications

Entity Responsible for Verification:

Fiscal Intermediary

Frequency of Verification:

At start of service and every 2 years

Appendix C: Participant Services

C-1/C-3: Service Specification

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 Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Cognitive Behavioral Programs

HCBS Taxonomy:

Category 1: **Sub-Category 1:**

Category 2: **Sub-Category 2:**

Category 3: **Sub-Category 3:**

Service Definition *(Scope)*:

Category 4: **Sub-Category 4:**

Individual interventions designed to increase an individual's cognitive and behavioral capabilities and to further the individual's adjustment to successful community engagement including:

- Comprehensive assessment of cognitive strengths and liabilities, quality of adjustment and behavioral functioning
- Development and implementation of cognitive and behavioral strategies
- Development of a structured cognitive/behavioral intervention plan
- Ongoing or periodic consultation with the waiver participant, support system and providers concerning cognitive and behavioral strategies and interventions specified in the cognitive/ behavioral intervention plan
- Ongoing or periodic assistance with training of the waiver participant, support system and providers concerning cognitive behavior strategies and interventions
- Periodic reassessment and revision as needed, of the cognitive/behavioral intervention plan.

This service is performed within the context of the individual's person-centered team, in concert with the case manager. Cognitive/behavioral programs may be provided in the individual's home or in the community in order to reinforce the training in a real-life situation.

The service will be delivered utilizing two procedure codes, one for in person face to face visits that include the participant, providers and/or supporters. A quarterly, in person meeting with the waiver participant is required for this service.
The second procedure code is for non face-to-face service that includes development of the cognitive behavioral plan and phone or other types of interactions with participants, providers or supporters.

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

Service Delivery Method *(check each that applies)*:

☒ **Participant-directed as specified in Appendix E**

☒ **Provider managed**

Specify whether the service may be provided by *(check each that applies)*:

☐ **Legally Responsible Person**

☐ **Relative**

☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Individual	Educational Psychologist
Agency	Community Agency
Individual	Board Certified Behavioral Analyst
Individual	Neuro-Psychologist
Individual	Physical Therapist
Individual	Psychologists
Individual	Occupational Therapist
Individual	Speech Therapist
Agency	Rehabilitation Hospital (Outpatient Department)

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Cognitive Behavioral Programs

Provider Category:

Individual

Provider Type:

Educational Psychologist

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Certification in Special Education CT General Statutes Sec. 10-145d-538 and Sec. 10-145d-539.

Other Standard *(specify):*

Ph.D. in Education with concentration in cognitive strategy development and remediation and/or post-doctoral experience in providing such services.

Verification of Provider Qualifications

Entity Responsible for Verification:

Fiscal Intermediary

Frequency of Verification:

At beginning of services and recertification (every two years).

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Cognitive Behavioral Programs

Provider Category:

Agency

Provider Type:

Community Agency

Provider Qualifications

License *(specify):*

Certificate *(specify):*

CARF certification in Brain Injury, or JCAHO, or Accreditation for Behavioral Health Care, or Accreditation for Behavioral Health Care or Board Certified Behavioral Analyst

Other Standard *(specify):*

Employ neuro-psychologists, educational psychologists, psychologists, occupational therapists, speech therapists, board certified behavioral analysts or physical therapists that meet the standards of individual providers.

Verification of Provider Qualifications

Entity Responsible for Verification:

Fiscal Intermediary

Frequency of Verification:

At beginning of services and recertification (every two years).

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service

Service Name: Cognitive Behavioral Programs

Provider Category:

Individual

Provider Type:

Board Certified Behavioral Analyst

Provider Qualifications

License *(specify):*

Licensed as a Behavioral Analyst in accordance with CT General Statutes 20-185k and 20-185l

Certificate *(specify):*

Board Certified Behavioral Analyst requires a minimum of a graduate degree, coursework, supervised experience and passing the certification exam

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

Fiscal intermediary

Frequency of Verification:

At time of enrollment and every two years thereafter

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Cognitive Behavioral Programs

Provider Category:

Individual

Provider Type:

Neuro-Psychologist

Provider Qualifications

License *(specify):*

State of CT Dept. of Health Services (DPH) Section 20-188-1

Certificate *(specify):*

Other Standard *(specify):*

Post-doctoral study or clinical supervision in neuropsychology

Verification of Provider Qualifications

Entity Responsible for Verification:

Fiscal Intermediary

Frequency of Verification:

At beginning of services and recertification (Every two years)

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Cognitive Behavioral Programs

Provider Category:

Individual

Provider Type:

Physical Therapist

Provider Qualifications

License *(specify):*

State of CT General Statutes Section 20-66

Certificate *(specify):*

Other Standard *(specify):*

At least three years experience in cognitive/behavioral programming for people with a brain injury, delivered in community settings.

Verification of Provider Qualifications

Entity Responsible for Verification:

Fiscal Intermediary

Frequency of Verification:

At beginning of services and recertification (every two years).

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service

Service Name: Cognitive Behavioral Programs

Provider Category:

Individual

Provider Type:

Psychologists

Provider Qualifications

License *(specify):*

State of CT DPH Chap.383B, Section 20-188-1 Sec. 20-188-2 and Sec. 20-188-3.

Certificate *(specify):*

Other Standard *(specify):*

At least three years experience in cognitive/behavioral programming for people with a brain injury, delivered in community settings.

Verification of Provider Qualifications

Entity Responsible for Verification:

Allied Community Resources, Inc

Frequency of Verification:

At beginning of services and recertification (every two years).

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Cognitive Behavioral Programs

Provider Category:
Individual
Provider Type:

Occupational Therapist
Provider Qualifications
License *(specify):*

State of CT General Statutes Section 20-74a
Certificate *(specify):*

Other Standard *(specify):*

At least three years experience in cognitive/behavioral programming for people with a brain injury, delivered in community settings.
Verification of Provider Qualifications
Entity Responsible for Verification:

Allied Community Resources, Inc
Frequency of Verification:

At beginning of services and recertification (every two years).

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Cognitive Behavioral Programs

Provider Category:
Individual
Provider Type:

Speech Therapist
Provider Qualifications
License *(specify):*

State of CT General Statutes Section 20-408.
Certificate *(specify):*

Other Standard *(specify):*

At least three years experience in cognitive/behavioral programming for people with a brain injury, delivered in community settings.

Verification of Provider Qualifications

Entity Responsible for Verification:

Fiscal Intermediary

Frequency of Verification:

At beginning of services and recertification (every two years).

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service

Service Name: Cognitive Behavioral Programs

Provider Category:

Agency

Provider Type:

Rehabilitation Hospital (Outpatient Department)

Provider Qualifications

License *(specify):*

Certificate *(specify):*

JCAHO

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

Fiscal Intermediary

Frequency of Verification:

At beginning of services and recertification (every two years).

Appendix C: Participant Services

C-1/C-3: Service Specification

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 Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Community Living Support Services (CLSS)

HCBS Taxonomy:

Category 1:	Sub-Category 1:
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

This service provides supervised living in the consumers residence that provides up to 24-hour support services, including overnight supervision, for up to three individuals with acquired brain injury. Services are provided in the residence or in the community and include supervision of and assistance with: self-care; medication management; communication and interpersonal skills; socialization; sensory/motor skills; mobility; community transportation skills; problem-solving skills; money management and ability to maintain a household. Assessment and training services are not provided under this component.

The CLSS provider must develop a plan that demonstrates its ability to work with the individual and to provide services that are consistent with the therapeutic goals of his or her overall service plan. When the individual chooses, or improves his or her ability to live more independently, the CLSS provider will work with the individual and the DSS Social Worker to develop and implement a plan to transition the individual to greater independence in the community.

CLSS participants are not precluded from attending or participating in other community-based services if these are determined by the individual and the DSS Social Worker to be of potential benefit in providing the individual with skills and training needed to achieve independence.

No ABI funds will be spent on the room and board component of CLSS services.

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

This service is purchased by the day or half (12-hour) day. If the individual is involved in other service plan activities that consistently involve being away from the CLSS for a significant period of time, more than six hours per day, this service shall be paid on a half-day basis.

Service Delivery Method *(check each that applies)*:

☐ **Participant-directed as specified in Appendix E**

☒ **Provider managed**

Specify whether the service may be provided by *(check each that applies)*:

☐ **Legally Responsible Person**

☐ **Relative**

☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Community Integration Agency Provider
Agency	Rehabilitation Hospital

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Community Living Support Services (CLSS)

Provider Category:

Agency

Provider Type:

Community Integration Agency Provider

Provider Qualifications

License *(specify)*:

Certificate *(specify)*:

Commission on Accreditation of Rehabilitative Facilities (CARF), Community Support Services, or JCAHO Accreditation for Behavioral Health Care, or

Other Standard *(specify)*:

Shall have an existing service contract with BRS, DMHAS or DMR, to provide rehabilitation services.
Residence must meet all provisions of CT State Building Code, fire prevention, safety and construction standards.
Employ staff who:
- are at least 18 years of age
- demonstrate the ability to maintain a safe and healthy living environment
- demonstrate knowledge of basic first aid
- demonstrate knowledge of response to fire and emergency situations
- demonstrate ability to implement cognitive and behavioral strategies
- demonstrate ability to function as a member of an interdisciplinary team.

Training requirement
Must have completed an approved training program(s) concerning acquired brain injury and person-centered planning, given by the a state agency, states fiduciary, community providers, Brain Injury Association of CT, or an Independent Living Center.

Verification of Provider Qualifications

Entity Responsible for Verification:

Fiscal Intermediary

Frequency of Verification:

At start of services and at recertification every 2 years.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Community Living Support Services (CLSS)

Provider Category:

Agency

Provider Type:

Rehabilitation Hospital

Provider Qualifications

License *(specify):*

Certificate *(specify):*

JCAHO/CARF certification in community support service and/or brain injury community integrated services, and

Other Standard *(specify):*

Residence must meet all provisions of CT State Building Code, Fire prevention, safety and construction standards.

Verification of Provider Qualifications

Entity Responsible for Verification:

Fiscal Intermediary

Frequency of Verification:

At start of services and at recertification (every two years).

Appendix C: Participant Services

C-1/C-3: Service Specification

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 Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Companion

HCBS Taxonomy:

Category 1: **Sub-Category 1:**

Category 2: **Sub-Category 2:**

Category 3: **Sub-Category 3:**

Service Definition *(Scope):*

Category 4: **Sub-Category 4:**

Non-medical care, supervision and socialization that are provided in accordance with a therapeutic goal included in the service plan. May assist in or supervise such tasks as meal preparation, laundry, or light housekeeping tasks that are incidental to the care and supervision of the individual.

This service is not duplicative of Personal Care Assistance because it does not provide hands-on care. This service is not duplicative of Chore because it does not provide household management tasks.

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

Service is limited to 18 service hours per day.

Service Delivery Method *(check each that applies)*:

☒ **Participant-directed as specified in Appendix E**

☒ **Provider managed**

Specify whether the service may be provided by *(check each that applies)*:

☐ **Legally Responsible Person**

☐ **Relative**

☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Individual	Private household Employee
Agency	Community Integration Services Agency

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Companion

Provider Category:

Individual

Provider Type:

Private household Employee

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

A provider shall:
be at least 18 years of age
be physically able to perform the services required
follow instructions given by the consumer or the consumers conservator
be able to report changes in the consumers condition or needs
maintain confidentiality
have the ability or skills necessary to meet the consumers needs as delineated in the service plan
demonstrate ability to implement cognitive and behavioral strategies
be able to function as a member of an interdisciplinary team
Training requirement:
Has completed an approve training program(s) concerning acquired brain injury and person-centered planning, given by a state agency, the fiduciary, community providers, Brain Injury Association of CT, or an Independent Living Center.

Or meet the qualifications for Independent Living Skills Training

All companions who provide services under this waiver are included in the new collective bargaining agreement whether or not the decide to join the union.

Verification of Provider Qualifications

Entity Responsible for Verification:

Fiscal Intermediary

Frequency of Verification:

At start of services and every two years.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Companion

Provider Category:

Agency

Provider Type:

Community Integration Services Agency

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

A provider shall:
be at least 18 years of age
be physically able to perform the services required
follow instructions given by the consumer or the consumers conservator
be able to report changes in the consumers condition or needs
maintain confidentiality
have the ability or skills necessary to meet the consumers needs as delineated in the service plan
demonstrate ability to implement cognitive and behavioral strategies
be able to function as a member of an interdisciplinary team
Training requirement:
Has completed an approve training program(s) concerning acquired brain injury and person-centered planning, given by a state agency, the fiduciary, community providers, Brain Injury Association of CT, or an Independent Living Center.

Verification of Provider Qualifications

Entity Responsible for Verification:

Fiscal Intermediary

Frequency of Verification:

At start of services and every two years.

Appendix C: Participant Services

C-1/C-3: Service Specification

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 Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Environmental Accessibility Adaptation

HCBS Taxonomy:

Category 1: **Sub-Category 1:**

Category 2: **Sub-Category 2:**

Category 3: **Sub-Category 3:**

Service Definition *(Scope):*

Category 4: **Sub-Category 4:**

Environmental Accessibility Adaptations are physical adaptations to the consumers home that ensure the health, welfare and safety of the consumer, that enhance and promote greater independence, and without which the individual would require institutionalization. Adaptations may include but are not limited to the installation of ramps, widening of doorways, modification of bathroom facilities and specialized electrical and plumbing installations.

All services must be provided in accordance with applicable state or local building codes. Adaptations not covered under the ABI program are improvements which are not of direct medical or remedial benefit to the individual, such as carpeting, central air conditioning, roof repair. In addition, adaptations that add to the square footage of the home are not covered.

Environmental accessibility adaptations may not be furnished to adapt living arrangements that are owned or leased by providers of waiver services

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

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☒ **Provider managed**

Specify whether the service may be provided by *(check each that applies)*:

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Private contractor/business

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Environmental Accessibility Adaptation

Provider Category:

Agency

Provider Type:

Private contractor/business

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

A DORS approved contractor
Home Improvement Registration by the Dept. of Consumer Protection Adheres to State/Local Building Codes.

Verification of Provider Qualifications

Entity Responsible for Verification:

Fiscal Intermediary

Frequency of Verification:

At time of services and every two years

Appendix C: Participant Services

C-1/C-3: Service Specification

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 Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Home-Delivered Meals

HCBS Taxonomy:

Category 1:

Sub-Category 1:

Category 2:

Sub-Category 2:

Category 3: **Sub-Category 3:**

Service Definition *(Scope):*

Category 4: **Sub-Category 4:**

The preparation and home delivery of meals for consumers who are unable to prepare or obtain nourishing meals independently, or when the individual responsible for this activity is temporarily absent or unable to prepare meals.

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

Meals provided shall not include a full nutrition regime (three meals per day).

Service Delivery Method *(check each that applies)*:

☐ **Participant-directed as specified in Appendix E**

☒ **Provider managed**

Specify whether the service may be provided by *(check each that applies)*:

☐ **Legally Responsible Person**

☐ **Relative**

☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Private agency

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Home-Delivered Meals

Provider Category:

Agency

Provider Type:

Private agency

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Must have an approval/contract through DSS, or a contractor of the department to provide home-delivered meals for other existing DSS programs. Reimbursment for home delivered meals shall be available under the ABI Waiver to providers which provide meals that meet a minimum of one-third of the current daily recommended dietary allowance and requirements as established by the Food and Nutrition Board of the National Academy of Sciences National Research Council.

All meals on wheels providers shall provide their menus to the department, contracted agencies or department designee for review and approval. Service providers must be in compliance with the dietary requirements and the requirements for the preparation and storage and delivery of food based on the department policies for the elderly nutrition program and Title (III) of the Older Americans Act.

Verification of Provider Qualifications

Entity Responsible for Verification:

Fiscal Intermediary

Frequency of Verification:

At start of services and at recertification every two years.

Appendix C: Participant Services

C-1/C-3: Service Specification

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 Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Independent Living Skills Training

HCBS Taxonomy:

Category 1:	Sub-Category 1:
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**

Service Definition *(Scope):*

Category 4:	Sub-Category 4:

Services designed and delivered on an individual or group basis to improve the consumers ability to live independently in the community, as well as to carry out strategies developed in Cognitive /Behavioral Programs. Independent Living Skills Training is a teaching service. Specific activities may include assessment and training in: self-care; medication management; task completion; communication and interpersonal skills; socialization, sensory/motor skills; mobility and community transportation skills; problem solving skills; and, money management and ability to maintain a household. Assistance and supervision are not provided under this component.

Services are purchased on an hourly basis and provided in the real world, i.e., in the individuals home, community, environment or specific life situation that calls for intensive assessment and training. Services are provided under this component when the individual has particular difficulty with transferring and generalizing knowledge and skills from one situation to another, as well as to carry-out strategies developed in Cognitive/Behavioral programs by the clinician.

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

Assistance and supervision are not provided under this component. Services may not exceed 12 hours per day

Service Delivery Method *(check each that applies)*:

☒ **Participant-directed as specified in Appendix E**

☒ **Provider managed**

Specify whether the service may be provided by *(check each that applies)*:

☐ **Legally Responsible Person**

☐ **Relative**

☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Individual	Individual private provider
Agency	Rehabilitation Hospital Outpatient Department
Agency	Community Integration Services Agency

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Independent Living Skills Training

Provider Category:

Individual

Provider Type:

Individual private provider

Provider Qualifications

License *(specify)*:

Certificate *(specify)*:

Other Standard *(specify):*

All providers of ILST must meet the following qualifications:
- are at least 18 years of age
- demonstrate the ability to maintain a safe and healthy living environment
- demonstrate knowledge of basic first aid
- demonstrate knowledge of response to fire and emergency situations
- demonstrate ability to implement cognitive and behavioral strategies
- demonstrate ability to function as a member of an interdisciplinary team.

Training requirement
Must have completed an approved training program(s) concerning acquired brain injury and person-centered planning, given by the a state agency, state's fiduciary, community providers, Brain Injury Alliance of CT, or an Independent Living Center.
ILST's must complete a minimum of six hours of continuing education/training on an annual basis to continue to provide ILST services

Verification of Provider Qualifications

Entity Responsible for Verification:

Fiscal Intermediary

Frequency of Verification:

At start of services and at recertification/re-accreditation every 2 years

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Independent Living Skills Training

Provider Category:

Agency

Provider Type:

Rehabilitation Hospital Outpatient Department

Provider Qualifications

License *(specify):*

Certificate *(specify):*

JCAHO

Other Standard *(specify):*

Employee staff who:
are at least 18 years old
have a minimum of a bachelor's degree and one year experience providing services to individuals with brain injuries in the community, and completed training program(s) concerning acquired brain injury and person-centered planning given by a state agency, the fiduciary, community providers, Brain Injury Alliance of CT, or Independent Living Center, or have a high school diploma and two years experience providing services to individuals with brain injuries in the community and completed training program(s) concerning acquired brain injury and person-centered planning given by a state agency, broker agency, community providers, Brain Injury Alliance of CT, or Independent Living Center
demonstrate ability to function as a member of an interdisciplinary team
have documented experience implementing cognitive/behavioral interventions developed by a clinician and utilized in community settings
or, meet qualifications for Cognitive/Behavioral Programs
ILSTs must complete a minimum of six hours of continuing education/training on an annual basis to continue to provide ILST services.

Verification of Provider Qualifications

Entity Responsible for Verification:

Fiscal Intermediary and recertification every two years.

Frequency of Verification:

At start of services and at recertification/re-accreditation every 2 years.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Independent Living Skills Training

Provider Category:

Agency

Provider Type:

Community Integration Services Agency

Provider Qualifications

License *(specify)*:

Certificate *(specify)*:

CARF certification in brain injury and/or Community Support, or JCAHO accreditation for Behavioral Health Care or meets requirements below under other standard

Other Standard *(specify)*:

Employee staff who:
are at least 18 years old
have a minimum of a bachelor's degree and one year experience providing services to individuals with brain injuries in the community, and completed training program(s) concerning acquired brain injury and person-centered planning given by a state agency, the fiduciary, community providers, Brain Injury Alliance of CT, or Independent Living Center, or have a high school diploma and two years experience providing services to individuals with brain injuries in the community and completed training program(s) concerning acquired brain injury and person-centered planning given by a state agency, broker agency, community providers, Brain Injury Alliance of CT, or Independent Living Center
demonstrate ability to function as a member of an interdisciplinary team
have documented experience implementing cognitive/behavioral interventions developed by a clinician and utilized in community settings
or, meet qualifications for Cognitive/Behavioral Programs
ILSTs must complete a minimum of six hours of continuing education/training on an annual basis to continue to provide ILST services.

Verification of Provider Qualifications

Entity Responsible for Verification:

Fiscal Intermediary

Frequency of Verification:

At start of services and at recertification/re-accreditation

Appendix C: Participant Services

C-1/C-3: Service Specification

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 Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Personal Emergency Response Systems (PERS)

HCBS Taxonomy:

Category 1:	Sub-Category 1:
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**

Service Definition *(Scope):*

Category 4: **Sub-Category 4:**

An electronic device that enables certain consumers at high risk of institutionalization to secure help in an emergency; the system may include a portable help button to allow for mobility. The system is connected to the persons telephone and programmed to signal a response center once help button is activated. Trained professionals shall staff the response center. Device installation, upkeep and maintenance are provided. Response center staff are available 24/7. The availability of this service under the ABI waiver is limited to individuals who live alone, or are alone for significant parts of the day, and who have no regular caregiver and who would otherwise require extensive routine supervision.

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

Service Delivery Method *(check each that applies)*:

☐ **Participant-directed as specified in Appendix E**

☒ **Provider managed**

Specify whether the service may be provided by *(check each that applies)*:

☐ **Legally Responsible Person**

☐ **Relative**

☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Vendors Who Sell and Install Appropriate Equipment

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Personal Emergency Response Systems (PERS)

Provider Category:

Agency

Provider Type:

Vendors Who Sell and Install Appropriate Equipment

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Vendor that meets the criteria to be a DSS as a performing provider.

Verification of Provider Qualifications

Entity Responsible for Verification:

Fiscal Intermediary

Frequency of Verification:

At start of service

Appendix C: Participant Services

C-1/C-3: Service Specification

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 Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Substance Abuse Programs

HCBS Taxonomy:

Category 1:	Sub-Category 1:
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

Services provided on an outpatient basis are individually designed interventions to reduce or eliminate the use of alcohol and/or drugs by the individual, when such behaviors may interfere with their ability to remain in the community. Substance abuse programs shall include: an in-depth assessment of the interrelationship of the individuals abuse of substances and brain injury; a learning/behavioral assessment; development of a structured treatment plan; implementation of the plan; on-going education and training of the individual, family members, care-givers and other service providers around participant-specific sequelae; individualized relapse strategies; periodic reassessment of the plan; and, on-going support to the individual.

Substance abuse programs shall be provided on an outpatient basis in a congregate setting or the individuals community. The individuals particular substance abuse plan may include both group and individual interventions and shall reflect the use of curricula and materials adopted from a traditional substance abuse program designed to meet the needs of individuals with traumatic brain injury. The substance abuse program provider shall communicate treatment regimens with all of the individuals other service providers.

Linkages to existing community-based, self-help/support groups, such as Alcoholics Anonymous and secular organizations for sobriety, shall be part of the treatment plan.

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

4 hours per day

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☒ **Provider managed**

Specify whether the service may be provided by *(check each that applies)*:

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Individual	Self-Employed Private Providers (i.e., Licensed Psychologists, Certified Alcohol and Drug Counselors)
Agency	Substance Abuse Diagnostic and Treatment Centers
Agency	Rehabilitation Hospitals

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Substance Abuse Programs

Provider Category:

Individual

Provider Type:

Self-Employed Private Providers (i.e., Licensed Psychologists, Certified Alcohol and Drug Counselors)

Provider Qualifications

License *(specify)*:

Certified Alcohol and Drug Counselor
Licensed Clinical Social Worker
Licensed Pyschologists

Certificate *(specify)*:

State of CT Department of Public Health (if private facility)

Other Standard *(specify)*:

At least 1 year experience in assessment and treatment of individuals with brain injury and substance abuse
Ability to develop linkages with community support programs

Ability to work as a member of an interdisciplinary team.

Verification of Provider Qualifications

Entity Responsible for Verification:

Fiscal Intermediary

Frequency of Verification:

At start of service and recertification, every two years

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Substance Abuse Programs

Provider Category:

Agency

Provider Type:

Substance Abuse Diagnostic and Treatment Centers

Provider Qualifications

License *(specify)*:

State of CT Department of Public Health (if private facility) and

Certificate *(specify)*:

JCAHO (if public facility) and

Other Standard *(specify)*:

Complete training concerning acquired brain injury given by a state agency, the fiduciary, community provider, Brain Injury Alliance of CT or Independent Living Centers.

Verification of Provider Qualifications

Entity Responsible for Verification:

Fiscal Intermediary

Frequency of Verification:

At start of services and recertification every two years

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Substance Abuse Programs

Provider Category:

Agency

Provider Type:

Rehabilitation Hospitals

Provider Qualifications

License *(specify):*

Certificate *(specify):*

JCAHO and

Other Standard *(specify):*

Staff with at least one year experience in providing services to individuals with brain injury and substance abuse issues.

Verification of Provider Qualifications

Entity Responsible for Verification:

Fiscal Intermediary

Frequency of Verification:

At start of services and recertification, every two years.

Appendix C: Participant Services

C-1/C-3: Service Specification

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 Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Transitional Living Services

HCBS Taxonomy:

Category 1: **Sub-Category 1:**

Category 2: **Sub-Category 2:**

Category 3: **Sub-Category 3:**

Service Definition *(Scope)*:

Category 4: **Sub-Category 4:**

Individualized, short-term, residential services providing up to 24-hour support and designed to improve the individuals skills and ability to live in the community. Services include assessment, training, supervision and assistance to an individual in the areas of: self care; medication management; communication and interpersonal skills; socialization; sensory/motor skills; mobility and community transportation skills; problem solving skills; money management and ability to maintain a household.

Transitional living services shall be provided only when the individual is unable to be supported in a permanent residence and is in need of intensive clinical interventions provided by this service.

Transitional living services may be provided only once and are expected to meet all of the ABI waiver service and support needs of the individual.

Prior to discharge from transitional living, the provider shall work with the individual and the case manager to develop a community living plan of care. Upon discharge, other ABI purchasable services shall become available to the individual in accordance with the revised service plan.
No ABI waiver funds shall be expended on the room and board component of transitional living services. The waiver service is completely separate from any consideration of room and board. The intent of this services is to step-down from higher level of care.

Mutually Exclusive Services: Cannot be provided with any services EXCEPT for
Case Management, Environmental Modifications, Specialized Medical Equipment and Vehicle Modifications

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

Services are limited to consumers who are unable to be supported in a permanent residence, and who is in need of intensive clinical interventions provided by this service. These services may be provided only once and are expected to meet all of the ABI waiver service and support needs of the individual.

Service Delivery Method *(check each that applies)*:

☐ **Participant-directed as specified in Appendix E**
☒ **Provider managed**

Specify whether the service may be provided by *(check each that applies)*:

☐ **Legally Responsible Person**
☐ **Relative**
☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Agency Provider
Agency	Rehabilitation Hospital

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Transitional Living Services

Provider Category:

Agency

Provider Type:

Agency Provider

Provider Qualifications

License *(specify):*

State of CT Dept. of Health Services

Certificate *(specify):*

CARF certification in brain injury, or
JCAHO and Accreditation for Behavioral Health Care, or

Other Standard *(specify):*

Residence must meet all provisions of CT State Building Code, fire prevention, safety and construction standards.

Verification of Provider Qualifications

Entity Responsible for Verification:

Fiscal Intermediary

Frequency of Verification:

At start of services and at re-certification/accreditation every 2 years.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Transitional Living Services

Provider Category:

Agency

Provider Type:

Rehabilitation Hospital

Provider Qualifications

License *(specify):*

State of CT Dept. of Health Services

Certificate *(specify):*

JCAHO, and

Other Standard *(specify):*

Residence must meet all provisions of CT State Building Code, fire prevention, safety and construction standards

Verification of Provider Qualifications

Entity Responsible for Verification:

Fiscal Intermediary

Frequency of Verification:

At start of services and at re-certification/accreditation every 2 years.

Appendix C: Participant Services

C-1/C-3: Service Specification

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 Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Transportation

HCBS Taxonomy:

Category 1:	Sub-Category 1:
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**

Service Definition *(Scope):*

Category 4:	Sub-Category 4:

Transportation consists of mobility services offered in accordance with the individuals service plan to allow him or her to access ABI waiver services. ABI funds may not be used for this purpose when public transportation is available or when friends, family, neighbors and/or community agencies are able to provide transportation free of charge. All reasonable transportation alternatives must be explored prior to receiving approval for ABI transportation services.

Transportation may be provided by a family member between home and a waiver-funded vocational setting when transportation is not otherwise available and is the most cost-effective alternative.

When authorized, this service is in addition to medical transportation services required under 42CFR 440.170(a), if applicable, and shall not replace them.

The following are specifically excluded: 1) adaptations or improvements to the vehicle that are of general utility, and are not of direct medical or remedial benefit to the individual; 2) purchase or lease of a vehicle; and 3) regularly scheduled upkeep and maintenance of a vehicle except upkeep and maintenance of the modifications.

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

ABI funds may not be used for this purpose when public transportation is available or when friends, family, and/or community agencies are able to provide transportation free of charge.

Service Delivery Method *(check each that applies)*:

☒ **Participant-directed as specified in Appendix E**

☒ **Provider managed**

Specify whether the service may be provided by *(check each that applies)*:

☐ **Legally Responsible Person**

☐ **Relative**

☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Individual	Individual Provider
Agency	Private transportation service
Agency	Adult Day Health provider

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Transportation

Provider Category:

Individual

Provider Type:

Individual Provider

Provider Qualifications

License *(specify)*:

Valid driver's license

Certificate *(specify)*:

Other Standard *(specify):*

The provider must possess a valid CT driver's license and provide evidence of automobile insurance.

Verification of Provider Qualifications

Entity Responsible for Verification:

Fiscal Intermediary

Frequency of Verification:

At approval; and when license and insurance are due for renewal or expiration every two years.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Transportation

Provider Category:

Agency

Provider Type:

Private transportation service

Provider Qualifications

License *(specify):*

DOT livery license

Certificate *(specify):*

Other Standard *(specify):*

Subcontractor for Medicaid Transportation Brokers
The provider must possess a valid CT driver's license and provide evidence of automobile insurance.

Verification of Provider Qualifications

Entity Responsible for Verification:

Fiscal Intermediary

Frequency of Verification:

At approval; when license and insurance are due for renewal or expiration.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Transportation

Provider Category:

Agency

Provider Type:

Adult Day Health provider

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Certified by CT Association of Adult Day Programs. Certification is valid for 3 years.

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

Fiscal Intermediary

Frequency of Verification:

At time of enrollment and every two years thereafter.

Appendix C: Participant Services

C-1/C-3: Service Specification

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 Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Vehicle Modification Services

HCBS Taxonomy:

Category 1:	Sub-Category 1:

Category 2:	Sub-Category 2:

Category 3: **Sub-Category 3:**

Service Definition *(Scope):*

Category 4: **Sub-Category 4:**

Alterations made to a vehicle, which is the individuals primary means of transportation when such modifications are necessary to improve the waiver participants 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.

"The following are specifically excluded: 1) adaptations or improvements to the vehicle that are of general utility, and are not of direct medical or remedial benefit to the individual; 2) purchase or lease of a vehicle; and 3) regularly scheduled upkeep and maintenance of a vehicle except upkeep and maintenance of the modifications.

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

Total Annual Individual Cost Limit $10,000.00

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☒ **Provider managed**

Specify whether the service may be provided by *(check each that applies)*:

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Private contractor/businesses that meet the qualifications listed below

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Vehicle Modification Services

Provider Category:

Agency

Provider Type:

Private contractor/businesses that meet the qualifications listed below

Provider Qualifications

License *(specify):*

DMV dealers and/or repairers license

Certificate *(specify):*

Other Standard *(specify):*

Must be an approved State of Connecticut Bureau of Rehabilitation Services vendor.

Verification of Provider Qualifications

Entity Responsible for Verification:

Fiscal Intermediary

Frequency of Verification:

At time of service with recertification every two years.

Appendix C: Participant Services

C-1: Summary of Services Covered (2 of 2)

b. Provision of Case Management Services to Waiver Participants. Indicate how case management is furnished to waiver participants (*select one*):

- ○ **Not applicable** - Case management is not furnished as a distinct activity to waiver participants.
- ◉ **Applicable** - Case management is furnished as a distinct activity to waiver participants.

  Check each that applies:

  - ☐ **As a waiver service defined in Appendix C-3.** *Do not complete item C-1-c.*
  - ☐ **As a Medicaid state plan service under §1915(i) of the Act (HCBS as a State Plan Option).** *Complete item C-1-c.*
  - ☐ **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.*
  - ☐ **As a primary care case management system service under a concurrent managed care authority.** *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:

DSS issued an RFP for providers of administrative case management. The selected contractors will perform comprehensive assessments, develop service plans, and monitor the effectiveness of the service plan. The case manager will also serve as the team leader in all team meetings.
The administratively claimed case management will incorporate the functions that were provided by the waiver service provider until 6/1/16 resulting in no diminution of support to the waiver participant. The case manager would be required to hold a Masters degree in social work, human services, Counseling or Rehabilitation Counseling. If the degree is in social work, LCSW or LMSW licensure is required. The case manager may also be a nurse with a minimum of a bachelor's degree. The agency that provides the case management must have a minimum of 5 years experience in the provision of case management in a home and community based setting and the individual case manager must have at least two years of case management experience in health care or human services settings. Additionally the case manager must have the ability to serve multicultural, multilingual populations; and the skill set to lead and facilitate the Care Team that includes the participant's team of providers and supporters, and reach consensus on the Service Plan. When selecting the contractors from the responses to the procurement, the department will assign a higher points value to those respondents that have experience working with persons with acquired brain injuries.
All new contractors will be provided with a comprehensive initial training program presented by clinicians working with persons with brain injuries. Over the course of the first year, two additional training programs will be required of all contractors. The Brain Injury Alliance of CT will provide these training programs.

Appendix C: Participant Services

C-2: General Service Specifications (1 of 3)

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):

○ **No. Criminal history and/or background investigations are not required.**

◉ **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):

DSS requires any persons serving as household employees* providing companion, independent living skills training and transportation services to a consumer submit to a State of Connecticut criminal background check.

DSS has the discretion to refuse payments for household employees performing services who have been convicted of a felony, as defined in section 53a-25 of the Connecticut General Statutes, involving forgery under section 53a-137 of the Connecticut General Statutes; robbery under section 53a-133 of the Connecticut General Statutes; larceny under sections 53a-119, 53a-122, 53a-123 and 53a-124 of the Connecticut General Statutes; or of a violation of section 53a-290 to 53a-296, inclusive of the Connecticut General Statutes; involving vendor fraud, section 53-20 of the Connecticut General Statutes involving cruelty to persons; sections 53a-70, 53a-70a, 53a-70b, 53a-71, 53a-72a, 53a-72b, or 53a-73a of the Connecticut General Statutes involving sexual assault; section 53a-59 of the Connecticut General Statutes involving assault; section 53a-59a of the Connecticut General Statutes involving assault of an elderly, blind, disabled, pregnant or mentally retarded person; and sections 53a-320 to 53a-323, inclusive, of the Connecticut General Statutes involving abuse of elderly, blind, disabled or mentally retarded persons.
This review is carried out by the fiduciary intermediary in which the contract requires that as part of consideration for employment by any ABI Waiver participant, they process background checks for Household Employee Provider Registry applicants upon submission of the Provider Registry application.. The nature of the criminal activity revealed by the background check, including but not limited to check fraud, theft, abuse, or assault may result in disqualification from continued enrollment in the Provider Registry, and consideration for employment by any ABI Waiver participant.

DSS will conduct an annual audit involving a sample of FI records to ensure criminal background checks and other required documents are on file.

*Household Employees: providers who perform chore, companion, homemaker, transportation, independent living skills training and respite services and who are not employed by an agency and are directly hired by the waiver participant who assumes responsibility for hiring, firing , training and supervision of the employee.

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):

- ◉ **No. The state does not conduct abuse registry screening.**
- ○ **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):

Appendix C: Participant Services

C-2: General Service Specifications (2 of 3)

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

- ◉ **No. Home and community-based services under this waiver are not provided in facilities subject to §1616(e) of the Act.**
- ○ **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).**

Appendix C: Participant Services

C-2: General Service Specifications (3 of 3)

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-1/C-3 the personal care or similar services for which payment may be made to legally responsible individuals under the state policies specified here.*

☐ **Self-directed**

☐ **Agency-operated**

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-1/C-3 each waiver service for which payment may be made to relatives/legal guardians.*

○ **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-1/C-3.**

Specify the controls that are employed to ensure that payments are made only for services rendered.

○ **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:

The Connecticut Department of Social Services contracts with a fiscal intermediary to conduct outreach activities in order to increase awareness of the ABI Waiver Program within the provider community and to recruit qualified providers to serve the ABI population. ABI Waiver Service Provider information is posted on the Fiscal Intermediarys Website. The Department establishes qualifications for each provider type, and publishes the qualifications in the Departments ABI Waiver Program Provider Manual. Outreach activities include:
1. Identifying those areas of the state in which service deficits exist;

2. Tailoring outreach approaches to best recruit the types of providers most needed to serve the ABI population on a regional and statewide basis;

3. Conducting at least one outreach session every twelve months in each of the Departments three regions during the contract period;

4. Conducting at least one community service provider outreach session each quarter during the contract period;

5. Utilizing appropriate methods to publicize outreach activities including but not limited to newsletters, individual contacts, direct mailings, print or other media advertisements, or other methods of communication as appropriate to each activity; and

6. Maintaining a log of potential providers who attend each activity or who are contacted through the outreach effort, including the date and place of each activity, the number of individuals who attend or are contacted, the number of individuals who subsequently participate in training, and the number of individuals, by specialty type, subsequently enrolled as Qualified Providers.

Appendix C: Participant Services

Quality Improvement: Qualified Providers

As a distinct component of the States quality improvement strategy, provide information in the following fields to detail the States methods for discovery and remediation.

a. Methods for Discovery: Qualified Providers

The state demonstrates that it has designed and implemented an adequate system for assuring that all waiver services are provided by qualified providers.

i. Sub-Assurances:

a. ***Sub-Assurance: The State verifies that providers initially and continually meet required licensure and/or certification standards and adhere to other standards prior to their furnishing waiver services.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance, complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the

method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Number and percent of waiver providers reviewed for ongoing licensure/certification and credentialing standards. Numerator= number of providers reviewed
Denominator= total number of providers

Data Source (Select one):
Reports to State Medicaid Agency on delegated Administrative functions
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☒ **Other** Specify: Fiscal Intermediary	☐ **Annually**	☐ **Stratified** Describe Group:
	☒ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☒ **Quarterly**
☒ **Other** Specify: Fiscal Intermediary	☐ **Annually**
	☐ **Continuously and Ongoing**
	☒ **Other** Specify: Every two years

Performance Measure:
Number and percent of providers, by provider type, meeting provider training requirements. Numerator= number of providers meeting training requirements Denominator=total number of providers

Data Source (Select one):
Training verification records
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☒ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☒ **Other** Specify: Fiscal Intermediary	☐ **Annually**	☐ **Stratified** Describe Group:

	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☒ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Number and percent of waiver providers meeting licensure/certification standards prior to delivery of services. Numerator= number of providers meeting certification standards Denominator= number of providers

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

Responsible Party for	**Frequency of data**	**Sampling Approach**

data collection/generation *(check each that applies):*	**collection/generation** *(check each that applies):*	*(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☒ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☒ **Other** Specify: Fiscal Intermediary	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☒ **Quarterly**
☒ **Other** Specify: Fiscal Intermediary	☐ **Annually**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

b. ***Sub-Assurance: The State monitors non-licensed/non-certified providers to assure adherence to waiver requirements.***

For each performance measure the State will use to assess compliance with the statutory assurance, complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Number and percent of waiver providers initially meeting waiver credentialing standards prior to delivery of services. Numerator=number of providers credentialed Denominator=number of providers

Data Source (Select one):
Reports to State Medicaid Agency on delegated Administrative functions
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☒ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☒ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:

Fiscal Intermediary		
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☒ **Quarterly**
☒ **Other** Specify:	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Number and percent of non-licensed/non-certified waiver providers that continuously meet waiver credentialing standards. Numerator= number of providers meeting ongoing credentialing requirements Denominator= total number of providers

Data Source (Select one):
Reports to State Medicaid Agency on delegated Administrative functions
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☒ **Other** Specify: Fiscal Intermediary	☐ **Annually**	☐ **Stratified** Describe Group:
	☒ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☒ **Quarterly**
☒ **Other** Specify:	☐ **Annually**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
Fiscal Intermediary	
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

c. ***Sub-Assurance: The State implements its policies and procedures for verifying that provider training is conducted in accordance with state requirements and the approved waiver.***

For each performance measure the State will use to assess compliance with the statutory assurance, complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Number and Percent of waiver providers who complete pre-requisite training prior to service provision. Numerator= number of providers completing training Denominator= number of providers

Data Source (Select one):
Training verification records
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☒ **Quarterly**	☐ **Representative Sample** Confidence Interval =

☒ **Other** Specify: Fiscal Intermediary	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☒ **Quarterly**
☒ **Other** Specify: Fiscal Intermediary	☐ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

The fiscal intermediary provides quarterly documentation of outreach activities to recruit (Providers) for the registry and the result of the outreach efforts. Additionally, the fiscal intermediary has a Program Compliance Supervisor who investigates potential fraud claims and provides the Department with a written summary and report of all claims.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the States method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the state to document these items.

An assigned CO staff member serves as the quality assurance officer for the ABI Waiver program. She/He has daily contact with the fiscal intermediary with the purpose of resolving any discrepancies or issues related to contract compliance. For example, if a consumer calls with a complaint that they were not trained on the managing of their employees, he would be in contact with fiscal intermediary to resolve the complaint. If any case manager believes a report to be potential fraud, it is referred to a Program Manager who decides if it should be referred to the Fraud and Recoveries Unit. Any correspondence done in written form is retained for future reference.

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☒ **Quarterly**
☒ **Other** Specify: Fiscal Intermediary	☐ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Qualified Providers that are currently non-operational.

◉ **No**

○ **Yes**

Please provide a detailed strategy for assuring Qualified Providers, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix C: Participant Services

C-3: Waiver Services Specifications

Section C-3 'Service Specifications' is incorporated into Section C-1 'Waiver Services.'

Appendix C: Participant Services

C-4: Additional Limits on Amount of Waiver Services

a. Additional Limits on Amount of Waiver Services. Indicate whether the waiver employs any of the following additional limits on the amount of waiver services (*select one*).

◉ **Not applicable**- The state does not impose a limit on the amount of waiver services except as provided in Appendix C-3.

○ **Applicable** - The state imposes additional limits on the amount of waiver services.

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; (f) how participants are notified of the amount of the limit. (*check each that applies*)

☐ **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.

☐ **Other Type of Limit.** The state employs another type of limit.
Describe the limit and furnish the information specified above.

Appendix C: Participant Services

C-5: Home and Community-Based Settings

Explain how residential and non-residential settings in this waiver comply with federal HCB Settings requirements at 42 CFR 441.301(c)(4)-(5) and associated CMS guidance. Include:

1. Description of the settings and how they meet federal HCB Settings requirements, at the time of submission and in the future.

2. Description of the means by which the state Medicaid agency ascertains that all waiver settings meet federal HCB Setting requirements, at the time of this submission and ongoing.

Note instructions at Module 1, Attachment #2, HCB Settings Waiver Transition Plan for description of settings that do not meet requirements at the time of submission. Do not duplicate that information here.

See Main Attachment #2.
The department has completed its survey process of ABI Waiver services and provider owned and controlled homes. The results identified some discrepancies in the responses between the providers and the participants so the department has determined that it is necessarily to do on site evaluations of the residential and non residential settings. Most of the non residential visits have been done and the findings are still being complied and analyzed. Within the next 60 days the state will complete the on site evaluations of the provider owned and controlled homes.