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

PURPOSE OF THE HCBS WAIVER PROGRAM

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

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

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:
Home and Community Based Services Waiver for Elders

C. Waiver Number:CT.0140
Original Base Waiver Number: CT.0140.

D. Amendment Number:

E. Proposed Effective Date: (mm/dd/yy)
11/12/23
Approved Effective Date of Waiver being Amended: 07/01/20

2. Purpose(s) of Amendment

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

The intent of these amendments is to transfer the temporary authority of already approved Appendix K provisions to the permanent authorities under this Medicaid waiver. All provisions were previously approved by the Connecticut General Assembly and CMS.

Appendix K provisions are temporary and expire six months following the expiration of the federal public health emergency related to the continued consequences of the Coronavirus Disease (COVID-19) pandemic, in November 2023.

The provisions must be amended into the permanent Medicaid Waivers to ensure the ability to execute section 9817 of the American Rescue Plan Act (ARPA) throughout the ARPA period until March 2025 and to incorporate flexibilities that will be retained in permanent authority that were authorized during public health emergency.

Addition of a new service titled “Training and Counseling Services for Unpaid Caregivers Supporting Participants” for all waivers referenced above. This service is an inter-professional model delivered through a structured number of visits by a team comprised of a Care of Persons with Dementia in their Environments (COPE) certified occupational therapist (OT) and a COPE certified registered nurse (RN) to a participant as defined in the participant’s person-centered plan. The service may include assessment and the development of a home treatment/support/action plan for this service, training and technical assistance to carry out the plan and monitoring of the individual and implementation of the service action plan. For participants without a dementia diagnosis, the service is referred to as “Confident Caregiver.”

Addition of a new service titled “Participant Training and Engagement to Support Goal Attainment and Independence.” This service implements services to the member utilizing the Community Aging in Place, Advancing Better Living for Elders (CAPABLE) program model. The CAPABLE program is a set of highly individualized, person-centered services that use the strengths of the participant to improve her/his safety and independence. The CAPABLE program services engage participants to develop action plans with the aim of achieving goals related to increasing functional independence, improving safety, decreasing depression and improving motivation as defined in the person-centered plan.

Addition of Remote Support as a new service (Request for temporary Appendix K authority is still under final review by CMS). This service includes the provision of supports by staff at a remote location who are engaged with the individual through technology/devices with the capability for live two-way communication. Individual interaction with the staff person may be scheduled, on-demand, or in response to an alert from a device in the remote support equipment system. Associated changes include expanding the list of authorized providers of PCA services to include adult day providers and remote support providers, adding certified community hubs as authorized provider types, and the addition of new rates for unscheduled back-up PCA services and remote live PCA services.

The Department is proposing to modify its expiring temporary authority that permits:
1. Mental health counseling to be provided virtually or telephonically into permanent authority to provide such counseling virtually, but not telephonically.
2. Adult Day programs to provide virtual services via video communication, including virtual assessments, and at least two meals per day, into permanent authority to allow Remote Services (virtual support) when a client is unable to attend the center in person. The absence may be due to symptoms of contagious illness; injury, illness or recovery from such; exacerbation of a chronic condition; or inclement weather. The adult day center must, at a minimum, provide a documented wellness call, and delivery of two meals per day.

Value based payments will be added to this waiver

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**	

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

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*):

Home and Community Based Services Waiver for Elders

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.0140
Draft ID: CT.020.07.02

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

Regular Waiver

E. Proposed Effective Date of Waiver being Amended: 07/01/20
Approved Effective Date of Waiver being Amended: 07/01/20

PRA Disclosure Statement

The purpose of this application is for states to request a Medicaid Section 1915(c) home and community-based services (HCBS) waiver. Section 1915(c) of the Social Security Act authorizes the Secretary of Health and Human Services to waive certain specific Medicaid statutory requirements so that a state may voluntarily offer HCBS to state-specified target group(s) of Medicaid beneficiaries who need a level of institutional care that is provided under the Medicaid state plan. Under the Privacy Act of 1974 any personally identifying information obtained will be kept private to the extent of the law.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0449 (Expires: December 31, 2023). The time required to complete this information collection is estimated to average 160 hours per response for a new waiver application and 75 hours per response for a renewal application, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

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:

○ **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:

The state is requesting a 1915b(4) concurrent with this submission for selective contracting for the provision of the care management service.
The concurrent 1915(b)(4) is on Temporary Extension (TE) and the selective contracting remains in effect as long as the b(4) authority remains in effect.

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.

The Department of Social Services, as the state Medicaid agency pursuant to CT General Statutes (CGS) 17b-1, operates the Home and Community Based Services Waiver according to CGS 17b-342 for individuals age 65 and over to enable frail elders to be deinstitutionalized or diverted from nursing home placement. The Department's Community Options Unit administers the waiver, accepts applications, does the initial level of care determination and refers the client to a contracted case management provider for the initial evaluation, confirmation of the level of care and development of the service plan. DSS is responsible for determining both financial and functional eligibility for the waiver.

The case management providers maintain ongoing contact with the clients and are required to do semi-annual face to face evaluations with the comprehensive evaluation being required annually. The case management organizations are also responsible for loading authorized service plans into the MMIS contractor portal so that enrolled providers can bill directly but only for services authorized as part of the care plan. The department contracts with a fiscal intermediary to credential the waiver providers. Providers then enroll directly with the Department. Their reenrollment is required every 2 years. Quality assurance and improvement activities are conducted by both the care management agencies and the Department. The Department has extensive reporting requirements of the case management agencies including quarterly quality assurance summaries.

Services provided by the waiver include Case Management, Homemaker, Adult Family Living/Foster Care, Companion, Chore, Adult Day Health,Personal Emergency Response Systems, Personal Care (Agency based), Assistive Technology, Respite, Transportation, Home Delivered Meals, Mental Health Counseling, Personal Care Assistant, Assisted Living, Bill Payer, Care Transitions, Chronic Disease Self Management, Recovery Assistant and Environmental Accessibility Adaptations. Personal Care Assistant will be available to clients either as a self directed model through the state's 1915(k) option or through an agency as a waiver service.

We are removing Independent Support Broker as a service under this waiver as the service is available as needed under the state's Community First Choice 1915(k) option. No waiver participants will be negatively impacted by this change.

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:

Notice was published in the CT Law Journal on December 31,2019.This is a statewide publication and is available to anyone who chooses to subscribe. It is a state register equivalent to the federal register In addition to the CT law Journal posting, the Department posted the renewal notice on its web site on January 02, 2020 under Partners and vendors and can be seen at the following link:

https://portal.ct.gov/DSS/Health-And-Home-Care/Medicaid-Waiver-Applications/Medicaid-Waiver-Applications

No comments were received from the postings.

The Ct tribes were notified via email on December 20,2019. They did not have any comments

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 Home and Community Based Services Unit

Agency: Department of Social Services

Address: 55 Farmington Ave.

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:

Independent support Broker is available under the state's 1915(k) in the scope, frequency and duration necessary to address the individual's need for support in self direction. No individuals will lose services as a result of this change.

The state assures that this waiver amendment or renewal will be subject to any provisions or requirements included in the state's most recent and/or approved home and community-based settings Statewide Transition Plan. The state will implement any required changes by the end of the transition period as outlined in the home and community-based settings Statewide Transition Plan.

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 this waiver amendment or renewal will be subject to any provisions or requirements included in the state's approved home and community-based settings Statewide Transition Plan. The state will implement any required changes by the end of the transition period as outlined in the home and community-based settings Statewide Transition Plan."

Additional Needed Information (Optional)

Provide additional needed information for the waiver (optional):

Appendix A: Waiver Administration and Operation

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

◉ **The waiver is operated by the state Medicaid agency.**

Specify the Medicaid agency division/unit that has line authority for the operation of the waiver program *(select one)*:

◉ **The Medical Assistance Unit.**

Specify the unit name:

Community Options Unit Unit

(Do not complete item A-2)

○ **Another division/unit within the state Medicaid agency that is separate from the Medical Assistance Unit.**

Specify the division/unit name. This includes administrations/divisions under the umbrella agency that has been identified as the Single State Medicaid Agency.

(Complete item A-2-a).

○ **The waiver is operated by a separate agency of the state that is not a division/unit of the Medicaid agency.**

Specify the division/unit name:

In accordance with 42 CFR §431.10, the Medicaid agency exercises administrative discretion in the administration and supervision of the waiver and issues policies, rules and regulations related to the waiver. The interagency agreement or memorandum of understanding that sets forth the authority and arrangements for this policy is available through the Medicaid agency to CMS upon request. *(Complete item A-2-b).*

Appendix A: Waiver Administration and Operation

2. Oversight of Performance.

a. Medicaid Director Oversight of Performance When the Waiver is Operated by another Division/Unit within the State Medicaid Agency. When the waiver is operated by another division/administration within the umbrella agency designated as the Single State Medicaid Agency. Specify (a) the functions performed by that division/administration (i.e., the Developmental Disabilities Administration within the Single State Medicaid Agency), (b) the document utilized to outline the roles and responsibilities related to waiver operation, and (c) the methods that are employed by the designated State Medicaid Director (in some instances, the head of umbrella agency) in the oversight of these activities:
As indicated in section 1 of this appendix, the waiver is not operated by another division/unit within the State Medicaid agency. Thus this section does not need to be completed.

b. Medicaid Agency Oversight of Operating Agency Performance. When the waiver is not operated by the Medicaid agency, specify the functions that are expressly delegated through a memorandum of understanding (MOU) or other written document, and indicate the frequency of review and update for that document. Specify the methods that the Medicaid agency uses to ensure that the operating agency performs its assigned waiver operational and administrative functions in accordance with waiver requirements. Also specify the frequency of Medicaid agency assessment of operating agency performance:
As indicated in section 1 of this appendix, the waiver is not operated by a separate agency of the State. Thus this section does not need to be completed.

Appendix A: Waiver Administration and Operation

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

◉ **Yes. Contracted entities perform waiver operational and administrative functions on behalf of the Medicaid agency and/or operating agency (if applicable).**
Specify the types of contracted entities and briefly describe the functions that they perform. *Complete Items A-5 and A-6.:*

The department contracts with Access Agencies as defined in CGS 17b-342(b). The Access Agency is required to hire appropriate staff to perform case management functions. The case managers conduct the initial assessment of the client for the purpose of developing a comprehensive plan of care and confirming the level of care determination that has been made by Department staff. Once the initial plan is developed, department approval of the plan is required. From that point forward, the Access Agency can modify plans as long as the plan remains within the nursing home cost cap. The Access Agency performs a supervisory level review of service plans. As part of the case management process, the Access Agency is responsible for evaluating the utilization of the authorized services. The Access Agencies have extensive quality assurance and quality improvement plans in place. The plans are presented to the Department for review at the time the contract is awarded. Access Agencies are required to conduct a quality survey utilizing the HCBS CAHPS tool on a representative sample of waiver participants

The Department's fiscal intermediary credentials the providers who wish to be enrolled as a waiver service provider. The direct service waiver providers will directly enroll with the Department's MMIS contractor and bill the waiver service claims directly through a portal developed by the MMIS contractor where the claim is compared to the authorized service plan. This occurs only after the provider has been credentialed by the fiscal intermediary. The contract for the Access Agencies and the fiscal intermediary were both awarded as the result of a competitive procurement. Electronic Visit Verification was implemented for providers in this waiver effective January 1, 2017.

○ **No. Contracted entities do not perform waiver operational and administrative functions on behalf of the Medicaid agency and/or the operating agency (if applicable).**

Appendix A: Waiver Administration and Operation

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

◉ **Not applicable**

○ **Applicable** - Local/regional non-state agencies perform waiver operational and administrative functions. Check each that applies:

☐ **Local/Regional non-state public agencies** perform waiver operational and administrative functions at the local or regional level. There is an **interagency agreement or memorandum of understanding** between the State and these agencies that sets forth responsibilities and performance requirements for these agencies that is available through the Medicaid agency.

Specify the nature of these agencies and complete items A-5 and A-6:

☐ **Local/Regional non-governmental non-state entities** conduct waiver operational and administrative functions at the local or regional level. There is a contract between the Medicaid agency and/or the operating agency (when authorized by the Medicaid agency) and each local/regional non-state entity that sets forth the responsibilities and performance requirements of the local/regional entity. The **contract(s)** under which private entities conduct waiver operational functions are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Specify the nature of these entities and complete items A-5 and A-6:

Appendix A: Waiver Administration and Operation

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

conducting waiver operational and administrative functions:

The Department of Social Services Community Options unit is responsible for overseeing the contractual operations of the Access Agencies. This is done through on site administrative reviews as well as clinical record reviews, client and provider visits and consumer satisfaction surveys. Monitoring of reporting requirements takes place on a monthly basis. The Department's Division of Quality Assurance also conducts regular audits to ensure the Access Agencies' compliance with billing and claims submission. The state also monitors the fiscal intermediary via reports and on site audits by the Department's Quality Assurance division.

Appendix A: Waiver Administration and Operation

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

The Department oversees performance of contracted entities by conducting comprehensive client record reviews through onsite or desk audit reviews. These reviews monitor access agency compliance with state and federal law in additon to contractual compliance. The Department reviews 100% of assessment outcomes on new client admissions to the program to verify level of care and authorize the service plan. The Department manages the waiver expenditures against the approved levels by utilizing paid claims data reports from our data warehouse. Our ability to do this has been enhanced by the creation of the MMIS portal through which all service authorizations and claims flow. Both Department HCBS staff and Access Agency staff assume responsibility for utilization management functions. All new Total Plans of Care and a sample of reassessment Total Plans of Care are reviewed by Community options Unit staff nurses. Additionally, Community Options staff conduct record audits of the Access Agencies' participant records and the appropriateness of the Total Plan of Care is compared to the identified needs. Access Agency supervisors do ongoing utilization review as they review clinical records. The Department has a formal reporting process for the Access Agencies to report the data captured in the supervisory record reviews. As new providers are seeking enrollment as a waiver provider, the fiscal intermediary reviews the application and determines if the provider meets the qualifications to be a waiver provider. They then facilitate the application through the Department's provider enrollment process. The final decision on enrollment is made by the Department's Quality Assurance staff who ensure that all qualifications are met. The Access Agencies and fiscal intermediary are also contractually obligated to provide reports to the Department either monthly, quarterly, semiannually or annually.

Quality assurance reports to the Department from the Access Agencies are reviewed by Department staff for trends and the possible need for remediation. Receipt of the reports is tracked by Community Options staff. Appropriate remedial actions are taken if needed.

Appendix A: Waiver Administration and Operation

7. **Distribution of Waiver Operational and Administrative Functions.** In the following table, specify the entity or entities that have responsibility for conducting each of the waiver operational and administrative functions listed (*check each that applies*):
In accordance with 42 CFR §431.10, when the Medicaid agency does not directly conduct a function, it supervises the performance of the function and establishes and/or approves policies that affect the function. All functions not performed directly by the Medicaid agency must be delegated in writing and monitored by the Medicaid Agency. *Note: More than one box may be checked per item. Ensure that Medicaid is checked when the Single State Medicaid Agency (1) conducts the function directly; (2) supervises the delegated function; and/or (3) establishes and/or approves policies related to the function.*

Function	Medicaid Agency	Contracted Entity
Participant waiver enrollment	☒	☒
Waiver enrollment managed against approved limits	☒	☐
Waiver expenditures managed against approved levels	☒	☒
Level of care evaluation	☒	☒

Function	Medicaid Agency	Contracted Entity
Review of Participant service plans	☒	☒
Prior authorization of waiver services	☒	☒
Utilization management	☒	☒
Qualified provider enrollment	☒	☒
Execution of Medicaid provider agreements	☒	☐
Establishment of a statewide rate methodology	☒	☐
Rules, policies, procedures and information development governing the waiver program	☒	☐
Quality assurance and quality improvement activities	☒	☒

Appendix A: Waiver Administration and Operation

Quality Improvement: Administrative Authority of the Single State Medicaid Agency

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: Administrative Authority

The Medicaid Agency retains ultimate administrative authority and responsibility for the operation of the waiver program by exercising oversight of the performance of waiver functions by other state and local/regional non-state agencies (if appropriate) and contracted entities.

i. Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance, complete the following. Performance measures for administrative authority should not duplicate measures found in other appendices of the waiver application. *As necessary and applicable, performance measures should focus on:*

- Uniformity of development/execution of provider agreements throughout all geographic areas covered by the waiver
- Equitable distribution of waiver openings in all geographic areas covered by the waiver
- Compliance with HCB settings requirements and other new regulatory components (for waiver actions submitted on or after March 17, 2014)

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 percentage of required aggregate reports recieved from contracted care management agencies in the time frame required in their contract. Numerator=number of required aggregate reports received on time and denominator is total number of reports due

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

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

collection/generation*(check each that applies):*	**collection/generation***(check each that applies):*	*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: contracted care management agency	☒ **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**

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

Performance Measure:
Number and percent of contracted care management agencies that receive both an annual clinical and administrative review by Department staff. Numerator is number of contracted care management agencies that receive an annual review and the denominator is the total number of contracted care management agencies

Data Source (Select one):
Provider performance monitoring
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: contracted care management agency	☐ **Annually**	☐ **Stratified** Describe Group:
	☒ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Source (Select one):
Record reviews, on-site
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: contracted care management agency	☒ **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**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☒ **Other** Specify: Every 18 months

Performance Measure:
Number and percent of monitoring reports from the fiscal intermediary received on time as specified in their contract. Numerator = number of monitoring reports received on time from the fiscal intermediary as specified in their contract. Denominator=total number of reports received.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Reports from the fiscal intermediary

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**	☐ **Other**

	Ongoing	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:

Performance Measure:
Number and percent of enrolled providers who sign the required Connecticut Home Care Program for Elders (CHCPE) Waiver Provider Agreement form. Numerator: number of enrolled providers who sign the CHCPE Provider Agreement form. Denominator: number of enrolled 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: State MMIS contractor	☐ **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: State MMIS contractor	☐ **Annually**
	☐ **Continuously and Ongoing**
	☒ **Other** Specify: upon initial enrollment and every two years thereafter

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.

Community Options Unit staff meetings are held as needed to collaborate and diseminate information with regards to waiver functions. Access Agency meetings are held on a bi-monthly basis. These meetings are used as a forum to exchange information and identify any problems/issues or trends occuring in the waiver program.

Multiple levels of record review occur on a regular basis. The Access Agency supervisors review records using a uniform tool for aggregate quarterly reporting to the Department. The Access Agencies also have an external quarterly audit process where outside professionals perform record reviews. That data is provided to the Department in an annual summary report.

In addition, department staff perform record audits of all the Access Agencies on a rotating basis to measure compliance with contract deliverables and quality of care provided to waiver participants. Sampling of chart reviews is not a representative sample. However, in combination with the number of supervisory record reviews done by the Access Agency supervisors, the sample exceeds the number required to constitute a representative sample

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.

When problems are identified, communications both written and within meetings provide opportunities for resolution of issues of concern. Audits result in issuance of formal reports and minutes are generated for meetings.

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:	☐ **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 Administrative Authority that are currently non-operational.

◉ **No**

○ **Yes**

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

Appendix B: Participant Access and Eligibility

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

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

Target Group	Included	Target SubGroup	Minimum Age	Maximum Age	
				Maximum Age Limit	No Maximum Age Limit
☒ **Aged or Disabled, or Both - General**					
	☒	**Aged**	65		☒
	☐	**Disabled (Physical)**			
	☐	**Disabled (Other)**			
☐ **Aged or Disabled, or Both - Specific Recognized Subgroups**					
	☐	**Brain Injury**			☐
	☐	**HIV/AIDS**			☐
	☐	**Medically Fragile**			☐
	☐	**Technology Dependent**			☐
☐ **Intellectual Disability or Developmental Disability, or Both**					
	☐	**Autism**			☐
	☐	**Developmental Disability**			☐
	☐	**Intellectual Disability**			☐
☐ **Mental Illness**					
	☐	**Mental Illness**			☐
	☐	**Serious Emotional Disturbance**			

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

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

◉ **Not applicable. There is no maximum age limit**

○ **The following transition planning procedures are employed for participants who will reach the waiver's**

maximum age limit.

Specify:

Appendix B: Participant Access and Eligibility

B-2: Individual Cost Limit (1 of 2)

a. Individual Cost Limit. The following individual cost limit applies when determining whether to deny home and community-based services or entrance to the waiver to an otherwise eligible individual *(select one)*. Please note that a state may have only ONE individual cost limit for the purposes of determining eligibility for the waiver:

- ○ **No Cost Limit.** The state does not apply an individual cost limit. *Do not complete Item B-2-b or item B-2-c.*
- ◉ **Cost Limit in Excess of Institutional Costs.** The state refuses entrance to the waiver to any otherwise eligible individual when the state reasonably expects that the cost of the home and community-based services furnished to that individual would exceed the cost of a level of care specified for the waiver up to an amount specified by the state. *Complete Items B-2-b and B-2-c.*

  The limit specified by the state is *(select one)*

  - ◉ **A level higher than 100% of the institutional average.**

    Specify the percentage: 125

  - ○ **Other**

    Specify:

- ○ **Institutional Cost Limit.** Pursuant to 42 CFR 441.301(a)(3), the state refuses entrance to the waiver to any otherwise eligible individual when the state reasonably expects that the cost of the home and community-based services furnished to that individual would exceed 100% of the cost of the level of care specified for the waiver. *Complete Items B-2-b and B-2-c.*
- ○ **Cost Limit Lower Than Institutional Costs.** The state refuses entrance to the waiver to any otherwise qualified individual when the state reasonably expects that the cost of home and community-based services furnished to that individual would exceed the following amount specified by the state that is less than the cost of a level of care specified for the waiver.

  Specify the basis of the limit, including evidence that the limit is sufficient to assure the health and welfare of waiver participants. Complete Items B-2-b and B-2-c.

  The cost limit specified by the state is *(select one)*:

  - ○ **The following dollar amount:**

    Specify dollar amount:

The dollar amount *(select one)*

○ **Is adjusted each year that the waiver is in effect by applying the following formula:**

Specify the formula:

○ **May be adjusted during the period the waiver is in effect. The state will submit a waiver amendment to CMS to adjust the dollar amount.**

○ **The following percentage that is less than 100% of the institutional average:**

Specify percent:

○ **Other:**

Specify:

Appendix B: Participant Access and Eligibility

B-2: Individual Cost Limit (2 of 2)

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

DSS refers the prospective participant to an Access Agency for the initial assessment and development of the plan of care. The care manager is responsible to develop the plan to maintain the participant's health and safety while staying within the cost cap specified in the waiver. This is done in consultation with the participant and/or their responsible party. The development of the care plan is based on a multidimensional assessment that covers the domains of health, function, psychosocial, cognition, environment, support system and finances. The Universal Assessment has an embedded algorithm that provides a Level of Need budget. Care plans beyond the level of need calculated through the assessment process require review and approval by Community Options Unit clinical staff. Risk factors are identified and mitigated through service plans. Once the plan is agreed upon, the costs are determined. Each service on the plan of care is evaluated to determine if a back-up plan is necessary to ensure participant health and/or safety. If an applicant's health and safety needs cannot be met, they are denied access to the waiver. The applicant, if denied, receives a Medicaid Notice of Action (NOA) advising of their rights to a hearing. Any plan that exceeds 100% (inclusive)of the average cost of nursing home are subject to prior authorization by Community Options Unit clinical staff.

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

☐ **The participant is referred to another waiver that can accommodate the individual's needs.**

☒ **Additional services in excess of the individual cost limit may be authorized.**

Specify the procedures for authorizing additional services, including the amount that may be authorized:

Services beyond the cost cap may be authorized on a short term basis to meet health and safety needs as long as there is evidence that the plan on an annualized basis will be equal to or less than cost limits specified in B-2(a). Applicants whose needs cannot be met within the caps are assisted in accessing other state plan services but are determined to be ineligible for the waiver. The client is issued a Notice of Action and advised of their right to a fair hearing. Services are continued at the participant's request while the hearing decision is pending. Participants are given a minimum of 10 days notice of any adverse action.

☐ **Other safeguard(s)**

Specify:

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served (1 of 4)

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

Table: B-3-a

Waiver Year	Unduplicated Number of Participants
Year 1	17707
Year 2	18186
Year 3	18753
Year 4	19324
Year 5	19897

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

◉ **The state does not limit the number of participants that it serves at any point in time during a waiver year.**

○ **The state limits the number of participants that it serves at any point in time during a waiver year.**

The limit that applies to each year of the waiver period is specified in the following table:

Table: B-3-b

Waiver Year	Maximum Number of Participants Served At Any Point During the Year
Year 1	
Year 2	
Year 3	
Year 4	

Waiver Year	Maximum Number of Participants Served At Any Point During the Year
Year 5	

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served (2 of 4)

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

○ **Not applicable. The state does not reserve capacity.**

◉ **The state reserves capacity for the following purpose(s).**

Purpose(s) the state reserves capacity for:

Purposes	
Transitions from PCA Waiver	
Transitions from the 1915 i HCBS State Plan Option	
Transitions from MFP	

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served (2 of 4)

Purpose *(provide a title or short description to use for lookup):*

Transitions from PCA Waiver

Purpose *(describe):*

The state reserves capacity to accommodate persons mandated to transition from the PCA Waiver when they turn 65.

Describe how the amount of reserved capacity was determined:

The estimate is based on the current enrollees expected to turn 65 in the next two waiver years.

The capacity that the State reserves in each waiver year is specified in the following table:

Waiver Year	Capacity Reserved
Year 1	48
Year 2	48
Year 3	48
Year 4	48
Year 5	48

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served (2 of 4)

Purpose *(provide a title or short description to use for lookup):*

Transitions from the 1915 i HCBS State Plan Option

Purpose *(describe):*

The state serves CT residents 65 and older who are less than nursing facility level of care under a 1915i state plan option.

Describe how the amount of reserved capacity was determined:

Historically, as these residents age in place, some of them experience increased care needs resulting in functional eligibility for the waiver.
We estimate, based on historical trends that an average of 10% of the 1915i recipients will have increased care needs that result in waiver eligibility.

The capacity that the State reserves in each waiver year is specified in the following table:

Waiver Year	Capacity Reserved
Year 1	45
Year 2	45
Year 3	45
Year 4	45
Year 5	45

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served (2 of 4)

Purpose *(provide a title or short description to use for lookup):*

Transitions from MFP

Purpose *(describe):*

The state reserves to accommodate transitions from the Money Follows the Person Demonstration.

Describe how the amount of reserved capacity was determined:

Based on the average number of transitions and current applications as well as historical trends.

The capacity that the State reserves in each waiver year is specified in the following table:

Waiver Year	Capacity Reserved
Year 1	156

Waiver Year	Capacity Reserved
Year 2	230
Year 3	312
Year 4	312
Year 5	312

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served (3 of 4)

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

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

e. Allocation of Waiver Capacity.

Select one:

- (●) **Waiver capacity is allocated/managed on a statewide basis.**
- ( ) **Waiver capacity is allocated to local/regional non-state entities.**

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

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

Applications are processed on a first come first serve basis. There is no waiting list for the waiver program. Applicants are screened by Department Community Options Unit nurses and social workers for level of care, financial eligibility, and whose care needs are consistent with the need for institutional level of care. Applicants must meet nursing facility level of care to be included in the waiver.

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served - Attachment #1 (4 of 4)

Answers provided in Appendix B-3-d indicate that you do not need to complete this section.

Appendix B: Participant Access and Eligibility

B-4: Eligibility Groups Served in the Waiver

a. 1. State Classification. The state is a *(select one)*:

- ( ) **§1634 State**

○ **SSI Criteria State**

◉ **209(b) State**

2. Miller Trust State.

Indicate whether the state is a Miller Trust State *(select one)*:

◉ **No**

○ **Yes**

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

Eligibility Groups Served in the Waiver (excluding the special home and community-based waiver group under 42 CFR §435.217)

☐ **Low income families with children as provided in §1931 of the Act**

☐ **SSI recipients**

☒ **Aged, blind or disabled in 209(b) states who are eligible under 42 CFR §435.121**

☒ **Optional state supplement recipients**

☐ **Optional categorically needy aged and/or disabled individuals who have income at:**

Select one:

○ **100% of the Federal poverty level (FPL)**

○ **% of FPL, which is lower than 100% of FPL.**

Specify percentage:

☒ **Working individuals with disabilities who buy into Medicaid (BBA working disabled group as provided in §1902(a)(10)(A)(ii)(XIII)) of the Act)**

☐ **Working individuals with disabilities who buy into Medicaid (TWWIIA Basic Coverage Group as provided in §1902(a)(10)(A)(ii)(XV) of the Act)**

☐ **Working individuals with disabilities who buy into Medicaid (TWWIIA Medical Improvement Coverage Group as provided in §1902(a)(10)(A)(ii)(XVI) of the Act)**

☐ **Disabled individuals age 18 or younger who would require an institutional level of care (TEFRA 134 eligibility group as provided in §1902(e)(3) of the Act)**

☐ **Medically needy in 209(b) States (42 CFR §435.330)**

☐ **Medically needy in 1634 States and SSI Criteria States (42 CFR §435.320, §435.322 and §435.324)**

☒ **Other specified groups (include only statutory/regulatory reference to reflect the additional groups in the state plan that may receive services under this waiver)**

Specify:

Persons defined as qualified severely impaired individuals in section 1619(b) and 1905(q) of the Social Security Act.

Special home and community-based waiver group under 42 CFR §435.217) *Note: When the special home and community-based waiver group under 42 CFR §435.217 is included, Appendix B-5 must be completed*

○ **No. The state does not furnish waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217.** *Appendix B-5 is not submitted.*

◉ **Yes. The state furnishes waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217.**

Select one and complete Appendix B-5.

○ **All individuals in the special home and community-based waiver group under 42 CFR §435.217**

◉ **Only the following groups of individuals in the special home and community-based waiver group under 42 CFR §435.217**

Check each that applies:

☒ **A special income level equal to:**

Select one:

◉ **300% of the SSI Federal Benefit Rate (FBR)**

○ **A percentage of FBR, which is lower than 300% (42 CFR §435.236)**

Specify percentage:

○ **A dollar amount which is lower than 300%.**

Specify dollar amount:

☒ **Aged, blind and disabled individuals who meet requirements that are more restrictive than the SSI program (42 CFR §435.121)**

☐ **Medically needy without spend down in states which also provide Medicaid to recipients of SSI (42 CFR §435.320, §435.322 and §435.324)**

☐ **Medically needy without spend down in 209(b) States (42 CFR §435.330)**

☐ **Aged and disabled individuals who have income at:**

Select one:

○ **100% of FPL**

○ **% of FPL, which is lower than 100%.**

Specify percentage amount:

☐ **Other specified groups (include only statutory/regulatory reference to reflect the additional groups in the state plan that may receive services under this waiver)**

Specify:

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (1 of 7)

In accordance with 42 CFR §441.303(e), Appendix B-5 must be completed when the state furnishes waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217, as indicated in Appendix B-4. Post-eligibility applies only to the 42 CFR §435.217 group.

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

Note: For the period beginning January 1, 2014 and extending through September 30, 2019 (or other date as required by law), the following instructions are mandatory. The following box should be checked for all waivers that furnish waiver services to the 42 CFR §435.217 group effective at any point during this time period.

☒ **Spousal impoverishment rules under §1924 of the Act are used to determine the eligibility of individuals with a community spouse for the special home and community-based waiver group. In the case of a participant with a**

community spouse, the state uses *spousal* post-eligibility rules under §1924 of the Act.
Complete Items B-5-e (if the selection for B-4-a-i is SSI State or §1634) or B-5-f (if the selection for B-4-a-i is 209b State) and Item B-5-g unless the state indicates that it also uses spousal post-eligibility rules for the time periods before January 1, 2014 or after September 30, 2019 (or other date as required by law).

Note: The following selections apply for the time periods before January 1, 2014 or after September 30, 2019 (or other date as required by law) (select one).

◉ **Spousal impoverishment rules under §1924 of the Act are used to determine the eligibility of individuals with a community spouse for the special home and community-based waiver group.**

In the case of a participant with a community spouse, the state elects to (*select one*):

◉ **Use spousal post-eligibility rules under §1924 of the Act.**
(Complete Item B-5-c (209b State) and Item B-5-d)

○ **Use regular post-eligibility rules under 42 CFR §435.726 (SSI State) or under §435.735 (209b State)**
(Complete Item B-5-c (209b State). Do not complete Item B-5-d)

○ **Spousal impoverishment rules under §1924 of the Act are not used to determine eligibility of individuals with a community spouse for the special home and community-based waiver group. The state uses regular post-eligibility rules for individuals with a community spouse.**
(Complete Item B-5-c (209b State). Do not complete Item B-5-d)

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (2 of 7)

Note: The following selections apply for the time periods before January 1, 2014 or after December 31, 2018.

b. Regular Post-Eligibility Treatment of Income: SSI State.

Answers provided in Appendix B-4 indicate that you do not need to complete this section and therefore this section is not visible.

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (3 of 7)

Note: The following selections apply for the time periods before January 1, 2014 or after December 31, 2018.

c. Regular Post-Eligibility Treatment of Income: 209(B) State.

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

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

○ **The following standard included under the state plan**

(*select one*):

○ **The following standard under 42 CFR §435.121**

Specify:

○ **Optional state supplement standard**

- ○ **Medically needy income standard**
- ○ **The special income level for institutionalized persons**

(*select one*):

- ○ **300% of the SSI Federal Benefit Rate (FBR)**
- ○ **A percentage of the FBR, which is less than 300%**

Specify percentage:

- ○ **A dollar amount which is less than 300%.**

Specify dollar amount:

- ○ **A percentage of the Federal poverty level**

Specify percentage:

- ○ **Other standard included under the state Plan**

Specify:

- ○ **The following dollar amount**

Specify dollar amount: If this amount changes, this item will be revised.

- ○ **The following formula is used to determine the needs allowance:**

Specify:

- ◉ **Other**

Specify:

200% of the Federal Poverty Level

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

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

Specify:

Specify the amount of the allowance (*select one*):

- ○ **The following standard under 42 CFR §435.121**

Specify:

- ○ **Optional state supplement standard**
- ○ **Medically needy income standard**
- ○ **The following dollar amount:**

  Specify dollar amount: If this amount changes, this item will be revised.

- ○ **The amount is determined using the following formula:**

  Specify:

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

- ○ **Not Applicable (see instructions)**
- ○ **AFDC need standard**
- ◉ **Medically needy income standard**
- ○ **The following dollar amount:**

  Specify dollar amount: The amount specified cannot exceed the higher of the need standard for a family of the same size used to determine eligibility under the State's approved AFDC plan or the medically needy income standard established under 42 CFR §435.811 for a family of the same size. If this amount changes, this item will be revised.

- ○ **The amount is determined using the following formula:**

  Specify:

- ○ **Other**

  Specify:

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

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

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

Select one:

- ○ **Not Applicable (see instructions)***Note: If the state protects the maximum amount for the waiver participant, not applicable must be selected.*
- ◉ **The state does not establish reasonable limits.**
- ○ **The state establishes the following reasonable limits**

Specify:

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (4 of 7)

Note: The following selections apply for the time periods before January 1, 2014 or after December 31, 2018.

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

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

i. Allowance for the personal needs of the waiver participant

(*select one*):

- ○ **SSI standard**
- ○ **Optional state supplement standard**
- ○ **Medically needy income standard**
- ○ **The special income level for institutionalized persons**
- ◉ **A percentage of the Federal poverty level**

  Specify percentage: 200
- ○ **The following dollar amount:**

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

  Specify formula:
- ○ **Other**

  Specify:

ii. If the allowance for the personal needs of a waiver participant with a community spouse is different from the amount used for the individual's maintenance allowance under 42 CFR §435.726 or 42 CFR §435.735, explain why this amount is reasonable to meet the individual's maintenance needs in the community.

Select one:

- ◉ **Allowance is the same**

○ **Allowance is different.**

Explanation of difference:

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

a. Health insurance premiums, deductibles and co-insurance charges
b. Necessary medical or remedial care expenses recognized under state law but not covered under the state's Medicaid plan, subject to reasonable limits that the state may establish on the amounts of these expenses.

Select one:

○ **Not Applicable (see instructions)***Note: If the state protects the maximum amount for the waiver participant, not applicable must be selected.*

◉ **The state does not establish reasonable limits.**

○ **The state uses the same reasonable limits as are used for regular (non-spousal) post-eligibility.**

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (5 of 7)

Note: The following selections apply for the five-year period beginning January 1, 2014.

e. Regular Post-Eligibility Treatment of Income: SSI State or §1634 State - 2014 through 2018.

Answers provided in Appendix B-4 indicate that you do not need to complete this section and therefore this section is not visible.

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (6 of 7)

Note: The following selections apply for the five-year period beginning January 1, 2014.

f. Regular Post-Eligibility Treatment of Income: 209(B) State - 2014 through 2018.

Answers provided in Appendix B-5-a indicate the selections in B-5-c also apply to B-5-f.

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (7 of 7)

Note: The following selections apply for the five-year period beginning January 1, 2014.

g. Post-Eligibility Treatment of Income Using Spousal Impoverishment Rules - 2014 through 2018.

The state uses the post-eligibility rules of §1924(d) of the Act (spousal impoverishment protection) to determine the contribution of a participant with a community spouse toward the cost of home and community-based care. There is deducted from the participant's monthly income a personal needs allowance (as specified below), a community spouse's allowance and a family allowance as specified in the state Medicaid Plan. The state must also protect amounts for incurred expenses for medical or remedial care (as specified below).

Answers provided in Appendix B-5-a indicate the selections in B-5-d also apply to B-5-g.

Appendix B: Participant Access and Eligibility

B-6: Evaluation/Reevaluation of Level of Care

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

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

i. Minimum number of services.

The minimum number of waiver services (one or more) that an individual must require in order to be determined to need waiver services is: 1

ii. Frequency of services. The state requires (select one):

- (●) **The provision of waiver services at least monthly**
- ( ) **Monthly monitoring of the individual when services are furnished on a less than monthly basis**

If the state also requires a minimum frequency for the provision of waiver services other than monthly (e.g., quarterly), specify the frequency:

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

- ( ) **Directly by the Medicaid agency**
- ( ) **By the operating agency specified in Appendix A**
- ( ) **By a government agency under contract with the Medicaid agency.**

Specify the entity:

- (●) **Other**

Specify:

The initial Level of Care evaluation is performed by nurses and social workers employed by DSS in the Community Options Unit utilizing a uniform health screen. The applicant is referred to the Access Agency that performs a comprehensive assessment and submits a summary of that assessment to the Department's clinical staff for review to confirm the level of care. Level of care reevaluations are conducted by Access Agency Care Managers with oversight by the Department's clinical staff.

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

Community Options Unit staff that conduct the inital level of care evaluations are either nurses or social workers with experience in long term care.

The care manager who conducts the assessments and reassessments, develops care plans and provides ongoing monitoring shall be either a registered nurse licensed in the State where care management services are provided or a social services worker who is a graduate of an accredited four-year college or university. The nurse or social services worker shall have a minimum of two years of experience in health care or human services. A bachelors degree in nursing, health, social work, gerontology or a related field may be substituted for one year of experience.
Care managers shall have the following additional
qualifications:

1.demonstrated interviewing skills which include the professional judgment to probe as necessary to uncover underlying concerns of the applicant;

2.demonstrated ability to establish and maintain empathetic relationships;

3.experience in conducting social and health assessments;

4.knowledge of human behavior, family/caregiver dynamics, human development and disabilities;

5.awareness of community resources and services;

6.the ability to understand and apply complex service reimbursement issues; and

7. the ability to evaluate, negotiate and plan for the costs of care options.

8.Care management supervisors shall meet all the qualifications of a care manager plus have demonstrated supervisory ability, and at least one year of specific experience in conducting assessments, developing care plans and monitoring home and community based services.

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

A Uniform Health Screen is utilized to determine nursing facility level of care. Nursing Facility Level of Care is defined as an individual requiring substantial daily assistance as defined by the following criteria:

Substantial daily personal care is defined by:
1. Supervision or cueing ≥ 3 ADLs daily + need factor
2. Hands-on ≥ 3 ADLs daily
3. Hands-on ≥ 2 ADLs daily + need factor
4. A cognitive impairment which requires a professionally staffed environment for monitoring on a daily basis.

Need factors are:
1. Cognitive Need: Requires daily supervision to prevent harm due to a cognitive impairment
2. Behavioral Need: Requires daily supervision to prevent harm
3. Medication supports: Requires assistance for administration of physician ordered daily medications. Includes supports beyond set up.

For the nursing facility sub-acute level of care, the individual would meet all of the above criteria with the addition of the need for comprehensive medical monitoring, intensive medical supervision such as intermittent nursing services throughout the day or have high intensity rehabilitative needs, are ventilator dependent, have complex wound care needs or a need for specialized infusion therapy.

e. Level of Care Instrument(s). Per 42 CFR §441.303(c)(2), indicate whether the instrument/tool used to evaluate level of

care for the waiver differs from the instrument/tool used to evaluate institutional level of care *(select one)*:

- (●) **The same instrument is used in determining the level of care for the waiver and for institutional care under the state Plan.**
- ( ) **A different instrument is used to determine the level of care for the waiver than for institutional care under the state plan.**

Describe how and why this instrument differs from the form used to evaluate institutional level of care and explain how the outcome of the determination is reliable, valid, and fully comparable.

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

The same care manager who conducts the initial evaluation visits the participant for the annual reevaluation and conducts a comprehensive, multidimensional assessment. The assessment covers seven domains: health, function, psychosocial, cognition, support system, environment and finances. The assessment identifies unmet needs and risk factors. After completion of the assessment, they are required to specify the level of care based on the findings of the reevaluation. The department reviews a random sample of reevaluations that summarize the reevaluation findings. Plans of care are also reviewed to evaluate if services meet the identified needs.

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

- ( ) **Every three months**
- ( ) **Every six months**
- (●) **Every twelve months**
- ( ) **Other schedule**

Specify the other schedule:

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

- (●) **The qualifications of individuals who perform reevaluations are the same as individuals who perform initial evaluations.**
- ( ) **The qualifications are different.**

Specify the qualifications:

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

The Department maintains an electronic database of all participants and their reevaluation schedule. Six weeks prior to the beginning of the month when reevaluations are due, the Department sends the list of reevaluations due to be completed. Compliance with this is also audited by the Department via record review.

j. Maintenance of Evaluation/Reevaluation Records. Per 42 CFR §441.303(c)(3), the state assures that written and/or electronically retrievable documentation of all evaluations and reevaluations are maintained for a minimum period of 3 years as required in 45 CFR §92.42. Specify the location(s) where records of evaluations and reevaluations of level of care

are maintained:

Records are retained in both the Community Options Unit of the Department of Social Services as well as in the offices of the Access Agencies. The Department's policy for record retention is seven years.

Appendix B: Evaluation/Reevaluation of Level of Care

Quality Improvement: Level of Care

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: Level of Care Assurance/Sub-assurances

The state demonstrates that it implements the processes and instrument(s) specified in its approved waiver for evaluating/reevaluating an applicant's/waiver participant's level of care consistent with level of care provided in a hospital, NF or ICF/IID.

i. Sub-Assurances:

a. ***Sub-assurance: An evaluation for LOC is provided to all applicants for whom there is reasonable indication that services may be needed in the future.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-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 applicants whose level of care has been evaluated by Department clinical staff prior to the initiation of services. Numerator: number of level of care evaluations. Denominator: number of applicants

Data Source (Select one):
Other
If 'Other' is selected, specify:
Data collected in Community Options web-based waiver system

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:
	☐ **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:

b. ***Sub-assurance: The levels of care of enrolled participants are reevaluated at least annually or as specified in the approved waiver.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-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.

c. ***Sub-assurance: The processes and instruments described in the approved waiver are applied appropriately and according to the approved description to determine participant level of care.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-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 participant records that have a completed level of care determination form. The numerator= the number of participant records that have a completed level of care determination form. The denominator is the total number of records.

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:
standardized forms maintained in program electronic data base

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: contracted care management agency	☒ **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 participants who received an initial assessment of level of care using the Universal Assessment tool. Numerator: the number of participants who receive an initial level of care assessment using the Universal Assessment tool.

Denominator: number of participants who received an initial assessment of level of care.

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: University of Connecticut; contracted care management agency	☐ **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**

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

Performance Measure:
Number and percent of initial level of care evaluations conducted using the approved level of care criteria. Numerator: number of initial level of care evaluations conducted using the approved level of care criteria. Denominator: number of initial level of care evaluations

Data Source (Select one):
Record reviews, on-site
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:

contracted care management agency		
	☒ **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:

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.

Every applicant seeking waiver services is initially screened for Level of Care by Community Options Unit Clinical staff. The level of care is confimed by the Access Agency staff when completing the comprehensive, initial face to face assessment.

The Community Options Unit conducts onsite or desk audit reviews of Access Agency and Assisted Living participant records. Participant in-home visits are conducted by Community Options Unit Quality Assurance staff on a sampling of both Access Agency and Assisted Living clients. Community Options Unit Quality Assurance staff conduct onsite visits to waiver service providers when there are quality of care concerns. Client satisfaction surveys are conducted to allow individuals a means to provide feedback on the quality of the services received. The Home Care Advisory Committee, comprised of a wide range of providers and advocates meets semi-annually with Department staff to discuss current issues affecting elders statewide.

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.

Individual concerns regarding participants' health and safety is reported to Quality Assurance staff. Quality Assurance staff investigate the basis of the complaint/referral, consult with the Unit Manager, and make a determination if corrective action is pursued by the access agency or Assisted Living Services Agency. QA staff monitors until a satisfactory resolution is achieved. Any final recommendations are made in consultation with the manager. Aditionally, QA staff monitor non health and safety complaints until satifactory resolution is obtained. The department maintains a web based critical incident reporting system that allows for identification and remediation of individual problems.

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: Contracted care management agencies	☐ **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 Level of Care that are currently non-operational.

◉ **No**

○ **Yes**

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

Appendix B: Participant Access and Eligibility

B-7: Freedom of Choice

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

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

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

As part of the inital evaluation conducted by the care manager, the participant is offered a choice of a home and community based service plan or institutional services. Each participant is asked to sign an Informed Consent form (W-889) where they are advised of their choice between community services or institutional care. They are advised that an assessment must be completed in order to access services under the waiver. A copy of the consent form is left with the participant.

The care manager also informs the individual about the range of services available under the waiver and the available providers.

b. Maintenance of Forms. Per 45 CFR §92.42, written copies or electronically retrievable facsimiles of Freedom of Choice forms are maintained for a minimum of three years. Specify the locations where copies of these forms are maintained.

The Informed Consent form W-889 is retained in the participant's record for seven years. The form is maintained in the Access Agencies records and is audited for in the Department's annual audit.

Appendix B: Participant Access and Eligibility

B-8: Access to Services by Limited English Proficiency Persons

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

Potential and active waiver participants with limited fluency in English must have access to services without undue hardship. The DSS home care request form is available in Spanish. The Community Options Unit has Spanish speaking staff to handle inquiries and referrals to the program. The Department also has language line services available with interpreters for a wide array of languages. The Access Agencies have bilingual case managers including Spanish, Russian, Italian and French. Non-English speaking waiver applicants may bring an interpreter of their choice to any meeting with the case manager. This is not a requirement but an option available to participants should they so choose. No person can be denied access to waiver services on the basis of English proficiency.

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	Adult Day Health
Statutory Service	Care Management
Statutory Service	Homemaker
Statutory Service	Personal Care Assistant
Statutory Service	Respite
Other Service	Adult Family Living
Other Service	Assisted Living
Other Service	Assistive Technology
Other Service	Bill Payer
Other Service	Care Transitions
Other Service	Chore Services
Other Service	Chronic Disease Self-Management Program
Other Service	Companion
Other Service	Environmental Accesibility Adaptations
Other Service	Home Delivered Meals
Other Service	Mental Health Counseling
Other Service	Participant Training and Engagement to Support Goal Attainment and Independence (CAPABLE)
Other Service	Personal Emergency Response Systems
Other Service	Recovery Assistant
Other Service	Remote Supports
Other Service	Training and Counseling Services for Unpaid Caregivers Supporting Participants (COPE)
Other Service	Transportation

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:

Adult Day Health

Alternate Service Title (if any):

HCBS Taxonomy:

Category 1:

17 Other Services

Sub-Category 1:

17990 other

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

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

Service Definition *(Scope):*

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

The service is provided 4 or more hours per day on a regularly scheduled basis for one or more days per week, or as specified in the service plan, in a non-institutional, community-based setting and shall encompass both health and social services needed to ensure the optimal functioning of the participant. Transportation to and from the center is included in the service definition and in the rate structure. Meals provided as part of these services shall not constitute a full nutritional regimen. Claims will denied by any Adult Day Health provider attempting to bill for transportation procedure codes. These procedure codes are not included on the Adult Day Health fee schedule and will deny as edits are built into the claim processing system to prevent duplicative transportation services for Adult Day Health from occurring.
Services Covered and Limitations
Payment for adult day services under the rate for a medical model is limited to providers that demonstrate to the department their ability to meet the following additional requirements:

a program nurse shall be available on site for not less than fifty percent of each operating day;

the program nurse shall be a registered nurse, except that a program nurse may be a licensed practical nurse if the program is located adjacent to a long term care facility licensed by the Department of Public Health, with ready access to a registered nurse from such long term care facility or the program nurse is supervised by a registered nurse who can be reached by telephone at any time during the operating day and who can be called to the center if needed within one half hour of the request. The program nurse is responsible for administering medications as needed and assuring that the participant's nursing services are coordinated with other services provided in the adult day health center, health and social services currently received at home or provided by existing community health agencies and personal physicians;

additional personal care services shall be provided as specified in the individual plan of care, including but not limited to, bathing and transferring;

ongoing training shall be available to the staff on a regular basis including, but not be limited to, orientation to key specialty areas such as physical therapy, occupational therapy, speech therapy and training in techniques for recognizing when to arrange or refer clients for such services; and

individual therapeutic and rehabilitation services shall be coordinated by the center as specified in the individual plan of care including but not limited to, physical therapy, occupational therapy and speech therapy. The center shall have the capacity to provide such services on site; this requirement shall not preclude the provider of adult day health services from also arranging to provide therapeutic and rehabilitation services at other locations in order to meet needs of individual clients.

Payment for adult day services shall include the costs of transportation, meals and all other required services except for individual therapeutic and rehabilitation services.

For participants receiving assisted living services, adult day services are included as part of the monthly rate. A separate reimbursement for this service is not authorized. The assisted living service agency may arrange for adult day health services and reimburse the adult day service provider from their all-inclusive rate.
Adult day programs will be able to provide virtual services via video communication, including virtual assessments, and at least two meals per day, into permanent authority to allow Remote Services (virtual support) when a client is unable to attend the center in person. The absence may be due to symptoms of contagious illness; injury, illness or recovery from such; exacerbation of a chronic condition; or inclement weather. The adult day center must, at a minimum, provide a documented wellness call, and delivery of two meals per day

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

May be provided up to seven times per week.

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	Provider agency

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Adult Day Health

Provider Category:

Agency

Provider Type:

Provider agency

Provider Qualifications

License *(specify):*

Providers of Adult Day Health services shall:
meet all applicable federal, state and local requirements including zoning, licensing, sanitation, fire and safety requirements;
provide, at a minimum, nursing consultation services, social work services, nutritionally balanced meals to meet specialized dietary needs as prescribed by health care personnel, personal care services, recreational therapy and transportation services for individuals to and from their homes;

provide adequate personnel to operate the program including:

a full-time program administrator;

nursing consultation during the full operating day by a Registered Nurse (RN) licensed in the state of Connecticut; and

the direct care staff-to-participant ratio shall be a minimum of one to seven. Staffing shall be adequate to meet the needs of the client base. Volunteers shall be included in the ratio only when they conform to the same standards and requirements as paid staff.

In order to be a provider of services to department clients, any facility located and operating within the state of Connecticut or located and operating outside the state of Connecticut, in a bordering state, shall be certified by the Connecticut Association of Adult Day Centers Incorporated, its successor agency or a department designee.

A facility (center) located and operating outside the state of Connecticut in a bordering state shall be licensed or certified by its respective state and comply at all times with all pertinent licensure or certification requirements in addition to the approved standards for certification by the department.

Certified facilities (centers) shall be in compliance with all applicable requirements in order to continue providing services to department clients. The failure to comply with any applicable requirements shall be grounds for the termination of its certification and participation as a department service provider.

Certificate *(specify):*

Certification required by the Adult Day Care Association of CT. Certification is for 3 years.

Other Standard *(specify):*

n/a

Verification of Provider Qualifications

Entity Responsible for Verification:

The Department's fiscal intermediary must ensure that the Day Care Program is certified by the association. The department maintains an ongoing list of certified Adult Day Programs and shares that information with the Access Agencies, other waiver personnel and Department social work staff who also might refer clients for the service.

Frequency of Verification:

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:

Case Management

Alternate Service Title (if any):

Care Management

HCBS Taxonomy:

Category 1:	Sub-Category 1:
01 Case Management	01010 case management
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**

Service Definition *(Scope):*

Category 4:	Sub-Category 4:

Services that assist participants in gaining access to needed waiver and other State plan services, as well as medical, social, educational and other services, regardless of the funding source for the services to which access is gained. Care managers additionally are responsible for monitoring the ongoing provision of services in the participant's plan of care and continually monitor that the client's health annd safety needs are being addressed. They complete the initial and annual assessment and reassessment of an individual's needs in order to develop a comprehensive plan of care. They confirm the initial level of care determination done by Department staff and reassess the level of care annually and maintain documentation for department review. Care Managers also explain opportunites for participant directed services under the Medicaid state plan options to participants.
The Departments allows for a status review vist by the case manager when a waiver participant is in a hospital or nursing facility setting when the purpose of that visit is to reevaluate the total plan of care needs upon discharge back to the community based setting. This transitional care management service is provided one time in the first 45 days of a nursing home stay and/or one time only during a hospital stay. The reimbursement is based on a percentage of the rate for an initial assessment.
DSS implemented a tiered case management system. Tiered case management is based on client's level of need and the number and type of case management interventions required. TIER A clients, with the fewest needs, receive a quarterly contact and an annual reassessment. Leveling Criteria for TIER A is 3 or less care management interventions in a 6 month period. If 2 of those interventions are crisis interventions, client is automatically elevated to level 2. TIER B clients receive monthly monitoring, a six month field visit and an annual reassessment. Leveling criteria is 4-6 care management interventions in a 6 month period. TIER C clients, the highest level, receive monthly monitoring, quarterly field visits, six month visit, and an annual reassessment. Leveling criteria is 7 or more care management interventions in a 6 month period. There are four categories of case management intervention: Crisis Intervention, Service Brokerage and Advocacy, Risk Management and Client Engagement/Re-engagement. Crisis Intervention Efforts have two principle aims 1) Cushion the stressful event by immediate or emergency emotional or environmental first aid and 2) Strengthen the person in his or her coping through immediate therapeutic clarification and guidance during the crisis period. Examples of incidents that precipitate crisis interventions: suicide assessment, incidents of abuse, victimization, neglect, exploitation, imminent threat of homelessness. Service Brokerage and Advocacy requires that the Care Manager facilitate continual interaction between various segments of the service delivery system. When service breakdowns or requests for service changes occur, the Care Manager assists clients to ensure their rights to receive services based upon the person-centered model of care are upheld. Service brokerage and advocacy interventions include activities around finding and keeping providers for clients with difficult service needs, pre and post transitioning from an inpatient setting to the community, hospice and end of life care. Risk Management includes the identification of potential and perceived risks to the individual falling into four general categories; health, behavior, personal safety risks, and in-community risks. Managing these risks includes identification and documenting risks, developing written plans for addressing them, negotiating with clients the risks presented keeping client choice central to the process, and monitoring outcomes related to the risk. Client engagement refers to the process through which clients become active or involved in their care plans and participation in the program. The engagement process has several conceptualizations where interventions are designed to enhance client 1) receptivity, 2) expectancy 3) investment, 4) working relationship. Care management interventions are weighted according to complexity, severity and number of tasks required. Crisis intervention is weighted highest followed by Service Brokerage and Advocacy, Risk Management and Client Engagement/Re-engagement. Clients may move to a different tier based on their current needs with prior authorization from DSS. Care management per diem rates will be adjusted according to which tier the client is in.

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

Service may be billed on a per diem basis as long as the client remains in a community-based setting. Care management per diem may not be billed when a client is in an institutional setting.
Prior authorization is required for a status review vist after the first 45 days of a nursing home stay.

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	Access Agency

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Care Management

Provider Category:

Agency

Provider Type:

Access Agency

Provider Qualifications

License *(specify):*

The care manager who conducts the assessments, develops care plans and provides ongoing monitoring shall be either a registered nurse licensed in the state where care management services are provided or a social services worker who is a graduate of an accredited four-year college or university. The nurse or social services worker shall have a minimum of two years of experience in health care or human services. A bachelors degree in nursing, health, social work, gerontology or a related field may be substituted for one year of experience.

Care managers shall have the following additional qualifications:
demonstrated interviewing skills which include the professional judgment to probe as necessary to uncover underlying concerns of the applicants; demonstrated ability to establish and maintain empathetic relationships; experience in conducting social and health assessments; knowledge of human behavior, family/caregiver dynamics, human development and disabilities; awareness of community resources and services; the ability to understand and apply complex service reimbursement issues; and the ability to evaluate, negotiate and plan for the costs of care options.

Certificate *(specify):*

The registered nurse shall hold a license to practice nursing in the State of CT. Care Managers are encouraged but not required to be certified as a long term care manager.

Other Standard *(specify):*

The concurrent 1915(b)(4) is on Temporary Extension (TE) and the selective contracting remains in effect as long as the b(4) authority remains in effect.

Verification of Provider Qualifications

Entity Responsible for Verification:

The Access Agency is responsible to ensure that employees meet the requirements specified in 17b-342-1(h)(1)(A). Department staff audit the Access Agencies for compliance with employee qualifications.

Frequency of Verification:

Upon employment and as part of the Case Manager's annual performance appraisal.

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:
08 Home-Based Services	08050 homemaker
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

Services consisting of general household activities (meal preparation, laundry and routine household care) provided by a trained homemaker, when the individual regularly responsible for these activities is temporarily absent or unable to manage the home and care for him or herself or others in the home. Homemakers shall meet such standards of education and training as are established by the State for the provision of these activities.

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	Provider agency

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Homemaker

Provider Category:

Agency

Provider Type:

Provider agency

Provider Qualifications

License *(specify):*

N/A

Certificate *(specify):*

Certification required from the Department of Consumer Protection.

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

The fiscal intermediary is responsible for verifying the certification prior to initiating enrollment of the agency.

Frequency of Verification:

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:

Statutory Service

Service:

Personal Care

Alternate Service Title (if any):

Personal Care Assistant

HCBS Taxonomy:

Category 1:	Sub-Category 1:
08 Home-Based Services	08030 personal care
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

Assisting an elder with tasks that the individual would typically do for him/herself in the absence of a disability. Such tasks may be performed at home or in the community. The participant has co-employer authority and is responsible to direct the activities of the PCA. Such services may include physical or verbal assistance to the consumer in accomplishing any Activity of Daily Living (ADL), or Instrumental Activities of Daily Living (IADL). ADLs include bathing, dressing, toileting, transferring, and feeding. IADLs include meal preparation, shopping, housekeeping, laundry and cueing/reminders for self medication administration. Transportation costs associated with the provision of personal care outside of the participant's home is billed separately and is not included in the scope of personal care.

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

Personal Care may not be provided to participants receiving Assisted Living Services as all of the functions of personal care are provided by the Assisted Living Service provider. The benefit plan for Assisted Living service recipients excludes personal care so that there could be no duplicative billing.

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	Provider Agency

Appendix C: Participant Services

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

Service Type: Statutory Service

Service Name: Personal Care Assistant

Provider Category:

Agency

Provider Type:

Provider Agency

Provider Qualifications

License *(specify):*

If the provider agency is a Home Health Agency, it is required to be licensed in the state of Connecticut as specified in Subsection (k) section 19a-490 of the Connecticut General Statutes.

Certificate *(specify):*

If the provider is a Homemaker/Companion Agency, it must be registered with the Department of Consumer Protection.

Other Standard *(specify):*

The PCA hired by the agency shall meet all of the same qualifications as an individual PCA as follows:
Be at least 18 years of age
Have experience doing personal care
Be able to follow written or verbal instructions given by the consumer or the consumer's conservator
Be physically able to perform the services required
Follow instructions given by the consumer or the consumer's conservator
Receive instruction/training from consumer or their designee concerning all personal care services delineated in the service plan
Be able to handle emergencies
Demonstrate the ability to implement cognitive behavioral interventions/take direction to carry out the plan.
All agency PCAs must complete department sponsored curriculum and pass the exam upon completion of the curriculum. Agencies are required to maintain evidence of the passing test score in the individual's personnel record.

Verification of Provider Qualifications

Entity Responsible for Verification:

Agency and fiscal intermediary

Frequency of Verification:

At the 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:

Statutory Service

Service:

Respite

Alternate Service Title (if any):

HCBS Taxonomy:

Category 1:	Sub-Category 1:
17 Other Services	17990 other
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

Services provided to individuals unable to care for themselves; furnished on a short-term basis because of the absence or need for relief of those persons normally providing the care. In home respite providers shall include but are not limited to homemakers, companions or Home Health aides. Services may be provided in the home or outside of the home including but not limited to a licensed or certified facility such as a Rest Home with Nursing Supervision or Chronic and Convalescent Nursing Home. Federal financial participation is not claimed for the cost of room and board except when provided as part of respite care furnished in a facility approved by the State that is not a private residence.

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

Respite services provided in a licensed facility are limited to 30 days per calendar year per recipient. In home respite services are limited to 720 hours per year per recipient.

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	Provider agencies of waiver services such as Homemaker/Companion Agencies or Home Health Agencies
Agency	Chronic and Convalescent Nursing Homes/Rest Homes with Nursing Supervision

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Respite

Provider Category:

Agency

Provider Type:

Provider agencies of waiver services such as Homemaker/Companion Agencies or Home Health Agencies

Provider Qualifications

License *(specify):*

Licensing is not applicable to Homemakers and Companions, however all requirements of a Homemaker/Companion Agency are applicable when providing respite services.
Home Health Agencies must be licensed by the CT Department of Public Health.

Certificate *(specify):*

N/A

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

Fiscal Intermediary for in home respite and CT Department of Public Health for facilities and Home Health Care Agencies.

Frequency of Verification:

Every 2 years

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Respite

Provider Category:

Agency

Provider Type:

Chronic and Convalescent Nursing Homes/Rest Homes with Nursing Supervision

Provider Qualifications

License *(specify):*

For respite in a facility, either Rest Home with Nursing Supervision or Chronic and Convalescent Nursing Home, facilities must be licensed by the CT Department of Public Health.

Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

CT Department of Public Health

Frequency of Verification:

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:

Adult Family Living

HCBS Taxonomy:

Category 1:	**Sub-Category 1:**
17 Other Services	17990 other
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

Personal care and supportive services (homemaker, chore, attendant services, meal preparation) that are furnished to waiver participants who reside in a private home by a principal caregiver who lives in the home. Adult Family Living is furnished to older adults who receive these services in conjunction with residing in the home. Service includes 24 hour response capability to meet scheduled or unpredictable resident needs to provide supervision, safety and security based on ADL, IADL, cognitive or behavioral needs. Service allocation is based on ADL, IADL, cognitive or behavioral needs. Services also include social and recreational activities and cueing or reminders to take medications. Separate payment will not be made for homemaker or chore services furnished to an individual receiving adult foster care services, since these are integral to and inherent in the provision of Adult Family Living services. Edits in the MMIS system do not allow these services to be billed when Adult Family Living is in place as a service. Four classifications of Adult Family Living service will be available under this Waiver:
Level 1: service provided to individuals who because of their impairments, require supervision on a daily basis and require cueing or supervision to perform ADLs and may also have cognitive or behavioral challenges
Level 2: services provided to individuals who require hands on assistance to perform 2 ADLs on a daily basis.
Level 3: services provided to individuals who require hands on assistance to perform 3 or more ADLs or 2 ADLs and co-occurring assistance for the management of challenging behaviors or cognitive deficits.
Level 4: services provided to individuals who require hands on assistance to perform 4 or more ADLs or 3 ADLs and co-occurring assistance for the management of challenging behaviors or cognitive deficits.
The agency that provides the Adult Family Living service will supervise the supports delivered by the direct care provider. This service may be provided in the home of either the care provider or the participant, whichever is preferable to the participant. The direct provider may be a relative of the client as long as they are not a legally liable relative. Adult Family Living is limited to no more than 3 participants in a home. The Adult Family Living provider may not administer medication but may supervise the participant's self-administration of medication. Payments made for Adult Family Living are not made for room and board, items of comfort or convenience, or the costs of home maintenance, upkeep and improvement. The methodology by which the costs of room and board are excluded from payments for Adult Family Living are described in Appendix I.

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	Provider Agency

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Adult Family Living

Provider Category:
Agency
Provider Type:

Provider Agency

Provider Qualifications

License *(specify):*

N/A

Certificate *(specify):*

N/A

Other Standard *(specify):*

In order to be an Adult Family Living provider setting, the provider agency must certify that the home is regularly maintained and that the interior floors, walls, ceiling and furnishings must be clean and in good repair including the kitchen area, bathroom and participant's bedroom, ventilation, heating, lighting and stairs. The home should conform to all applicable building codes, health and safety codes and ordinances and meet the participant's need for privacy. The home should also be equipped with a fire extinguisher and an emergency first aid kit. It is the responsibility of the provider agency to ensure that the home meets all of these specifications. In addition, the agency is responsible to verify that the provider is at least 18 year of age, be in good health and able to follow written and verbal instruction, report changes in a participant's condition, maintain confidentiality and complete record keeping requirements specified by the provider agency. The provider agency will provide nursing oversight / supervision of the provision of care by the Adult Family Living/Foster Care provider on a minimum of a bi-monthly basis. Their role will include orientation, competency evaluations in the provision of daily care and ongoing continuing education for the direct caregiver. The agency provider as well as the care manager are responsible to assure the health and safety needs of the participant are met. The direct caregiver will provide nutritionally balanced meals and healthy snacks each day to the waiver participant, as dictated by their medical/nutritional needs. The reimbursement rate does not include room and board. The payment for room and board costs are negotiated between the direct service provider and the waiver participant. The provider agency in order to be credentialed to provide Adult Family Living/Foster Care must provide evidence of an ability to certify that the individual homes meet all of the requirements included in this description and can demonstrate an ability to monitor the delivery and quality of service provided to the waiver participant. The agency may also provide relief to the direct service provider or the care manager can provide relief through the provision of other waiver services. The provider agency bills the MMIS directly and is then responsible to pay the direct caregiver.

Verification of Provider Qualifications

Entity Responsible for Verification:

Fiscal Intermediary

Frequency of Verification:

Upon enrollment and bi-annually 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:

Assisted Living

HCBS Taxonomy:

Category 1:	**Sub-Category 1:**
17 Other Services	17990 other
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**

Service Definition *(Scope):*

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

Personal care and services, homemaker, chore, attendant care, companion services, medication oversight, therapeutic social and recreational programming provided in a home-like environment in a Managed Residential Community, in conjunction with residing in the community. A managed residential community is a living arrangement consisting of private residential units that provides a managed group living environment including housing and services. A private residential unit means a living arrangement rented by the participant that includes a private full bath within the unit and facilities and equipment for the preparation and storage of food. This service includes 24 hour on-site response staff to meet scheduled or unpredictable needs in a way that promotes maximum dignity and independence, and to provide supervision, safety and security. Other individuals or agencies may also furnish care directly, or under arrangement with the Managed Residential Community, but the care provided by these other entities supplements that provided by the community care facility and does not supplant it. Mental health counseling and the Personal Emergency Response System are services available to assisted living clients. Nursing and skilled therapy services are incidental rather than integral to the provision of assisted living services. Payment is not made for 24 hour skilled care. Federal financial participation is not available for room and board, items of comfort or convenience, or the costs of facility maintenance, upkeep and improvement. The methodology by which the costs of room and board are excluded from payments for assisted living services is described in Appendix I-5.

Personalized care is furnished to individuals who reside in their own living units (which may include dually occupied units when both occupants consent to the arrangement) which includes kitchenette and living rooms and which contain bedrooms and toilet facilities. The consumer has a right to privacy. Living units may be locked at the discretion of the consumer, except when a physician or mental health professional has certified in writing that the consumer is sufficiently cognitively impaired as to be a danger to self or others if given the opportunity to lock the door. Each living unit is separate and distinct from each other. The communities have a central dining room, living room or parlor, and common activity center(s)(which may also serve as living rooms or dining rooms). The consumer retains the right to assume risk, tempered only by the individual's ability to assume responsibility for that risk. Care must be furnished in a way which fosters the independence of each consumer. Routines of care provision and service delivery must be consumer-driven to the maximum extent possible, and treat each person with dignity and respect.
Care plans will be developed based on the individual's service needs. There are four levels of service provided in assisted living facilities based on the consumer's combined needs for personal care and nursing services. The four levels are occasional which is 1-3.75 hours per week of service, limited which is 4-8.75 hours per week of service, moderate which is 9-14.75 hours per week of service and extensive which is 15-25 hours per week of service. Level of service assigned depends upon the volume and extent of services needed by each individual and is not a limitation of service.

Assisted Living services are provided under the waiver statewide in Private Assisted Living Facilities under CGS 17b-365 and in 17 state funded congregate and 4 HUD facilities under CGS 8-206e(e). Additionally, Assisted Living Services are provided in 4 demonstration sites under 19-13-D105 of the regulations of CT state agencies.

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

Persons receiving Assisted Living services may not receive PCA services and PCA is not included on the fee schedule for clients receiving Assisted Living services preventing duplicative billing. The claims would reject as "not being covered under the participant's benefit plan."

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	Assisted Living Service Agency

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Assisted Living

Provider Category:

Agency

Provider Type:

Assisted Living Service Agency

Provider Qualifications

License *(specify):*

The Assisted Living Service Provider (ALSA) is licensed by the CT Department of Public Health in accordance with chaper 368v. Regulations regarding a Managed Residential Community and the ALSA are found in Regulations of the State of CT agencies in 19-13-D104 and 19-13-D105.

Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

MMIS contractor and Department Quality Assurance staff

Frequency of Verification:

At the time of enrollment as a Medicaid provider and bi-annually 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:

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 (ADLs) or Instrumental Activities of Daily Living (IADLs). Assistive technology service means 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 the participants.

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

Care plans will 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.

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
Agency	Pharmacies

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:

Agency

Provider Qualifications

License *(specify):*

For telemonitoring services must be a Home Health Agency licensed in the state of Connecticut as specified in Subsection (k) section 19a-490 of the Connecticut General Statutes.

Certificate *(specify):*

Other Standard *(specify):*

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 the start of service

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 Department of Consumer Protection Pharmacy Practice Act: Regulations concerning practice of pharmacy Sec. 20-175-4-6-7

Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

Fiscal Intermediary

Frequency of Verification:

at the initiation of the 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:

Bill Payer

HCBS Taxonomy:

Category 1:	**Sub-Category 1:**
17 Other Services	17990 other
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

A bill payer is a trained agency staff member who is paired with a client that is having difficulty managing their routine monthly finances. Staff member assists with writing checks that client signs, budgeting, paying bills on time, balancing checkbook, Social Security and Medicare questions and problems. The person can assist with applications for financial assistance programs, medical insurance claims and other financial matters including applications for senior housing and medical insurance. Electronic bill payment is permitted as part of this service.

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

Service is limited to 3 hours per month.

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

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Bill Payer

Provider Category:

Agency

Provider Type:

Agency

Provider Qualifications

License *(specify):*

Certificate *(specify):*

If the agency provider is a Homemaker/Companion Agency, they must be registered with the Department of Consumer Protection.

Other Standard *(specify):*

Agency providing bill payer service is bonded and insured against fraudulent behavior. Bill payer's activities are overseen by the agency administrator or their designee. Cases are regularly reviewed and coaching is provided to the bill payer as needed. Online banking and bill paying is an option as part of this service

Verification of Provider Qualifications

Entity Responsible for Verification:

Fiscal Intermediary

Frequency of Verification:

At the 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:

Care Transitions

HCBS Taxonomy:

Category 1:	**Sub-Category 1:**
13 Participant Training	13010 participant training
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

An evidence-based set of actions designed to ensure health care coordination, continuity and avoidance of preventable poor outcomes in vulnerable participants as they move between institutional and home and community based settings. Core activities include: building a trusting relationship, facilitating coaching and teaching, helping participants identify "red flags" to prevent readmissions, understand contributing factors for current admission, scheduling timely follow up with primary care provider, partnering with hospital care coordinators to enhance continuity of care. Service includes either a home visit or telephone follow up no more than 72 hours after discharge.

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

Available only to those who have been enrolled in the waiver as an active participant which means they are receiving waiver services. Not available to waiver applicants. Limited to no more than one unit in 60 days. Cannot be billed concurrently with a status review.

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	Access Agency

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Care Transitions

Provider Category:

Agency

Provider Type:

Access Agency

Provider Qualifications

License *(specify):*

The care manager who conducts the assessments, develops care plans and provides ongoing monitoring shall be either a registered nurse licensed in the state where care management services are provided or a social services worker who is a graduate of an accredited four-year college or university. The nurse or social services worker shall have a minimum of two years of experience in health care or human services. A bachelors degree in nursing, health, social work, gerontology or a related field may be substituted for one year of experience. A licensed social worker is preferred for this service but not required.

Certificate *(specify):*

The registered nurse shall hold a license to practice nursing in the State of CT. Care Managers are encouraged but not required to be certified as a long term care manager.

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

The Access Agency is responsible to ensure that employees meet the requirements specified in 17b-342-1(h)(1)(A). Department staff audit the Access Agencies for compliance with employee qualifications.

Frequency of Verification:

At the time of hire and annually at the time of annual performance appraisal.

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 Services

HCBS Taxonomy:

Category 1:	**Sub-Category 1:**
08 Home-Based Services	08060 chore
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

Services needed to maintain the home in a clean, sanitary and safe environment. This service includes heavy household chores such as washing floors, windows and walls, tacking down loose rugs and tiles, moving heavy items of furniture in order to provide safe access and egress. These services will be provided only in cases where neither the individual, nor anyone else in the household, is capable of performing or financially providing for them, and where no other relative, caregiver, landlord, community/volunteer agency, or third party payor is capable of or responsible for their provision. In the case of rental property, the responsibility of the landlord, pursuant to the lease agreement, will be examined prior to any authorization of service.

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

When an individual requires one-time only unique or specialized services in order to maintain a healthy and safe environment, they may receive highly skilled chore services which include but are not limited to moving, extensive cleaning or extermination services. Highly skilled chore services are subject to prior authorization by the department.

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	Licensed Contractor
Agency	Provider Agency

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Chore Services

Provider Category:

Individual

Provider Type:

Licensed Contractor

Provider Qualifications

License *(specify):*

Electrician, plumbers and other contractors must hold the appropriate license to perform highly skilled chore services.

Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

Fiscal intermediary

Frequency of Verification:

At the time of service

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Chore Services

Provider Category:

Agency

Provider Type:

Provider Agency

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

If provider is a homemaker/companion/chore agency, they must be registered with the Department of Consumer Protection. Chore services providers shall demonstrate the ability to meet the needs of the individual seeking services.

Verification of Provider Qualifications

Entity Responsible for Verification:

Fiscal intermediary

Frequency of Verification:

At the time of enrollment and biannually 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:

Chronic Disease Self-Management Program

HCBS Taxonomy:

Category 1:	Sub-Category 1:
13 Participant Training	13010 participant training
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition (Scope):

The Chronic Disease Self-Management Program (Live-Well) is a workshop given two and a half hours, once a week, for six weeks, in community settings such as senior centers, churches, libraries and hospitals. People with different chronic health problems attend together. Workshops are facilitated by two trained leaders, one or both of whom are non-health professionals with chronic diseases themselves.
Subjects covered include:
1) techniques to deal with problems such as frustration, fatigue, pain and isolation, 2) appropriate exercise for maintaining and improving strength, flexibility, and endurance, 3) appropriate use of medications, 4) communicating effectively with family, friends, and health professionals, 5) nutrition, 6) decision making, and 7) how to evaluate new treatments.
The program is helpful for people with chronic conditions, as it gives them the skills to coordinate all the things needed to manage their health, as well as to help them keep active in their lives. The therapeutic goals of the service are adjustment to serious impairments, maintenance or restoration of physical functioning, self management of chronic disease, acquisition of skills to address minor depression, management of personal care and development of skills to work with care providers including behavior management. The program is also available in Spanish and is called Tomando Control de su Salud.

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

The program provides up to six sessions of two hours each. The participant is strongly encouraged to attend all six sessions. The service is limited to one six session service per calendar year.

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 Chronic Disease Self Management Trainer
Agency	Agency

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Chronic Disease Self-Management Program

Provider Category:
Individual
Provider Type:

Individual Chronic Disease Self Management Trainer

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Certification in an evidence-based chronic disease self management training program such as the Stanford University Chronic Disease Self Management Program (CDSMP).

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

Fiscal Intermediary

Frequency of Verification:

Upon initial contracting and every two years thereafter

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Chronic Disease Self-Management Program

Provider Category:

Agency

Provider Type:

Agency

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Individual Employee Qualification: Certification in an evidence- based chronic disease self-management training program such as the Stanford University Chronic Disease Self Management Program.

Verification of Provider Qualifications

Entity Responsible for Verification:

Provider agency and fiscal intermediary

Frequency of Verification:

Upon initial contracting 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:

Companion

HCBS Taxonomy:

Category 1:	Sub-Category 1:
08 Home-Based Services	08040 companion
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

Non-medical care, supervision and socialization provided to a functionally impaired adult. Companions may assist or supervise the individual with such tasks as meal preparation, laundry and shopping, but do not perform these activities as discrete services. The provision of companion services does not entail hands-on nursing care. Providers may also perform light housekeeping tasks which are incidental to the care and supervision of the individual. This service is provided in accordance with a therapeutic goal in the plan of care, and is not purely diversional in nature. Companion services may include, but are not limited to, the following activities:

(A) escorting an individual to recreational activities or to necessary medical, dental or business appointments;

(B) reading to or for an individual;

(C) supervising or monitoring an individual during the self-performance of activities of daily living such as meal preparation and consumption, dressing, personal hygiene, laundry and simple household chores;

(D) reminding an individual to take self-administered medications;

(E) providing monitoring to ensure the safety of an individual;

(F) assisting with telephone calls and written communications; and

(G) reporting changes in an individual's needs or condition to the supervisor or care manager.

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	Provider agency

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Companion

Provider Category:

Agency

Provider Type:

Provider agency

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

In order to provide companion services and receive reimbursement from the Connecticut Home Care program, Agency must be registered as a provider of Companion Services with the Department of Consumer Protection in the state of CT.
The companion employed by the agency shall be at least eighteen (18) years of age, be of good health, have the ability to read, write and follow instructions, be able to report changes in a person's condition or needs to the department, the access agency, or the agency or organization that contracted the persons to perform such functions and shall maintain confidentiality and complete required record-keeping of the employer or contractor of services.

Companion services are not licensed or regulated and shall be provided by a person hired by an agency or organization. Relatives of the client cannot be provider of services as defined in section 17b-342-1(b)29) of the Regulations of Connecticut State Agencies. Providers shall demonstrate the ability to meet the needs of the service recipient. The access agency or a department designee shall also ensure that the services provided are appropriate for companion services and are not services which should be provided by a licensed provider of home health services.

Companion service agencies or organizations shall abide by the standards and requirements as described in the performing provider agreement and sub-contract with the department or any authorized entity.

Any homemaker-companion agency must register with the Department of Consumer Protection pursuant to sections 20-671 to 20-680, inclusive, of the Connecticut General Statutes.

Verification of Provider Qualifications

Entity Responsible for Verification:

Fiscal intermediary

Frequency of Verification:

Upon enrollment as a performing provider and bi-annually 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:

Environmental Accesibility Adaptations

HCBS Taxonomy:

Category 1:	Sub-Category 1:
14 Equipment, Technology, and Modifications	14020 home and/or vehicle accessibility adaptations

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

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

Service Definition *(Scope):*

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

Minor Home Modifications required by the individual's plan of care which are necessary to ensure health, welfare and safety of the individuals to function with greater independence in the home and without which the individual would require institutionalization. Such adaptations may include the installation of hand rails and grab bars in the tub area, widening of doors and installation of ramps. Excluded are those adaptations or improvements to the home which are of general utility and are not of direct medical or remedial benefit to the individual such as carpeting, roof repair or air conditioning. Adaptations which add to the total square footage of the home are excluded from this benefit. All services shall be provided in accordance with applicable state or local building codes. Adaptations are excluded if the residence is owned by someone other than the participant and the adaptations would be the responsibility of the owner/landlord.

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

This service is subject to prior authorization by Department staff.

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	Non relative able to meet the individual's needs

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Environmental Accesibility Adaptations

Provider Category:

Individual

Provider Type:

Non relative able to meet the individual's needs

Provider Qualifications

License *(specify):*

Certificate *(specify):*

1. The vendor or contractor shall provide all services, materials, and labor that are necessary to complete the project/minor home modification(s) as indicated.
2. The vendor or contractor must be registered with the Department of Consumer Protection to do business in the State of Connecticut.
3. The vendor or contractor must show evidence of a valid home improvement registration and evidence of workers' compensation (if applicable) and liability insurance, at the time they provide an estimate for the project.
4. If applicable, the vendor or contractor must apply for, obtain, and pay for all permits. All work done shall be done per applicable codes, regulations and standards of construction, including American National Standards Institute (ANSI) standards for barrier-free access and safety requirement.
5. The vendor or contractor shall warranty all work, including labor and materials, for one year from the date of acceptance and thereafter, one year from the date of completion of the project.
6. When equipment is required to make the home accessible, a separate vendor may provide and install the equipment.

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

Fiscal intermediary

Frequency of Verification:

prior to the provision 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:

Home Delivered Meals

HCBS Taxonomy:

Category 1:	Sub-Category 1:
06 Home Delivered Meals	06010 home delivered meals

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

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

Service Definition *(Scope):*

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

Home delivered meals, or "meals on wheels," include the preparation and delivery of one or two meals for persons who are unable to prepare or obtain nourishing meals on their own. Meals on Wheels providers include delicatessens, Family Services Agencies, Community Action Agencies, Catholic Charities, Town Social Services, visiting nurse agencies, assisted living agencies, senior centers, and soup kitchens. Meals must meet a minimum of one-third for single meals and two-thirds for double meals of the daily recommended allowance and requirements as established by the Food and Nutrition Academy of Sciences National Reasearch Council. Special diet meals are available such as diabetic, cardiac,low sodium and renal as are ethnic meals such as Hispanic and Kosher meals. Liquid supplements, such as Ensure, are generally unavailable as the home delivered meals. There is one Community Action Agency in Northwest CT that provides liquid supplement meal replacement.

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

No more than two meals per day up to seven times per week as specified in the individual service plan. Liquid supplements are covered by the CT Medicaid program with prior authorization for clients who are tube fed.

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	Home Delivered Meals Providers

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:

Home Delivered Meals Providers

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Reimbursment for home delivered meals shall be available under the waiver only 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. Quality assurance and quality control shall be performed by the department's contracted providers to ensure that the meals on wheels service providers are 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 the time of enrollment as a provider and biannually 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:

Mental Health Counseling

HCBS Taxonomy:

Category 1:	Sub-Category 1:
10 Other Mental Health and Behavioral Services	10060 counseling
Category 2:	**Sub-Category 2:**

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

Service Definition *(Scope):*

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

Mental Health Counseling Services are professional counseling services provided to help resolve or enable the eligible individual to cope with individual, family, and/or environmentally related problems and conditions. Counseling focuses on issues such as problems in maintaining a home in the community, relocation within the community, dealing with long term disability, substance abuse, and family relationships.
The department shall pay for mental health services conforming to accepted methods of diagnosis and treatment, including:

(A) mental health evaluation and assessment;

(B) individual counseling;

(C) group counseling; and

(D) family counseling.

Mental Health Counseling can be provided in the client's home or location best suited for the client. Mental Health Counseling can also be provided virtually with clients consent

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	Community Agency
Individual	Masters Level or Licensed Social Worker or Counselor

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Mental Health Counseling

Provider Category:

Individual

Provider Type:

Community Agency

Provider Qualifications

License *(specify):*

The community agency may provide this service utilizing licensed providers.For purposes of receiving reimbursement under the Connecticut Home Care Program, the agency must utilize a mental health counseling provider who is a licensed clinical social worker as defined in Connecticut General Statutes 20-195m or a Licensed Professional Counselor as defined in section 20-195aa of the Connecticut General Statutes, and shall have experience and training in providing mental health services to persons with disabilities.

Certificate *(specify):*

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: Mental Health Counseling

Provider Category:

Individual

Provider Type:

Masters Level or Licensed Social Worker or Counselor

Provider Qualifications

License *(specify):*

For purposes of receiving reimbursement under the Connecticut Home Care Program, a mental health counseling provider shall be a licensed independent social worker as defined in Connecticut General Statutes 20-195m or a Licensed Professional Councelor as defined in section 20-195aa of the Connecticut General Statutes, and shall have experience and training in providing mental health services to the elderly.

Certificate *(specify):*

Other Standard *(specify):*

A social worker who holds a masters degree from an accredited school of social work, or an individual who has a masters degree in counseling, psychology or psychiatric nursing and has experience in providing mental health services to the elderly may also provide mental health counceling.

Verification of Provider Qualifications

Entity Responsible for Verification:

Fiscal intermediary

Frequency of Verification:

At time of enrollment as a performing provider and bi-annually 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:

Participant Training and Engagement to Support Goal Attainment and Independence (CAPABLE)

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 CAPABLE program is a set of highly individualized, person-centered services that use the strengths of the participant to improve her/his safety and independence. The CAPABLE program services engage participants to develop action plans with the aim of achieving goals related to increasing functional independence, improving safety, decreasing depression and improving motivation as defined in the person-centered plan.

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

6 OT visits and 4 RN visits and 1-2 visits of handy worker.
Usually, services are provided within 4-5 months but additional visits can be authorized based on medical necessary.

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	Occupational Therapist
Agency	Home Health Agency

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Participant Training and Engagement to Support Goal Attainment and Independence (CAPABLE)

Provider Category:

Individual

Provider Type:

Occupational Therapist

Provider Qualifications

License *(specify):*

DPH license and CAPABLE license

Certificate *(specify):*

Other Standard *(specify):*

Complete 8-12 hrs of online CAPABLE training

Verification of Provider Qualifications

Entity Responsible for Verification:

Fiscal Intermediary

Frequency of Verification:

Upon enrollment and every 2 years after

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Participant Training and Engagement to Support Goal Attainment and Independence (CAPABLE)

Provider Category:

Agency

Provider Type:

Home Health Agency

Provider Qualifications

License *(specify):*

DPH license and CAPABLE License

Certificate *(specify):*

Other Standard *(specify):*

RN to complete online CAPABLE Training (8-12hours)

Verification of Provider Qualifications

Entity Responsible for Verification:

Fiscal Intermediary

Frequency of Verification:

Upon enrollment and then every 2 years after.

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

HCBS Taxonomy:

Category 1:	Sub-Category 1:
14 Equipment, Technology, and Modifications	14010 personal emergency response system (PERS)
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

PERS is an electronic device which enables certain individuals at high risk of institutionalization to secure help in an emergency. The individual may also wear a portable "help" button to allow for mobility. The system is connected to the person's phone and programmed to signal a response center once a "help" button is activated. The response center is staffed by trained professionals 24/7. PERS services are limited to those individuals who live alone, or who are alone for significant parts of the day, and have no regular caregiver for extended periods of time, and who would otherwise require extensive routine supervision. Installation, upkeep and maintenance of the device is provided.

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 PERS equipment

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Personal Emergency Response Systems

Provider Category:

Agency

Provider Type:

Vendors who sell and install appropriate PERS equipment

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Vendor that has an approved contract through DSS

Verification of Provider Qualifications

Entity Responsible for Verification:

fiscal intermediary

Frequency of Verification:

At the initiation of the contract and biannually 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:

Recovery Assistant

HCBS Taxonomy:

Category 1:	Sub-Category 1:
08 Home-Based Services	08030 personal care
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**

Service Definition *(Scope):*

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

A flexible range of supportive assistance provided face-to-face in accordance with a Waiver, the service that enables a participant to maintain a home/apartment, encourages the use of existing natural supports, and fosters involvement in social and community activities. Service activities include: performing household tasks, providing instructive assistance, or cuing to prompt the participant to carry out tasks (e.g., meal preparation; routine household chores, cleaning, laundry, shopping, and bill-paying; and participation in social and recreational activities), and providing supportive companionship. The Recovery Assistant may also provide instruction or cuing to prompt the participant to dress appropriately and perform basic hygiene functions; supportive assistance and supervision of the participant; and short-term relief in the home for a participant who is unable to care for himself/herself when the primary caregiver is absent or in need of relief. The Recovery Assistant service is provided to persons with a mental health or substance abuse diagnosis.

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	Provider Agency

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Recovery Assistant

Provider Category:

Agency

Provider Type:

Provider Agency

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Recovery Assistant must have certification from the Dept. of Mental Health and Addiction Services in order to be a provider of this service.

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

Fiscal intermediary and provider agency

Frequency of Verification:

At the time of employment 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:

Remote Supports

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 includes the provision of supports by staff at a remote location who are engaged with the individual through technology/devices with the capability for live two-way communication. Individual interaction with the staff person may be scheduled, on-demand, or in response to an alert from a device in the remote support equipment system. Associated changes include expanding the list of authorized providers of PCA services to include adult day providers and remote support providers, adding certified community hubs as authorized provider types, and the addition of new rates for unscheduled back-up PCA services and remote live PCA services.

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

The limitation of services provided by Remote Supports will be to work inside the allowable budget. If there is not room for added technology features or frequency of contact remotely, they will have to be purchased out of pocket. Each service plan will be tailored to the consumer and consumer's budget

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	Congregate and other subsidized housing and Senior Center/municipalities.
Agency	Homemaking/Companion agencies
Agency	Adult Day Centers

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Remote Supports

Provider Category:

Agency

Provider Type:

Congregate and other subsidized housing and Senior Center/municipalities.

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

Frequency of Verification:

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Remote Supports

Provider Category:

Agency

Provider Type:

Homemaking/Companion agencies

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Registered with the Department of Consumer Protection

Verification of Provider Qualifications

Entity Responsible for Verification:

Fiscal Intermediary

Frequency of Verification:

upon enrollment and every 2 years after

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Remote Supports

Provider Category:

Agency

Provider Type:

Adult Day Centers

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

Frequency of Verification:

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:

Training and Counseling Services for Unpaid Caregivers Supporting Participants (COPE)

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:**

This service is an inter-professional model delivered through a structured number of visits by a team comprised of a Care of Persons with Dementia in their Environments (COPE) certified occupational therapist (OT) and a COPE certified registered nurse (RN) to a participant as defined in the participant's person-centered plan. The service may include assessment and the development of a home treatment/support/action plan for this service, training and technical assistance to carry out the plan and monitoring of the individual and implementation of the service action plan. For participants without a dementia diagnosis, the service is referred to as "Confident Caregiver."

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

Total 13 visits of services (10 OT, 3 RN visits; first OT and RN visit will take 2 hours each)
*Additional visits can be authorized based on medical necessity

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	Home Health Agency
Individual	Occupational Therapist

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Training and Counseling Services for Unpaid Caregivers Supporting Participants (COPE)

Provider Category:

Agency

Provider Type:

Home Health Agency

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

Fiscal Intermediary

Frequency of Verification:

upon enrollment and every 2 years

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Training and Counseling Services for Unpaid Caregivers Supporting Participants (COPE)

Provider Category:

Individual

Provider Type:

Occupational Therapist

Provider Qualifications

License *(specify):*

licensed by the CT Department of Public Health

Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

Fiscal Intermediary

Frequency of Verification:

Upon enrollment and every 2 years following.

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:
15 Non-Medical Transportation	15010 non-medical transportation
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

Transportation services provide access to social services, community services and appropriate social or recreational facilities that are essential to help some individuals avoid institutionalization by enabling these individuals to retain their role as community members. This service is offered in addition to medical transportation offered under the state plan and shall not replace it.

(A) These services are provided when transportation is required to promote and enhance independent living and self-support; and

(B) Transportation services may be provided by taxi, livery, bus, invalid coach, volunteer organization or individuals. They shall be reimbursed when they are necessary to provide access to needed community based services or community activities as specified in the approved plan of care.

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

Adult Day Health providers cannot bill the transportation procedure code. Transportation is a separate and distinct procedure code and that service is not contracted to be provided by Adult Day Care providers thus preventing duplicate billing.

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	Commercial Transportation Providers
Individual	Individual Provider

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Transportation

Provider Category:

Agency

Provider Type:

Commercial Transportation Providers

Provider Qualifications

License *(specify):*

In order to receive payment from the Connecticut Home Care Program, all commercial transportation providers shall be regulated carriers and meet all applicable state and federal permit and licensure requirements, and vehicle registration requirements. Commercial transportation providers shall also meet all applicable Medicaid program enrollment requirements.

Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

Fiscal intermediary

Frequency of Verification:

At the time of enrollment and bi-annually thereafter

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):*

Certificate *(specify):*

Other Standard *(specify):*

There are no enrollment requirements for private transportation. Private transportation is defined as transportation by a vehicle owned by a volunteer organization, or a private individual, provided the vehicle is not used for commercial carriage. 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 the time of enrollment and biannually thereafter

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:

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):

Homemaker/Companion agencies that provide Homemaker, Companion and chore Services must register with the CT Department of Consumer Protection in order to be credentialed to provide services under the waiver as required in Chapter 400 Sections 20-670-680.
Sec. 20-678 specifies that prospective employees of Homemaker/Companion agencies are required to submit to comprehensive background check. Written statements re prior criminal convictions or disciplinary action.
Maintenance and inspection of records. On or after January 1, 2012, each homemaker-companion agency, prior to extending an offer of employment or entering into a contract with a prospective employee, shall require such prospective employee to submit to a comprehensive background check. In addition, each homemaker-companion agency shall require that such prospective employee complete and sign a form which contains questions as to whether the prospective employee was convicted of a crime involving violence or dishonesty in a state court or federal court in any state; or was subject to any decision imposing disciplinary action by a licensing agency in any state, the District of Columbia, a United States possession or territory or a foreign jurisdiction. Any prospective employee who makes a false written statement regarding such prior criminal convictions or disciplinary action shall be guilty of a class A misdemeanor. Each homemaker-companion agency shall maintain a paper or electronic copy of any materials obtained during the comprehensive background check and shall make such records available for inspection upon request of the Department of Consumer Protection.
Sec. 20-675. Disciplinary actions against homemaker-companion agency. Grounds. Notice and hearing. (a) The Commissioner of Consumer Protection may revoke, suspend or refuse to issue or renew any certificate of registration as a homemaker-companion agency or place an agency on probation or issue a letter of reprimand for: (1) Conduct by the agency, or by an employee of the agency while in the course of employment, of a character likely to mislead, deceive or defraud the public or the commissioner; (2) engaging in any untruthful or misleading advertising; (3) failure of such agency that acts as a registry to comply with the notice requirements of section 20-679a; or (4) failing to perform a comprehensive background check of a prospective employee or maintain a copy of materials obtained during a comprehensive background check, as required by section 20-678.
The contracted fiscal intermediary also conducts on site audits annually of 10% of the enrolled providers. Their review includes a review as to whether the background checks have been completed as required.

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

- ◉ **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)

Note: Required information from this page (Appendix C-2-c) is contained in response to C-5.

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.*

The care manager monitors the appropriateness and effectiveness of the services provided as part of their required monthly monitoring contract. The Department does not pay legally liable relatives or relatives of Conservators of Person (COP) or Conservators of Estate (COE) to provide care. A COP is appointed by the Probate Court to supervise the personal affairs of an individual including the arrangement for medical needs and ensuring the individual has nutritious meals, clothing, safe and adequate housing, personal hygiene and is protected from physical abuse or harm. A COE is also appointed by the Probate Court to supervise the financial affairs of an individual found to be incapable of managing his/her own affairs to the extent that property is jeopardized unless management is provided. The participant or their conservator must sign timesheets to confirm the dates and times services were performed. The fiscal intermediary reviews timesheets for accuracy and whether they match the allocation in the service plan. Any discrepancy results in the notification to DSS prior to the issuance of payment. Family members must meet the same qualifications as unrelated providers. Any reported concerns regarding fraudulent billing are addressed as it would be with other service vendors(e.g., investigation, provider termination, etc.).

○ **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 fiscal intermediary is responsible to recruit, train, and assist with the enrollment process of qualified providers. The MMIS contractor also facilitates the enrollment process for providers using a web based enrollment program. The fiscal intermediary is mandated in their contract with the Department to establish working relationships with community providers and provide education to potential providers about the program services. All willing providers are sent an initial enrollment packet when requested. When inquiries from potential providers come directly to the Department, they are referred to the fiscal intermediary who will initiate the enrollment process. Additionally, the state's MMIS contractor maintains a web site that provides extensive information to prospective providers. The website is ctdssmap.com. The application and instructions can be downloaded from the website. The provider is given a specific list of accompanying required documentation with their provider enrollment application.
Provider relations and enrollment specialists within the MMIS contractor attempt to make the process as efficient as possible and provide providers with assistance during the enrollment process. The usual timeframe for enrollment is approximately 60 days but may be extended if the provider requests additional time to collect the required information.

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 enrolled Adult Day Centers that are certified through peer review by the CT Adult Day Care Association. Numerator=number of enrolled Adult Day Centers certified Denominator= number of Adult Day Centers enrolled

Data Source (Select one):
Reports to State Medicaid Agency on delegated Administrative functions
If 'Other' is selected, specify:
ADC certification listing is provided to the department quarterly by the Day Care Association updating the certification status

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: CT Adult Day Care Association	☐ **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: CT Adult Day Care Association	☐ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

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

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:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*

Performance Measure:
Number and percent of waiver providers that continue to meet licensure/certification standards. Numerator=waiver providers that continue to meet licensure/certification standards. Denominator= total number of waiver providers requiring licensure/certification.

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:

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 & percent of non-licensed/non-certified waiver providers that continue to meet waiver provider qualifications when re-credentialed every 2 years. Numerator=number of non-licensed, non-certified waiver providers reviewed that continue to meet waiver qualifications at re-credentialing. Denominator: number of non-licensed, non-certified waiver providers reviewed for re-credentialing.

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:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*

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 contractually required training from the fiscal intermediary. Numerator=Number of waiver providers who complete contractually required training. Denominator: number of waiver providers who were required to complete training

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

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 Department cross matches providers with the HHS-OIG Fraud Protection and Detection Exclusion list to block participation of providers found on this list. Access Agencies perform checks of staff licensure routinely at time of annual performance review. Enrolled Connecticut Medical Assistance Program providers are required to perform criminal background checks on all of their employees prior to employment. Providers are responsible for verifying staff credentials, i.e., training completed, degree programs and licensure prior to employment.

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.

The Fiscal Intermediary is contractually obligated to assist providers in meeting the provider qualifications needed to be a participating provider. They offer training programs both for existing providers as well as for providers who wish to enroll. The MMIS contractor operates a provider assistance call center to provide information and guidance to providers experiencing difficulty with the enrollment process and getting set up in the web-based system.

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 Module Attachment #1

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (1 of 8)

State Participant-Centered Service Plan Title:

Total Plan of Care

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

- ☒ **Registered nurse, licensed to practice in the state**
- ☐ **Licensed practical or vocational nurse, acting within the scope of practice under state law**
- ☐ **Licensed physician (M.D. or D.O)**
- ☒ **Case Manager** (qualifications specified in Appendix C-1/C-3)
- ☐ **Case Manager** (qualifications not specified in Appendix C-1/C-3).
  Specify qualifications:
- ☐ **Social Worker**
  Specify qualifications:
- ☐ **Other**
  Specify the individuals and their qualifications:

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (2 of 8)

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

- ◉ **Entities and/or individuals that have responsibility for service plan development may not provide other direct waiver services to the participant.**
- ○ **Entities and/or individuals that have responsibility for service plan development may provide other direct waiver services to the participant.**

The state has established the following safeguards to ensure that service plan development is conducted in the best interests of the participant. *Specify:*

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (3 of 8)

c. Supporting the Participant in Service Plan Development. Specify: (a) the supports and information that are made

available to the participant (and/or family or legal representative, as appropriate) to direct and be actively engaged in the service plan development process and (b) the participant's authority to determine who is included in the process.

At the point of intake, applicants to the waiver program are asked to identify a "responsible party" or other person they would like to have present for the assessment visit. When the care manager calls to make the appointment, he/she generally calls the person identified on the referral as wanting to be present for the assessment visit. The visit is scheduled at a time convenient for both the applicant and the person or persons they wish to be included in the visit. The care manager discusses with the potential participant their choices between home care and institutional services. The care manager is expected to fully inform the applicant about services available and different agencies. The client is provided a W-990, The CT Home Care Program for Elders, Your Rights and Responsibilities. This document outlines choice of services, providers, the participant's right to participate in and have control over their services, their rights will be respected by service providers and they should expect high quality in the care or services they receive. The client is asked to sign an Informed Consent Form (W-889)that explains their choices in detail and are given a copy of the document as well as other documents they sign. Participants are required to sign a copy of their Total Plan of Care indicating their agreement with the service plan.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (4 of 8)

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

Once the referral is processed by Community Options Unit staff and the applicant appears to meet functional and financial eligibility criteria for the waiver, the referral is sent to a contracted care management agency for the initial evaluation. The Care Manager meets with the applicant and his or her representative and explains the program prior to initiating the assessment. If the applicant consents, the care manager initiates the assessment. The Universal Assessment instrument evaluates multiple domains including health, function, psychosocial, environment, cognition, support system and finances. Risk indicators are discussed with the participant and/or their representative. Based on the assessment, a budget is generated, needs are identified and service options are discussed with the participant and their representative. Options regarding service providers are presented for the client to choose their services and providers.

The assessment is utilized to develop person-centered goals and plans are developed that assist the participant to achieve those goals. The Department, as part of its audit process, reviews records to ensure that participant goals are identified and reviewed at least annually.

The cost of the plan is calculated once it has been approved. The participant and/or their representative is asked to sign off on the plan indicating their approval and/or agreement with it. The final plan of care is submitted to the department to assess if needs and goals are addressed by the plan and to approve.

The contracted care management agencies are required by their contract with the Department to perform monthly monitoring contacts with participants and/or their representatives to evaluate the plan and if there are any changes that would necessitate a change in the plan. The contract further requires that the Care Manager change the plan to reflect changes in participant needs. This occurs on a continuous basis. Regulations of CT State Agencies 17b-342(d)(7) state: For the Connecticut Home Care Program, all home care services shall be included as part of a written plan of care developed initially and updated regularly by the access agency, the assisted living service agency, department staff or department designee. The plan of care shall specify the start date of services, services, type, frequency, cost, funding source and the providers of all home care services. The type and frequency of services contained in the plan of care shall be based upon the documented needs found in the assessment of the elderly persons needs and shall be reimbursed by the department only when it is determined that each service is needed in order to avoid institutional placement. For any services where the client would be at risk if the schedule of the service varied, a back-up plan shall be identified in the total plan of care. Services not included as part of the approved plan of care or not covered by sections 17b-342-1 to 17b-342-5, inclusive, of the Regulations of Connecticut State Agencies are not eligible for reimbursement from the Connecticut Home Care Program.
The participant's individualized plan of care must be signed by the participant/representative.
The Total Plan of Care is coordinated by the care manager and includes not only waiver and state plan services but also in-kind, Medicare covered, other insurance covered services and other federal funded such as Older American's Act programs.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (5 of 8)

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

The responsibility to assure health and welfare is balanced with the waiver participant's right to choose their services and their providers. It is imperative to accurately identify the services and supports that are needed to ensure the health and welfare of the waiver participant. During the service plan development process, the Care Manager, the participant and his/her representative, and any other person identified by the participant collaborate to assess the individual from a multidimentional perspective as well as any risk factors including: inadequate supervision, social isolation, cognitive impairment, fall risk, inability to summon assistance, emotional and behavioral issues, and communication capabilities. This information is used to provide the background necessary to identify areas of potential risk to the waiver participant.

When risk issues are identified, the Care Manager discusses these issues with the Supervisor and/or interdisciplinary team and then provides feedback to the waiver participant regarding the area(s) of concern. This allows the participant and the care manager to have a dialogue and exchange of ideas on how to mitigate the risk by developing a back-up plan in collaboration with the participant and/or their representative. A back-up plan is informal, utilizing in-kind support from family, friends, or neighbors, and formal, provided by the service agency which prioritizes clients whose health and safety would be at risk without scheduled service providers. All clients are reviewed for the need for a back up plan. The back up plan is indicated on the Total Plan of Care. The waiver participant has the right to accept, reject or modify recommendations that address risk.

If a waiver participant's choices are such that the waiver program is concerned that it will not be able to assure the waiver participant's health and welfare, this concern is clearly discussed with the waiver participant. If the waiver participant's health and welfare can be assured, then the waiver participant can remain on the waiver. If this is not possible, then the waiver participant is issued a Notice of Action (NOA), indicating discontinuance from the waiver. The participant is informed that they have a right to a fair hearing, pursuant to Medicaid rules and the NOA includes information about their right to a fair hearing.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (6 of 8)

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

During the development of the Total Plan of Care, participants select providers from a list of credentialed providers prepared by the Department's Fiscal Intermediary. The Fiscal Intermediary maintains the list of credentialed waiver providers that includes services provided and area covered. The care managers make a concerted effort to provide participants with as many choices as possible and the expectation is that there is documentation in the clinical record of the choices given. The participant may request a copy of the list at any time. If the participant does not have a specific choice, providers are assigned on a rotating basis as long as the provider can meet all of the specifications requested by the participant such as language spoken and the days and times that services are available. The Care Manager will describe the services available from providers on the list. Participants choose providers from the list and their signature on the total Plan of Care acknowledges freedom of choice.

During every monthly monitoring contact, the participants are asked if they are satisfied with the services provided and if there are any problems with the delivery of the formal services. If the participant indicates there are problems, then changing to another service provider is discussed as an option and the Care Manager again reviews with the participant the service providers available to choose from. Again, that documentation is found in the clinical record.

New providers are added to the list as they meet the qualifications and are enrolled. Once added to the list, the care managers provide the info to the participant as part of the monthly monitoring contact if the participant wishes to change providers and is also provided as a choice to all new participants.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (7 of 8)

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

Community Options Unit staff review 100% of all new service plans and must authorize them in order to for the care management agency to initiate service. Community Nurse Coordinators match needs with services to ensure all health and safety needs are being met.

Community Options Unit staff conducts annual on site client record reviews for each of the care management agencies. Approximately one hundred (150) client records are randomly selected for review. The reviews include an examination of the client's most recent reassessment and confirm that the identified critical needs are consistent with the plan of care. The plan of care is reviewed to ensure that all identified needs are being met.

Participant record reviews are conducted to monitor contractual agreements. Contracted care management agencies are contractually obligated to conduct client record reviews including assessing appropriateness of the plan of care and report annually to the Department of Social Services.

Contracted care management agencies must update the POC at the time of reassessment or when a significant change occurs in the client's status, and utilize care plans consistent with the program's Uniform Client Care Plan. The Uniform Client Care Plan identifies provider, type of service, number of hours provided, date service began, and date service was discontinued, noting the need for a back up plan.

On annual reassessment Community Options clinical staff select for review, every 10th care plan submitted monthly. The review consists of an evaluation of whether the plan is meeting health and safety needs of the participant and monitors outlier care plans(utilization below 20% or above 80% of the cost limits).

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (8 of 8)

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

- ○ **Every three months or more frequently when necessary**
- ○ **Every six months or more frequently when necessary**
- ◉ **Every twelve months or more frequently when necessary**
- ○ **Other schedule**

Specify the other schedule:

i. Maintenance of Service Plan Forms. Written copies or electronic facsimiles of service plans are maintained for a minimum period of 3 years as required by 45 CFR §92.42. Service plans are maintained by the following *(check each that applies):*

- ☐ **Medicaid agency**
- ☐ **Operating agency**
- ☒ **Case manager**
- ☐ **Other**

Specify:

Appendix D: Participant-Centered Planning and Service Delivery

D-2: Service Plan Implementation and Monitoring

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

Care Managers are responsible for monitoring the implementation of the service plan and participant health and welfare. By contract, care managers conduct monthly contacts with the participant, the participant's representative or provider by telephone or home visit. Monthly contacts verify that services in the plan of care meet current needs of the participant, verify that services are being provided as specified in the plan of care, verify that the plan remains within cost limits, verify satisfaction with services, verify that participant goals remain appropriate,revise goals as needed, identify any potential problems relating to participant's health, safety or participation in the waiver and implement corrective actions as needed, verify that the corrective action is effective and verify that the informal support system remains active and provides the assistance noted on the Total Plan of Care.
The monthly monitoring contact has specific questions that must be answered by the participant or their representative. The questions include, are you satisfied with your services? Is there a change in your level of satisfaction with the services provided? Any problems with formal services? Any problems with informal services or assistance? The Total Plan of Care is reviewed which includes whether a back-up is needed in the event a specific service is not delivered. The back up plan is documented on the Total Plan of Care which is reviewed as part of the monitoring contact. The Total Plan of Care includes both waiver services and non-waiver services and both types of services are included in this monitoring contact.
The care managers are required to conduct face-to-face visits with participants as often as needed but no less frequently than every six months.

b. Monitoring Safeguards. *Select one:*

- (●) **Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare may not provide other direct waiver services to the participant.**
- ( ) **Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare may provide other direct waiver services to the participant.**

The state has established the following safeguards to ensure that monitoring is conducted in the best interests of the participant. *Specify:*

Appendix D: Participant-Centered Planning and Service Delivery

Quality Improvement: Service Plan

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: Service Plan Assurance/Sub-assurances

The state demonstrates it has designed and implemented an effective system for reviewing the adequacy of service plans for waiver participants.

i. Sub-Assurances:

a. ***Sub-assurance: Service plans address all participants assessed needs (including health and safety risk factors) and personal goals, either by the provision of waiver services or through other means.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-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 service plans/participant records that address all of participant's identified needs. Numerator=number of service plans/participant records that address identified needs. Denominator=number of service plans/participant records reviewed.

Data Source (Select one):
Record reviews, on-site
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 = confidence interval=95% margin of error=+/- 5%
☒ **Other** Specify: Contracted care management agency	☐ **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: contracted care management agency	☒ **Annually**
	☒ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Number and percent of service plans/participant records that identify and address the participant's personal goals. Numerator: number of service plans/participant records that identify and address personal goals. Denominator: Number of service plans/participant records reviewed.

Data Source (Select one):
Record reviews, on-site
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 = Confidence Interval=95% Margin of Error= =/- 5%
☒ **Other** Specify: Contracted care management agency	☐ **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:

b. ***Sub-assurance: The State monitors service plan development in accordance with its policies and procedures.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-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 approved service plans that are within cost caps specified in the waiver. numerator=number of approved service plans within cost caps specified in the waiver denominator=number of records reviewed

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:
off site record reviews are also conducted

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 = confidence interval=95% Margin of error= +/- 5%
☒ **Other** Specify: contracted care management agency	☐ **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:

c. ***Sub-assurance: Service plans are updated/revised at least annually or when warranted by changes in the waiver participants needs.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-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 of participant charts audited that indicate that the care manager has

reviewed and updated the service plan as warranted due to changes in the participant's needs. Numerator: number of service plans audited that indicate the service plan was reviewed and updated as warranted. Denominator: Number of service plans audited.

Data Source (Select one):
Record reviews, on-site
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 = confidence interval = 95% margin of error = +/- 5%
☒ **Other** Specify: contracted Access Agency	☐ **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: Contracted access agencies	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
The number and percent of service plans that are reviewed/updated at least annually. Numerator is number of service plans reviewed annually and the denominator is the number of plans due to be reviewed annually.

Data Source (Select one):
Record reviews, on-site
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:

contracted care management agency		
	☒ **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: contracted care management agency	☒ **Annually**
	☒ **Continuously and Ongoing**
	☐ **Other** Specify:

d. ***Sub-assurance: Services are delivered in accordance with the service plan, including the type, scope, amount, duration and frequency specified in the service plan.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-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 percentage of waiver participants who report via HCBS CAHPS survey that their staff come to work on time. Numerator is number of survey respondents who report their staff come to work on time and denominator is number of participants who completed the HCBS CAHPS survey.

Data Source (Select one):
Analyzed collected data (including surveys, focus group, interviews, etc)
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 = confidence interval=95% Margin of error= +/- 5%
☒ **Other** Specify: contracted care management agency	☐ **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: University of Connecticut	☒ **Annually**
	☒ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Number and percent of participants who have completed the HCBS CAHPS survey who report that staff worked as long as they were supposed to. Numerator is number of clients who indicate in responses to HCBS CAHPS survey that staff worked as long as they were supposed to and denominator is number of participants who completed the survey.

Data Source (Select one):
Analyzed collected data (including surveys, focus group, interviews, etc)
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 = confidence interval=95% margin of error= +/- 5%

☒ **Other** Specify: contracted care management agency	☐ **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: University of Connecticut	☒ **Annually**
	☒ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Number and percent of participant records that document waiver services were delivered in the type, scope, amount, duration and frequency per the service plan. Numerator: number of waiver participant records documenting that waiver services were delivered in the type, scope, amount, duration and frequency per the service plan Denominator: Number of waiver participants whose records were reviewed

Data Source (Select one):

Record reviews, on-site
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 = confidence interval=95% margin of error= +/- 5%
☒ **Other** Specify: contracted care management agency	☒ **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**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **Other** Specify: contracted care management agency	☒ **Annually**
	☒ **Continuously and Ongoing**
	☐ **Other** Specify:

e. ***Sub-assurance: Participants are afforded choice: Between/among waiver services and providers.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-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:
The number and percent of participants who sign a Freedom of Choice form w-990 which states that the participant has the right to choose from and between services and providers. Numerator is the number of participants who sign the freedom of choice form and the denominator is the total number of participant records reviewed.

Data Source (Select one):
Record reviews, on-site
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 = confidence interval=95% margin of error= +/- 5%
☒ **Other** Specify: contracted care management agency	☒ **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:
The number and percent of participants completing the HCBS CAHPS survey who indicate that they can choose the services which matter to them. The numerator is the number who report they were able to choose services that mattered and the denominator is the number of participants who completed surveys.

Data Source (Select one):
Analyzed collected data (including surveys, focus group, interviews, etc)
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 = confidence interval=95% margin of error= +/- 5%
☒ **Other** Specify: contracted care management agency	☐ **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: University of Connecticut	☒ **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.

Feedback from contracted providers and Department staff is collected through scheduled bi-monthly meetings. There are several levels of record audits and quality improvement/assurance activities that occur. Contracted care management agencies do supervisory record reviews and also have an external record review process in place as required by their contract with the Department. In addition, the department does a random sample of chart audits on a rotating basis for all of the contracted care management agencies annually. Participant chart audits identify inconsistencies in required documentation and identify trends.
A committee, led by the DMHAS APRN Program Director of Geriatric Services, was established to discuss identified mental health issues of waiver clients. As a result, a network of community mental health support services has been established, additional training sessions for care managers have been planned.

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.

Individual problems are discovered through chart audits, satisfaction surveys, participants reporting concerns directly, and reporting individual concerns through the critical incident reporting system. HCBS clinical quality assurance staff are notified of concerns, collect information from other parties involved, and provide oversight and monitoring until satisfactory resolution is achieved. Documentation is maintained in the online system to record incidents and identify trends. Identified trends lead to needed procedural changes and influence policy development.

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**

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☐ **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 Service Plans that are currently non-operational.

◉ **No**

○ **Yes**

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

Appendix E: Participant Direction of Services

Applicability *(from Application Section 3, Components of the Waiver Request)*:

○ **Yes. This waiver provides participant direction opportunities.** Complete the remainder of the Appendix.

◉ **No. This waiver does not provide participant direction opportunities.** Do not complete the remainder of the Appendix.

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

Indicate whether Independence Plus designation is requested *(select one):*

○ **Yes. The state requests that this waiver be considered for Independence Plus designation.**

○ **No. Independence Plus designation is not requested.**

Appendix E: Participant Direction of Services

E-1: Overview (1 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (2 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (3 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (4 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (5 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (6 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (7 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (8 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (9 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (10 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (11 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (12 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (13 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant Direction (1 of 6)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (2 of 6)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (3 of 6)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (4 of 6)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (5 of 6)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (6 of 6)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix F: Participant Rights

Appendix F-1: Opportunity to Request a Fair Hearing

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

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

Applicants for and participants under this Waiver may request and receive a fair hearing in accordance with DSS' policy and procedures. Applicants will receive a copy of the DSS W-889 Informed Consent Form and W-990, Your Rights and Responsibilities, during the first visit with the Care Manager. Participants are eligible for Fair Hearings in the following circumstances:

Participant was not offered the choice of home and community services as an alternative to institutional care;
DSS does not reach a determination of financial eligibility within standards of promptness;
DSS denies the application for the individual not meeting the level of care or other eligibility criteria;
DSS disapproves the individual's Plan of Care;
DSS denies or terminates a service of the individual's choice;
DSS denies or terminates a payment to a provider of the individual's choice; or
DSS discharges an individual from this Waiver.

In accordance with Connecticut Medicaid rules, a Notice of Action (NOA) will be sent to a Waiver participant when any service is denied, reduced, suspended or terminated. The NOA and Freedom of Choice/Fair Hearing Notification will be provided in Spanish to support providing persons with LEP or non-English proficiency.

Per the Department of Social Services Uniform Policy Manual (UP-91-8 1570.20), the Department does not terminate or reduce the participant's benefits until the Fair Hearing decision is reached if the participant requests a Fair Hearing within the 10 day notice period. The participant's benefits remain the same pending the Fair Hearing decision. Per DSS Uniform Policy Manual (UP-91-32 1570.10), the Department mails or gives adequate notice at least ten days prior to the date of the intended action if the Department intends to discontinue, terminate, suspend, or reduce benefits. The only exceptions to this policy are if the participant dies or state or federal law supersede the Department's policy to continue benefits while awaiting a Fair Hearing decision.

The Department issues and publicizes all Fair Hearing policies and procedures in all participant correspondence. At the time of application and at the time of any action affecting the participant's benefits, the Department informs the participant, in writing, of the right to a Fair Hearing; how the participant can request a Fair Hearing; and that the requester may be self-representative, may use legal counsel, a relative, friend, or other spokesperson and is provided with contact information for the local Legal Aid office.

Form W-1513 is an example of a form used by the CT Home Care Program for Elders that provides detailed instructions for requesting a fair hearing in English and in Spanish.

The Office of Legal Counsel, Regulations and Administrative Hearings, the participant and Community Options Unit receive copies of documentation related to the Fair Hearing. Copies are kept on file with the Office of Legal Counsel, Regulations and Administrative Hearings as well as in the participant's chart. The participant is informed in writing of the outcome of the fair hearing.

Appendix F: Participant-Rights

Appendix F-2: Additional Dispute Resolution Process

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

- (●) **No. This Appendix does not apply**
- ( ) **Yes. The state operates an additional dispute resolution process**

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

Appendix F: Participant-Rights

Appendix F-3: State Grievance/Complaint System

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

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

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

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

Appendix G: Participant Safeguards

Appendix G-1: Response to Critical Events or Incidents

a. Critical Event or Incident Reporting and Management Process. Indicate whether the state operates Critical Event or Incident Reporting and Management Process that enables the state to collect information on sentinel events occurring in the waiver program.*Select one:*

- (●) **Yes. The state operates a Critical Event or Incident Reporting and Management Process** *(complete Items b through e)*
- ( ) **No. This Appendix does not apply** *(do not complete Items b through e)*

If the state does not operate a Critical Event or Incident Reporting and Management Process, describe the process that the state uses to elicit information on the health and welfare of individuals served through the program.

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

Connecticut employs strict protocols regarding the reporting of abuse, neglect, and exploitation. DSS has demanding and prescriptive procedures for incident and management reporting systems. These procedures are dictated by State statute and regulation. The objective is to identify, address and seek to prevent instances of abuse, neglect and exploitation. See the overview below for a summary of DSS procedures.

Overview
Persons served by this waiver are under the authority of the PSE Statute 17b-450-461 for Elders. Mandadory reporting is required for serious incidents which are defined as involving abuse/neglect or other imediate risk. Mandated reporters include all staff employed directly by client, provider or agency, including Care Manager and central office staff. In addition, clergy, police officers, social workers, medical professionals and nursing home staff are mandatory reporters for elders.

An electronic system has been developed to receive and process information regarding critical incidents. A user guide has been developed to assist mandated reporters in making reports into the Ascend system:

Critical Incident Reporting Policy and Procedure

The purpose of Critical Incident reporting is to document, evaluate and monitor serious or severe occurrences that affect the well-being of CHC clients. A Critical Incident is an actual or alleged event, incident or course of action involving the perceived or actual threat to a client's health, welfare or ability to remain in the community.

It is the responsibility of the care manager or other staff person that discovers the critical incident or has knowledge of the critical incident to investigate and report the alleged critical incident to ACU using the Ascend online system. When reporting a critical incident, be prepared to provide enough information so the reviewer knows:

- Who was involved in the inciden?
- What were the circumstances of the incident - details
- Where the incident happened
- When the incident took place, date and time
- What provider agency was involved (drop down box)

The report should provide enough detail to understand the circumstances of the incident, document the steps taken to respond to the incident, identify how the client's safety has been addressed, the follow-up measures taken and/or planned, and document whether mandatory reporting has occurred.

Additional follow-up will be required when the report lacks sufficient information for the reviewer to understand the nature of the incident, how a client or situation has been stabilized, what safety measures have been taken to investigate and remedy the circumstances. ACU should be notified if it appears that a more formal investigation of the provider agency is warranted.

Critical incidents should be reported using the Ascend website
https://www.ascendami.com/CTHomeCareForElders/SharedFiles/CriticalIncident.aspx?ddmkey=kOfDQfA1U/e5kyikGdPaoOknW
All requested data should be entered and accompanying narrative should be as specific as possible.
It is expected that critical incident reports will be made within 2 business days from occurrence. The following incidents must be reported:

Unexpected Absence of the Primary Caregiver
Any event that results in the client's inability to receive services that places his or her health or safety at risk. This includes involuntary termination by the provider agency and failure of the client's back up plan. This occurs when the primary caregiver becomes ill, calls out sick, does not report to client's home for duty, experiences a family emergency, other circumstance. The narrative should document the occurrence, name of caregiver, reason for absence, agency, and any adverse events that may have resulted from the incident. Unexpected absences should only be reported when they present specific risks to health and safety. There is no need to report every caregiver who fails to show up for their shift.

Untimely Death
The client dies unexpectedly from either natural causes, accident, alleged caregiver malpractice, or suspected criminal action. This does not include deaths that can be anticipated such as terminal illness. The narrative should include the cause of death, if known, circumstances such as who reported the death, involvement of law enforcement, and other

pertinent information.

Emergency Room Visit or Unplanned Hospitalization
Incidents should be documented when there is an emergency room visit or hospitalization four times or more within a six month period. This will help to detect potential preventive measures or identify medical interventions that may prevent unnecessary use of emergency room or hospital inpatient stays. The narrative should state date, distinguish between hospitalization or emergency room visit, which facility utilized and diagnosis. Once reported, the clock resets and the following four or more in six months is then reported. Scheduled hospitalizations should not be reported.

Suicide Attempt
All actual or suspected suicide attempts must be reported and followed up by appropriate intervention and linkage with mental health services. Suicidal threats or ideation would not be documented in this area.

Serious Criminal Allegation – Client as Victim
Any action committed against the client that could result in arrest and/or incarceration of an alleged perpetrator must be reported, followed up by appropriate law enforcement intervention, with client's or authorized representative's permission.

Serious Criminal Allegation – Client as Perpetrator
Client is the alleged perpetrator of criminal activity that may result in client's arrest and/or incarceration. If client has assaulted a paid caregiver, narrative should describe the alleged criminal action, intervention, safety strategy and results.

Allegations of Abuse, Neglect, Exploitation
Abuse is the willful infliction of injury, unreasonable confinement, intimidation or punishment with resulting physical harm, pain or mental anguish. Abuse can include sexual assault, physical assault, verbal abuse, rape.

Neglect is the failure to provide goods and services necessary to avoid physical harm, mental anguish, or mental illness. Neglect can include insufficient staffing; staff not performing assigned tasks; care not being given by family or others who have agreed to provide support; self-neglect (refuses food, hygiene, medications including substance abuse and dangerous behavior); refuses necessary services; residential environments that may create a threat to life, health or safety such as lack of repairs, heat, hot water, electricity, unsanitary or toxic conditions.

Exploitation is the misappropriation of property, the deliberate misplacement of client's property, or wrongful, temporary or permanent use of a client's belongings or money without the client's consent; deliberate damage, destruction, theft, misplacement or use of a client's belongings or money without the client's consent, including the deliberate diversion of medications.

Narratives should be clear and contain sufficient detail about who was involved, provider agency, request for and results of provider agency investigation, name of alleged perpetrator, description of what happened, actions taken, notification of or involvement with Protective Services for the Elderly, Law Enforcement, changes in care plans, referrals to other services as needed.

Restraint: A restraint is any manual method, physical or mechanical device, material or equipment that immobilizes or reduces the ability of a client to move his or her arms, legs, body, or head freely or a drug or medication when it is used as a restriction to manage the client's behavior or restrict the client's freedom of movement and is not a standard treatment or dosage for that clients condition.

Seclusion: the involuntary confinement of a client alone in a room or an area from which the client is physically prevented from leaving. Seclusion may also be used for the management of violent or destructive behavior.

Other
Describe any other incident that poses a risk to the client's health or safety in the space provided.

For DSS Internal Review
"Recommendations for waiver or system change -In the agency's internal review of this event, are there any recommendations offered to improve the quality of care for other waiver participants or changes in policy/procedure? If so, summarize the recommendations/changes and the plans for implementation." ACU staff may notice patterns from

data reporting that emerge as a widespread systemic problem or may suggest the need for programmatic changes.

All members of the participant's care planning team, support staff and service agency staff members are required to report critical incidents. Recipients of Critical Incident reporters include:

Participant's Care Manager
Participant and/or Conservator
DSS Quality Assurance Staff
Participant's Provider.

Response to Serious Events
All State departments involved with HCBS waivers initiate investigations of any serious issues. Other parties are contacted and interviewed as appropriate. If a concern were raised about any matter that has come up while the consumer was under the support of a provider, the provider would be required to submit an incident report. The specific manner of follow-up for such concerns is determined by the nature of the allegation and the results of the investigation. Possible actions include the suspension or removal of a provider from the active registry/approved provider list or reporting to law enforcement or licensure agencies (e.g., Department of Public Health). Action to ensure the safety of a participant who is at imminent risk occurs immediately (removal of provider and replacement with equivalent service provider). Additional follow-up with other entities include but are not limited to DSS units/divisions (e.g., Quality Assurance, Medical Policy, Legal), law enforcement, Department of Public Health may be necessary.

When a participant in this waiver is a victim of abuse, neglect or exploitation, a referral to Protective Services for Elders is made. The care manager is responsible for ensuring that the report is made. In addition, police are notified if any criminal action occurs. Any party involved in the investigation process may initiate contact with PSE or the police. All contacts with PSE and/or the police must be documented as part of the investigation process.
PSE Statute 17b-450 - 461 provides the framework for the investigation of abuse or neglect.

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

Critical incident reporting comes to quality assurance clinical staff members who handle quality assurance for this waiver. At this time, a Licensed Clinical Social Worker and a Health Program Supervisor receive and document all reported critical events or incidents. Reports are reviewed upon receipt and responses are tracked. Staff members also confer with the Protective Services Manager when needed. The Ascend data base is maintained and analysis is done for trends. Policies and procedures are developed in response to identified trends and utilized to prevent reoccurrence. Problematic situations are monitored and addressed on an individual and ongoing basis as needed.

The PSE worker is required to provide a written status report using DSS form W-917 regarding the disposition of the case within 5 working days of the completion of the investigation. DSS quality assurance staff monitors the situation until satisfactory resolution is reached.

The Department quality assurance staff consisting of a Licensed Clinical Social Worker and a Health Program Supervisor oversees the critical incident reporting system and coordinates activities with Protective Services for Elders.

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

Training is provided to all participants and involved family or other unpaid caregivers via Care Managers on protections from abuse, neglect, and exploitation, including how participants(and/or families or legal representatives, as appropriate) can notify appropriate authorities or entities when the participant may have experienced abuse, neglect or exploitation. Identification and the prevention of neglect, abuse and exploitation is a standard component of Care Manager orientation and training. Upon assessment, when services are initiated, and on an ongoing basis, no less than monthly contact, participants and caregivers are given training as teaching opportunities arise. Protective Services for Elders has a statewide toll-free number for reporting abuse, neglect and exploitation. Infoline 211 handles after hours reports. DSS publishes a brochure on PSE reporting.

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

Critical incident reporting comes to quality assurance staff, a Health Program Supervisor and a Licensed Clinical Social Worker who receive all reported critical events or incidents through the Ascend on-line system. Reports are reviewed upon receipt and responses are tracked. The Community Nurse supervisor is also the unit's liaison with the Protective Services Manager. A database is maintained within Community Options and analysis is done for trends. Policies and procedures are developed in response to identified trends and utilized to prevent reoccurrence. Problematic situations are monitored and addressed on an individual and ongoing basis as needed. As problematic providers are identified, staff do on site visits and make recommendations for remediation activities.

Any suspected abuse, neglect, exploitation and/or abandonment of home care program clients is mandated for report to Elderly Protective Services. Appropriate referrals will be initiated via telephone within 72 hours of suspecting that an elder has been abused, neglected and/or exploited. The telepohne report is followed up with a written referral using the DSS form W-675 within 5 working days. A written copy of all referrals made to PSE by care managers or ALSA staff shall be sent to DSS ACU Health and Safety Nurse Consultant. PSE will investigate and determine whether substantiation should occur. The PSE worker is required to provide a written status report using DSS form W-917 regarding the disposition of the case within 5 working days of the completion of the investigation. DSS quality assurance staff monitor the situation until satisfactory resolution is reached and share the outcome with the care manager, client and/or their representative generally within 24 hours of receiving the information.

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

The Department quality assurance staff consisting of a Health Program Supervisor, Community Nurse Coordinator and Licensed Clinical Social Worker oversee the critical incident reporting system and coordinates activities with Protective Services for Elders. The critical incident reports are available on the on-line system immediately. Quality Assurance Staff monitor the critical incident queue on a daily basis and can respond immediately upon receiving the report. Quality Assurance Staff review the report and may request more information, follow up, reports on provider agency investigations of alleged abuse, neglect or exploitation. The type of incidents that are reported are as follows: unexpected absence of the primary caregiver; untimely death; emergency room visit or unplanned hospitalization; suicide attempt; serious criminal allegation -client as victim; serious criminal allegation - client as perpetrator; allegations of abuse, neglect, or exploitation of client; fire in residence with significant risk to client; missing person reported to police; misappropriation of client's funds; seclusion; restraint; and other situations that fall outside of these categories. DSS Quality Assurance staff may conduct an internal review to make recommendations for system change. In the agency's internal review of this event, recommendations may be offered to improve the quality of care for other waiver participants or changes in policy/procedure.

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (1 of 3)

a. Use of Restraints. *(Select one)*: *(For waiver actions submitted before March 2014, responses in Appendix G-2-a will display information for both restraints and seclusion. For most waiver actions submitted after March 2014, responses*

regarding seclusion appear in Appendix G-2-c.)

◉ **The state does not permit or prohibits the use of restraints**

Specify the state agency (or agencies) responsible for detecting the unauthorized use of restraints and how this oversight is conducted and its frequency:

DSS investigates cases of abuse, neglect, abandonment and exploitation of the elderly and the disabled as noted above. Suspected use of restraints or seclusion which occurs in the home or community is reported to the state's 24-hour abuse hotline and investigations are completed within 24 hours or less. DSS also investigates complaints and incidents where restraints or seclusion are used in institutional settings. Investigation may be delegated to the Care Manager or conducted jointly with Department staff. The use of restraints or seclusion is not allowed in the State of Connecticut.
Care manager visits, observation and interview is the methodology utilized to detect any unauthorized use of restrictive interventions or seclusion used for home care clients. The state is using the Universal Assessment tool based on the interRAI model. Questions are included in the assessment regarding the use of restraints, restrictive interventions and seclusion.

○ **The use of restraints is permitted during the course of the delivery of waiver services**. Complete Items G-2-a-i and G-2-a-ii.

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

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

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (2 of 3)

b. Use of Restrictive Interventions. *(Select one)*:

◉ **The state does not permit or prohibits the use of restrictive interventions**

Specify the state agency (or agencies) responsible for detecting the unauthorized use of restrictive interventions and how this oversight is conducted and its frequency:

DSS is responsible for investigating reports of abuse, neglect, abandonment and exploitation of the elderly and the disabled. Incidents of restrictive interventions which occur in the home or community are reported to the state's 24-hour abuse hotline and investigations are completed within 24 hours or less. Incidents which occur in institutional facilities would also be investigated by DSS as well. Investigations may be delegated to the Care Managers or conducted jointly with Department staff.

Care manager visits, observations and interviews are the methodologies utilized to detect any unauthorized use of restricitve interventions used for waiver participants.
The Universal Assessment tool, based on the interRAI model,includes questions regarding the use of restraints, restrictive interventions and seclusion.

○ **The use of restrictive interventions is permitted during the course of the delivery of waiver services** Complete Items G-2-b-i and G-2-b-ii.

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

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

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (3 of 3)

c. Use of Seclusion. *(Select one)*: *(This section will be blank for waivers submitted before Appendix G-2-c was added to WMS in March 2014, and responses for seclusion will display in Appendix G-2-a combined with information on restraints.)*

◉ **The state does not permit or prohibits the use of seclusion**

Specify the state agency (or agencies) responsible for detecting the unauthorized use of seclusion and how this oversight is conducted and its frequency:

DSS is responsible for investigating reports of abuse, neglect, abandonment and exploitation of the elderly and the disabled. Incidents of seclusion which occur in the home or community are reported to the state's 24-hour abuse hotline and investigations are completed within 24 hours or less. Incidents which occur in institutional facilities would also be investigated by DSS as well. Investigations may be delegated to the Care Managers or conducted jointly with Department staff.

Care manager visits, observations and interviews are the methodologies utilized to detect any unauthorized use of restricitve interventions used for waiver participants. The HCBS unit also has modified its critical incident reporting form to include reporting of incidents of restraints, seclusion or restrictive interventions. Incident reports are compared to reports created from the assessment and reassessment that specifically ask these questions.

The Universal Assessment tool,based on the interRAI model, includes questions regarding the use of restraints, restrictive interventions and seclusion.

○ **The use of seclusion is permitted during the course of the delivery of waiver services**. Complete Items G-2-c-i and G-2-c-ii.

i. Safeguards Concerning the Use of Seclusion. Specify the safeguards that the state has established concerning the use of each type of seclusion. State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

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

Appendix G: Participant Safeguards

Appendix G-3: Medication Management and Administration (1 of 2)

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

a. Applicability. Select one:

◉ **No. This Appendix is not applicable** *(do not complete the remaining items)*

○ **Yes. This Appendix applies** *(complete the remaining items)*

b. Medication Management and Follow-Up

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

ii. Methods of State Oversight and Follow-Up. Describe: (a) the method(s) that the state uses to ensure that participant medications are managed appropriately, including: (a) the identification of potentially harmful practices

(e.g., the concurrent use of contraindicated medications); (b) the method(s) for following up on potentially harmful practices; and, (c) the state agency (or agencies) that is responsible for follow-up and oversight.

Appendix G: Participant Safeguards

Appendix G-3: Medication Management and Administration (2 of 2)

c. Medication Administration by Waiver Providers

Answers provided in G-3-a indicate you do not need to complete this section

i. Provider Administration of Medications. *Select one:*

- ○ **Not applicable.** *(do not complete the remaining items)*
- ○ **Waiver providers are responsible for the administration of medications to waiver participants who cannot self-administer and/or have responsibility to oversee participant self-administration of medications.** *(complete the remaining items)*

ii. State Policy. Summarize the state policies that apply to the administration of medications by waiver providers or waiver provider responsibilities when participants self-administer medications, including (if applicable) policies concerning medication administration by non-medical waiver provider personnel. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

iii. Medication Error Reporting. *Select one of the following:*

- ○ **Providers that are responsible for medication administration are required to both record and report medication errors to a state agency (or agencies).**
  Complete the following three items:

  (a) Specify state agency (or agencies) to which errors are reported:

  (b) Specify the types of medication errors that providers are required to *record:*

  (c) Specify the types of medication errors that providers must *report* to the state:

- ○ **Providers responsible for medication administration are required to record medication errors but make information about medication errors available only when requested by the state.**

Specify the types of medication errors that providers are required to record:

iv. State Oversight Responsibility. Specify the state agency (or agencies) responsible for monitoring the performance of waiver providers in the administration of medications to waiver participants and how monitoring is performed and its frequency.

Appendix G: Participant Safeguards

Quality Improvement: Health and Welfare

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: Health and Welfare

The state demonstrates it has designed and implemented an effective system for assuring waiver participant health and welfare. *(For waiver actions submitted before June 1, 2014, this assurance read "The State, on an ongoing basis, identifies, addresses, and seeks to prevent the occurrence of abuse, neglect and exploitation.")*

i. Sub-Assurances:

a. ***Sub-assurance: The state demonstrates on an ongoing basis that it identifies, addresses and seeks to prevent instancesof abuse, neglect, exploitation and unexplained death.*** *(Performance measures in this sub-assurance include all Appendix G performance measures for waiver actions submitted before June 1, 2014.)*

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-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 participants whose records indicate they received information about how to identify and report abuse, neglect, and exploitation.
Numerator=Number of participants records that indicate they received information about how to identify and report abuse, neglect, and exploitation.
Denominator=number of participant records reviewed.

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

Responsible Party for data collection/generation	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(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: contracted care management agency	☒ **Annually**	☐ **Stratified** Describe Group:
	☒ **Continuously and Ongoing**	☒ **Other** Specify: The supervisory reviews are done on a representative sample of records. The on site reviews done by Community Options staff are above and beyond that representative sample.
	☐ **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: contracted care management agency	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
The number and percent of participants completing the HCBS CAHPS survey who can identify someone they would contact in case of an emergency. Numerator is the number of participants who can identify someone they would contact in case of emergency, and the denominator is the total sample of participants who answer the question.

Data Source (Select one):
Analyzed collected data (including surveys, focus group, interviews, etc)
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 = confidence interval= 95% margin of error= +/- 5%

☒ **Other** Specify: contracted care management agency	☒ **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: University Of Connecticut	☒ **Annually**
	☒ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Number and percent of abuse, neglect, exploitation and unexplained death incidents investigated within the required timeframe. Numerator: number of incidents of abuse, neglect, exploitation and unexplained death incidents investigated within the required timeframe. Denominator: Number of abuse, neglect, exploitation and unexplained death incidents.

Data Source (Select one):

Critical events and incident reports
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:
	☒ **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**	☒ **Annually**

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

Performance Measure:
Number and percent of cases of substantiated abuse, neglect, exploitation and unexplained death in which the required follow up was completed. Numerator: Number of cases of substantiated abuse, neglect, exploitation and unexplained death in which the required follow up was completed Denominator: number of cases of substantiated abuse, neglect, exploitation and unexplained death.

Data Source (Select one):
Critical events and incident reports
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: contracted care management agency	☒ **Annually**	☐ **Stratified** Describe Group:
	☒ **Continuously and**	☐ **Other**

	Ongoing	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: contracted care management agency	☒ **Annually**
	☒ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Number and percent of participants who respond positively to questions on Safety and Respect on the HCBS CAHPS survey that staff didn't steal from them, yell at them and there is someone the participant can talk to if someone hurts them. Numerator: number of participants who respond affirmatively to the composite questions. Denominator: number of participants in the sample completing the survey

Data Source (Select one):
Analyzed collected data (including surveys, focus group, interviews, etc)
If 'Other' is selected, specify:

Responsible Party for data collection/generation	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(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 = confidence interval=95% margin of error= +/- 5%
☒ **Other** Specify: contracted care management agency CAHPS survey	☒ **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):*
University of Connecticut CAHPS Survey	
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

b. ***Sub-assurance: The state demonstrates that an incident management system is in place that effectively resolves those incidents and prevents further similar incidents to the extent possible.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-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 serious incident reports that are reported using the HCBS unit's critical incident reporting system within 2 business days as required by the waiver. Numerator= Number of serious incident reports that are reported within 2 business days. Denominator: Number of serious incident reports.

Data Source (Select one):
Critical events and incident reports
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: contracted care management agency	☐ **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: contracted care management agencies	☒ **Annually**
	☒ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Number and percent of critical incidents requiring investigation where the Department followed up using the HCBS Unit's policies and procedures. Numerator: number of critical incident investigations adhering to the Unit's policies and

procedures. Denominator is the total number of critical incidents.

Data Source (Select one):
Critical events and incident reports
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: case management agency	☒ **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**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **Sub-State Entity**	☐ **Quarterly**
☒ **Other** Specify: contracted care management agency	☒ **Annually**
	☒ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Number and percent of participants responding to the CAHPS survey who indicate that none of their staff have hit them or hurt them. Number of participants surveyed who report that staff have not hit or hurt them. Denominator: number of completed participant surveys

Data Source (Select one):
Analyzed collected data (including surveys, focus group, interviews, etc)
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 = confidence interval=95% margin of error = +/- 5%
☒ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:

case management agency		
	☒ **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: University of Connecticut	☒ **Annually**
	☒ **Continuously and Ongoing**
	☐ **Other** Specify:

c. ***Sub-assurance: The state policies and procedures for the use or prohibition of restrictive interventions (including restraints and seclusion) are followed.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-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:
The number and percent of incident reports that report restrictive intervention, restraints and/or seclusion, were used in which the remediation was completed per policy. Numerator: number of reports of restrictive interventions, restraints/seclusion remediated and followed up according to policy. Denominator: total number reports of restrictive interventions, restraints, and/or seclusion.

Data Source (Select one):
Critical events and incident reports
If 'Other' is selected, specify:
Data reports from the Universal Assessment

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: contracted care management agency	☐ **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: contracted care management agency	☐ **Annually**
	☒ **Continuously and Ongoing**
	☐ **Other** Specify:

d. ***Sub-assurance: The state establishes overall health care standards and monitors those standards based on the responsibility of the service provider as stated in the approved waiver.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-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 participants who are assessed for age appropriate preventative health care. Numerator is the number of participants who are assessed for age appropriate health care, and denominator is the total number of participants assessed.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Data reports on universal assessments completed

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**	☐ **Weekly**	☒ **100% Review**

Agency		
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☒ **Other** Specify: contracted care management agency	☐ **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: University of Connecticut	☒ **Annually**
	☒ **Continuously and Ongoing**
	☐ **Other** Specify:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*

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 state relies on the incident management system and reports generated from the Universal assessment to identify specific problems

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.

Clinical staff review critical incidents as they are submitted and work with the access agency on remediation strategies

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:	☐ **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 Health and Welfare that are currently non-operational.

◉ **No**

○ **Yes**

Please provide a detailed strategy for assuring Health and Welfare, the specific timeline for implementing identified

strategies, and the parties responsible for its operation.

Appendix H: Quality Improvement Strategy (1 of 3)

Under §1915(c) of the Social Security Act and 42 CFR §441.302, the approval of an HCBS waiver requires that CMS determine that the state has made satisfactory assurances concerning the protection of participant health and welfare, financial accountability and other elements of waiver operations. Renewal of an existing waiver is contingent upon review by CMS and a finding by CMS that the assurances have been met. By completing the HCBS waiver application, the state specifies how it has designed the waiver's critical processes, structures and operational features in order to meet these assurances.

- Quality Improvement is a critical operational feature that an organization employs to continually determine whether it operates in accordance with the approved design of its program, meets statutory and regulatory assurances and requirements, achieves desired outcomes, and identifies opportunities for improvement.

CMS recognizes that a state's waiver Quality Improvement Strategy may vary depending on the nature of the waiver target population, the services offered, and the waiver's relationship to other public programs, and will extend beyond regulatory requirements. However, for the purpose of this application, the state is expected to have, at the minimum, systems in place to measure and improve its own performance in meeting six specific waiver assurances and requirements.

It may be more efficient and effective for a Quality Improvement Strategy to span multiple waivers and other long-term care services. CMS recognizes the value of this approach and will ask the state to identify other waiver programs and long-term care services that are addressed in the Quality Improvement Strategy.

Quality Improvement Strategy: Minimum Components

The Quality Improvement Strategy that will be in effect during the period of the approved waiver is described throughout the waiver in the appendices corresponding to the statutory assurances and sub-assurances. Other documents cited must be available to CMS upon request through the Medicaid agency or the operating agency (if appropriate).

In the QIS discovery and remediation sections throughout the application (located in Appendices A, B, C, D, G, and I) , a state spells out:

- The evidence based discovery activities that will be conducted for each of the six major waiver assurances; and
- The *remediation* activities followed to correct individual problems identified in the implementation of each of the assurances.

In Appendix H of the application, a state describes (1) the *system improvement* activities followed in response to aggregated, analyzed discovery and remediation information collected on each of the assurances; (2) the correspondent *roles/responsibilities* of those conducting assessing and prioritizing improving system corrections and improvements; and (3) the processes the state will follow to continuously *assess the effectiveness of the OIS* and revise it as necessary and appropriate.

If the state's Quality Improvement Strategy is not fully developed at the time the waiver application is submitted, the state may provide a work plan to fully develop its Quality Improvement Strategy, including the specific tasks the state plans to undertake during the period the waiver is in effect, the major milestones associated with these tasks, and the entity (or entities) responsible for the completion of these tasks.

When the Quality Improvement Strategy spans more than one waiver and/or other types of long-term care services under the Medicaid state plan, specify the control numbers for the other waiver programs and/or identify the other long-term services that are addressed in the Quality Improvement Strategy. In instances when the QIS spans more than one waiver, the state must be able to stratify information that is related to each approved waiver program. Unless the state has requested and received approval from CMS for the consolidation of multiple waivers for the purpose of reporting, then the state must stratify information that is related to each approved waiver program, i.e., employ a representative sample for each waiver.

Appendix H: Quality Improvement Strategy (2 of 3)

H-1: Systems Improvement

a. System Improvements

i. Describe the process(es) for trending, prioritizing, and implementing system improvements (i.e., design changes) prompted as a result of an analysis of discovery and remediation information.

The State of Connecticut has been utilizing a comprehensive system of checks and balances in order to establish consistent quality assurance within services provided to participants through this waiver. The state has been guided by state and federal regulations to assist in establishing procedures and the many varied data collection, agregation and analysis processes that are currently utilized. Through the productive process of analysis, discovery, remediation and improvement, the state recognizes the benefit to participant services that can be obtained through some system design changes.

Currently, statewide chart audits of Access Agency participants are conducted quarterly. Access Agencies are required to provide a summary report of supervisory record reviews done on a regular basis. The Department increased the sampling size of Assisted Living Services Agency onsite record reviews to monitor improvement as a result of the collaborative efforts of the Department and the ALSA Association. Onsite reviews are conducted of 100% of ALSA facilities identified as problematic.
A tool was developed for Access Agency supervisors to complete when conducting supervisory record reviews, and its use has been implemented. Data is aggregated and adjustments are made to the tool as necessary.
DXC, our MMIS vendor, will be providing a report to the Department to provide data on the difference between services authorized and services actually delivered sorted by service type. This will allow for an analysis of trends and targeted remediation.
The State of Connecticut contracts with DXC to employ a data system to ensure reimbursement is consistent with waiver requirements. The provider relations unit oversees the contract with DXC, as part of the medical operations process. They can make changes to procedure codes, edits and audits. Clients are identified by Medical Eligibility or Benefit Plan code. Providers are based on type and specialty. The system is designed to make sure it can be billed only for what is allowed through the edits and audits system.

In addition, DXC developed a care plan portal in which the Access Agency Care Managers enter the client's care plan and prior authorization for services including date spans, number of units, authorized provider so that the providers can only bill what is authorized in the care plan.
The state has fully implemented Electronic Visit Verification (EVV) for in home providers under this waiver. This became effective 1/1/17. The system is comprehensive in which the authorization creates a schedule and time captured electronically in the system , is matched against the authorization. If there is a match, the system creates the claim to be submitted to DXC.

ii. System Improvement Activities

Responsible Party*(check each that applies):*	**Frequency of Monitoring and Analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☒ **Quality Improvement Committee**	☐ **Annually**
☒ **Other** Specify: contracted care management agencies ALSA facilities	☒ **Other** Specify: Continuous and Ongoing

b. System Design Changes

i. Describe the process for monitoring and analyzing the effectiveness of system design changes. Include a description of the various roles and responsibilities involved in the processes for monitoring & assessing system design changes. If applicable, include the state's targeted standards for systems improvement.

The process for monitoring service quality standards is through participant record audits at each contracted care management agency. DSS quality assurance clinical staff review each chart using a developed tool to measure compliance with documention required through contracts and regulations. Trending of information is gleaned from tools used. The DSS audit teams conducts an exit interview with the contracted care management agency supervisory staff to discuss findings. A formal report is generated to the contracted care management agency reflecting findings and recomendations for remediation. The agencies respond in writing with a plan of correction including timetables and process for implementation of improvements.

DSS utilizes the web-based critical incident reporting system whch allows for aggregation of data and has enhanced our ability to produce summary reports, detect trends and identify areas for improvement including on site monitoring of provider agencies.

ii. Describe the process to periodically evaluate, as appropriate, the Quality Improvement Strategy.

Evaluation of the Quality Improvement Strategy is continuous and ongoing. Reports are generated on the aggregated, analyzed data, scrutinized for trends and potential process improvements.

Ongoing dialog and opportunities for improved collaboration have been established in order to better serve this state's elder population. A QA workgroup composed of DSS Community Options Unit and contracted care management agency management and supervisory staff address ongoing QA/QI activities. This work group meets on a bi-monthly basis.

Appendix H: Quality Improvement Strategy (3 of 3)

H-2: Use of a Patient Experience of Care/Quality of Life Survey

a. Specify whether the state has deployed a patient experience of care or quality of life survey for its HCBS population in the last 12 months *(Select one):*

- ○ **No**
- ◉ **Yes** *(Complete item H.2b)*

b. Specify the type of survey tool the state uses:

- ◉ **HCBS CAHPS Survey :**
- ○ **NCI Survey :**
- ○ **NCI AD Survey :**
- ○ **Other** *(Please provide a description of the survey tool used):*

Appendix I: Financial Accountability

I-1: Financial Integrity and Accountability

Financial Integrity. *Describe the methods that are employed to ensure the integrity of payments that have been made for waiver services, including: (a) requirements concerning the independent audit of provider agencies; (b) the financial audit program that the state conducts to ensure the integrity of provider billings for Medicaid payment of waiver services, including the methods, scope and frequency of audits; and, (c) the agency (or agencies) responsible for conducting the financial audit program. State laws, regulations, and policies referenced in the description are available to CMS upon*

request through the Medicaid agency or the operating agency (if applicable).

The Auditors of Public Accounts monitor state agencies regarding fiscal and compliance matters. Auditors provide independent, unbiased and objective opinions and recommendations on the operation of state agencies and effectiveness in safeguarding resources. Financial compliance auditing is the principal responsibility plus an examination of performance in order to determine the effectiveness of an agency in achieving its expressed legislative purpose. The Performance Audit Team devotes its time mainly to performance auditing, focusing on particular programs administered by a state agency. Findings are reported and discrepancies are identified and presented to the program and/or the provider. The Auditors follow up to make sure that changes are made to achieve compliance with state and federal regulations.

The Department's Quality Assurance Unit conducts annual onsite provider audits to ensure that state and federal funds are being expended appropriately. Financial statements, paid claims data, and other material are reviewed to assure that services were rendered and the agency is compliant with federal and state regulations and to detect fraud. Providers who are found out of compliance may be fined, terminated from the Medicaid program as a provider or given recommendations for improvement to achieve compliance.

The Office of Quality Assurance conducts audits of billings and claim payments of providers. The Medical Audit Unit of Quality Assurance takes a statistically valid sample of 100 paid waiver claims per provider to test for compliance with applicable regulation, policy and contract language. They examine supporting documentation, including: time sheets; service orders, activity sheets; Plans of Care and other business records. Special audits can be initiated if increased financial volume indicates a potential problem or if complaints have been received regarding a specific provider. Access Agencies are required to obtain independent financial audits annually. These reports are reviewed by the Office of Quality Assurance and any identified weaknesses are addressed. In addition, the State Auditors of Public Accounts conduct audits of the Department's audit process in compliance with the Federal Single Audit Act Amendments of 1996 and the Federal Office of Management and Budget Circular A-133.

The Department's Provider Relations Unit monitors provider enrollment to assure that the MMIS contractor and fiscal intermediary are collecting and verifying required provider documentation prior to enrolling participating providers.

The Department fully implemented Electronic Visit Verification for waiver provider effective 1/1/17 and or skilled providers, 4/1/17

Appendix I: Financial Accountability

Quality Improvement: Financial Accountability

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: Financial Accountability Assurance:

The State must demonstrate that it has designed and implemented an adequate system for ensuring financial accountability of the waiver program. *(For waiver actions submitted before June 1, 2014, this assurance read "State financial oversight exists to assure that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver.")*

i. Sub-Assurances:

a. Sub-assurance: The State provides evidence that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver and only for services rendered.
(Performance measures in this sub-assurance include all Appendix I performance measures for waiver actions submitted before June 1, 2014.)

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-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 claims that are coded and paid for in accordance with the approved reimbursement methodology specified in the waiver. Numerator= number of claims paid in accordance with the approved waiver reimbursement strategy Denominator= total number of claims paid

Data Source *(Select one):*
Reports to State Medicaid Agency on delegated
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:* *MMIS contractor*	☒ ***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:* *MMIS contractor*	☐ ***Annually***
	☒ ***Continuously and Ongoing***
	☐ ***Other*** *Specify:*

Performance Measure:
Number and percent of waiver claims that are appropriately denied due to existing system edits and audits. Numerator= total number of claims that appropriately denied Denominator= total number of denied claims

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:* *MMIS contractor*	☐ ***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:* *MMIS contractor*	☒ ***Annually***
	☐ ***Continuously and Ongoing***
	☐ ***Other*** *Specify:*

Performance Measure:
Number and percent of paid claims that are supported by visit data captured in the EVV system and service authorizations. Numerator: number of paid claims supported by visit data captured in the EVV system. Denominator: number of paid claims for EVV mandated services

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***	☐ ***Weekly***	☒ ***100% Review***

Agency		
☐ ***Operating Agency***	☐ ***Monthly***	☐ ***Less than 100% Review***
☐ ***Sub-State Entity***	☐ ***Quarterly***	☐ ***Representative Sample*** *Confidence Interval =*
☒ ***Other*** *Specify:* *MMIS contractor*	☒ ***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:* *MMIS Contractor*	☒ ***Annually***
	☐ ***Continuously and Ongoing***
	☐ ***Other*** *Specify:*

Responsible Party for data aggregation and analysis *(check each that applies):*	***Frequency of data aggregation and analysis****(check each that applies):*

b. Sub-assurance: The state provides evidence that rates remain consistent with the approved rate methodology throughout the five year waiver cycle.

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-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 rates that remained consistent with the approved rate methodology specified in the waiver. Numerator: number of rates that remained consistent with the approved rate methodology specified in the waiver. Denominator: number of rates.

Data Source *(Select one):*
Other
If 'Other' is selected, specify:
Reports developed by Medicaid rate setting unit

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:*

	☐ ***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:*

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 state's fiscal intermediary must verify that each direct service provider meets the eligibility criteria to be a waiver provider. The fiscal intermediary monitors direct service provider eligibility and adherence to program requirements and standards while the Access Agencies moniotor the quality of service,service delivery in accordance with clients' plans of care and report concerns to the Department for further investigation. The fiscal intermediary is also required to do an on site review of a sample of providers to assess for the adequacy of documentation that would support the billing for the service. All providers are limited to billing approved procedure codes from the waiver fee schedule at the established rate. The MMIS system is coded with edits and audits that prohibit claim payment to non-waiver providers. Participants are assigned to a care management agency. All providers must be directly enrolled as CT Home Care Program for Elders provider type/specialty and bill from the allowed set of procedure codes and a specified rate. The care manager will load the authorized service plan into a web portal and the provider agencies will bill against the authorized plan. The EVV system checks the time data captured in the system electronically and compares it to the service authorization. Claims will deny when providers bill for services that were not authorized.

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.*

Billing irregularities are analyzed and necessary action is taken to correct the problem. Additional training may be provided if needed either by the fiscal intermediary, MMIS contractor or or both. Money may be recouped and legal action taken, if fraudulent claim activity is suspected and/or substantiated. The billing providers receive a remittance advice from the MMIS contractor listing all claims submitted, claim status (paid, denied, suspended, recoupment, mass adjustment). The remittance advice shows amount allowed, amount paid, applied income deducted. Denied claims use a four digit Explanation of Benefits code to denote denial reason. The code key appears on the remittance advice. There are two basic categories of denial reasons for the waiver - eligibility errors and provider errors. The MMIS contractor provider relations unit is available to help providers by phone and through formal training sessions or by onsite visits to help providers who need extra assistance with their claim submissions. The MMIS contactor has a dedicated Help Desk for providers experiencing difficulties with electronic claim submissions. All provider interaction with the MMIS contractor are documented through the Contact Tracking Management System (CTMS) which logs the date, provider, reason for the call and resolution of the problem.

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:* *contracted entity*	☒ ***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 Financial Accountability that are currently non-operational.

- (●) ***No***
- ( ) ***Yes***

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

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (1 of 3)

a. Rate Determination Methods. *In two pages or less, describe the methods that are employed to establish provider payment rates for waiver services and the entity or entities that are responsible for rate determination. Indicate any opportunity for public comment in the process. If different methods are employed for various types of services, the description may group services for which the same method is employed. State laws, regulations, and policies referenced in the description are available upon request to CMS through the Medicaid agency or the operating agency (if applicable).*

Rates are determined by the Department's Rate Setting Unit.
Pursuant to the Connecticut Department of Social Services Provider Manual, all schedules of payment for covered Medical Assistance Program goods and services shall be established by the Commissioner of Social Services and paid by the Department of Social Services in accordance with applicable federal and state statutes and regulations. Waiver service rates are based on direct and indirect costs of providing Waiver services. Consumers, provider organizations and DSS staff have had the opportunity to review the Waiver application and rates pursuant to the public notice. The Waiver application has been reviewed and approved by the committees of cognizance of the Connecticut state legislature. The rate structure for the program consists of 1) fee-for-service billing from an established fee schedule that pays uniform rates across providers; 2) usual and customary rates established individually with providers based on special provider needs such as serving hazardous urban areas which require accompaniment by security personnel; 3)"up to max" rates that are used for assistive technology equipment or other services such as home modifications that require manual pricing.
Maximum allowable rate for services are established by the department in its fee schedule. Rates do not vary for different providers of waiver services. Rates are usually prospective. If retroactive rate setting should occur, this will result in mass adjustments during a claim cycle to either compensate providers for a rate increase or recoupments if rates are decreased. During the life of this waiver, service rates may be adjusted based on legislatively approved increases or decreases to the Department's appropriation. The following services are priced at max fee - Adult Day Health Full Day Medical Model, Adult Day Health non-Medical model, Adult Day Health half day, Adult Family Living/Foster Care, Meals on Wheels -single, double, kosher/ethnic; Homemaker, Companion, Recovery Assistant Choreperson, Personal Care Attendant agency, Mental Health Counseling - office or home visit; Emergency Response System installation, one way, two way ongoing; Respite care by companion, homemaker, transportation - taxi, livery, invalid coach; case management, status review - hospital, nursing facility, home; initial assessment and reassessment. All are paid off a fee schedule. Assisted Living is paid at a usual and customary rate The following are manually priced: Highly skilled chore service and minor home modifications. The following is priced up to max: Assistive Technology and Environmental Accessibility Adaptations. Waiver participants are provided with rate information by the care manager during the development of the total plan of care. The efficient and economic rates for the various levels of Adult Family Living/Foster Care were developed by the Department's rate setting unit. The rates were built on a base rate established previously in an earlier version of this waiver. There were add-ons at each level of the service based on the individual participants assessed cognitive, functional and behavioral needs. The initial rate for Adult Family Living was a historic cost-based rate. Add-ons were the equivalent of the base rate plus a cost allocation for the average number of hours of personal care that would be needed. For example, Level 2 would be the base rate plus the approximate cost of 1.5 hours per day of personal care.
The department issued an RFP in December of 2012 to procure care management services. Contracts were awarded in June of 2013. The rate methodology for care management was cost-based, determined by the budgets submitted by each Access Agency in response to the RFP. The department will be reissuing an RFP for care management services during the new five year waiver cycle. A concurrent 1915-b(4) has been submitted The maximum allowable rate for the per diem care management service was lowered as a result of the unbundling and reassigning of the fiscal intermediary functions to a currently contracted fiscal intermediary. The rates for assessments, status reviews and annual reassessments were also based on costs and budgets in the RFP. Based on requirements of each service, status reviews are billed at one third the cost of the assessment and the annual reassessment is seventy five percent of the cost of a full assessment. The rate for Care Transitions is calculated at one-half the cost of the assessment based on budget information, care manager costs and time estimates for the provision of this service.
The Chronic Disease Self Management Program is a national program that has been utilized in the state as a grant funded program. The rate is based on the national average (NCOA cost calculator) and the rate used in the state when the program was grant funded.
The rate for the Bill Payer service was based on the rate for Homemaker with a bump up based on additional bonding requirements and a skill set beyond that of the Homemaker.
The department is engaging with Myers and Stauffer to perform a comprehensive rate study for a rebasing of our waiver service rates. Overall objective is to have a rate methodology developed with the various rate components that can be modified as those components change to determine revised rates. The objective is to complete this process by the end of calendar year 2020.
Assisted Living
Assisted Living services are provided under the waiver statewide in Private Assisted Living Facilities under CGS 17b-365 and in 17 state funded congregate and 4 HUD facilities under CGS 8-206e(e). Additionally, Assisted Living Services are provided in 4 demonstration sites under 19-13-D105 of the regulations of CT state agencies. The Demonstration Project was established by PA 00-2, and allows the state to pay for assisted living services in up to four federally funded elderly housing complexes

Rates are determined by the Department's Rate Setting Unit. Pursuant to the Connecticut Department of Social Services Provider Manual, all schedules of payment for covered Medical Assistance Program goods and services shall be established by the Commissioner of Social Services and paid by the Department of Social Services in accordance with applicable federal and state statutes and regulations

The rate structure for Assisted Living Services consists of 1) fee-for-service billing from an established fee schedule that pays uniform rates across providers; 2) usual and customary rates established individually with providers. Maximum allowable rate for services are established by the department in its fee schedule. Private Assisted Living, HUD and Congregate facilities bill an established fee-for-service rate. Rates are based on the agencies' budget.

Rates are also based on service packages according to the participants' level of need:
- *Occasional Personal Service- 1 hour per week, up to 3.75 hours per week of personal services plus nursing visits as needed.*
- *Limited Personal Service- 4 hours per week, up to 8.75 hours per week of personal services plus nursing visits as needed.*
- *Moderate Personal Service- 9 hours per week, up to 14.75 hours per week of personal services plus nursing visits as needed.*
- *Extensive Personal Services-15 hours per week, up to 25 hours per week of personal services plus nursing visits as needed*

Recovery Assistant
Recovery assistants provide a flexible range of supportive assistance, such as household chores and supportive companionship. Rates are established by the rate setting unit and are posted on the fee schedule.

Environmental Accessibility Adaptations
Environmental Accessibility Adaptations may be required by the individual's plan of care to ensure health, welfare and safety of the individuals to function with greater independence in the home and without which the individual would require institutionalization. Such adaptations may include the installation of hand rails and grab bars in the tub area, widening of doors and installation of ramps. Rates and payment are unique to the item being purchased. The contracted case management agency is required to submit 3 bids from potential providers. The cost of the item cannot exceed a maximum annual amount.

These previously approved increased provider rates and payments, which would expire on November 11, 2023 unless added to the base waiver documents, include the following:

3.5% increase in existing rates approved by CMS for all provider types covered under these 1915(c) waivers, already approved as a temporary measure retroactive to July 1, 2021 under the Appendix K. Of the 3.5% increase, 1.8% is included in the ARPA HCBS Spending Plan. This impacts all service rates other than those provider types and services specifically excluded. Excluded providers and services: Assistive Technology; Environmental Accessibility Modifications, Personal Response Systems, Skilled Chore, Specialized Medical Equipment, Individual Goods and Services, and all Self-Directed Services.
6% minimum wage increase, already approved as a temporary measure retroactive to August 1, 2021, for provider types where rates, as approved, are based on the state's minimum wage. This 6% minimum wage increase is pursuant to Public Act 19-4. Service rates impacted by the increase in the minimum wage: agency-based personal care assistants (PCAs), chore/homemaker, companion services, assisted living services, adult day health, recovery assistant, community mentor, and agency-based respite services. Of the 6% increase, 1.2% is funded under the ARPA HCBS Spending Plan.

b. Flow of Billings. *Describe the flow of billings for waiver services, specifying whether provider billings flow directly from providers to the state's claims payment system or whether billings are routed through other intermediary entities. If billings flow through other intermediary entities, specify the entities:*

Contracted care management agencies enter authorized service plans into a web-based care plan portal where the contracted care management agency enters the authorized service plan into the portal and the providers bill claims through the portal. Claims are checked against the service plan authorized by the care manager which checks against the time in and time out captured in the EVV system. Services that were not authorized will deny. The care plan portal will allow only authorized services to pay ensuring compliance with the plan of care. Contracted care management agencies bill for the case management services and assessment services. Claims are submitted to the MMIS contractor. The following servies are subject to electronic visit verification: Homemaker, Companion, Chore, Personal Care Assistant,Respite, Mental Health Counseling and Recovery Assistant. Home Health Agencies and Assisted Living Service Agencies bill the MMIS system directly.

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (2 of 3)

c. Certifying Public Expenditures *(select one):*

- ◉ ***No. state or local government agencies do not certify expenditures for waiver services.***
- ○ ***Yes. state or local government agencies directly expend funds for part or all of the cost of waiver services and certify their state government expenditures (CPE) in lieu of billing that amount to Medicaid.***

Select at least one:

☐ ***Certified Public Expenditures (CPE) of State Public Agencies.***

Specify: (a) the state government agency or agencies that certify public expenditures for waiver services; (b) how it is assured that the CPE is based on the total computable costs for waiver services; and, (c) how the state verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51(b).(Indicate source of revenue for CPEs in Item I-4-a.)

☐ ***Certified Public Expenditures (CPE) of Local Government Agencies.***

Specify: (a) the local government agencies that incur certified public expenditures for waiver services; (b) how it is assured that the CPE is based on total computable costs for waiver services; and, (c) how the state verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51(b). (Indicate source of revenue for CPEs in Item I-4-b.)

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (3 of 3)

d. Billing Validation Process. *Describe the process for validating provider billings to produce the claim for federal financial participation, including the mechanism(s) to assure that all claims for payment are made only: (a) when the individual was eligible for Medicaid waiver payment on the date of service; (b) when the service was included in the participant's approved service plan; and, (c) the services were provided:*

Payments are made directly to providers of Waivers and State Plan services. Provider agreements are required between DSS and each service provider and between DSS and the Fiscal Intermediary under the Waiver. Payments for all Waiver and State Plan services will be made through the same fiscal agent as used in the rest of the Medicaid program. The EVV system captures the service authorization and creates a schedule for each service. The electronic check in and check out is captured and compared to the schedule. If it matches, a claim is created which is submitted to DXC through the EVV system. Community Options staff and DSS Division of Quality Assurance staff all have a real time, jurisdictional view into the EVV system. The Quality Assurance unit utilizes this view to identify provider anomalies and potentially select that provider for an on site audit.The MMIS interfaces with the DSS Eligibility Management System to validate client eligibility to assure that claims are paid only for eligible participants. MMIS assigns participants to a benefit plan. The benefit plan provides eligibility parameters for both the participants and for what services the providers can bill. For example, companion is not a Medicaid state plan covered service. The Benefit Plan "CT Home Care Program for Elders (CHCPE)" would allow that claim with the procedure code for companion to pay. Another example of a Benefit Plan is Assisted Living. The procedure code for home modifications is not a payable procedure code for Assisted Living Providers, the claim will deny if presented to the MMIS contractor for processing because the procedure code for home modifications is not part of the Assisted Living benefit plan. It is the care manager's responsibility to design a plan of care in conjunction with the participant and significant others, to prevent client care plans from exceeding cost caps and to ensure that designated services are actually being provided. Proof of service delivery can be detected upon audit by DSS Quality Assurance and to a large extent through the electronic capture of time in and time out in the EVV system.

e. Billing and Claims Record Maintenance Requirement. *Records documenting the audit trail of adjudicated claims (including supporting documentation) are maintained by the Medicaid agency, the operating agency (if applicable), and providers of waiver services for a minimum period of 3 years as required in 45 CFR §92.42.*

Appendix I: Financial Accountability

I-3: Payment (1 of 7)

a. Method of payments -- MMIS *(select one):*

- (●) ***Payments for all waiver services are made through an approved Medicaid Management Information System (MMIS).***
- ( ) ***Payments for some, but not all, waiver services are made through an approved MMIS.***

  Specify: (a) the waiver services that are not paid through an approved MMIS; (b) the process for making such payments and the entity that processes payments; (c) and how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:

- ( ) ***Payments for waiver services are not made through an approved MMIS.***

  Specify: (a) the process by which payments are made and the entity that processes payments; (b) how and through which system(s) the payments are processed; (c) how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:

- ( ) ***Payments for waiver services are made by a managed care entity or entities. The managed care entity is paid a monthly capitated payment per eligible enrollee through an approved MMIS.***

  Describe how payments are made to the managed care entity or entities:

Appendix I: Financial Accountability

I-3: Payment (2 of 7)

b. Direct payment. *In addition to providing that the Medicaid agency makes payments directly to providers of waiver services, payments for waiver services are made utilizing one or more of the following arrangements (select at least one):*

☐ ***The Medicaid agency makes payments directly and does not use a fiscal agent (comprehensive or limited) or a managed care entity or entities.***

☒ ***The Medicaid agency pays providers through the same fiscal agent used for the rest of the Medicaid program.***

☐ ***The Medicaid agency pays providers of some or all waiver services through the use of a limited fiscal agent.***

Specify the limited fiscal agent, the waiver services for which the limited fiscal agent makes payment, the functions that the limited fiscal agent performs in paying waiver claims, and the methods by which the Medicaid agency oversees the operations of the limited fiscal agent:

☐ ***Providers are paid by a managed care entity or entities for services that are included in the state's contract with the entity.***

Specify how providers are paid for the services (if any) not included in the state's contract with managed care entities.

Appendix I: Financial Accountability

I-3: Payment (3 of 7)

c. Supplemental or Enhanced Payments. *Section 1902(a)(30) requires that payments for services be consistent with efficiency, economy, and quality of care. Section 1903(a)(1) provides for Federal financial participation to states for expenditures for services under an approved state plan/waiver. Specify whether supplemental or enhanced payments are made. Select one:*

○ ***No. The state does not make supplemental or enhanced payments for waiver services.***

◉ ***Yes. The state makes supplemental or enhanced payments for waiver services.***

Describe: (a) the nature of the supplemental or enhanced payments that are made and the waiver services for which these payments are made; (b) the types of providers to which such payments are made; (c) the source of the non-Federal share of the supplemental or enhanced payment; and, (d) whether providers eligible to receive the supplemental or enhanced payment retain 100% of the total computable expenditure claimed by the state to CMS. Upon request, the state will furnish CMS with detailed information about the total amount of supplemental or enhanced payments to each provider type in the waiver.

In the current contract, performance incentives reward quality outcomes for waiver participants. It is the goal of the Department to improve the experience for waiver participants, improve participant outcomes, improve access to care, ensure participants have choice and control, ensure that participants are treated respectfully and their dignity is maintained and that participants have opportunities for community integration and/or inclusion. The payments will be made as an adjustment to the case management rate for each provider that qualifies for the incentive.
Performance Incentive Standards are as follows in year one and each subsequent year of the Contract:
Client satisfaction with care management services, consumer feedback on quality of care management services, length of stay above the statewide average and average care plan costs are the performance incentives. The HCBS CAHPS survey provides the data source for the quality data.

All Access Agencies will be eligible for all of the incentive payments. Access Agencies who might have been under a performance improvement plan will not be eligible to receive performance incentive payments.

The data from the HCBS/CAHPS Survey will enable the state to determine the baseline for each of the measures. Each provider is eligible for an incentive payment for each of the performance measures.

The Community Options unit receives all HCBS CAHPS data in a report from the UConn Center on Aging which compiles and analyzes the survey data. Incentives are calculated based on that data. In the current year, the incentive pool was $250,000. Once the calculations are completed, each agency is notified via email specifically which incentives they qualified for and the dollar amount they will receive.

The state's share of the performance incentive payments will come from the General Fund
The care management providers will retain 100% of the total computable expenditure

These previously approved increased provider rates and payments, which would expire on November 11, 2023 unless added to the base waiver documents, include the following:
Performance Supplemental Payments: (i). On or before July 31, 2023, benchmark payments will be paid to providers effective for and calculated based on 2% of expenditures from March 1, 2023 through June 30, 2023. Benchmarks must be met no later than June 15, 2023, and are as follows: (a) Participation in the Department of Social Services' racial equity training and related learning collaboratives; (b) Accessing and viewing data within the Health Information Exchange (HIE) and participation in data use learning collaboratives and training. (ii). On or before November 30, 2023, benchmark payments will be paid to providers effective for and calculated based on 2% of expenditures from July 1, 2023 through October 31, 2023. Benchmarks must be met no later than October 15, 2023, and are as follows: (a) Including the Department of Social Services' racial equity training as a required component of all new staff orientation and participation in related learning collaboratives; (b) Accessing and viewing data within the HIE and participation in data use learning collaboratives and training. (iii). Beginning with payments to be made on or before March 31, 2024, and every six months thereafter, payments will be paid to providers who meet the following outcomes: (a) Decrease in avoidable hospitalization; (b) Increase in percent of people who need ongoing services discharged from hospital to community in lieu of nursing home; and (c) Increase in probability of return to community within 100 days of nursing home admission. Payments are based on up to 2% of expenditures for the 6 months that immediately precede each payment (other than the first outcome payment which will be based on the 4 months that immediately precede the first payment). If the total cost of the 2% payout is less than total funds available, excess funds will be prorated up to a maximum limit of 4% and paid to providers who qualify for the outcome payment. This higher limit of 4% will be based on availability of funds as approved within the ARPA HCBS Spending Plan. Providers who meet all of the performance measures will receive a full payment. Providers who meet fewer than the maximum possible number of performance measures will receive a partial payment based on the number of performance measures that they meet, in which meeting each measure is associated with a pro rata equal share of the total payment for the provider.

Quality Infrastructure Supplemental Payments: Payments will be made on or before July 31, 2023, November 30, 2023, and March 31, 2024 to providers who meet the benchmarks set forth below based on the greater of 5% of expenditures during the four calendar months that immediately precede the month in which the payment is made or $5,000. For purposes of determining the applicability of the $5,000 in lieu of the percentage, expenditures used as the basis of the payment are total HCBS expenditures for the provider across all programs. The following benchmarks apply and must be met no later than the first day of the month in which the payment is made: (a) Benchmark for July 2023 payment – Providers have met requirements to document improved member service

delivery and contracts in place with vendors to modify delivery system; providers have member satisfaction survey drafted; (b) Benchmark for November 2023 payment – Providers have delivery system modifications complete; (c) Benchmark for March 2024 payment – Providers have delivery system implemented and integrated into member service planning; member satisfaction survey complete.

Appendix I: Financial Accountability

I-3: Payment (4 of 7)

d. Payments to state or Local Government Providers. *Specify whether state or local government providers receive payment for the provision of waiver services.*

- ◉ ***No. State or local government providers do not receive payment for waiver services.*** *Do not complete Item I-3-e.*
- ○ ***Yes. State or local government providers receive payment for waiver services.*** *Complete Item I-3-e.*

Specify the types of state or local government providers that receive payment for waiver services and the services that the state or local government providers furnish:

Appendix I: Financial Accountability

I-3: Payment (5 of 7)

e. Amount of Payment to State or Local Government Providers.

Specify whether any state or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed its reasonable costs of providing waiver services and, if so, whether and how the state recoups the excess and returns the Federal share of the excess to CMS on the quarterly expenditure report. Select one:

Answers provided in Appendix I-3-d indicate that you do not need to complete this section.

- ○ ***The amount paid to state or local government providers is the same as the amount paid to private providers of the same service.***
- ○ ***The amount paid to state or local government providers differs from the amount paid to private providers of the same service. No public provider receives payments that in the aggregate exceed its reasonable costs of providing waiver services.***
- ○ ***The amount paid to state or local government providers differs from the amount paid to private providers of the same service. When a state or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed the cost of waiver services, the state recoups the excess and returns the federal share of the excess to CMS on the quarterly expenditure report.***

Describe the recoupment process:

Appendix I: Financial Accountability

I-3: Payment (6 of 7)

f. Provider Retention of Payments. *Section 1903(a)(1) provides that Federal matching funds are only available for expenditures made by states for services under the approved waiver. Select one:*

◉ ***Providers receive and retain 100 percent of the amount claimed to CMS for waiver services.***

○ ***Providers are paid by a managed care entity (or entities) that is paid a monthly capitated payment.***

Specify whether the monthly capitated payment to managed care entities is reduced or returned in part to the state.

Appendix I: Financial Accountability

I-3: Payment (7 of 7)

g. Additional Payment Arrangements

i. Voluntary Reassignment of Payments to a Governmental Agency. *Select one:*

◉ ***No. The state does not provide that providers may voluntarily reassign their right to direct payments to a governmental agency.***

○ ***Yes. Providers may voluntarily reassign their right to direct payments to a governmental agency as provided in 42 CFR §447.10(e).***

Specify the governmental agency (or agencies) to which reassignment may be made.

ii. Organized Health Care Delivery System. *Select one:*

◉ ***No. The state does not employ Organized Health Care Delivery System (OHCDS) arrangements under the provisions of 42 CFR §447.10.***

○ ***Yes. The waiver provides for the use of Organized Health Care Delivery System arrangements under the provisions of 42 CFR §447.10.***

Specify the following: (a) the entities that are designated as an OHCDS and how these entities qualify for designation as an OHCDS; (b) the procedures for direct provider enrollment when a provider does not voluntarily agree to contract with a designated OHCDS; (c) the method(s) for assuring that participants have free choice of qualified providers when an OHCDS arrangement is employed, including the selection of providers not affiliated with the OHCDS; (d) the method(s) for assuring that providers that furnish services under contract with an OHCDS meet applicable provider qualifications under the waiver; (e) how it is assured that OHCDS contracts with providers meet applicable requirements; and, (f) how financial accountability is assured when an OHCDS arrangement is used:

iii. Contracts with MCOs, PIHPs or PAHPs.

◉ ***The state does not contract with MCOs, PIHPs or PAHPs for the provision of waiver services.***

○ ***The state contracts with a Managed Care Organization(s) (MCOs) and/or prepaid inpatient health plan(s) (PIHP) or prepaid ambulatory health plan(s) (PAHP) under the provisions of §1915(a)(1) of the Act for the delivery of waiver and other services. Participants may voluntarily elect to receive waiver and other services through such MCOs or prepaid health plans. Contracts with these health plans are on file at the state***

Medicaid agency.

Describe: (a) the MCOs and/or health plans that furnish services under the provisions of §1915(a)(1); (b) the geographic areas served by these plans; (c) the waiver and other services furnished by these plans; and, (d) how payments are made to the health plans.

○ ***This waiver is a part of a concurrent §1915(b)/§1915(c) waiver. Participants are required to obtain waiver and other services through a MCO and/or prepaid inpatient health plan (PIHP) or a prepaid ambulatory health plan (PAHP). The §1915(b) waiver specifies the types of health plans that are used and how payments to these plans are made.***

○ ***This waiver is a part of a concurrent ?1115/?1915(c) waiver. Participants are required to obtain waiver and other services through a MCO and/or prepaid inpatient health plan (PIHP) or a prepaid ambulatory health plan (PAHP). The ?1115 waiver specifies the types of health plans that are used and how payments to these plans are made.***

○ ***If the state uses more than one of the above contract authorities for the delivery of waiver services, please select this option.***

In the textbox below, indicate the contract authorities. In addition, if the state contracts with MCOs, PIHPs, or PAHPs under the provisions of §1915(a)(1) of the Act to furnish waiver services: Participants may voluntarily elect to receive waiver and other services through such MCOs or prepaid health plans. Contracts with these health plans are on file at the state Medicaid agency. Describe: (a) the MCOs and/or health plans that furnish services under the provisions of §1915(a)(1); (b) the geographic areas served by these plans; (c) the waiver and other services furnished by these plans; and, (d) how payments are made to the health plans.

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (1 of 3)

a. State Level Source(s) of the Non-Federal Share of Computable Waiver Costs. *Specify the state source or sources of the non-federal share of computable waiver costs. Select at least one:*

☒ ***Appropriation of State Tax Revenues to the State Medicaid agency***

☐ ***Appropriation of State Tax Revenues to a State Agency other than the Medicaid Agency.***

If the source of the non-federal share is appropriations to another state agency (or agencies), specify: (a) the state entity or agency receiving appropriated funds and (b) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if the funds are directly expended by state agencies as CPEs, as indicated in Item I-2-c:

☐ ***Other State Level Source(s) of Funds.***

Specify: (a) the source and nature of funds; (b) the entity or agency that receives the funds; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by state agencies as CPEs, as indicated in Item I-2-c:

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (2 of 3)

b. Local Government or Other Source(s) of the Non-Federal Share of Computable Waiver Costs. *Specify the source or sources of the non-federal share of computable waiver costs that are not from state sources. Select One:*

- ◉ ***Not Applicable***. *There are no local government level sources of funds utilized as the non-federal share.*
- ○ ***Applicable***

Check each that applies:

☐ ***Appropriation of Local Government Revenues.***

Specify: (a) the local government entity or entities that have the authority to levy taxes or other revenues; (b) the source(s) of revenue; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement (indicate any intervening entities in the transfer process), and/or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2-c:

☐ ***Other Local Government Level Source(s) of Funds.***

Specify: (a) the source of funds; (b) the local government entity or agency receiving funds; and, (c) the mechanism that is used to transfer the funds to the state Medicaid agency or fiscal agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2-c:

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (3 of 3)

c. Information Concerning Certain Sources of Funds. *Indicate whether any of the funds listed in Items I-4-a or I-4-b that make up the non-federal share of computable waiver costs come from the following sources: (a) health care-related taxes or fees; (b) provider-related donations; and/or, (c) federal funds. Select one:*

- ◉ ***None of the specified sources of funds contribute to the non-federal share of computable waiver costs***
- ○ ***The following source(s) are used***

Check each that applies:

☐ ***Health care-related taxes or fees***

☐ ***Provider-related donations***

☐ ***Federal funds***

For each source of funds indicated above, describe the source of the funds in detail:

Appendix I: Financial Accountability

I-5: Exclusion of Medicaid Payment for Room and Board

a. Services Furnished in Residential Settings. *Select one:*

- ○ ***No services under this waiver are furnished in residential settings other than the private residence of the individual.***
- ◉ ***As specified in Appendix C, the state furnishes waiver services in residential settings other than the personal home of the individual.***

b. Method for Excluding the Cost of Room and Board Furnished in Residential Settings. *The following describes the methodology that the state uses to exclude Medicaid payment for room and board in residential settings:*

Room and board shall be excluded from the rate for Adult Family Living. If they reside in the caregiver's home, the room and board amount is determined between the participant and the caregiver. The payment for the waiver service is not part of that negotiation. The waiver rate is based on the participants' assessed needs.

Appendix I: Financial Accountability

I-6: Payment for Rent and Food Expenses of an Unrelated Live-In Caregiver

Reimbursement for the Rent and Food Expenses of an Unrelated Live-In Personal Caregiver. *Select one:*

- ◉ ***No. The state does not reimburse for the rent and food expenses of an unrelated live-in personal caregiver who resides in the same household as the participant.***
- ○ ***Yes. Per 42 CFR §441.310(a)(2)(ii), the state will claim FFP for the additional costs of rent and food that can be reasonably attributed to an unrelated live-in personal caregiver who resides in the same household as the waiver participant. The state describes its coverage of live-in caregiver in Appendix C-3 and the costs attributable to rent and food for the live-in caregiver are reflected separately in the computation of factor D (cost of waiver services) in Appendix J. FFP for rent and food for a live-in caregiver will not be claimed when the participant lives in the caregiver's home or in a residence that is owned or leased by the provider of Medicaid services.***

The following is an explanation of: (a) the method used to apportion the additional costs of rent and food attributable to the unrelated live-in personal caregiver that are incurred by the individual served on the waiver and (b) the method used to reimburse these costs:

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing *(1 of 5)*

a. Co-Payment Requirements. *Specify whether the state imposes a co-payment or similar charge upon waiver participants for waiver services. These charges are calculated per service and have the effect of reducing the total computable claim for federal financial participation. Select one:*

- ◉ ***No. The state does not impose a co-payment or similar charge upon participants for waiver services.***
- ○ ***Yes. The state imposes a co-payment or similar charge upon participants for one or more waiver services.***

i. Co-Pay Arrangement.

Specify the types of co-pay arrangements that are imposed on waiver participants (check each that applies):

Charges Associated with the Provision of Waiver Services *(if any are checked, complete Items I-7-a-ii through I-7-a-iv):*

- ☐ ***Nominal deductible***
- ☐ ***Coinsurance***
- ☐ ***Co-Payment***
- ☐ ***Other charge***

Specify:

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (2 of 5)

a. Co-Payment Requirements.

ii. Participants Subject to Co-pay Charges for Waiver Services.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (3 of 5)

a. Co-Payment Requirements.

iii. Amount of Co-Pay Charges for Waiver Services.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (4 of 5)

a. Co-Payment Requirements.

iv. Cumulative Maximum Charges.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (5 of 5)

b. Other State Requirement for Cost Sharing. *Specify whether the state imposes a premium, enrollment fee or similar cost sharing on waiver participants. Select one:*

- ◉ ***No. The state does not impose a premium, enrollment fee, or similar cost-sharing arrangement on waiver participants.***
- ○ ***Yes. The state imposes a premium, enrollment fee or similar cost-sharing arrangement.***

Describe in detail the cost sharing arrangement, including: (a) the type of cost sharing (e.g., premium, enrollment fee); (b) the amount of charge and how the amount of the charge is related to total gross family income; (c) the groups of participants subject to cost-sharing and the groups who are excluded; and, (d) the mechanisms for the collection of cost-sharing and reporting the amount collected on the CMS 64:

Appendix J: Cost Neutrality Demonstration

J-1: Composite Overview and Demonstration of Cost-Neutrality Formula

Composite Overview. *Complete the fields in Cols. 3, 5 and 6 in the following table for each waiver year. The fields in Cols. 4, 7 and 8 are auto-calculated based on entries in Cols 3, 5, and 6. The fields in Col. 2 are auto-calculated using the Factor D data from the J-2-d Estimate of Factor D tables. Col. 2 fields will be populated ONLY when the Estimate of Factor D tables in J-2-d have been completed.*

Level(s) of Care: Nursing Facility

Col. 1	Col. 2	Col. 3	Col. 4	Col. 5	Col. 6	Col. 7	Col. 8
Year	Factor D	Factor D'	Total: D+D'	Factor G	Factor G'	Total: G+G'	Difference (Col 7 less Column4)
1	28121.36	8309.00	36430.36	69073.00	8448.00	77521.00	41090.64
2		8674.00	8674.00	71145.00	8820.00	79965.00	71291.00
3		9056.00	9056.00	73280.00	9208.00	82488.00	73432.00
4		9454.00	9454.00	75478.00	9613.00	85091.00	75637.00
5		9870.00	9870.00	77743.00	10036.00	87779.00	77909.00

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates *(1 of 9)*

a. Number Of Unduplicated Participants Served. *Enter the total number of unduplicated participants from Item B-3-a who will be served each year that the waiver is in operation. When the waiver serves individuals under more than one level of care, specify the number of unduplicated participants for each level of care:*

Table: J-2-a: Unduplicated Participants

Waiver Year	Total Unduplicated Number of Participants (from Item B-3-a)	Distribution of Unduplicated Participants by Level of Care (if applicable)
		Level of Care:
		Nursing Facility
Year 1	17707	17707
Year 2	18186	18186
Year 3	18753	18753
Year 4	19324	19324
Year 5	19897	19897

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates *(2 of 9)*

b. Average Length of Stay. *Describe the basis of the estimate of the average length of stay on the waiver by participants in item J-2-a.*

The projected average length of stay for each of the five renewal years is the same as that reported on the 372 Report for the July 1, 2018 - June 30, 2019 period.

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (3 of 9)

c. Derivation of Estimates for Each Factor. *Provide a narrative description for the derivation of the estimates of the following factors.*

i. Factor D Derivation. *The estimates of Factor D for each waiver year are located in Item J-2-d. The basis and methodology for these estimates is as follows:*

The beginning caseload for July 1, 2020 was projected based on the actual billing caseload as of July 1, 2019 and the net growth for the prior 12 month period. The total intake for the prior 12 month period was added to the projected beginning caseload for July 1, 2020 to obtain the unduplicated recipient count for Year 1. The beginning caseload for each year was projected based on the actual net growth experienced July 1, 2018 – June 30, 2019 and the impact of an initiative to increase MFP transitions in Year 2 to a level to be maintained throughout the renewal period.

Informal Caregiver assumes 6 units of service per year at $250 per unit for 378 participants in Year 4 and 252 participants in Year 5. CAPABLE assumes $3,000 cost per participant for 567 participants in Year 4 and for 743 participants in Year 5.Remote Supports assumes 165 users in Year 4 and 510 users in Year 5 at $846 cost per unit utilizing 1 unit per month. Assumes expanded definition of Assistive Technology will add $34,092 in expenditures for 36 recipients in Year 4 and $52,549 for 42 recipients in Year 5.

The source of users for each service used to calculate Factor D is the same as the percentage of total users for each service reported in the Initial CMS-372(S) for July 1, 2018 – June 30, 2019. The units per user is the same as reported in the Initial CMS-372(S) for July 1, 2018 – June 30, 2019. The cost per unit is trended at 4.4% based the published September 2019 Consumer Price index for Medical Care.

ii. Factor D' Derivation. *The estimates of Factor D' for each waiver year are included in Item J-1. The basis of these estimates is as follows:*

The factor D' was calculated by applying CPI to the Initial 372 report for July 1, 2018 - June 30, 2019.The historical cost data were trended forward for each renewal year using 4.4% based on the published September 2019 Consumer Price index for Medical Care. The Actual Factor G' from the CMS-372(T) is nearly the same as the Actual Factor D' as reported from the CMS-372(S) report for July 1, 2018 – June 30, 2019. The projections for WY1-5 use the actual Factor D' and G' adjusted for actual LOS and apply the 4.4% CPI published September 2019 Consumer Price index for Medical Care is applied to both factors.

iii. Factor G Derivation. *The estimates of Factor G for each waiver year are included in Item J-1. The basis of these estimates is as follows:*

The factor G was calculated by applying CPI to the Initial 372 report for July 1, 2018 - June 30, 2019. Inflation projection for Factor G is based on the published September 2019 Consumer Price Index for Nursing Home Care at: 3.0%

iv. Factor G' Derivation. *The estimates of Factor G' for each waiver year are included in Item J-1. The basis of these estimates is as follows:*

The factor G' was calculated by applying CPI to the Initial 372 report for July 1, 2018 - June 30, 2019. The historical cost data were trended forward by 4.4% for each renewal year, based on the published September 2019 Consumer Price index for Medical Care.

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (4 of 9)

Component management for waiver services. *If the service(s) below includes two or more discrete services that are reimbursed separately, or is a bundled service, each component of the service must be listed. Select "manage components" to add these components.*

Waiver Services	
Adult Day Health	
Care Management	
Homemaker	
Personal Care Assistant	
Respite	
Adult Family Living	
Assisted Living	
Assistive Technology	
Bill Payer	
Care Transitions	
Chore Services	
Chronic Disease Self-Management Program	
Companion	
Environmental Accesibility Adaptations	
Home Delivered Meals	
Mental Health Counseling	
Participant Training and Engagement to Support Goal Attainment and Independence (CAPABLE)	
Personal Emergency Response Systems	
Recovery Assistant	
Remote Supports	
Training and Counseling Services for Unpaid Caregivers Supporting Participants (COPE)	
Transportation	

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (5 of 9)

d. Estimate of Factor D.

ii. Concurrent §1915(b)/§1915(c) Waivers, or other authorities utilizing capitated arrangements (i.e., 1915(a), 1932(a), Section 1937). *Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. If applicable, check the capitation box next to that service. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.*

Waiver Year: Year 1

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Day Health Total:							**14180394.24**
Adult Day Health	☐	per day	1964	92.00	78.48	**14180394.24**	
Care Management Total:							**25686659.55**
Care Management	☐	per day	17707	285.00	5.09	**25686659.55**	
Homemaker Total:							**23902880.22**
Homemaker	☐	per 15 minutes	5531	954.00	4.53	**23902880.22**	
Personal Care Assistant Total:							**314964731.46**
Personal Care Assistant	☐	per 15 minutes	9778	6159.00	5.23	**314964731.46**	
Respite Total:							**2362897.04**
Respite	☐	per 15 min	469	887.00	5.68	**2362897.04**	
Adult Family Living Total:							**56430757.08**
Adult Family Living	☐	per day	2276	229.00	108.27	**56430757.08**	
Assisted Living Total:							**5060946.06**
Assisted Living	☐	per day	746	129.00	52.59	**5060946.06**	
Assistive Technology Total:							**238299.40**
Assistive Technology	☐	per unit	202	1.00	1179.70	**238299.40**	
Bill Payer Total:							**102102.00**
Bill Payer	☐	per 15 min	238	78.00	5.50	**102102.00**	
Care Transitions Total:							**49495.08**
Care Transitions	☐	per unit	316	1.00	156.63	**49495.08**	
Chore Services Total:							**205504.00**
Chore Services	☐	per unit	160	190.00	6.76	**205504.00**	
Chronic Disease Self-Management Program Total:							**3302.40**

GRAND TOTAL:	**497944892.03**
Total: Services included in capitation:	
Total: Services not included in capitation:	497944892.03
Total Estimated Unduplicated Participants:	**17707**
Factor D (Divide total by number of participants):	**28121.36**
Services included in capitation:	
Services not included in capitation:	28121.36
Average Length of Stay on the Waiver:	307

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Chronic Disease Self-Management Program	☐	per session	10	6.00	55.04	3302.40	
Companion Total:							39886240.59
Companion	☐	per 15 min	4363	2073.00	4.41	39886240.59	
Environmental Accesibility Adaptations Total:							150706.98
Environmental Accesibility Adaptations	☐	per session	27	1.00	5581.74	150706.98	
Home Delivered Meals Total:							8007952.00
Home Delivered Meals	☐	per day	4990	160.00	10.03	8007952.00	
Mental Health Counseling Total:							585333.00
Mental Health Counseling	☐	per session	652	15.00	59.85	585333.00	
Mental Health Counseling	☐		0	0.00	0.00	0.00	
Participant Training and Engagement to Support Goal Attainment and Independence (CAPABLE) Total:							0.00
Participant Training and Engagement to Support Goal Attainment and Independence (CAPABLE)	☐	per unit	0	0.00	3000.00	0.00	
Personal Emergency Response Systems Total:							6052450.50
Personal Emergency Response Systems	☐	per month	10370	9.00	64.85	6052450.50	
Recovery Assistant Total:							73920.00
Recovery Assistant	☐	per 15 min	5	2400.00	6.16	73920.00	

GRAND TOTAL:	**497944892.03**
Total: Services included in capitation:	
Total: Services not included in capitation:	497944892.03
Total Estimated Unduplicated Participants:	**17707**
Factor D (Divide total by number of participants):	**28121.36**
Services included in capitation:	
Services not included in capitation:	28121.36
Average Length of Stay on the Waiver:	307

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Remote Supports Total:							**0.00**
Remote Supports	☐	per unit	0	0.00	845.62	**0.00**	
Training and Counseling Services for Unpaid Caregivers Supporting Participants (COPE) Total:							**0.00**
Training and Counseling Services for Unpaid Caregivers Supporting Participants (COPE)	☐	per unit	0	0.00	250.00	**0.00**	
Transportation Total:							**320.43**
Transportation	☐	per unit	3	1.00	106.81	**320.43**	

GRAND TOTAL:	**497944892.03**
Total: Services included in capitation:	
Total: Services not included in capitation:	497944892.03
Total Estimated Unduplicated Participants:	**17707**
Factor D (Divide total by number of participants):	**28121.36**
Services included in capitation:	
Services not included in capitation:	28121.36
Average Length of Stay on the Waiver:	307

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (6 of 9)

d. Estimate of Factor D.

ii. Concurrent §1915(b)/§1915(c) Waivers, or other concurrent managed care authorities utilizing capitated payment arrangements. *Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. If applicable, check the capitation box next to that service. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.*

Waiver Year: Year 2

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Day Health Total:							**15210796.08**
Adult Day Health	☐	per day				**15210796.08**	

GRAND TOTAL:	
Total: Services included in capitation:	
Total: Services not included in capitation:	533854384.97
Total Estimated Unduplicated Participants:	**18186**
Factor D (Divide total by number of participants):	
Services included in capitation:	
Services not included in capitation:	29355.24
Average Length of Stay on the Waiver:	307

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
			2018	92.00	81.93		
Care Management Total:							**27521783.10**
Care Management	☐	per day	18186	285.00	5.31	**27521783.10**	
Homemaker Total:							**25635058.02**
Homemaker	☐	per 15 minutes	5681	954.00	4.73	**25635058.02**	
Personal Care Assistant Total:							**337727410.02**
Personal Care Assistant	☐	per 15 minutes	10043	6159.00	5.46	**337727410.02**	
Respite Total:							**2530016.71**
Respite	☐	per 15 min	481	887.00	5.93	**2530016.71**	
Adult Family Living Total:							**60490604.19**
Adult Family Living	☐	per day	2337	229.00	113.03	**60490604.19**	
Assisted Living Total:							**5424888.60**
Assisted Living	☐	per day	766	129.00	54.90	**5424888.60**	
Assistive Technology Total:							**254943.27**
Assistive Technology	☐	per unit	207	1.00	1231.61	**254943.27**	
Bill Payer Total:							**109243.68**
Bill Payer	☐	per 15 min	244	78.00	5.74	**109243.68**	
Care Transitions Total:							**52980.48**
Care Transitions	☐	per unit	324	1.00	163.52	**52980.48**	
Chore Services Total:							**219989.60**
Chore Services	☐	per unit	164	190.00	7.06	**219989.60**	
Chronic Disease Self-Management Program Total:							**3447.60**
Chronic Disease Self-Management	☐	per session	10	6.00	57.46	**3447.60**	

GRAND TOTAL:		
Total: Services included in capitation:		
Total: Services not included in capitation:		*533854384.97*
Total Estimated Unduplicated Participants:		**18186**
Factor D (Divide total by number of participants):		
Services included in capitation:		
Services not included in capitation:		*29355.24*
Average Length of Stay on the Waiver:	*307*	

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Program							
Companion Total:							**42729919.80**
Companion	☐	per 15 min	4481	2073.00	4.60	**42729919.80**	
Environmental Accesibility Adaptations Total:							**163165.52**
Environmental Accesibility Adaptations	☐	per unit	28	1.00	5827.34	**163165.52**	
Home Delivered Meals Total:							**8585400.00**
Home Delivered Meals	☐	per day	5125	160.00	10.47	**8585400.00**	
Mental Health Counseling Total:							
Mental Health Counseling	☐	per session	670	15.00	62.48	**627924.00**	
Mental Health Counseling	☐						
Participant Training and Engagement to Support Goal Attainment and Independence (CAPABLE) Total:							
Participant Training and Engagement to Support Goal Attainment and Independence (CAPABLE)	☐	per unit					
Personal Emergency Response Systems Total:							**6489654.30**
Personal Emergency Response Systems	☐	per month	10651	9.00	67.70	**6489654.30**	
Recovery Assistant Total:							**77160.00**
Recovery Assistant	☐	per 15 min	5	2400.00	6.43	**77160.00**	
Remote Supports Total:							

GRAND TOTAL:		
Total: Services included in capitation:		
Total: Services not included in capitation:		533854384.97
Total Estimated Unduplicated Participants:		**18186**
Factor D (Divide total by number of participants):		
Services included in capitation:		
Services not included in capitation:		29355.24
Average Length of Stay on the Waiver:	307	

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Remote Supports	☐	per unit					
Training and Counseling Services for Unpaid Caregivers Supporting Participants (COPE) Total:							
Training and Counseling Services for Unpaid Caregivers Supporting Participants (COPE)	☐	per unit					
Transportation Total:							**0.00**
Transportation	☐	per unit	0	0.00	0.01	**0.00**	

GRAND TOTAL:		
Total: Services included in capitation:		
Total: Services not included in capitation:		533854384.97
Total Estimated Unduplicated Participants:		**18186**
Factor D (Divide total by number of participants):		
Services included in capitation:		
Services not included in capitation:		29355.24
Average Length of Stay on the Waiver:	307	

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (7 of 9)

d. Estimate of Factor D.

ii. Concurrent §1915(b)/§1915(c) Waivers, or other concurrent managed care authorities utilizing capitated payment arrangements. *Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. If applicable, check the capitation box next to that service. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.*

Waiver Year: Year 3

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Day Health Total:							**16367020.80**
Adult Day Health	☐	per day	2080	92.00	85.53	**16367020.80**	
Care							**29609111.70**

GRAND TOTAL:		
Total: Services included in capitation:		
Total: Services not included in capitation:		574617970.14
Total Estimated Unduplicated Participants:		**18753**
Factor D (Divide total by number of participants):		
Services included in capitation:		
Services not included in capitation:		30641.39
Average Length of Stay on the Waiver:	307	

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Management Total:							
Care Management	☐	per day	18753	285.00	5.54	**29609111.70**	
Homemaker Total:							**27607348.08**
Homemaker	☐	per 15 minutes	5858	954.00	4.94	**27607348.08**	
Personal Care Assistant Total:							**363525736.50**
Personal Care Assistant	☐	per 15 minutes	10355	6159.00	5.70	**363525736.50**	
Respite Total:							**2723302.88**
Respite	☐	per 15 min	496	887.00	6.19	**2723302.88**	
Adult Family Living Total:							**65123020.00**
Adult Family Living	☐	per day	2410	229.00	118.00	**65123020.00**	
Assisted Living Total:							**5841481.20**
Assisted Living	☐	per day	790	129.00	57.32	**5841481.20**	
Assistive Technology Total:							**273875.40**
Assistive Technology	☐	per unit	213	1.00	1285.80	**273875.40**	
Bill Payer Total:							**117739.44**
Bill Payer	☐	per 15 min	252	78.00	5.99	**117739.44**	
Care Transitions Total:							**57187.85**
Care Transitions	☐	per unit	335	1.00	170.71	**57187.85**	
Chore Services Total:							**236650.70**
Chore Services	☐	per unit	169	190.00	7.37	**236650.70**	
Chronic Disease Self-Management Program Total:							**3959.34**
Chronic Disease Self-Management Program	☐	per session	11	6.00	59.99	**3959.34**	
Companion							**45970848.00**

GRAND TOTAL:		
Total: Services included in capitation:		
Total: Services not included in capitation:		574617970.14
Total Estimated Unduplicated Participants:		**18753**
Factor D (Divide total by number of participants):		
Services included in capitation:		
Services not included in capitation:		30641.39
Average Length of Stay on the Waiver:	307	

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Total:							
Companion	☐	per 15 min	4620	2073.00	4.80	**45970848.00**	
Environmental Accesibility Adaptations Total:							**176428.46**
Environmental Accesibility Adaptations	☐	per unit	29	1.00	6083.74	**176428.46**	
Home Delivered Meals Total:							**9240659.20**
Home Delivered Meals	☐	per day	5284	160.00	10.93	**9240659.20**	
Mental Health Counseling Total:							
Mental Health Counseling	☐	per session	691	15.00	65.23	**676108.95**	
Mental Health Counseling	☐						
Participant Training and Engagement to Support Goal Attainment and Independence (CAPABLE) Total:							
Participant Training and Engagement to Support Goal Attainment and Independence (CAPABLE)	☐	per unit					
Personal Emergency Response Systems Total:							**6986505.96**
Personal Emergency Response Systems	☐	per month	10983	9.00	70.68	**6986505.96**	
Recovery Assistant Total:							**80520.00**
Recovery Assistant	☐	per 15 min	5	2400.00	6.71	**80520.00**	
Remote Supports Total:							
Remote Supports	☐	per unit					

GRAND TOTAL:		
Total: Services included in capitation:		
Total: Services not included in capitation:		574617970.14
Total Estimated Unduplicated Participants:		**18753**
Factor D (Divide total by number of participants):		
Services included in capitation:		
Services not included in capitation:		30641.39
Average Length of Stay on the Waiver:		307

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Training and Counseling Services for Unpaid Caregivers Supporting Participants (COPE) Total:							
Training and Counseling Services for Unpaid Caregivers Supporting Participants (COPE)	☐	per unit					
Transportation Total:							**465.68**
Transportation	☐	per trip	4	1.00	116.42	**465.68**	

GRAND TOTAL:	
Total: Services included in capitation:	
Total: Services not included in capitation:	574617970.14
Total Estimated Unduplicated Participants:	**18753**
Factor D (Divide total by number of participants):	
Services included in capitation:	
Services not included in capitation:	30641.39
Average Length of Stay on the Waiver:	307

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (8 of 9)

d. Estimate of Factor D.

ii. Concurrent §1915(b)/§1915(c) Waivers, or other concurrent managed care authorities utilizing capitated payment arrangements. *Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. If applicable, check the capitation box next to that service. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.*

Waiver Year: Year 4

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Day Health Total:							**17612273.92**
Adult Day Health	☐	per day	2144	92.00	89.29	**17612273.92**	
Care Management Total:							**31832425.20**

GRAND TOTAL:	
Total: Services included in capitation:	
Total: Services not included in capitation:	618146468.97
Total Estimated Unduplicated Participants:	**19324**
Factor D (Divide total by number of participants):	
Services included in capitation:	
Services not included in capitation:	31988.54
Average Length of Stay on the Waiver:	307

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Care Management	☐	per day	19324	285.00	5.78	31832425.20	
Homemaker Total:							29713055.04
Homemaker	☐	per 15 minutes	6036	954.00	5.16	29713055.04	
Personal Care Assistant Total:							391049999.55
Personal Care Assistant	☐	per 15 minutes	10671	6159.00	5.95	391049999.55	
Respite Total:							2933770.24
Respite	☐	per 15 min	512	887.00	6.46	2933770.24	
Adult Family Living Total:							70074906.84
Adult Family Living	☐	per day	2484	229.00	123.19	70074906.84	
Assisted Living Total:							6283559.04
Assisted Living	☐	per day	814	129.00	59.84	6283559.04	
Assistive Technology Total:							295323.60
Assistive Technology	☐	per unit	220	1.00	1342.38	295323.60	
Bill Payer Total:							126262.50
Bill Payer	☐	per 15 min	259	78.00	6.25	126262.50	
Care Transitions Total:							61485.90
Care Transitions	☐	per unit	345	1.00	178.22	61485.90	
Chore Services Total:							254231.40
Chore Services	☐	per unit	174	190.00	7.69	254231.40	
Chronic Disease Self-Management Program Total:							4133.58
Chronic Disease Self-Management Program	☐	per session	11	6.00	62.63	4133.58	
Companion Total:							49446460.53
Companion	☐					49446460.53	

GRAND TOTAL:		
Total: Services included in capitation:		
Total: Services not included in capitation:		618146468.97
Total Estimated Unduplicated Participants:		19324
Factor D (Divide total by number of participants):		
Services included in capitation:		
Services not included in capitation:		31988.54
Average Length of Stay on the Waiver:	307	

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
		per 15 min	4761	2073.00	5.01		
Environmental Accesibility Adaptations Total:							**190542.60**
Environmental Accesibility Adaptations	☐	per unit	30	1.00	6351.42	**190542.60**	
Home Delivered Meals Total:							**9940392.00**
Home Delivered Meals	☐	per day	5445	160.00	11.41	**9940392.00**	
Mental Health Counseling Total:							
Mental Health Counseling	☐	per session	712	15.00	68.10	**727308.00**	
Mental Health Counseling	☐						
Participant Training and Engagement to Support Goal Attainment and Independence (CAPABLE) Total:							
Participant Training and Engagement to Support Goal Attainment and Independence (CAPABLE)	☐	per unit					
Personal Emergency Response Systems Total:							**7515732.87**
Personal Emergency Response Systems	☐	per month	11317	9.00	73.79	**7515732.87**	
Recovery Assistant Total:							**84120.00**
Recovery Assistant	☐	per 15 min	5	2400.00	7.01	**84120.00**	
Remote Supports Total:							
Remote Supports	☐	per unit					
Training and Counseling							

	GRAND TOTAL:	
	Total: Services included in capitation:	
	Total: Services not included in capitation:	*618146468.97*
	Total Estimated Unduplicated Participants:	***19324***
	Factor D (Divide total by number of participants):	
	Services included in capitation:	
	Services not included in capitation:	*31988.54*
	Average Length of Stay on the Waiver:	*307*

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Services for Unpaid Caregivers Supporting Participants (COPE) Total:							
Training and Counseling Services for Unpaid Caregivers Supporting Participants (COPE)	☐	per unit					
Transportation Total:							**486.16**
Transportation	☐	per unit	4	1.00	121.54	**486.16**	

GRAND TOTAL:	
Total: Services included in capitation:	
Total: Services not included in capitation:	618146468.97
Total Estimated Unduplicated Participants:	**19324**
Factor D (Divide total by number of participants):	
Services included in capitation:	
Services not included in capitation:	31988.54
Average Length of Stay on the Waiver:	307

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (9 of 9)

d. Estimate of Factor D.

ii. Concurrent §1915(b)/§1915(c) Waivers, or other concurrent managed care authorities utilizing capitated payment arrangements. *Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. If applicable, check the capitation box next to that service. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.*

Waiver Year: Year 5

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Day Health Total:							**18927761.68**
Adult Day Health	☐	per day	2207	92.00	93.22	**18927761.68**	
Care Management Total:							**34193989.35**
Care Management	☐	per day	19897	285.00	6.03	**34193989.35**	

GRAND TOTAL:	
Total: Services included in capitation:	
Total: Services not included in capitation:	664315719.15
Total Estimated Unduplicated Participants:	**19897**
Factor D (Divide total by number of participants):	
Services included in capitation:	
Services not included in capitation:	33387.73
Average Length of Stay on the Waiver:	307

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Homemaker Total:							**31957902.90**
Homemaker	☐	per 15 minutes	6215	954.00	5.39	**31957902.90**	
Personal Care Assistant Total:							**420224073.93**
Personal Care Assistant	☐	per 15 minutes	10987	6159.00	6.21	**420224073.93**	
Respite Total:							**3150606.26**
Respite	☐	per 15 min	527	887.00	6.74	**3150606.26**	
Adult Family Living Total:							**75307971.33**
Adult Family Living	☐	per day	2557	229.00	128.61	**75307971.33**	
Assisted Living Total:							**6753131.94**
Assisted Living	☐	per day	838	129.00	62.47	**6753131.94**	
Assistive Technology Total:							**316725.44**
Assistive Technology	☐	per unit	226	1.00	1401.44	**316725.44**	
Bill Payer Total:							**135993.78**
Bill Payer	☐	per 15 min	267	78.00	6.53	**135993.78**	
Care Transitions Total:							**66051.30**
Care Transitions	☐	per unit	355	1.00	186.06	**66051.30**	
Chore Services Total:							**273100.30**
Chore Services	☐	per unit	179	190.00	8.03	**273100.30**	
Chronic Disease Self-Management Program Total:							**4315.74**
Chronic Disease Self-Management Program	☐	per session	11	6.00	65.39	**4315.74**	
Companion Total:							**53146454.58**
Companion	☐	per 15 min	4902	2073.00	5.23	**53146454.58**	
Environmental							**205557.28**

	GRAND TOTAL:	
Total: Services included in capitation:		
Total: Services not included in capitation:		*664315719.15*
Total Estimated Unduplicated Participants:		***19897***
Factor D (Divide total by number of participants):		
Services included in capitation:		
Services not included in capitation:		*33387.73*
Average Length of Stay on the Waiver:		*307*

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Accesibility Adaptations Total:							
Environmental Accesibility Adaptations	☐	per unit	31	1.00	6630.88	**205557.28**	
Home Delivered Meals Total:							**10684699.20**
Home Delivered Meals	☐	per day	5607	160.00	11.91	**10684699.20**	
Mental Health Counseling Total:							
Mental Health Counseling	☐	per session	733	15.00	71.10	**781744.50**	
Mental Health Counseling	☐						
Participant Training and Engagement to Support Goal Attainment and Independence (CAPABLE) Total:							
Participant Training and Engagement to Support Goal Attainment and Independence (CAPABLE)	☐	per unit					
Personal Emergency Response Systems Total:							**8079724.08**
Personal Emergency Response Systems	☐	per month	11653	9.00	77.04	**8079724.08**	
Recovery Assistant Total:							**105408.00**
Recovery Assistant	☐	per 15 min	6	2400.00	7.32	**105408.00**	
Remote Supports Total:							
Remote Supports	☐	per unit					
Training and Counseling Services for Unpaid Caregivers Supporting							

GRAND TOTAL:		
Total: Services included in capitation:		
Total: Services not included in capitation:		664315719.15
Total Estimated Unduplicated Participants:		**19897**
Factor D (Divide total by number of participants):		
Services included in capitation:		
Services not included in capitation:		33387.73
Average Length of Stay on the Waiver:	307	

Waiver Service/ Component	*Capi-tation*	*Unit*	*# Users*	*Avg. Units Per User*	*Avg. Cost/ Unit*	*Component Cost*	*Total Cost*
Participants (COPE) Total:							
Training and Counseling Services for Unpaid Caregivers Supporting Participants (COPE)	☐	*per unit*					
Transportation Total:							***507.56***
Transportation	☐	*per unit*	*4*	*1.00*	*126.89*	***507.56***	

	GRAND TOTAL:	
	Total: Services included in capitation:	
	Total: Services not included in capitation:	*664315719.15*
	Total Estimated Unduplicated Participants:	***19897***
	Factor D (Divide total by number of participants):	
	Services included in capitation:	
	Services not included in capitation:	*33387.73*
	Average Length of Stay on the Waiver:	*307*