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:
Personal Care Assistance Waiver

C. Waiver Number:CT.0301
Original Base Waiver Number: CT.0301.

D. Amendment Number:

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

11/12/23

Approved Effective Date of Waiver being Amended: 10/01/19

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.

3. Nature of the Amendment

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

Component of the Approved Waiver	Subsection(s)
Waiver Application	
Appendix A Waiver Administration and Operation	
Appendix B Participant Access and Eligibility	
Appendix C Participant Services	
Appendix D Participant Centered Service Planning and Delivery	
Appendix E Participant Direction of Services	
Appendix F Participant Rights	
Appendix G Participant Safeguards	
Appendix H	
Appendix I Financial Accountability	
Appendix J Cost-Neutrality Demonstration	

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

Modify target group(s)

Modify Medicaid eligibility

Add/delete services

Revise service specifications

Revise provider qualifications

Increase/decrease number of participants

Revise cost neutrality demonstration

Add participant-direction of services

Other

Specify:

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

1. Request Information (1 of 3)

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

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

Personal Care Assistance Waiver

C. Type of Request: amendment

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

3 years **5 years**

Original Base Waiver Number: CT.0301
Draft ID: CT.017.05.02

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

Regular Waiver

E. Proposed Effective Date of Waiver being Amended: 10/01/19
Approved Effective Date of Waiver being Amended: 10/01/19

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:

1915b-4 submitted approved through June 30, 2020

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 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.

Goals and Objectives:
The Department of Social Services operates the Personal Care Assistance Waiver Program that assists eligible disabled adults by providing services to wrap around the 1915(k) state plan option established in July of 2015. The purpose of this Medicaid Waiver Program is to provide adults who have permanent, severe, and chronic physical disabilities, with access to both waiver and state plan services to help with self-care activities, enabling them to reside in the community rather than an institution. The goal of the PCA Waiver is to provide an alternative to institutionalization via a flexible, cost-effective program not based on the medical model, designed to give consumer's control over their lives and to achieve greater independence in a community setting.

Organizational Structure:

The Department of Social Services (DSS), as the state Medicaid Agency pursuant to Connecticut General Statutes (CGS)section 17b-1, directly administers the PCA Waiver according to CGS section 17b-605. DSS assures that all individuals receiving waiver services meet the categorically and medically needy eligibility and income/asset requirements. DSS is responsible for calculating the consumer's share of liability that can be applied to the cost of waiver services. DSS also informs individuals determined eligible to receive waiver services of their due process rights and gives them the choice of institutional or home and community-based services.
The Department's Community Options Unit will administer the waiver, accept applications, perform the initial level of care determination and refer 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 are required to do annual face-to-face evaluations.
DSS contracts with the fiscal agent to credential providers. Self-directed PCA is available in the state under the state plan 1915(k) option. Quarterly reports, at a minimum, are submitted to the Department to facilitate State oversight of the waiver program. In addition, routine quality assurance activities through staff meetings, training, case conferences, consumer record maintenance, and staff supervision are components of the Department's oversight of the PCA waiver program.

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:

For this amendment notice was published in the CT Law Journal on June 9,2023. In addition to the CT law Journal posting, the Department posted the amendment notice on its web site on June 09, 2023 under "News" 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 June 9,2023. 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: Dumont

First Name: Amy

Title: Interim Director, Community Options Unit

Agency: Department of Social Services

Address: 55 Farmington Ave

Address 2:

City: Hartford

State: **Connecticut**

Zip:

06105

Phone:

(860) 424-5173 **Ext:** **TTY**

Fax:

(860) 424-4963

E-mail:

amy.dumont@ct.gov

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

Last Name:

First Name:

Title:

Agency:

Address:

Address 2:

City:

State: **Connecticut**

Zip:

Phone:

Ext: **TTY**

Fax:

E-mail:

8. Authorizing Signature

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

Signature:

State Medicaid Director or Designee

Submission Date:

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

Last Name:

First Name:

Title:

Agency:

Address:

Address 2:

City:

State: **Connecticut**

Zip:

Phone:

Ext: **TTY**

Fax:

E-mail:

Attachments

Attachment #1: Transition Plan

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

Replacing an approved waiver with this waiver.

Combining waivers.

Splitting one waiver into two waivers.

Eliminating a service.

Adding or decreasing an individual cost limit pertaining to eligibility.

Adding or decreasing limits to a service or a set of services, as specified in Appendix C.

Reducing the unduplicated count of participants (Factor C).

Adding new, or decreasing, a limitation on the number of participants served at any point in time.

Making any changes that could result in some participants losing eligibility or being transferred to another waiver under 1915(c) or another Medicaid authority.

Making any changes that could result in reduced services to participants.

Specify the transition plan for the waiver:

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

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

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

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

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

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

The state's Statewide Transition Plan was approved and the state continues to assure to meet requirements as articulated.

Additional Needed Information (Optional)

Provide additional needed information for the waiver (optional):

DSS is adding Home Delivered Meals as a service as well as Training and Counseling Services for Unpaid Caregivers Supporting Participants also known as COPE.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."

DSS is adding Participant Training and Engagement to Support Goal Attainment and Independence also known as CAPABLE.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.

Expanding the definition of assistive technology to reference remote equipment and associated requirements for internet access.

Amending the definition of "Environmental Adaptations" service and adding it as a new service where applicable. Environmental Adaptations are those physical adaptations to the private residence of the participant or the participant's family, required by the participant's service plan, that are necessary to ensure the health, welfare and safety of the participant or that enable the participant to function with greater independence in the home. Such adaptations include the installation of ramps and grab-bars, widening of doorways, modification of bathroom facilities, or the installation of specialized electric and plumbing systems that are necessary to accommodate the medical equipment and supplies. Excluded are those adaptations or improvements to the home that are of general utility and are not of direct medical or remedial benefit to the participant. Adaptations that add to the total square footage of the home are excluded from this benefit except when necessary to complete an adaptation (e.g., in order to improve entrance/egress to a residence or to configure a bathroom to accommodate a wheelchair). All services must be provided in accordance with applicable state or local building codes.

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

(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 assessment and reassessment 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. 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.

The department also contracts with DXC as its MMIS provider. Care managers enter service authorizations into a DXC portal and providers are authorized to bill for those services through the portal.
The department also contracts with a fiscal intermediary whose primary function relative to this waiver is provider credentialing and recredentialing. They also conduct a sample of provider audits and are required to submit monthly, quarterly and annual reports to the department.

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 HCBS CAHPS surveys. Monitoring of reporting requirements takes place on a monthly basis. The Department's Office 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 Office of Quality Assurance. The Department also oversees the contract for the fiscal intermediary and oversees all of the functions performed by the contracted entity.
Both the Access Agency and fiscal intermediary contracts were awarded as a result of a competitive procurement.

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:

1. Quarterly and ad hoc reports from the Fiscal Intermediary.
2. Annual on-site visits to review operational and administrative functions.
3. Annual survey of waiver participants utilizing the HCBS CAHPS survey for consumer input on program needs as well as the performance of the fiscal intermediary.
4. Ongoing correspondence between the fiscal intermediary and DSS staff regarding progress on deliverables (e.g., training schedules, number of eligible providers, etc.).
5. Annual on-site audits of Access Agencies.

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		
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 percent of new waiver providers who meet licensure/certification standards prior to delivery of services. Numerator = number of new waiver providers who meet licensure/certification standards prior to delivery of services. Denominator = total number of new waiver providers recruited.

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: 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:

Performance Measure:

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

Data Source (Select one):

Reports to State Medicaid Agency on delegated Administrative functions
If 'Other' is selected, specify:

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

Data Aggregation and Analysis:

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

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

Performance Measure:
Number and Percent of new waiver providers who complete their required training prior to delivery of services. Numerator = number of new waiver providers who received training prior to service delivery. Denominator = the total number of new providers.

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

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

	Specify:	

Data Aggregation and Analysis:

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

Performance Measure:
Number and percent of existing providers who are successfully re-credentialed and re-enrolled as providers for this waiver. Numerator: number of providers who are successfully re-credentialed and re-enrolled. Denominator: Number of providers who attempt to be re-credentialed and re-enrolled.

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 agent	**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 agent	**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 Community Options Unit Manager has ongoing correspondence with the fiscal intermediary and Access Agency to proactively address any issues or potential issues.

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.

Central Office Community Options staff, who is assigned oversight of the contract with the fiscal intermediary or the Access Agency is the point person for all problems that may occur. The staff member would hear and assess the problem, contact any person or department that needs to address the problem and then follow up to assure that there was resolution.

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: As needed

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			
		Disabled (Physical)	18	64	
		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:

PCA Waiver participants, who are age 64 and 6 months or older, shall be given a minimum of 60 days advance notice of the required program change. This notice will provide adequate information about the changes taking place so that participants and/or their legal representative will be able to make an informed choice of their service options (i.e., transition to the Connecticut Home Care Program for Elders or state plan services). The State will ensure successful transition to the waiver program through the following activities:

1.Access Agency Care Manager will conduct a home visit with the waiver participant/representative. At this home visit, the care manager will do the following:

a. alert the participant to the program change
b. review option of other waiver or state plan service options
c. provide a letter detailing the program change and participant options
d. provide a copy of the CHCPE Brochure
e. have the participant/representative sign a release of information for the CHCPE program.

2. Participants will have 14 days from the date of the home visit to determine their service choice. They can do this in writing or call their care manager to let them know.

3. If the participant/representative does not follow-up, Access Agency care managers will contact them to support their election.

If these efforts to support affirmative selection are not successful, PCA Waiver participants will be automatically enrolled in the CHCPE Waiver and their services will remain the same.

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:

Other

Specify:

The state increased the individual cost cap to 120% of the average Medicaid cost of nursing home effective 7/1/18 and to 125% of the average Medicaid cost of nursing home effective 7/1/19. All plans in excess of 100% of the average institutional cost will be subject to prior authorization by the department.

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 must determine that the cost of waiver services necessary to ensure the individual's health and safety does not exceed identified level of care annual cost limits. The Access Agency care manager will develop a cost effective plan of care in consultation with the consumer and his/her representative, if applicable, based on the level of need as determined by the universal assessment. The initial plan is developed using a standardized form that requires plan development in the following areas: health, life planning, behavioral and cognitive issues, communication, risk indicators, functional needs, and community-based supports. The universal assessment has a level of need algorithm built into its functionality which generates a budget amount for each participant. Care managers may request an exception to the level of need determination.

The Cost of Care Plan is also calculated. This plan includes all services funded under Medicaid including state plan PCA, home health care, nursing services, PT/OT, PERS, adult family living, independent support broker and assistive technology. The plan also factors in the cost of state-funded services such as Adult Day Care, Home Delivered Meals and Department of Developmental Services supports such as case management and supported living. All plans are initial plans and are reviewed and approved by Community Options Unit staff. All plans in excess of 100% of the average Medicaid cost of nursing home are subject to prior authorization by department staff.

Applicants whose health and safety needs cannot be reasonably assured will first be assessed to determine capacity to sign a risk agreement assuming risk for choosing to continue with home and community-based services. Risk mitigation agreement releases are offered to the applicant. If this is not tenable, the participant will not be enrolled or shall be discontinued from the PCA waiver. In the event that an applicant is denied enrollment, or a participant has services reduced, suspended or terminated, the applicant/participant is notified via a Medicaid Notice of Action (NOA) regarding their right to a Fair Hearing in accordance with the rules of the Department's Medicaid program.

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:

When a consumer's service level is thought to be inappropriate, Access Agency staff reassess that individual, with oversight by the Department's PCA Waiver manager. Potentially, a change in assessed needs could increase the level of need budget. If the services cannot be accommodated within appropriate program limits, it is then determined that a client does not qualify for services under the PCA Waiver. Clients are afforded the opportunity for a Fair Hearing in accordance with the Department's Medicaid policy. Services cannot be reduced until the hearing decision is issued if a client requests a hearing within 10 days of the date of the NOA. Department staff may authorize additional services on a short-term basis if it is expected that the plan could be reduced and be within the individual cost limits on an annualized basis. Other options such as state plan home health services would also be investigated for the participant.

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	1149
Year 2	1311
Year 3	1477
Year 4	1637
Year 5	1795

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	1101
Year 2	1254
Year 3	1414
Year 4	1565
Year 5	1716

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
Money Follows the Person transition
Transitions from Community First Choice 1915(k) State Plan Participants

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):*

Money Follows the Person transition

Purpose *(describe):*

PCA Waiver that will be used for clients transitioning from Money Follows the Person (MFP) onto the PCA Waiver.

Describe how the amount of reserved capacity was determined:

These clients will need to transition off the MFP Waiver and onto the PCA Waiver over the next five years.

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

Waiver Year	Capacity Reserved
Year 1	120
Year 2	155
Year 3	165
Year 4	165
Year 5	165

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 Community First Choice 1915(k) State Plan Participants

Purpose *(describe):*

Community First Choice (CFC)offers PCA services to Medicaid recipients with both budget and employer authority to self-direct their PCA services. CFC provides technical assistance to individuals who find aspects of self-direction difficult to manage.
A participant’s need for additional technical assistance and support is reported to the case management agency by the fiscal intermediary. Alternatively, assistance needs may be identified during the care manager's status review or reassessment. A participant may be the subject of a maltreatment report, or the participant may seek assistance to resolve problems encountered in plan implementation or service management.
While not an inclusive list, the matters below may indicate a need for additional technical assistance and support:
• Not spending enough for services needed to support health and safety without a reasonable explanation;
• A history of three months of more where the participant authorizes services in excess of what is approved in his or her plan resulting in unpaid care;
• On-going difficulty in arranging for services needed for health and safety;
• Failure to respond to notices requesting missing information from the fiscal intermediary;
• Not implementing the CFC service plan as approved.

Technical Assistance may be provided on up to four occasions. The waiver is reserving capacity for up to 10 individuals per year who, after, four technical assistance interventions, continues to demonstrate an inability to self-direct their services, putting them at risk for health and safety concerns or nursing facility admission.

Describe how the amount of reserved capacity was determined:

This number is based on three years of experience with CFC and is based on the number of participants identified who are continually challenged in managing self-direction

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

Waiver Year	Capacity Reserved
Year 1	10
Year 2	10
Year 3	10
Year 4	10
Year 5	10

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:

All applicants for the PCA waiver shall meet all the requirements for eligibility in the Department's medical assistance program that are applicable to disabled adults as stated in the regulations promulgated by the Department and contained in the Uniform Policy Manual pursuant to Section 17b-10 of the Connecticut General Statutes. This includes without limitation all regulations establishing medical assistance eligibility requirements related to the filing by applicants for assistance, verifications, and redeterminations, existence of a disabling condition, citizenship status, residency, institutional status, assistance unit composition and income and asset limits.

Waiting List:
If an individual applies for PCA waiver services at a time when the participant cap has been reached, his or her application shall be reviewed and processed for financial eligibility and fulfillment of the level of care criteria. An otherwise eligible individual who is denied solely because of the program quota shall be placed on the Department's waiting list for the PCA program. The date of application will determine the numerical location of the client on the waitlist.

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 1619b 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:

200% of the Federal poverty level

Other

Specify:

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:

The deduction for medical and remedial care expenses that were incurred as a result of imposition of a transfer of assets penalty is limited to zero.

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:

Department staff do the initial level of care evaluation and this is confirmed by the care manager at assessment and reassessment through utilization of the universal assessment.

Other

Specify:

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

Community Options Unit staff that conduct the initial level of care evaluations are Community Nurse Coordinators or Social Workers with experience in long-term care.
The care manager who conducts the assessments and reassessments and develops care plans 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 bachelor's 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.

The Department conducts level of care assessments to evaluate and reevaluate whether an individual needs services through the waiver that otherwise would require an institutional level of care. The level of care assessment is based on information obtained directly from the individual during a home visit. The level of care criteria utilized are as follows:

1. Supervision or cueing ≥ 3 ADLs + need factor
2. Hands-on ≥ 3 ADLs
3. Hands-on ≥ 2 ADLs + need factor
4. A cognitive impairment which requires daily supervision to prevent harm

*Need factors are:
1. Rehabilitative Services PT, OT, ST. The individual has restorative potential.
2. Behavioral Need: Requires daily supervision to prevent harm.
3. Medication Supports: Requires assistance for administration of physician-ordered medications; includes supports beyond setup.

**Only these ADL items are considered: bathing, dressing upper OR lower body, toilet use, transferring, eating.

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.

While the waiver applicants are screened utilizing the department's health screen and are assessed utilizing in interRAI home care assessment tool, the criteria utilized to determine nursing facility level of care both in an institution and in the community are the same.

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:

For the purposes of determining level of care, a Community Options Unit staff member (nurse or social worker) performs a level of care screening evaluation of each applicant. Confirmation of the level of care is determined by information gathered for the evaluation/reevaluation during face-to-face interviews and includes a thorough evaluation using the interRAI assessment instrument. The reevaluation process is the same as the evaluation process.

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):*

Reevaluations are an administrative component performed by Access Agency care managers. DSS utilizes an electronic case management system in which care plan review dates are logged. The system generates a list of reassessments due each month which queues up to the appropriate Access Agency.

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:

Written copies of the care plan evaluations and reevaluations documents are maintained by the Department of Social Services Community Options Unit and Access Agency records in conformance with 42 CFR 441.303 (c)(3) and 45 CFR 74.53. The DSS case management database also retains an electronic record of the performance of evaluations and reevaluations.

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:
The number and percent of PCA waiver applicants who received a level of care

evaluation by Department clinical staff. Numerator= number of LOC determinations and denominator= number of applicants.

Data Source (Select one):
Record reviews, off-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:
	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:

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 records that have a completed level of care determination form. The numerator is the number of records that have a completed LOC determination form and the denominator is the total number of records.

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**
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):*
	Continuously and Ongoing
	Other Specify:

Performance Measure:
:Number and percent of participants with an initial assessment of LOC using the Universal Assessment tool. Numerator is the number of participants who receive an initial assessment of LOC using the Universal Assessment tool. Denominator is the number of participants who required an initial assessment of LOC.

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: University of Connecticut, 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: University of Connecticut	**Annually**
	Continuously and Ongoing
	Other Specify:

Performance Measure:
The number and percent of initial LOC evaluations conducted utilizing the approved LOC criteria. Numerator: number of initial LOC evaluations conducted utilizing the approved LOC criteria. Denominator: number of initial LOC 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: contracted care management agencies	**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:

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.

If a consumer's level of care is thought to be inappropriate during any part of the evaluation process, the individual is reassessed by the care manager with oversight by the department's PCA Waiver manager to ensure that all necessary factors have been considered in assigning the care level.

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 processes contained in the policy manual must be followed in order for care management agencies to get paid and avoid programmatic and fiscal auditing consequences. There are standard forms that must be completed and contained in the participant chart. DSS staff conduct a quality assurance audit of care management agencies annually to determine if the appropriate forms are completed and present in participant's charts. An audit report is issued to the provider detailing the findings including any missing forms and documents. A corrective action plan may be requested if there are a significant number missing. Any missing documents are enumerated in the audit report.

The care manager will re-assess participants who appears to require a different level of care. If it is determined that a level of care is either too high or too low, the service plan is adjusted and a Notice of Action is sent to the client if services are reduced in the service plan. The consumer is afforded full access to the Medicaid appeals process, which is administered by the DSS Office of Legal Counsel, Regulations, and Administrative Hearings. Community Options maintains a fair hearings log to track different types of fair hearings including service reductions due to level of care assessments.

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:

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

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).

At the time of screening for eligibility to participate in this waiver, the care manager informs the potential participant of his or her option of receiving services in a long-term care institution or through this waiver. The applicant is informed of any services available under the waiver as well as self-directed PCA available under the state plan. The individual is also advised of his/her right to a Fair Hearing. This is documented on the Freedom of Choice/Fair Hearing Notification (form W-1035). This form is maintained in the participant's case file.

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.

All materials pertaining to a specific waiver participant are maintained in their individual files in the Access Agency records.

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 Request for Waiver Services (W-1130) is available in Spanish. For applicants who speak other languages, the department would utilize its contracted language line to complete the application. Access Agencies are required to make arrangements to provide interpretation or translation services for potential and active waiver participants who need them. This is accomplished through the use of bilingual staff and/or purchasing/contracting for interpreters. Non-English speaking waiver applicants/participants may bring an interpreter of their choice with them to the DSS planning meetings. They cannot, however, be required to bring their own interpreter. No person can be denied access 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	Agency-based Personal Care Assistant
Statutory Service	Care Management
Other Service	Adult Family Living
Other Service	Assisted Technology
Other Service	Environmental Accessibility 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 System (PERS)
Other Service	Remote Supports
Other Service	Training and Counseling Services for Unpaid Caregivers Supporting Participants (COPE)

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):

Adult Day Health

HCBS Taxonomy:

Category 1:	Sub-Category 1:
04 Day Services	04050 adult day health

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

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

Service Definition *(Scope)*:

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

Adult Day Health is not a state plan service.

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 be 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 health 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 health 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.

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

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

Participant-directed as specified in Appendix E

Provider managed

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

Legally Responsible Person

Relative

Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Agency Provider

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Adult Day Health

Provider Category:

Agency

Provider Type:

Agency Provider

Provider Qualifications

License *(specify)*:

Certificate *(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 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 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.

Other Standard *(specify):*

Recertification by the Adult Day Health Association is required every three years.

Verification of Provider Qualifications

Entity Responsible for Verification:

Fiscal Intermediary

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:

Personal Care

Alternate Service Title (if any):

Agency-based Personal Care Assistant

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:**

Agency-based PCA services are not a state plan service.

Service to assist 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 Activities 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:

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: Agency-based 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.
Individual PCAs must have viewed the PCA training curriculum developed collaboratively by DSS, provider agencies and access agencies. PCAs must pass the follow up exam with a score of 70% in each section of the training. A certificate indicating a passing score is retained in the employee's personnel record and subject to audit by the department or its designee.

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.

Verification of Provider Qualifications

Entity Responsible for Verification:

Fiscal intermediary

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:**

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 to monitor 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 options under the state's 1915(k) state plan option to participants. DSS has 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. 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. The rate methodology is described in Appendix I-2.

Providers are selected as a result of a competitive bidding process and approved, qualified providers are directly enrolled as Medicaid providers. Client choice is assured as they can request a change in their care manager at any time.

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.

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	Care Management 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:

Care Management 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.

Certificate *(specify):*

Other Standard *(specify):*

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 empathic 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.

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 annual evaluation

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

Service Definition *(Scope):*

Adult family living is not a state plan service.

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 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 Family Living 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 4 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):*

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 are 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 years of age, is 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 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 must provide evidence of an ability to certify that the individual home meets 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 Access Agency which holds the provider agreement with the state which then pays the provider. The provider is then responsible to pay the direct caregiver.

Verification of Provider Qualifications

Entity Responsible for Verification:

Fiscal intermediary.

Frequency of Verification:

At the initiation of service 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:

Assisted Technology

HCBS Taxonomy:

Category	Sub-Category
Category 1: 14 Equipment, Technology, and Modifications	**Sub-Category 1:** 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.

The definition of assistive technology is expanded now to include equipment used for remote support such as motion sensing system, radio frequency identification, live video feed, live audio feed, or web-based monitoring. Assistive technology equipment does not include non-technical, non-electronic equipment (e.g., grab bars or wheelchair ramps) or items otherwise available as environmental accessibility adaptations or specialized medical equipment and supplies. Internet service may be provided through assistive technology equipment only when the remote support vendor indicates internet service is required for the equipment used for remote support to function and for the vendor to secure the connection to ensure appropriate use of the internet service solely for the function of equipment used for remote support. All other elements of the assistive technology definition remain in effect, including with respect to remote supports assistive technology

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

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Assisted 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 enrollment and every two 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:

Environmental Accessibility Adaptations

HCBS Taxonomy:

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

Service Definition *(Scope)*:

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
Agency	

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Environmental Accessibility Adaptations

Provider Category:

Agency

Provider Type:

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:

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:

Home Delivered Meals

HCBS Taxonomy:

Category		Sub-Category	
Category 1:	06 Home Delivered Meals	**Sub-Category 1:**	06010 home delivered meals
Category 2:		**Sub-Category 2:**	
Category 3:		**Sub-Category 3:**	
Category 4:		**Sub-Category 4:**	

Service Definition *(Scope)*:

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
Individual	Home Delivered Meals Provider
Agency	Home Delivered Meals Provider

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Home Delivered Meals

Provider Category:

Individual

Provider Type:

Home Delivered Meals Provider

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Reimbursement 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 follow 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 American's 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: Provider Specifications for Service

Service Type: Other Service
Service Name: Home Delivered Meals

Provider Category:

Agency

Provider Type:

Home Delivered Meals Provider

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Reimbursement 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 follow 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 American’s Act.

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:

Mental Health Counseling

HCBS Taxonomy:

Category 1:

10 Other Mental Health and Behavioral Services

Sub-Category 1:

10060 counseling

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Service Definition *(Scope):*

Category 4:

Sub-Category 4:

Mental health counseling is not a state plan service.

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.

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	Masters Level Licensed Clinical Social Worker or Masters Level Licensed Professional Counselor (LCSW or LPC)
Agency	Community Agency

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 Licensed Clinical Social Worker or Masters Level Licensed Professional Counselor (LCSW or LPC)

Provider Qualifications
License *(specify):*

For purposes of receiving reimbursement under the Connecticut Home Care Program, a mental health counseling provider shall be a licensed clinical social worker as defined in section 20-195m of the Connecticut General Statutes 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:

Initially and bi-annually thereafter

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Mental Health Counseling

Provider Category:
Agency
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: 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	Sub-Category
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:**

Evidence based program with a teaming approach of a nurse, occupational therapist and a handy person to ensure the person's home surroundings. Home environment modification is provided and the program emphasizes the strengths of the older adults themselves to help them set goals and improve safety and independence.

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
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:

Agency

Provider Type:

Home Health Agency

Provider Qualifications

License *(specify):*

DPH licensure

Certificate *(specify):*

Other Standard *(specify):*

RN partnered with OTs

Verification of Provider Qualifications

Entity Responsible for Verification:

Fiscal Intermediary

Frequency of Verification:

upon enrollment and then every 2 years

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

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

Service Title:

Personal Emergency Response System (PERS)

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)*:

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	PERS vendors

Appendix C: Participant Services

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

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

Provider Category:

Agency

Provider Type:

PERS vendors

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Vendors must sign DSS provider agreement and enroll as Medicaid provider

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:

Remote Supports

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)*:

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

Provider Category	Provider Type Title
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):*

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:

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	Sub-Category
Category 1: 09 Caregiver Support	**Sub-Category 1:** 09020 caregiver counseling and/or training
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope)*:

Evidence based program targeting patients with dementia and their informal caregivers, designed with the 4-month intervention to optimize older adult's functional independence and to improve their family caregivers' dementia management skills and health related outcomes.

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

Provider Category:
Individual
Provider Type:

Occupational Therapist

Provider Qualifications

License *(specify):*

DPH Licensure

Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

Fiscal Intermidiary

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

Provider Category:

Agency

Provider Type:

Home Health Agency

Provider Qualifications

License *(specify):*

DPH license

Certificate *(specify):*

COPE certificate (10 modules of COPE online training)

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

Fiscal Intermediary

Frequency of Verification:

Upon Enrollment then every 2 years.

Appendix C: Participant Services

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

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

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

Applicable - Case management is furnished as a distinct activity to waiver participants.
Check each that applies:

As a waiver service defined in Appendix C-3. *Do not complete item C-1-c.*

As a Medicaid state plan service under §1915(i) of the Act (HCBS as a State Plan Option). *Complete item C-1-c.*

As a Medicaid state plan service under §1915(g)(1) of the Act (Targeted Case Management). *Complete item C-1-c.*

As an administrative activity. *Complete item C-1-c.*

As a primary care case management system service under a concurrent managed care authority. *Complete item C-1-c.*

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

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):

The provider agencies are expected to do a background check on all of their prospective employees. Providers are also expected to check the OIG list.

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.*

Relatives/legal guardians may be paid for providing waiver services whenever the relative/legal guardian is qualified to provide services as specified in Appendix C-1/C-3.

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

Other policy.

Specify:

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

The Connecticut Department of Social Services contracts with a fiscal intermediary to conduct outreach activities in order to increase awareness of the PCA Waiver Program within the community and to recruit qualified providers to serve the PCA population. Outreach activities include:

1. Identifying those areas of the state in which service deficits exist;
2. Tailoring outreach approaches to best recruit the types of providers most needed to serve the PCA population on a regional and statewide basis;
3. Conducting at least one outreach session every twelve months in each of the Department's three regions during the contract period;
4. Conducting at least one community service provider outreach session each quarter during the contract period;
5. Utilizing appropriate methods to publicize outreach activities including, but not limited to, newsletters, individual contacts, direct mailings, print or other media advertisements, or other methods of communication as appropriate to each activity; and
6. Maintaining a directory of potential providers who attend each activity or who are contacted through the outreach effort, including the date and place of each activity, the number of individuals who attend or are contacted, the number of individuals who subsequently participate in training, and the number of individuals, by specialty type, subsequently enrolled as Qualified Providers.

Appendix C: Participant Services

Quality Improvement: Qualified Providers

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

a. Methods for Discovery: Qualified Providers

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

i. Sub-Assurances:

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

Performance Measures

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

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

Performance Measure:
The number and percent of providers who meet licensure or certification standards prior to furnishing waiver services and continually. The numerator is the number of qualified/credentialed providers who meet licensure or certification standards prior to furnishing waiver services and the denominator is the total number of providers requiring licensure or 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:	**Annually**

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

Performance Measure:
The number and percent of Agencies utilizing the DSS Community Options training modules and certification tests. Numerator: number of agencies utilizing the DSS Community Options training modules and certification tests. Denominator: number of agencies 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 =
Other Specify: provider 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 fiscal intermediary	**Annually**
	Continuously and Ongoing
	Other Specify: Random audits annually of 10% of the providers

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

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

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

Performance Measure:
Number and percent of non licensed/non certified providers by provider type who continually meet waiver qualifications. Numerator: number who continue to meet qualifications. Denominator: number of providers who re-enroll.

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	**Annually**

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

Performance Measure:
Number and percent of new non licensed/non certified providers by provider type who meet waiver qualifications. Numerator is Number of new providers who meet qualifications. Denominator is Number of new providers enrolled.

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: Contracted 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: Contracted fiscal intermediary	**Annually**
	Continuously and Ongoing
	Other Specify:

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

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

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

Performance Measure:
The number and percent of providers who complete required training from the fiscal intermediary. The numerator is the number of providers who completed the training and the denominator is the number of providers reviewed.

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	**Annually**

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

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

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

There are no continuous training requirements for providers. Providers are expected to attend various ad hoc training opportunities as they become available provided by the Fiscal Intermediary and DXC Technologies. providers have been required to attend training on the state's Electronic Visit Verification system in order to continue to provide services and submit claims.

b. Methods for Remediation/Fixing Individual Problems

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

State Quality Assurance staff work with the fiscal intermediary for the purpose of resolving any discrepancies or issues related to contract compliance. If there is reason to suspect fraud, Quality Assurance staff make a referral to the Fraud and Recoveries Unit. Individual situations may be reported through the critical incident system. Each incident is reviewed and addressed by Community Options Unit clinical staff.

When Community Options staff become aware of a quality of care issue, Quality Assurance staff in the unit conduct a quality of care audit, which may be announced or unannounced. An audit report is written and sent to the provider with specific items that need to be corrected with a due date. Depending on the severity of the findings, DSS may suspend new referrals to the agency or refer the matter to the Office of Quality Assurance to terminate the provider from the Connecticut Medical Assistance Program.

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	**Annually**

Responsible Party(*check each that applies*):	**Frequency of data aggregation and analysis** (*check each that applies*):
Specify: fiscal intermediary	
	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 B

Appendix D: Participant-Centered Planning and Service Delivery

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

State Participant-Centered Service Plan Title:

Personal Care Assistance Service Plan

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

The Access Agency Care Managers are required to assist every PCA Waiver participant in developing a Person-Centered Service Plan based on the needs identified using the Universal Assessment tool and the participant's stated personal goals.Goals are developed from information gained during the assessment.The assessment process helps to identify each individual's and family's unique attributes, including needs, problems, strengths, resources, barriers and priorities in reaching the goals. Services and goals are reviewed at each reassessment. This individualized plan is written through a team process that includes the participant, his or her conservator as applicable, and other relevant persons as directed by the participant. The waiver participant, is made aware of the availability of self-directed PCA services available under the state plan as well as services to support them in their choice to self-direct their services. The Person-Centered Planning process training covers issues such as client choice, networking, and team building.

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):

To be eligible for PCA Waiver services, consumers must meet nursing facility level of care based on standardized state criteria. The criteria are as follows:
1. Supervision or cueing ≥ 3 ADLs + need factor
2. Hands-on ≥ 3 ADLs
3. Hands-on ≥ 2 ADLs + need factor
4. A cognitive impairment which requires daily supervision to prevent harm.

*Need factors are:
1. Rehabilitative Services PT, OT, ST. The individual has restorative potential.
2. Behavioral Need: Requires daily supervision to prevent harm.
3. Medication supports: Requires assistance for administration of physician-ordered medications; includes supports beyond setup.

**Only these ADL items are considered: bathing, dressing upper OR lower body, toilet use, transferring, eating.

The care manager in consultation with the consumer and his/her representative develop the person-centered service plan. A person-centered planning process is utilized and is driven by the participant. The individual also has the right to decide who should be included in the person-centered planning process. The process also provides all necessary information to support the individual to direct the process to the maximum extent possible. The process also occurs at a time and location convenient to the individual. The person-centered planning process also reflects cultural considerations and discusses strategies for addressing areas of disagreement. It also offers the participant choices regarding services and supports and who they receive them from. A plan of care is developed with the consumer based on the their level of need as identified through the assessment. The plan needs to reflect what is important to the individual to ensure delivery of services in a manner reflecting personal preferences while ensuring health and welfare of the participant. The planning process identifies strengths, preferences, needs and desired outcomes for the participant. It also identifies person-centered goals and preferences related to all aspects of their life. The plan includes identified risks and plans to address the risks. The initial plan is submitted to the Community Options Unit for final approval. The department utilizes an InterRAI-based universal assessment to explore all domains relevant to identifying participant's needs.

The Cost of Care Plan is also calculated based on the level of need identified in the assessment. The care manager may request an exception to the budget based on any unmet needs. This plan includes all services funded under Medicaid and outside sources including, but not limted to, PCA, nursing services, PT/OT, PERS, Adult Day Care and Home-Delivered Meals. The initial Service Plan and the Cost of Care Plan are submitted to the Community Options Unit for final approval.

Care Managers then discuss the plans with the client and/or their representative and any other person they want involved in the planning process and sign with the client an agreed upon plan that best meets the needs of the consumer. Additionally, after an initial plan is developed, if the client and/or their representative feel an increase or decrease in service is needed, they will contact their care manager who will make a home visit and reassess the plan as needed.

The PCA waiver program is person-centered, reflective of an approach to ensure that individual consumer preferences and needs are supported congruent with the eligible population standards. This service operates under ongoing oversight checks and balances built in through DSS staff monitoring, fiscal agent coordination and reporting, and service system documentation. All client specific actions are documented in the consumer's case record.

The requirement for documented client choice regarding institutional versus community-based services is

evidenced through consumer attestation and signature as part of the waiver application process. A process is also in place to ensure that consumers can affect individualized provider choice. Care managers share with waiver consumers the provider listing, which is developed by a DSS contracted fiduciary. Clients are afforded the opportunity to speak with and/or interview prospective providers prior to selection.

Form W-990 Clients Rights and Responsibilities specifically states that participants are expected to actively participate in choosing their providers. Presence of this document, signed by the participant, is required to be in the participant's chart when DSS Community Options staff conduct care management agency audits.

The written service plan must:
(i) Reflect that the setting chosen by the individual is integrated in, and supports full access of individuals receiving HCBS to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community living, control personal resources, and receive services in the community to the same degree of access as individuals not receiving Medicaid HCBS.
(ii) Reflect the individual’s strengths and preferences.
(iii) Reflect clinical and support needs as identified through an assessment of functional need.
(iv) Include individually identified goals and desired outcomes.
(v) Reflect the services and supports (paid and unpaid) that will assist the individual to achieve identified goals, and the providers of those services and supports, including natural supports.
(vi) Reflect risk factors and measures in place to minimize them, including individualized back-up plans and strategies when needed.
(vii) Be understandable to the individual receiving services and supports, and the individuals important in supporting him or her. At a minimum, for the written plan to be understandable, it must be written in plain language and in a manner that is accessible to individuals with disabilities and persons who are limited English proficient, consistent with §435.905(b).
(viii) Identify the individual and/or entity responsible for monitoring the plan.
(ix) Be finalized and agreed to, with the informed consent of the individual in writing, and signed by all individuals and providers responsible for its implementation.
(x) Be distributed to the individual and other people involved in the plan.
(xi) Include those services, the purpose or control of which the individual elects to self-direct.
(xii) Prevent the provision of unnecessary or inappropriate services and supports.
(xiii) Document any modification of the additional conditions, which must be supported by a specific assessed need and justified in the person-centered service plan. The following requirements must be documented in the person-centered service plan:
a. Identify a specific and individualized assessed need.
b. Document the positive interventions and supports used prior to any modifications to the person-centered service plan.
c. Document less intrusive methods of meeting the need that have been tried but did not work.
d. Include a clear description of the condition that is directly proportionate to the specific assessed need.
e. Include a regular collection and review of data to measure the ongoing effectiveness of the modification.
f. Include established time limits for periodic reviews to determine if the modification is still necessary or can be terminated.
g. Include informed consent of the individual.
h. Include an assurance that interventions and supports will cause no harm to the individual.

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 select 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 consumer and his/her conservator, and any other person identified by the consumer collaborate to assess the consumer's ADL needs as well as any risk factors including: inadequate supervision, social isolation, 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 will discuss this with their Supervisor and then provide feedback to the waiver participant regarding the area(s) of concern. This allows the consumer 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 consumer. The waiver participant has the right to accept, reject or modify recommendations that address risk. In addition, all participants are required to have, and document on the service plan, an emergency back up plan, if a provider does not report to work.

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. Risk mitigation procedures and documents are completed. If this does not sufficiently mitigate risk, then the waiver participant is issued a Notice of Action (NOA), indicating discontinuance from the waiver. The consumer 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.

Care managers share the provider listing with waiver participants which is developed and maintained by the fiscal intermediary. This listing identifies providers and geographic locations. Participants may hire the agency of their choosing and the fiscal intermediary reviews their qualifications. PCAs would not be included in the list of waiver providers. However, the care manager, who would also be assisting the client with the application for CFC, could provide the PCA directory to the client as well. The care managers who do the waiver assessments are the same providers who will be doing the CFC assessments.

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):

The staff of DSS, Connecticut's Medicaid agency, directly approves the developed service plan.

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 the development, management, administration, and monitoring of the HCBS waiver participant service plan implementation. The care manager promotes participant choice, ensures the delivery of high quality services; assists in the development of needed services and oversees waiver cost-effectiveness, with the support of the agency supervisors and Community Options Unit staff. DSS, through the Community Options, Medical Operations and Quality Assurance units, is the central component in managing and delivering the program objectives of deinstitutionalization, diversion and waiver administration. DSS is responsible for implementing the HCBS waiver and facilitating access to waiver program supports for eligible individuals.

Monitoring Methods and frequency:
A comprehensive plan of care is developed within 10 days of waiver eligibility. Discharge from institutional care and receipt of community-based services from providers must occur within 90 days. During this process an Access Agency care manager will consult with a client/representative via telephone or in person to monitor the client's plan and service needs. If the client or the care manager identify any problems during the service plan implementation process, the care manager will conduct a home visit to re-assess the level of care needs. The plan would be resubmitted to the Community Options Unit for approval. If the participants' needs are assessed as being more than can safely be provided by the waiver, the client is issued a notice of action and is afforded the right to a fair hearing.

The care manager, consumer, and the consumer's conservator and/or supports meet a minimum of semi-annually to evaluate the plan. If, however, at any time a consumer reports that a service plan is no longer effective, care managers will conduct a home visit to re-evaluate the level of care necessary to maintain the client safely in the community.

The care manager contacts the client at least monthly and conducts a face-to-face visit 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:
The number and percent of service plans/participant records that address all of the participant's identified needs. Numerator is number of service plans/participant records that address identified needs. Denominator is the 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 = 95% with 5% margin of error
Other Specify: Contracted care management entitiy	**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 = 95%, margin of error 5%

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: 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 = 95%
Other Specify: Contracted care management entity	**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 = 95%
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: Contracted care management entity	**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 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.

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 CM has reviewed/updated service plan as warranted due to changes in the participant's needs. Numerator= Number of charts reviewed indicating plans were reviewed and updated as client's needs changed. Denominator: Number of charts indicating a change in participants' needs 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 = 95%
Other Specify: contracted care management entity	**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:

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

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: Contracted care management entitiy	**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 entitiy	**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 percent of waiver participants who report via the 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	**Weekly**	**100% Review**

Agency		
Operating Agency	**Monthly**	**Less than 100% Review**
Sub-State Entity	**Quarterly**	**Representative Sample** Confidence Interval = 95%. Margin of error 5%
Other Specify: 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):*

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 = 95%, margin of error 5%
Other Specify: 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 waiver participants records that document services are delivered in accordance with the type, scope, frequency and duration specified in the service plan. Numerator= #participants records that document that services delivered in accordance with type, scope, frequency and duration in 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 = 95%. Department reviews combined with CM agency record reviews constitute a representative sample
Other Specify:	**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 =

		95%
Other Specify: Contracted care management agencies supervisory record review	**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:

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 during the assessment process. Numerator is the number of participants who sign the freedom of choice form and the denominator is the total number or participants 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 = 95%, 5% margin of error
Other Specify: 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 who completed surveys

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

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 = 95%, margin of error 5%
Other Specify: Contracted access agencies	**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.

There is a system of checks and balances in place that all Service Plans must be approved by the Community Options Unit staff. Community Options staff use the results from the Universal Assessment to determine if the service plan and category of service are appropriate based on the assessed level of need. Service plans are available for Community Options staff to view and refer to using the Ascend system as well as the DXC care plan portal.

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 service plan assessment and review process works on a system of checks and balances. Documentation is reviewed by Access Agency supervisors until all parts of the service plan are complete and are in compliance with the waiver requirements. Community Options unit staff authorize the plan before services are initiated. Questions regarding the plan are forwarded back to the Access Agency for further review and documentation. Should the consumer not agree with the service change, they may request a fair hearing when services are denied or reduced due to failure to meet criteria for the scope and amount of service desired by the participant.

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 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 recipients of services under the PCA Waiver, may request and receive a fair hearing, in accordance with the rules of the Department's Medical Assistance Program. The W-944 notice of action form is issued by a care manager when services are reduced, denied or suspended. For active participants who are notified of a reduction or elimination of a particular service, it states that services will not be discontinued during the fair hearing process, if the request for fair hearing is received by the department prior to the effective date of the service change in the notice. Care managers will notify clients of this and not stop services until after a fair hearing decision is issued. Fair Hearings are provided in the following circumstances:

When the Department:
1. did not offer the choice of home and community-based services as an alternative to institutional care
2. does not reach a determination of financial eligibility within the department's standard of promptness
3. denies the application for any reasons other than the limitations on the number of individuals who can be served and/or funding limitations as established in the approved PCA waiver
4. disapproves the individual's service plan
5. denies or terminates a service of the individual's choice
6. denies or terminates payment to a qualified provider of the individual's choice or;
7. discharges the individual from the PCA waiver program.

In accordance with Medicaid rules (Connecticut General Statutes, sections 17b-60 through 17b-66), a Notice of Action (NOA) is issued to waiver participants when any service is denied, reduced, suspended or terminated. The NOA and Freedom of Choice/Fair Hearing notification are also provided in Spanish to support persons with limited-English proficiency or non-English proficiency.

DSS' Office of Legal Counsel, Regulations and Administrative Hearings keeps a record of all fair hearings and the results of any cases heard.

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).

The Department seeks to identify, address and prevent instances of abuse, neglect and exploitation. For consistency in programming, the department has established a web-based critical incident reporting system. A reportable incident is defined as any situation in which the waiver participant experiences a perceived or actual threat to his/her welfare or to their ability to remain in the community. These incidents include:

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.

Untimely Death
The participant dies unexpectedly from 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 was 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 is not 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, 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 client's 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.

Caregiver Name
Enter the name of the caregiver involved with:
Unexpected absence of the primary caregiver
Untimely death
Serious criminal allegation – client as victim
Allegations of abuse, neglect or exploitation of client
Misappropriation of client's funds
Seclusion
Restraint

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."

Community Options Unit staff report DSS actions taken and outcome information. Community Options Unit staff may notice patterns from data reporting that emerge as a widespread systemic problem or may suggest the need for programmatic changes.

Reporting Methods and timeframes:

All critical incidents are required to be submitted to the department through the web-based system within 2 business days of the care manager becoming aware of the incident. Community Options Unit clinical staff review and address each incident generally the same day it is received.
Protective Services in CT applies only to persons age 60 and over and there are specific mandatory reporting requirements and timeframes depending on the severity of the incident. For our critical incident reporting system, the goal is to review and take action on any critical incident report in 2 business days. Emergent situations such as missing persons are addressed upon receipt. The time to complete the investigation varies depending on the type, nature and severity of the incident. Police are notified immediately in the event of potential criminal activity or a missing person. The individual or their representative is notified of the outcome of the investigation upon completion.
CT does not have Adult Protective Services only Protective Services for Elders and statutorily only persons age 60 or over can be served.

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.

QI strategy: The fiscal intermediary provides information to participants/representatives during the orientation to the program. Consumers/representatives will be informed of the necessity to report events to the care manager immediately. All participants will sign the Right and Responsibilities form to evidence that such information has been given. As a best practice, we also incorporate a discussion of reporting abuse/neglect into the annual reassessment process.

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.

DSS investigates any serious issues or refers the issue to the appropriate agency. DSS will interview the consumer, and any other parties that were involved, or have knowledge of the incident. The specific manner for follow-up is determined by the nature of the allegation and the results of the investigation. Possible actions include the suspension or removal of the consumer from the program, or remedial actions taken with the provider. Reporting to law enforcement is also possible. Action to ensure the safety of a waiver participant who is at imminent risk occurs immediately. Additional follow-up may include referrals to other DSS divisions, such as Quality Assurance, Medical Policy or the Legal department.

Connecticut has no Adult Protective Services; therefore, law enforcement is called when appropriate for participants under the age of 60. Referrals are made to Protective Services for the Elderly (PSE) when a waiver participant is age sixty or older and it is deemed appropriate. The care manager will either make the report or ensure that the provider agency has made a report. 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 (sections 17b-450 through 17b-461 of the Connecticut General Statutes) provides the framework for the investigation of abuse or neglect.

The Community Options Unit has developed a system that facilitates:
- Analysis of the types and numbers of complaints at a systemic level
- Looking for trends by area
- Identifying statewide issues
- Developing and implementing plans for improvement

This electronic system has been operational since May of 2013 and has had several modifications and upgrades for enhanced functioning. This system is working extremely well and allows for the identification of trends. It has the ability to track individual remediation as well.

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.

DSS is responsible for overseeing the reporting of and response to critical incidents or events that affect waiver participants. The Department directly administers this and follow-up frequency is ongoing. Incidents queue up in the electronic database as they are submitted and are reviewed promptly by clinical staff.
Incidents are reviewed as they are received and assigned to clinical staff for follow up and investigation. Actions are taken depending on the nature of the incident. For example, if an incident involving a provider neglecting a participant is substantiated by the investigation, the provider would be terminated, removed from the registry and employer retraining might be offered to the participant. The investigation would be a collaboration between the department and the care manager.

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:

At any time a participant, community provider or private citizen can report to the DSS staff that a client may have been restrained or placed in seclusion. Because the use of restaints are unauthorized and pursuant to Connecticut State PCA Regulation 262-596 (d) the Department reserves the right to terminate any provider who violates any rules or policies of the PCA program. Any use of restraints or seclusion would be a violation of program rules resulting in the provider being terminated and his/her name would be removed from the registry. Employers will also be encouraged and counseled to notify the police if the situation warrants such an intervention.
Participants are advised of their rights that prohibit restraints in the employer guide that is given to each new waiver participant. Effective 6/1/2018, the state launched a new universal assessment that will be used across all waiver programs. The tool specifically asks questions to determine if there have been any incidents of restraints and will be conducted on an annual basis. The care managers will review this with the client at each reassessment and also encourage the client to contact them directly if there are any concerns that arise between visits.

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:

At any time, a client, community provider or private citizen can report to DSS staff the use of restrictive intervention. Because the use of restrictive intervention is unauthorized and pursuant to Connecticut State PCA Regulation 262-596 (d) the Department reserves the right to terminate any provider who violates any rules or policies of the PCA program. Any use of restrictive intervention would be a violation of program rules resulting in the PCA being terminated and his/her name would be removed from the PCA registry. Employers will also be encouraged and counseled to notify the police if the situation warrants such an intervention.
Participants are advised of their rights that prohibits restrictive interventions in the employer guide that is given to each new waiver participant. Effective 6/1/2018, the state launched a new universal assessment that will be used across all waiver programs. The tool specifically asks questions to determine if there have been any incidents of restrictive interventions and will be conducted on an annual basis. The care managers will review this with the client at each reassessment and also encourage the client to contact them directly if there are any concerns that arise between visits.

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:

At any time, a client, community provider or private citizen can report to DSS staff the use of seclusion. Because the use of seclusion is unauthorized and pursuant to Connecticut State PCA Regulation 262-596 (d) the Department reserves the right to terminate any provider who violates any rules or policies of the PCA program. Any use of seclusion would be a violation of program rules resulting in the provider being terminated. Employers will also be encouraged and counseled to notify the police if the situation warrants such an intervention.
Participants are advised of their rights that prohibits the use of seclusion in the employer guide that is given to each new waiver participant. Effective 6/1/2018, the state launched a new universal assessment that will be used across all waiver programs. The tool specifically asks questions to determine if there have been any incidents of restrictive interventions and/or seclusion and will be conducted on an annual basis. The care managers will review this with the client at each reassessment and also encourage the client to contact them directly if there are any concerns that arise between visits.

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 and/or legal guardian who receive information about how to identify and report abuse, neglect and exploitation. Numerator = number of participants reviewed and/or legal guardian who receive information about how to identify and report abuse, neglect and exploitation. Denominator = number of participants

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 = 95%, margin of error 5%
Other Specify: case management agency	**Annually**	**Stratified** Describe Group:
	Continuously and Ongoing	**Other** Specify:

		participant record review at care management agencies
	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 abuse, neglect, exploitation and unexplained death incidents investigated within the required timeframe. Numerator: number of incidents of abuse, neglect, exploitation and unexplained death investigated within the required timeframe. Denominator: number of abuse, neglect, exploitation and unexplained death critical incidents within the timeframe.

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

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

data collection/generation *(check each that applies):*	collection/generation *(check each that applies):*	*(check each that applies):*
State Medicaid Agency	**Weekly**	**100% Review**
Operating Agency	**Monthly**	**Less than 100% Review**
Sub-State Entity	**Quarterly**	**Representative Sample** Confidence Interval =
Other Specify: Contracted care management agencies	**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):*
	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 abuse, neglect, exploitation and unexplained death cases that received the required follow up. Denominator: Number of substantiated cases of 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: Care management agencies and provider agencies	**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 completing the HCBS CAHPS survey who respond affirmatively to questions re Safety and Respect indicating that staff did not steal from them, yell or swear at them and the participant has someone to talk to if someone hurts them. Numerator= participants who respond affirmatively to the composite questions, denominator= number of participants completing the survey

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

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 = 95%
Other Specify: Contracted access agencies, University of CT	**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 CT	**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 participants completing HCBS CAHPS survey who can identify someone to contact in case of emergency. Numerator= number of participants who can identify someone, denominator= number who completed survey

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

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 = 95%
Other Specify: contracted care management agencies, University of CT	**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 CT	**Annually**
	Continuously and Ongoing
	Other Specify:

Performance Measure:
Number and percent of participants who have an emergency back up or action plan to accommodate needs in an emergency. Numerator= number of participants who answer affirmatively, denominator= total number of participants assessed/reassessed who answered the question

Data Source (Select one):
Analyzed collected data (including surveys, focus group, interviews, etc)
If 'Other' is selected, specify:
Data from 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 agencies	**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 CT	**Annually**
	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 to the department unit within 2 business days. Numerator = serious incident reports that are reported within 2 business days. Denominator= all serious incident reports.

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

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 and provider agencies and care managers	**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 critical incident requiring investigation where the Department followed up utilizing the Unit's policies and procedures. Numerator is critical incident investigations adhering to the Unit's policies and procedures and the 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	**Weekly**	**100% Review**

Agency		
Operating Agency	**Monthly**	**Less than 100% Review**
Sub-State Entity	**Quarterly**	**Representative Sample** Confidence Interval =
Other Specify: reports can be generated by care managers	**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: critical incident spreadsheet	**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:
The number and percent of participants responding to the HCBS CAHPS survey who indicate that none of their staff has hit them or hurt them. Numerator is number or participants who reported via the survey that they were not hurt and the denominator is the number of 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 = 95%
Other Specify: Contracted care management agencies	**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:

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:
Number and percent of reports of restrictive interventions that were reviewed and remediated in accordance with the prohibition per waiver policy. Numerator= number of reports of restrictive interventions reviewed and remediated in accordance with policy Denominator= total number of reports of restrictive interventions

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 Source (Select one):
Other
If 'Other' is selected, specify:
Data from the questions in 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: Care managers who complete assessment/reassessment visits	**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 CT	**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:
The number and percent of participants responding to assessment questions who indicate they were not restrained physically or chemically. Numerator is number of assessed participants who reported no restraints and denominator is number of assessments completed

Data Source (Select one):
Analyzed collected data (including surveys, focus group, interviews, etc)
If 'Other' is selected, specify:
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 agencies	**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 CT	**Annually**
	Continuously and Ongoing
	Other Specify:

Performance Measure:
The number and percent of waiver participants assessed who reported they were not kept in involuntary seclusion. Numerator is number of participants who reported they were not secluded and denominator is number of participants who completed the assessment

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

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 waiver participants who are assessed for age appropriate preventive health care. Numerator is the number of participants at reassessment who are assessed for age appropriate health care, and the denominator is the total number of waiver participants reassessed.

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

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: Care management agencies	**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:

The number and percent of waiver participants who express satisfaction with the quality of the services provided. The numerator is the number of clients reporting satisfaction and the denominator is the total number of participants who completed surveys

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

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 = 95%, 5% margin of error
Other Specify: Fiscal Intermediary University of Connecticut	**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 staff conduct annual on-site clinical record reviews of a random sample of waiver participants served by each Access Agency. This provides an additional method of problem identification. The random sample is derived from a list of active waiver participants. Every tenth active waiver participant is selected.

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.

Community Options clinical staff review critical incidents as they are submitted to the department. This review consists of follow up with the care managers and providers. Additionally, clinical staff are available to provide ongoing consultation to care managers.

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.

Assurance: Level of Care

Level of Care (LOC) is determined at least annually and more frequently if needed. Care managers use a standardized assessment that has a level of care algorithm that determines nursing facility level of care.

After the care manager has determined a level of care, it is reviewed by department staff in the Community Options Unit for the final determination of functional eligibility for the waiver. All LOC determinations are required to be documented in the waiver consumer's case record and a file is also maintained at Central Office. Care managers are required to do annual assessment twelve months from the date of the initial Community Options Unit waiver approval. The web-based client database sends a list of required reassessments monthly to the Access Agency work queue. The system tracks completion dates. The process for the review is the same as the initial LOC determination. The care manager will conduct a home visit, assess the client needs as well as hear from consumers their needs utilizing the standardized assessment which will generate the level of care determination. This is reviewed by Community Options Unit clinical staff for final approval to ensure compliance with all LOC waiver guidelines.

Assurance: Service Plans

To be eligible for waiver services, consumers must meet nursing facility level of care. The care manager, in consultation with the consumer and his/her representative, develop a plan of care based on the consumer's physical limitations governed by the level of need generated from the assessment.

Initial care plans are developed using a standardized plan of care form which requires identification of the need for a back-up plan and is signed by either the participant or their authorized representative.

Cost of Care Plans are also developed and calculated. This plan includes all services funded under Medicaid and outside sources including PCA provided under the state plan, home health care, nursing services, PT/OT, PERS, and Home-Delivered Meals. The Service Plan and the Cost of Care Plan are submitted to the department's Community Options Unit for review and approval.

The PCA waiver is managed on a case-by-case basis, reflective of an approach to ensure that individual consumer's preferences and needs are supported congruent with the eligible population standards. This service operates under ongoing oversight, checks and balances built in through contracts with the Access Agencies and oversight and monitoring by Community Options Unit staff. All client specific actions are documented in the consumer's case record. All records, paper and electronic, are subject to periodic reviews by the Community Options Unit.

The State's requirement for documented client choice regarding institutional versus community-based services is evidenced through consumer attestation and signature as part of the waiver application process.

Quality Improvement Strategies:

The department is utilizing the HCBS CAHPS Participant Experience Survey as a quality assurance tool to identify trends or areas in need of improvement.

Assurance: Health and Welfare

DSS administers and manages the PCA waiver using contracted Access Agency care managers who engage in client assessment, service plan development and ongoing monitoring to ensure the welfare of PCA waiver consumers is addressed. DSS also requires a clear emergency back-up plan be written for each consumer to better ensure services continuity, safety and uninterrupted care and support.

Quality Improvement Strategies:

DSS' general agency quality assurance/improvement initiatives and activities apply to all programs it operates. Quality assurance activities with the Department include referrals to its Fraud and Recovery unit if a reported incident is of a fiscal nature.

Assurance: Administrative Authority:

DSS, as the state Medicaid Agency pursuant to Connecticut General Statutes (CGS) Sec. 17b-1, directly administers the PCA Waiver according to CGS Sec. 17b-605. DSS assures that all individuals receiving waiver services meet the categorically and medically needy eligibility and income/asset requirements. DSS informs individuals determined eligible to receive waiver services of their due process rights and gives them the choice of institutionalization or home and community-based services.

Quality Improvement Strategies:

DSS contracts with the fiscal agent to conduct provider recruitment, training, engage in fiscal monitoring, claims processing and reporting. Quarterly reports, at a minimum are submitted to the Department to facilitate state oversight of the waiver program. It is the responsibility of the Waiver Program Manager to analyze the data and bring any pertinent information to the Management team and the Director if any systems problems need to be addressed.

Assurance: Fiscal Accountability:

DSS has contracted with an MMIS vendor to process waiver claims. The vendor developed a web portal where all services are prior authorized by the care managers. The portal interfaces with the state's mandated electronic verification (EVV) system that captures time in and time out for in-home providers. If there is no authorization in the portal, claims will deny. If the logged time in and time out matches the schedule, a claim is created and can be submitted through the EVV system. This ensures that only services authorized by the care manager can be billed and paid. Central Office staff will coordinate with Access Agency care managers and department eligibility staff and DXC to resolve any payment issues. The EVV system allows department staff to have a real time, jurisdictional view of caregivers in the waiver participants' homes.

Care managers are available to respond to questions, and clarify for the consumer any issues related to the Cost of Care Plan or the Medicaid application process. This may also involve coordinating with DSS eligibility staff, to ensure that the consumer's application is approved in a timely manner.

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:	**Other** Specify: ongoing as needed

Responsible Party*(check each that applies):*	**Frequency of Monitoring and Analysis***(check each that applies):*

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 Department contracts with the fiscal intermediary and Access Agencies to provide the following activity and compliance reports:
- Administrative report
- Fiscal reports
- Programmatic reports
- Provider credentialing activities
- Reconciliation reports.

The care management agency will also use both telephone and print surveys to gather information. Surveys shall be conducted within sixty (60) days with all new participants, conservators, as appropriate, and any other agencies involved. Thereafter, surveys shall be solicited on an annual basis and constitute a representative sample of waiver participants. The survey being utilized is the HCBS CAHPS. Data is collated by the University of Connecticut which analyzes the data and submits it to the department annually or more often if requested.

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

The Community Options Unit holds regular QA/QI meetings with contracted care management agencies and other agencies that might be appropriate to discuss and address ongoing QA/QI activities.

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 Department of Social Services has contracted with a fiscal intermediary to credential providers prior to enrollment in the MMIS. Services are authorized by the care managers who enter the authorization into a billing portal developed and maintained by the state's MMIS contractor. This ensures that services billed beyond what has been authorized, will be rejected. The Fiscal Intermediary reports suspected fraud to the DSS Office of Quality Assurance to investigate.

Self directed person care services are not provided by this waiver, they are provided under the state plan 1915k authority.

All services are prior authorized in the care plan portal. Providers cannot bill or receive payment for any services not authorized or in a greater frequency than authorized.

The DSS Office of Quality Assurance (QA) conducts financial audits of Medicaid providers and issues exceptions when appropriate for issues of non-compliance with the State's policy requirements. The Office of Quality Assurance activities extend to all DSS programs, and QA staff are located at the central and regional DSS offices. Functions are grouped into three major areas of focus: audits, quality control, and fraud and recoveries.

All waiver providers are subject to audits performed by the QA. Overall audit demands and audit resources available to DSS QA impact the frequency of audit and waiver providers. These audits include ad hoc reviews when Community Options Unit staff are alerted to potential issues. Community Options and the Fiscal Intermediary refer cases of suspected fraud to the QA unit.

Audits of payments to providers are performed on a universe of claim payments within a two-year period. A random sample of 100 claims per provider is chosen. The number of claims selected for auditing is determined by the DSS Quality Assurance Unit and the staff conducting the audit. The auditor reviews supporting documentation maintained by the provider and claim information maintained by the department. The purpose of the review is to determine if services and associated payments were made in accordance with applicable state regulations. Errors identified in the sample are extrapolated to the universe of paid claims to arrive at a financial audit adjustment. Provider audits are not waiver specific.

Access Agencies, the care management providers, are required to submit findings of an independent audit annually.

The state has fully implemented Electronic Visit Verification (EVV) for PCS. The state's system is a comprehensive, single state option system that links authorizations from the care managers in a portal operated and maintained by the state's MMIS contractor. Visit data is captured in the EVV system and if the captured data matches the authorization in the portal, a claim is created. This system allows a real time view for the provider agencies, program staff and QA staff. Agencies have the ability to adjust visits but any modification to visit data captured electronically creates an audit trail that date and time stamps the change, who made the change and the reason for the change. The mobile application includes GPS tracking capability to verify that the caregiver is located at the appropriate location. Telephony must be conducted from approved phone numbers. No shows, staff leaving early or arriving late are tracked by the agency. In addition, there is a jurisdictional view available to DSS to monitor provider compliance rate. Providers must achieve 90% compliance DSS considers a provider to be compliant if 90% of the visits performed are validated by a check-in and a check-out documented by the caregiver via telephony, Mobile Visit Verification (MVV) or a Fixed Visit Verification (FVV) device.Providers who fail to reach this 90% threshold may be subject to audit, suspension of referrals or claim recoupments until the provider becomes compliant.

State of Connecticut Regulations Section 17b-262-530. Payment Rates states:
(b) A provider whose rates are established by the department based on the provider's cost may be required to submit data in a format prescribed by the department which may include, but not be limited to, the following: (1) a copy of the provider's financial statement and an independent auditor's report for the most recently completed fiscal year, or anticipated costs if the program or service is new;
(2) a copy of the provider's financial statement for the current year to date.

With the exception of care management providers, provider rates for the PCA waiver are not based on provider cost and therefore, do not require an independent audit. Only Access Agencies, the care management providers, are required to submit findings of an independent audit annually."

The office of the Auditors of Public Accounts is a legislative agency of the State of Connecticut whose primary mission is to conduct audits of all state agencies. Included in such audits is an annual Statewide Single Audit of the State of Connecticut to meet federal requirements.

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 reimbursement methodology specified in the waiver. Numerator= number of claims paid in accordance with 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 appropriately denied denied Denominator= total number of claims denied

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***

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

Performance Measure:
Number and percent of claims paid 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 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 Agency	***Weekly***	***100% Review***
Operating Agency	***Monthly***	***Less than 100% Review***
Sub-State Entity	***Quarterly***	***Representative Sample*** *Confidence Interval =*
Other *Specify:* *Contracted MMIS and EVV providers*	***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 claims paid in accordance with the participants' authorized services in the care plan portal. Numerator = authorized claims payments. Denominator= total number of payments

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:*

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:
The number and percent of rates that remain consistent with the approved rate methodology through the entire waiver cycle. Numerator is the number of rates that remain consistent with the approved rate methodology and the denominator is the total number of rates.

Data Source *(Select one):*
Other
If 'Other' is selected, specify:
Data warehouse reports

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.*

DSS has contracted with a fiscal intermediary to maintain the payment records on services received and billed under the PCA waiver. The fiscal intermediary ensures that all billed services are within a participant's Plan of Care and submits appropriate claims to the MMIS vendor whose system reviews the claim for Medicaid eligibility and other elements (i.e., hospitalization dates), before reimbursing the fiscal agent. The fiscal intermediary ensures that all services and corresponding claim payments are coded and properly documented. To ensure maximum reimbursement, the fiscal intermediary will report to DSS Central Office staff any difficulties with billing. Central Office staff will coordinate with eligibility staff and the MMIS venfor to resolve the payment issue.

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.*

DSS staff communicate on a regular basis with the MMIS contractor regarding provider utilization of the state's EVV system that has been in place since January of 2017. State staff have a real time jurisdictional view into all visit data captured in the system. The state has mandated a 90% compliance by providers in utilizing the EVV system to check in and check out. The state has issued several compliance letters to providers who were below the 90% threshold. Individual remediation steps were identified including not allowing the provider to take on new waiver clients or possible referral to the department's Quality Assurance unit.
Problems are communicated through the Critical Incident Reporting on-line tool. There is a wide variety of incident types including timesheet fraud and misappropriation of participant funds as well as reporting abuse, neglect and exploitation. In addition to care management and fiscal intermediary staff, Community Options staff conduct an investigation of the incidents. Depending on circumstances, an on-site provider audit may be conducted to review compliance with DSS policies and regulations.

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:* *as requested*

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).*

Pursuant to Connecticut Department of Social Services Provider manual, all schedules of payment for coverable Medical Assistance Program goods and services shall be established by the Commissioner and paid by the department in accordance with all applicable federal and state statutes and regulations. Waiver services rates in appendix J are based on a an increase using the CPI-Medical. However, the rates are increased upon legislative action. Input on the waiver, including rates were afforded to all parties who commented on the PCA waiver to support the application. This includes consumers, family, and providers. For the addition of Agency-based PCA, Mental Health Counseling and Adult Day Health, the Department published notice and accepted comments on the new service and rates. The Agency-based PCA, Mental Health counseling, and Adult Day Health are fee-for-service billing from an established fee schedule that pays uniform rates across providers. These are max fee services. The rates were developed using components of direct care costs, indirect costs and administrative costs and compared to data from the Dept. of Labor statistics. The Care Management rates were developed in 2015 and Adult Family Living rates were developed in 2014. The final approval was given by the Legislative Committees of Cognizance after a public comment period. The efficient and economic rates for the various levels of Adult Family Living were developed by the Department's rate setting unit. The rates were built on a rate established based on a cost comparable to two hours per day of Homemaker service and one hour of Companion, since this comports with the expectation of the preparation of meals and housekeeping service. There were add-ons at each level of the service based on the individual participant's assessed cognitive, functional and behavioral needs. At each level, the rate increases because the participant's needs increase, requiring additional care. The add-ons were based on the comparable number of hours and costs for the PCA service. 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; level 3 would be the base rate plus the approximate cost of 2 hours per day of personal care; and level 4 would be the base rate plus the approximate cost of 3 hours of personal care. This methodology has not changed.

Case management is provided as a service under this waiver. There are four procedure codes that are billable. They are initial assessment, reassessment, status review and ongoing care management. The rates were based on direct and indirect costs and billed off the department's fee schedule. The rate methodology for care management (per diem) was cost-based, determined by the budgets submitted by each Access Agency in response to the RFP. The state set a maximum allowable rate for each case management agency. 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 base rate for CM was Tier B and was determined as a result of the RFP and contract negotiations with the providers. The rates for Tiers A and C were determined based on the time requirements for client contacts and visits either subtracting from or adding to the Tier B rate. All three tiers of the care management service are billed as a per diem service. The assessment, reassessment and status reviews have specific procedure codes specific rates for the unit of service.

The Community Options Quality Assurance Committee collaborated to develop the criteria for tier levels. The purpose of tiered case management is to accurately reflect the client's needs and adjust the frequency of required client contacts based on current status. Complexity, severity, number of tasks required for care management interventions are used so that clients with the most intense needs are elevated to the highest tier of case management while those with fewer needs are assigned the lowest tier. The number and intensity of interventions is used as the measuring stick for tier assignment.An intervention includes the totality of care management tasks and duties required to complete the process. The four categories for interventions are crisis intervention, service brokerage and advocacy, risk mitigation, and client engagement/re-engagement. An intervention does not include routine care management duties.
The Universal Assessment (copyrighted by interRAI, 1994-2009) is used to determine the level of care. All participants start out on Tier B. After six months, during the six month review, the tier level is evaluated and may be adjusted according to DSS policy.
Rates for waiver services are under review and will be adjusted based upon legislative action to increasing the state's minimum wage in phases with the goal to raise it to $15/hour. Rates were reviewed for this waiver as part of the renewal process and posted both for public comment and also at a statutorily required public hearing regarding the waiver renewal. No comments regarding the rates were received.

The states reviews all rates for adequacy with each waiver renewal. The review is not a rebasing of the rate. We published the rates, received no negative comments or testimony and do not have an issue with network adequacy.

The rates for meals on wheels and PERS are paid off a fee schedule which is published at ctdssmap.com.

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:*

Payments are made by the Medicaid agency directly to the providers of waiver and state plan services. There are provider agreements between DSS and the provider of services under the waiver. Payments for all waiver and other state plan services are to be made through an approved Connecticut Medicaid Management Information System (MMIS). DSS pays providers through the same fiscal agent used in the rest of the Medicaid program. For Adult Family Living, the provider agency will bill the Fiscal Intermediary based on the rate for the level of service authorized in the plan of care. All service authorizations are entered into a portal maintained by the state's MMIS contractor.

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 by the Medicaid agency directly to the providers of waiver and state plan services. There are provider agreements between the DSS and provider of service under the waiver. Payments for all waiver and other state plan services are to be made through an approved Medicaid Management Information System (MMIS). DSS pays providers through the same fiscal agent used in the rest of the Medicaid program. (a)Edits in the MMIS system cause claims to deny if the participant is not eligible on the date of service. (b)Authorized services from the service plan are uploaded into the MMIS portal if there service is not authorized, the claim will deny. (c) The EVV system is the assurance that services were in fact provided as they are captured in the check in and check out process. For those services not subject to EVV, a client signature and/or an attendance log are utilized to show the provision of service.
Adult Family Living, Adult Day Health, Agency-based PCA, Care Management and Mental Health Counseling provider claims are paid by submitting them through the MMIS. Agency provider claims are paid via EFT from the MMIS system. The Fiscal Intermediary pays the individual PCAs who are not agency-based. Mental Health Counseling and Adult Day Health providers bill the MMIS directly for services provided and the claims are matched against the prior authorization in the MMIS contractor's portal.

Care management agencies submit their claims to the MMIS system and receive payment via EFT out of the MMIS system.

Edits and audits are built into the MMIS system to deny claims when participants are not eligible, the services are not prior authorized and when there is no visit validation in the EVV system. For participants using paper time sheets, the Fiscal Intermediary validates the time sheet. Service plans are entered into a care plan portal listing the service, procedure code, date, date range, units of service, specific provider ID. Attempts to bill services other than those present in the portal will be denied. Specific audits and edits include: 3003 Prior Authorization is required for payment of this service; 3015 Care plan required; 3016 Service is not covered under care plan; 3327 Confirmed Visit Not Found (EVV); 4021 The procedure billed is not a covered service under the client's benefit plan as well as several other edits which prohibit payment of ineligible claims.

When DSS Community Options detects inappropriate billing, providers may be given the opportunity to voluntarily recoup their claims. The MMIS system withholds payment from the next claim cycle. When DSS Quality Assurance conduct audits and incorrect billing is discovered, the provider must recoup claims and are subject to the extrapolation process.

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.

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.
B. 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. There are four levels of care based on the number of functional needs that have been assessed using the Universal Assessment, copyrighted by interRAI, 1994-2009.

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		41232.00	41232.00	74859.00	8951.00	83810.00	42578.00
2		36630.00	36630.00	76368.00	9000.00	85368.00	48738.00
3		34564.00	34564.00	80323.00	9329.00	89652.00	55088.00
4		32964.00	32964.00	83963.00	9611.00	93574.00	60610.00
5		32065.00	32065.00	88028.00	9931.00	97959.00	65894.00

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	1149	1149
Year 2	1311	1311
Year 3	1477	1477
Year 4	1637	1637
Year 5	1795	1795

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.*

We anticipate that Department initiatives to increase reserved capacity for MFP and Community First Choice intervention recipients would result in a material decrease the ALOS from that reported in the 372 for 2018 (10/1/17 – 9/30/18). Therefore, the ALOS was calculated using the anticipated caseload as of 10/1/19 as the baseline recipient count. This projection was based on the actual number of recipients with paid clams in October 2018 according to the MMIS and trend of discharges and entrants.

Our program goal is to maintain zero growth in participation during the renewal period, except for expansion due to Money Follows the Person. Discharge rates were projected at 0.4% based on the trend for 2018. The monthly entrants were projected based our goal to refill discharges and reserved capacity for Money Follows the Person and Community First Choice transitions. We projected monthly waiver days by multiplying the number of anticipated participants in each month by the number of days in the month. Then,client days for each waiver year were totaled and divided by the number of unduplicated recipients served in the waiver year to arrive at the ALOS. The projected ALOS decreases from Year 1 to Year 2 because of the increase in reserved capacity for MFP participants increases in Year 2 due to a program initiative.

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:*

Factor D was estimated applying projected caseloads and ALOS to the utilization reported in the Initial 372 report for 2018 (10/1/17 – 9/30/18) for existing services. The historical cost data were trended forward by 2.4% for each renewal year, based on the published January 2109 Consumer Price index for Medical Care.

Adult Day Health is anticipated to be utilized by 1% of recipients with units per user based on the Elder Wavier Initial 372 report for 2018. Mental Health Counseling is anticipated to be utilized by 4% of participants with units per user based on the Initial 372 utilization in the Elder Waiver for 2018. Mental Health Counseling and Adult Day Health were estimated by applying projected caseloads, ALOS, and the 2.4% CPI inflation factor applied to the cost per unit. Home Delivered Meals was estimated based on 2018 utilization by 2.5% of participants and by applying projected caseloads, ALOS, and a 10% inflation factor applied to the cost per unit for WY2 due to a legislative rate increase for the service. WY 3-5 include a 2.4% CPA inflation factor applied to the cost per unit. Personal Emergency Response Services was estimated based on 2018 utilization by 49% of participants and by applying caseloads, ALOS, and the 2.4% CPI inflation factor applied to the cost per unit.

Agency PCA services are estimated to be utilized by 50% of new recipients and 5.5% of current recipients until 39% of all waiver recipients utilize the service as estimated by the waiver program manager. PCA Agency services was estimated using the units per user data for self-directed personal care services for FFY 2018 obtained from the MMIS for recipients currently on the PCA Waiver, ALOS, and rates paid for the same service in the Elder Waiver trended using the 2.4% inflation factor.

The historical cost data were trended forward by 2.4% for each renewal year, based on the published January 2109 Consumer Price index for Medical Care. The utilization data from the Initial 372 report for 10/1/17 – 9/30/18 was trended forward by 4.8% for Year 1, due to the 2 year gap between the base year and Year 1.

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:*

For each year, the factor D' was calculated by adjusting the cost per person in the Initial 372T report for 2018 (10/1/17 – 9/30/18) for projected annual ALOS. Then applying an inflation factor of 2.4% per year, based on the published January 2019 Consumer Price index for Medical Care. Year 1 includes 2 years of inflation. The submitted application did not contain the cost of prescribed drugs for dual eligible Medicare/Medicaid clients. Factor D'was based on 372 reports that exclude dual eligible clients pharmacy expenditures;therefore, Factor D' did not require additional adjustment.

A decrease was applied to Factor D' as an offset for services added to the waiver. The offset for the Agency PCA service cost was estimated at based on actual average units of service per person for PCA Waiver participants using Self-Directed PCA service under the state plan for August 2018. The units per person were adjusted for ALOS and multiplied by the number of participants and rates effective January 2019 and trended using a 2.4% inflation factor based on the published January 2019 Consumer Price index for Medical Care.

A decrease was applied to Factor D' in the amount of the increase applied to Factor D to add Mental Health Counseling, Adult Day Health, Home Delivered Meals, and Personal Emergency Response Services for each waiver year.

iii. ***Factor G Derivation.*** *The estimates of Factor G for each waiver year are included in Item J-1. The basis of these estimates is as follows:*

Factor G was calculated by applying the 3.9% CPI for Nursing Home Care published January 2019 to the Initial 372T report for 2018 (10/1/17 – 9/30/18).

iv. ***Factor G' Derivation.*** *The estimates of Factor G' for each waiver year are included in Item J-1. The basis of these estimates is as follows:*

Factor G' was based on the 2018 Initial(10/1/17 – 9/30/18)372 report for the PCA waiver. The historic cost data were trended forward using actual CPI trends 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	
Agency-based Personal Care Assistant	
Care Management	
Adult Family Living	
Assisted Technology	
Environmental Accessibility Adaptations	
Home Delivered Meals	
Mental Health Counseling	
Participant Training and Engagement to Support Goal Attainment and Independence (CAPABLE)	
Personal Emergency Response System (PERS)	
Remote Supports	
Training and Counseling Services for Unpaid Caregivers Supporting Participants (COPE)	

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:							**100210.00**
Adult Day Health		per day	11	125.00	72.88	100210.00	
Agency-based Personal Care Assistant Total:							**3198720.00**
Agency-based Personal Care Assistant		per hour	136	4704.00	5.00	3198720.00	
Care Management Total:							**1573762.32**
Care Management		per day	1149	312.00	4.39	1573762.32	
Adult Family Living Total:							**452297.28**
Adult Family Living		per day	16	274.00	103.17	452297.28	
Assisted Technology Total:							
Assisted Technology							
Environmental Accessibility Adaptations Total:							
Environmental Accessibility Adaptations							
Home Delivered Meals Total:							
Home Delivered Meals							
Mental Health Counseling Total:							**35042.80**
Mental Health Counseling		per hour	46	13.00	58.60	35042.80	
GRAND TOTAL:							
Total: Services included in capitation:							
Total: Services not included in capitation:							5650219.90
Total Estimated Unduplicated Participants:							**1149**
Factor D (Divide total by number of participants):							
Services included in capitation:							
Services not included in capitation:							4917.51
Average Length of Stay on the Waiver:							331

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Participant Training and Engagement to Support Goal Attainment and Independence (CAPABLE) Total:							
Participant Training and Engagement to Support Goal Attainment and Independence (CAPABLE)							
Personal Emergency Response System (PERS) Total:							290187.50
Personal Emergency Response System (PERS)		per unit	625	10.00	46.43	290187.50	
Remote Supports Total:							
Remote Supports							
Training and Counseling Services for Unpaid Caregivers Supporting Participants (COPE) Total:							
Training and Counseling Services for Unpaid Caregivers Supporting Participants (COPE)							
GRAND TOTAL:							
Total: Services included in capitation:							
Total: Services not included in capitation:							5650219.90
Total Estimated Unduplicated Participants:							1149
Factor D (Divide total by number of participants):							
Services included in capitation:							
Services not included in capitation:							4917.51
Average Length of Stay on the Waiver:							331

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:							119333.37
Adult Day Health		per day	13	123.00	74.63	119333.37	
Agency-based Personal Care Assistant Total:							10357166.08
Agency-based Personal Care Assistant		per hour	283	7148.00	5.12	10357166.08	
Care Management Total:							1805247.00
Care Management		per day	1311	306.00	4.50	1805247.00	
Adult Family Living Total:							511557.30
Adult Family Living		per day	18	269.00	105.65	511557.30	
Assisted Technology Total:							
Assisted Technology							
Environmental Accessibility Adaptations Total:							
Environmental Accessibility Adaptations							
Home Delivered Meals Total:							
Home Delivered Meals							
Mental Health Counseling Total:							40566.76
Mental Health Counseling		per hour	52	13.00	60.01	40566.76	
Participant Training and Engagement to Support Goal Attainment and Independence (CAPABLE) Total:							

GRAND TOTAL:	
Total: Services included in capitation:	
Total: Services not included in capitation:	13172830.71
Total Estimated Unduplicated Participants:	1311
Factor D (Divide total by number of participants):	
Services included in capitation:	
Services not included in capitation:	10047.93
Average Length of Stay on the Waiver:	325

Waiver Service/ Component	Capi- tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Participant Training and Engagement to Support Goal Attainment and Independence (CAPABLE)							
Personal Emergency Response System (PERS) Total:							338960.20
Personal Emergency Response System (PERS)		per unit	713	10.00	47.54	338960.20	
Remote Supports Total:							
Remote Supports							
Training and Counseling Services for Unpaid Caregivers Supporting Participants (COPE) Total:							
Training and Counseling Services for Unpaid Caregivers Supporting Participants (COPE)							
GRAND TOTAL:							
Total: Services included in capitation:							
Total: Services not included in capitation:							13172830.71
Total Estimated Unduplicated Participants:							1311
Factor D (Divide total by number of participants):							
Services included in capitation:							
Services not included in capitation:							10047.93
Average Length of Stay on the Waiver:							325

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:							142141.20
Adult Day Health		per day	15	124.00	76.42	142141.20	
Agency-based Personal Care Assistant Total:							18242174.44
Agency-based Personal Care Assistant		per hour	427	8153.00	5.24	18242174.44	
Care Management Total:							2110780.70
Care Management		per day	1477	310.00	4.61	2110780.70	
Adult Family Living Total:							588553.60
Adult Family Living		per day	20	272.00	108.19	588553.60	
Assisted Technology Total:							
Assisted Technology							
Environmental Accessibility Adaptations Total:							
Environmental Accessibility Adaptations							
Home Delivered Meals Total:							
Home Delivered Meals							
Mental Health Counseling Total:							47132.15
Mental Health Counseling		per hour	59	13.00	61.45	47132.15	
Participant Training and Engagement to Support Goal Attainment and Independence (CAPABLE) Total:							
Participant Training and Engagement to Support							

GRAND TOTAL:	
Total: Services included in capitation:	
Total: Services not included in capitation:	21521682.49
Total Estimated Unduplicated Participants:	1477
Factor D (Divide total by number of participants):	
Services included in capitation:	
Services not included in capitation:	14571.21
Average Length of Stay on the Waiver:	329

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Goal Attainment and Independence (CAPABLE)							
Personal Emergency Response System (PERS) Total:							390900.40
Personal Emergency Response System (PERS)		per unit	803	10.00	48.68	390900.40	
Remote Supports Total:							
Remote Supports							
Training and Counseling Services for Unpaid Caregivers Supporting Participants (COPE) Total:							
Training and Counseling Services for Unpaid Caregivers Supporting Participants (COPE)							
GRAND TOTAL:							
Total: Services included in capitation:							
Total: Services not included in capitation:							21521682.49
Total Estimated Unduplicated Participants:							1477
Factor D (Divide total by number of participants):							
Services included in capitation:							
Services not included in capitation:							14571.21
Average Length of Stay on the Waiver:							329

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:							**156500.00**
Adult Day Health		per day	16	125.00	78.25	156500.00	
Agency-based Personal Care Assistant Total:							**26225898.60**
Agency-based Personal Care Assistant		per hour	562	8690.00	5.37	26225898.60	
Care Management Total:							**2410711.68**
Care Management		per day	1637	312.00	4.72	2410711.68	
Adult Family Living Total:							**667842.12**
Adult Family Living		per day	22	274.00	110.79	667842.12	
Assisted Technology Total:							
Assisted Technology							
Environmental Accessibility Adaptations Total:							
Environmental Accessibility Adaptations							
Home Delivered Meals Total:							
Home Delivered Meals							
Mental Health Counseling Total:							**53167.40**
Mental Health Counseling		per hour	65	13.00	62.92	53167.40	
Participant Training and Engagement to Support Goal Attainment and Independence (CAPABLE) Total:							
Participant Training and Engagement to Support							

GRAND TOTAL:	
Total: Services included in capitation:	
Total: Services not included in capitation:	29957784.80
Total Estimated Unduplicated Participants:	**1637**
Factor D (Divide total by number of participants):	
Services included in capitation:	
Services not included in capitation:	18300.42
Average Length of Stay on the Waiver:	331

Waiver Service/ Component	*Capi-tation*	*Unit*	*# Users*	*Avg. Units Per User*	*Avg. Cost/ Unit*	*Component Cost*	*Total Cost*
Goal Attainment and Independence (CAPABLE)							
Personal Emergency Response System (PERS) Total:							***443665.00***
Personal Emergency Response System (PERS)		per unit	890	10.00	49.85	***443665.00***	
Remote Supports Total:							
Remote Supports							
Training and Counseling Services for Unpaid Caregivers Supporting Participants (COPE) Total:							
Training and Counseling Services for Unpaid Caregivers Supporting Participants (COPE)							
GRAND TOTAL:							
Total: Services included in capitation:							
Total: Services not included in capitation:							*29957784.80*
Total Estimated Unduplicated Participants:							***1637***
Factor D (Divide total by number of participants):							
Services included in capitation:							
Services not included in capitation:							*18300.42*
Average Length of Stay on the Waiver:							331

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:							181734.84
Adult Day Health		per day	18	126.00	80.13	181734.84	
Agency-based Personal Care Assistant Total:							34120163.00
Agency-based Personal Care Assistant		per hour	694	8939.00	5.50	34120163.00	
Care Management Total:							2722332.90
Care Management		per day	1795	314.00	4.83	2722332.90	
Adult Family Living Total:							785641.25
Adult Family Living		per day	25	277.00	113.45	785641.25	
Assisted Technology Total:							
Assisted Technology							
Environmental Accessibility Adaptations Total:							
Environmental Accessibility Adaptations							
Home Delivered Meals Total:							
Home Delivered Meals							
Mental Health Counseling Total:							60306.48
Mental Health Counseling		per hour	72	13.00	64.43	60306.48	
Participant Training and Engagement to Support Goal Attainment and Independence (CAPABLE) Total:							
Participant Training and Engagement to Support							

GRAND TOTAL:	
Total: Services included in capitation:	
Total: Services not included in capitation:	38368426.47
Total Estimated Unduplicated Participants:	1795
Factor D (Divide total by number of participants):	
Services included in capitation:	
Services not included in capitation:	21375.17
Average Length of Stay on the Waiver:	334

Waiver Service/ Component	Capi- tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Goal Attainment and Independence (CAPABLE)							
Personal Emergency Response System (PERS) Total:							498248.00
Personal Emergency Response System (PERS)		per unit	976	10.00	51.05	498248.00	
Remote Supports Total:							
Remote Supports							
Training and Counseling Services for Unpaid Caregivers Supporting Participants (COPE) Total:							
Training and Counseling Services for Unpaid Caregivers Supporting Participants (COPE)							
GRAND TOTAL:							
Total: Services included in capitation:							
Total: Services not included in capitation:							38368426.47
Total Estimated Unduplicated Participants:							1795
Factor D (Divide total by number of participants):							
Services included in capitation:							
Services not included in capitation:							21375.17
Average Length of Stay on the Waiver:							334