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

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

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

1. Major Changes

Describe any significant changes to the approved waiver that are being made in this renewal application:

Changes that are being made in this renewal application include the following:
Appendix C:1 Addition of a 5th level of care under Assisted Living services, to align with the addition of this level of care in the Connecticut Home Care Program for Elders waiver.
Appendix C:1.d was completed to answer questions about how telehealth services are provided.
Appendix C:2.g was completed to demonstrate the provision of Transitional Case Management services in acute care hospitals.
Appendix C:5 Home and Community-Based Setting was completed.
Per CMS guidance, a performance measure was added to the sub-assurance under Appendix B: Quality Improvement, subsection (a)(i)(b).
Per CMS guidance, updates were made to the performance measures under Appendix A: Quality Improvement under subsection (a)(i) and sub-assurances in Appendix B: Quality Improvement under subsections (a)(i)(a) and (a)(i)(c).

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 section 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*):

Mental Health Waiver

C. Type of Request: renewal

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**

Draft ID: **CT.005.04.00**

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

Regular Waiver

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

04/01/27

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: July 31, 2027). The time required to complete this information collection is estimated to average 163 hours per response for a new waiver application and 78 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 in 42 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 section 1915(a)(1)(a) of the Act and described in Appendix I**
- ☐ **Waiver(s) authorized under section 1915(b) of the Act.**

Specify the section 1915(b) waiver program and indicate whether a section 1915(b) waiver application has been submitted or previously approved:

Specify the section 1915(b) authorities under which this program operates *(check each that applies):*

- ☐ **section 1915(b)(1) (mandated enrollment to managed care)**
- ☐ **section 1915(b)(2) (central broker)**
- ☐ **section 1915(b)(3) (employ cost savings to furnish additional services)**
- ☐ **section 1915(b)(4) (selective contracting/limit number of providers)**

- ☐ **A program operated under section 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 section 1915(i) of the Act.**
- ☐ **A program authorized under section 1915(j) of the Act.**
- ☐ **A program authorized under section 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.

This Medicaid waiver is targeted for adults with serious mental illness who are being discharged or diverted from nursing home care. This waiver provides participants with the medical and psychiatric services and supports necessary to live independently in the community. By year 5, the waiver will serve up to 798 participants at any point in time and up to 925 unduplicated individuals who are being transitioned out of nursing facilities or who are at risk for this level of care and are being diverted from admission. Waiver services are generally provided face-to-face, in the participant's residence, but can be provided through an alternate means, including virtually, in the event of a pandemic, epidemic, natural disaster, or other temporary cause preventing the safe provision of in-person services. Individualized assessment, Recovery Plan development, and service delivery focus on participant strengths and assets, utilization of natural supports, and community integration. In other words, service delivery emphasizes recovery from the disabling effects of psychiatric disorders. The waiver is operated by the Department of Mental Health and Addiction Services with oversight by the Department of Social Services, Connecticut's single state agency for Medicaid.

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 section 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 section 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 section 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 section 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 section 1915(b) or another provision of the Act.

F. FFP Limitation. In accordance with 42 CFR Part 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. 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 Part 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 (fill in date). In addition to the CT Law Journal posting, the Department posted the amendment notice on its web site on (fill in date) 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 these postings.

The CT tribes were notified via email on (fill in date). They did not have any comments.

Prior to submission, the amendment was presented to the CT legislature's committees of cognizance at a public hearing on (fill in date). The committees approved the waiver amendment for submission.

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:

Weston

First Name: Christine

Title: Director

Agency: Department of Social Services

Address: 55 Farmington Ave

Address 2:

City: Hartford

State: **Connecticut**

Zip: 06106

Phone: (860) 805-8742 **Ext:** ☐ **TTY**

Fax: (860) 424-4963

E-mail: christine.weston@ct.gov

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

Last Name: Luongo

First Name: Ann Marie

Title: Waiver Program Manager

Agency: Department of Mental Health and Addiction Services

Address: Beers Hall 3rd Floor

Address 2: PO Box 351

City: Middletown

State: **Connecticut**

Zip: 06457

Phone:

(860) 262-6956 **Ext:** **TTY**

Fax:

(860) 262-5852

E-mail:

ann.luongo@ct.gov

8. Authorizing Signature

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

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

Signature:

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:

Additional Needed Information (Optional)

Provide additional needed information for the waiver (optional):

Appendix A: Waiver Administration and Operation

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

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

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

   ○ **The Medical Assistance Unit.**

   Specify the unit name:

   (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:

Department of Mental Health and Addiction Services

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:

The CT Department of Mental Health and Addiction Services (DMHAS) is the operating agency under the supervision of the Single State Medicaid Agency, the Department of Social Services (DSS). DSS will ensure that DMHAS performs its operational and administrative functions in accordance with the requirements set forth in this waiver. DSS and DMHAS have executed a Memorandum of Understanding (MOU) that outlines this relationship. This MOU establishes the functions DMHAS performs, expectations regarding the performance of these functions and specific reporting requirements.

DSS is the Single State Medicaid agency responsible for the overall administration of the HCBS Waiver and assuring that federal reporting and procedural requirements are satisfied. In carrying out these responsibilities, DSS performs the following functions:

- Coordinates communication with federal officials concerning the waiver; Specifies and approves policies and procedures and consults with DMHAS in the implementation of such policies and procedures, that are necessary and appropriate for the administration and operation of the waiver in accordance with federal regulations and guidance;
- Monitors waiver operations for compliance with federal regulations including, but not limited to, the areas of waiver eligibility determinations, service quality systems, plans of care, qualification of providers, and fiscal controls and accountability;
- Determines Medicaid eligibility for potential waiver recipients/enrollee;
- Establishes, in consultation and cooperation with DMHAS, the rates of reimbursement for services provided under the waiver;
- Assists with the billing process for waiver services, completes billing process and claims for FFP for such services;
- Prepares and submits, with assistance from DMHAS, all reports required by CMS or other federal agencies regarding the waiver; and,
- Administers the hearing process through which an individual may request a reconsideration of any decisions that affect eligibility or the denial of waiver services as provided under federal law.
- Provides oversight of the quality assurance and quality improvement activities.

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

- Conducts initial assessments and required re-assessments of potential waiver enrollees/participants using uniform assessment instruments, documentation and procedure to establish whether an individual meets all eligibility criteria;
- Documents individual plans of care for waiver recipients in format(s) approved by DSS, which set forth: (1) individual service needs, (2) waiver services necessary to meet such needs, (3) the authorized service provider(s), and (4) the amount of waiver services authorized for the individual;
- Establishes and maintains quality assurance and improvement systems designed to assure the ongoing recruitment of qualified providers of waiver services and documents adherence to all applicable state and federal laws and regulations pertaining to health and welfare consistent with the assurance made in the approved waiver application(s);
- Establishes and maintains a system that provides for continuous monitoring of the provision of waiver services to assure compliance with applicable health and welfare;
- Assists DSS in establishing and maintaining rates of reimbursement for waiver services;
- Assists DSS in the preparation of all waiver-related reports and communications with CMS; and,
- Consults with DSS regarding all waiver-related activities and initiatives including, but not limited to, waiver applications and waiver amendments.

DSS meets with DMHAS on a quarterly basis to review key operating agency activities; as well as on an as needed basis to review individual or systemic issues as they arise. DSS prepares the annual 372 reports.

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.:*

DSS and DMHAS contract with a fiscal intermediary to perform various administrative functions and assist participants who choose to direct recovery assistant services. The Fiscal Intermediary (FI) serves as the Medicaid billing provider for some waiver services. The FI performs the following functions:

- Provides information and training materials regarding the waiver, participants, and service delivery;
- Identifies and recruits agencies and individuals who can provide waiver services;
- Accepts applications and verifies the credentials of agencies and individuals that will provide waiver services;
- Enrolls waiver agencies and individuals that will provide waiver services;
- Maintains a registry of agencies and individuals who provide waiver services;
- Accepts and makes payment for waiver services to agencies and individuals who provide certain waiver services.

For individuals who choose to direct their own care, the FI functions as the intermediary between each participant and the individual that performs recovery assistant services. The FI assists the individual and/or caregivers to facilitate the employment of staff by the waiver participant or their caregivers. Specific tasks performed by the FI include:

- Managing, on a monthly basis, all invoices for recovery assistants against the amount of recovery assistant services authorized in a participant's Recovery Plan.
- Performing background checks on prospective individuals who will provide these services.

In addition to utilizing DMHAS staff to work as waiver care managers, DMHAS may also contract with private non profit agencies to provide waiver care managers that will perform level of care evaluations, develop participant service plans and carry out all other duties performed by waiver care managers. Individuals contracted by the operating agency must have the same qualifications as those employed by the operating agency as outlined in Appendix B 6 c.

○ **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:

DSS and DMHAS monitor and assess the performance of the functions performed by the fiscal intermediary. DSS, DMHAS, and the FI meet at least quarterly to review operational issues. At this time any questions or issues raised through monitoring and monthly reporting are addressed.
DMHAS is responsible for assessing the performance of contracted staff working as Waiver Care Managers. Waiver Care Manager activities include conducting level of care evaluations, completing level of care assessments; developing recovery plans, monitoring the implementation of the service plans and monitoring ongoing delivery of services outlined in the recovery plans, and all other tasks carried out by the Waiver Care Manager as described in the waiver renewal application.

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:

DSS and DMHAS assess the performance of the functions performed by the fiscal intermediary. This is achieved through weekly, monthly and quarterly reports. Additionally, there are quarterly project meetings. DMHAS will conduct an annual administrative audit involving a sample of FI records to ensure criminal background checks and other required documents are on file, as well as verification that license, certification and qualifications are monitored and documented for providers.

DSS reviews and authorizes all level of care evaluations and Recovery Plans, including those completed by contracted Waiver Care Managers. The DMHAS Waiver Manager or designee meets at least twice monthly with contracted Waiver Care Managers to provide oversight and supervision.

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.* Note: Medicaid eligibility determinations can only be performed by the State Medicaid Agency (SMA) or a government agency delegated by the SMA in accordance with 42 CFR § 431.10. Thus, eligibility determinations for the group described in 42 CFR § 435.217 (which includes a level-of-care evaluation, because meeting a 1915(c) level of care is a factor of determining Medicaid eligibility for the group) must comply with 42 CFR § 431.10. Non-governmental entities can support administrative functions of the eligibility determination process that do not require discretion including, for example, data entry functions, IT support, and implementation of a standardized level-of-care evaluation tool. States should ensure that any use of an evaluation tool by a non-governmental entity to evaluate/determine an individual's required level-of-care involves no discretion by the non-governmental entity and that the development of the

requirements, rules, and policies operationalized by the tool are overseen by the state agency.

Function	Medicaid Agency	Other State Operating Agency	Contracted Entity
Participant waiver enrollment	☑	☑	☑
Waiver enrollment managed against approved limits	☑	☑	☑
Waiver expenditures managed against approved levels	☑	☑	☑
Level of care waiver eligibility 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 state's quality improvement strategy, provide information in the following fields to detail the state's 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 of data reports specified in agreement with the Medicaid agency that were submitted by the operating agency and fiscal intermediary on time and in the correct

format, divided by number of reports due in period

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 of LOC determinations completed by the operating agency and contracted Waiver Care Managers, divided by number of LOC determinations required/due during audit period

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 entity providing Waiver 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:
Number of critical incidents reviewed within time frames specified in the waiver application, divided by total number of incident reports received during audit period

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

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

☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

Performance Measure:
Number of credentialing applications processed by fiscal intermediary according to contract standards, divided by number of applications received during audit period.

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

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

Data Aggregation and Analysis:

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

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

b. Methods for Remediation/Fixing Individual Problems

i. Describe the state's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction and the state's method for analyzing information from individual problems, identifying systemic deficiencies, and implementing remediation actions. In addition, provide information on the methods used by the state to document these items.

Waiver leadership staff from DSS, DMHAS, and the FI meet at least quarterly to review operational issues. At this time any questions or issues raised through monitoring and monthly/quarterly reporting are addressed. A Waiver leadership meeting is held by DMHAS and the FI weekly to identify issues. When problems are identified, communications both written and within meetings provide opportunities for resolution of issues of concern.

ii. Remediation Data Aggregation

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

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

c. Timelines

When the state does not have all elements of the quality improvement strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of 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 Sub Group	Minimum Age	Maximum Age	
				Maximum Age Limit	No Maximum Age Limit
☐ **Aged or Disabled, or Both - General**					
	☐	**Aged**			☐
	☐	**Disabled (Physical)**			
	☐	**Disabled (Other)**			
☐ **Aged or Disabled, or Both - Specific Recognized Subgroups**					
	☐	**Brain Injury**			☐
	☐	**HIV/AIDS**			☐
	☐	**Medically Fragile**			☐
	☐	**Technology Dependent**			☐
☐ **Intellectual Disability or Developmental Disability, or Both**					
	☐	**Autism**			☐
	☐	**Developmental Disability**			☐
	☐	**Intellectual Disability**			☐
☑ **Mental Illness**					
	☑	**Mental Illness**	22		☑
	☐	**Serious Emotional Disturbance**			

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

Waiver participant must meet all of the requirements of Section 1 and one of the requirements of Section 2:

Section 1 (all of the following five requirements)
o An adult, 22 years of age or older;
o Medicaid-eligible;
o Meets criteria for nursing home level of care;
o Voluntarily chooses to participate in the waiver;
o Has a diagnosis of serious mental illness as defined by State of Connecticut PASRR policy;

Section 2 (one of the following three requirements)
o Is currently a resident of a nursing facility;
o Is a participant in Money Follows the Person (MFP);
o Psychiatric history, impairment and service needs as evidenced by the following:

1. Is currently experiencing two or more of the following circumstances due to serious mental illness:
- Has been recommended to take, or currently uses, prescribed medication to control psychiatric symptoms;
- Is unable to work in a full-time competitive employment situation;
- Requires ongoing supervision and support to maintain a community living arrangement;
- Is homeless or at risk for homelessness;
- Has had, or will predictably have, repeated episodes of decompensation, such as increased symptoms of psychosis; self-injury; suicidal/homicidal ideation; or psychiatric hospitalization.

2. Has level of risk to self or others that a Waiver Care Manager has determined can be managed safely in the community.

3. Has the following core services needs if living in the community:
- One-on-one rehabilitative activities in the home or in other community settings to assist in managing psychiatric, substance use, or medical problems, and in meeting requirements of everyday independent living; and
- Support coordination to assist in developing and implementing a Recovery Plan that ensures psychiatric and/or medical needs are met.

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

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

● **The following transition planning procedures are employed for participants who will reach the waiver's maximum age limit.**

Specify:

Appendix B: Participant Access and Eligibility

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

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

○ **No Cost Limit.** The state does not apply an individual cost limit. *Do not complete Item B-2-b or item B-2-c.*

● **Cost Limit in Excess of Institutional Costs.** The state refuses entrance to the waiver to any otherwise eligible individual when the state reasonably expects that the cost of the home and community-based services furnished to that individual would exceed the cost of a level of care specified for the waiver up to an amount specified by the state.

Complete Items B-2-b and B-2-c.

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

- (●) **A level higher than 100% of the institutional average.**

  Specify the percentage: 125

- ( ) **Other**

  Specify:

- ( ) **Institutional Cost Limit.** Pursuant to 42 CFR § 441.301(a)(3), the state refuses entrance to the waiver to any otherwise eligible individual when the state reasonably expects that the cost of the home and community-based services furnished to that individual would exceed 100% of the cost of the level of care specified for the waiver. *Complete Items B-2-b and B-2-c.*

- ( ) **Cost Limit Lower Than Institutional Costs.** The state refuses entrance to the waiver to any otherwise qualified individual when the state reasonably expects that the cost of home and community-based services furnished to that individual would exceed the following amount specified by the state that is less than the cost of a level of care specified for the waiver.

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

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

  - ( ) **The following dollar amount:**

    Specify dollar amount:

    The dollar amount *(select one)*

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

      Specify the formula:

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

  - ( ) **The following percentage that is less than 100% of the institutional average:**

    Specify percent:

  - ( ) **Other:**

    Specify:

Appendix B: Participant Access and Eligibility

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

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

DMHAS and DSS will determine if the cost of the waiver services necessary to ensure the participant's health and safety exceeds the cost limit established by the state. The Waiver Care Manager is responsible to develop the plan to maintain the participant's health and safety while staying within the cost cap. This is done in consultation with the participant and/or their responsible party. The development of the care plan is based on a multidimensional assessment that covers the domains of health, function, psychosocial, cognition, environment, support system and finances. Risk factors are identified and mitigated through service plans. Once the plan is agreed upon, the costs are determined. Each service on the plan of care is evaluated to determine if a back-up plan is necessary to ensure participant health and/or safety. If an applicant's health and safety needs cannot be met, they are denied access to the waiver. In the event that an individual's service plan cannot be approved because it exceeds the individual cap, the Department will work with the individual and other members of the person-centered team to determine if revisions can be made that will provide appropriate services at the dollar amount available. If the Waiver Care Manager determines that an applicant's need is more extensive than the services in the waiver are able to support, the Waiver Care Manager will inform the applicant that their health and safety cannot be assured. The plan may be resubmitted in the future if the total average cost of program participation has decreased sufficiently or the needs of the individual are reduced to a sufficient degree. In the event that the applicant is denied enrollment or a current participant's services are being reduced or terminated, the applicant or participant will receive a Medicaid Notice of Action (NOA) regarding their right to a fair hearing in accordance with the rules of the 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:

The Waiver Care Manager may convene a Recovery Plan team Meeting in the event of an increased need for service by a waiver participant. If the team review determines a need for increased intensity of services, the DMHAS Waiver Manager and DSS may approve a time-limited increase (less than 180 days) in the intensity of services. If it is determined at the time of the meeting or at the end of 180 days that the participant has an extended need for increased intensity of services, the individual will be re-assessed by the Waiver Care Manager and transitioned to a nursing facility or inpatient hospital if the health and safety of the participant cannot be assured.

☐ **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	714
Year 2	770
Year 3	819
Year 4	873
Year 5	925

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	618
Year 2	663
Year 3	708
Year 4	753
Year 5	798

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	
Reserved Capacity for Money Follows the Person 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):*

Reserved Capacity for Money Follows the Person Participants

Purpose *(describe):*

The State of Connecticut will reserve capacity to accommodate the community transition for individuals who are currently participating in the Money Follows the Person (MFP) demonstration.

Describe how the amount of reserved capacity was determined:

The reserve capacity amount is based on the anticipated number of consumers transitioning off of MFP and onto the Mental Health waiver from April 1, 2027 through March 31, 2032, contingent upon continuation of the demonstration project.

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

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

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served (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:

Each individual who seeks to be enrolled in the waiver will be required to meet the following criteria:

1) 22 years and older.
2) Medicaid-eligible.
3) Meets the current criteria for nursing home level of care.
4) Voluntarily chooses to participate in the waiver
5) Meets the criteria set forth in Appendix B-1.b

Entrance into the waiver will be on a first come-first served basis for those who meet the above listed criteria. The exception to this first come-first served policy is those individuals who meet these criteria and participates in the state's Money Follows the Person initiative.

Entry into the waiver will be offered to individuals based on their date of application for the waiver. Individuals who are referred in excess of the allocated waiver capacity within any given year will be placed on a waiting list. The waiting list will be managed by the DMHAS Waiver Manager. The DMHAS Waiver Manager will review individuals on the waiting list on a monthly basis against current capacity.

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)*:

- ○ **Section 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)

- ☐ **Parents and Other Caretaker Relatives (42 CFR § 435.110)**
- ☐ **Pregnant Women (42 CFR § 435.116)**
- ☐ **Infants and Children under Age 19 (42 CFR § 435.118)**
- ☐ **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 section 1902(a)(10)(A)(ii)(XIII)) of the Act)**

☑ **Working individuals with disabilities who buy into Medicaid (TWWIIA Basic Coverage Group as provided in section 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 section 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 section 1902(e)(3) of the Act)**

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

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

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

Specify:

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

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

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

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

Select one and complete Appendix B-5.

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

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

Check each that applies:

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

Select one:

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

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

Specify percentage:

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

Specify dollar amount:

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

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

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

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

Select one:

○ **100% of FPL**

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

Specify percentage amount:

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

Specify:

Appendix B: Participant Access and Eligibility

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

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

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

Note: For the period beginning January 1, 2014 and extending through September 30, 2027 (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 section 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 section 1924 of the Act.**
Complete Items B-5-e (if the selection for B-4-a-i is SSI State or section 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 period after September 30, 2027 (or other date as required by law).

Note: The following selections apply for the time period after September 30, 2027 (or other date as required by law) (select one).

● **Spousal impoverishment rules under section 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 section 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 (Section 1634 State/SSI Criteria 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 section 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 period after September 30, 2027 (or other date as required by law).

b. Regular Post-Eligibility Treatment of Income: Section 1634 State and SSI Criteria State after September 30, 2027 (or other date as required by law).

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 period after September 30, 2027 (or other date as required by law).

c. Regular Post-Eligibility Treatment of Income: 209(b) State or after September 30, 2027 (or other date as required by law).

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 section 1924 of the Act. Payment for home and community-based waiver services is reduced by the amount remaining after deducting the following amounts and expenses from the waiver participant's income:

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

The following standard included under the state plan

(*select one*):

The following standard under 42 CFR § 435.121

Specify:

Optional state supplement standard

Medically needy income standard

The special income level for institutionalized persons

(*select one*):

300% of the SSI Federal Benefit Rate (FBR)

A percentage of the FBR, which is less than 300%

Specify percentage:

A dollar amount which is less than 300%.

Specify dollar amount:

A percentage of the Federal poverty level

Specify percentage:

- **Other standard included under the state plan**

  Specify:

- **The following dollar amount**

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

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

  Specify:

- **Other**

  Specify:

  200 percent of the Federal poverty level

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

- **Not Applicable**
- **The state provides an allowance for a spouse who does not meet the definition of a community spouse in section 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 § 435.735:

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

Select one:

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

  Specify:

Appendix B: Participant Access and Eligibility

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

Note: The following selections apply for the time period after September 30, 2027 (or other date as required by law).

d. Post-Eligibility Treatment of Income Using Spousal Impoverishment Rules after September 30, 2027 (or other date as required by law)

The state uses the post-eligibility rules of section 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 section 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 or 42 CFR § 435.735:

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

Select one:

- **Not Applicable (see instructions)** *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 period beginning January 1, 2014 and extending through September 30, 2027 (or other date as required by law).

e. Regular Post-Eligibility Treatment of Income: Section 1634 State or SSI Criteria State - January 1, 2014 through September 30, 2027 (or other date as required by law).

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 period beginning January 1, 2014 and extending through September 30, 2027 (or other date as required by law).

f. Regular Post-Eligibility Treatment of Income: 209(b) State - January 1, 2014 through September 30, 2027 (or other date as required by law).

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 period beginning January 1, 2014 and extending through September 30, 2027 (or other date as required by law).

g. Post-Eligibility Treatment of Income Using Spousal Impoverishment Rules - January 1, 2014 through September 30, 2027 (or other date as required by law).

The state uses the post-eligibility rules of section 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:

A minimum of one qualifying Mental Health waiver service must be provided at least monthly. A qualified waiver service is defined as Community Support Program, Recovery Assistant, Transitional Case Management, Peer Support, or Assisted Living Services.

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 an entity under contract with the Medicaid agency.**

Specify the entity:

- **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:

A Waiver Care Manager will perform the nursing facility level of care evaluation. Determination whether the individual meets the criteria for serious mental illness will be performed by a Waiver Care Manager with at least three years mental health experience. A Waiver Care Manager is a licensed, or license eligible, mental health professional such as registered nurse, psychologist, clinical social worker, professional counselor, marriage and family therapist or psychiatrist. Waiver Care Managers without the requisite three years' experience will be supervised by licensed mental health professionals who meet the experience requirement.

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 Waiver Care Manager will conduct level of care assessments to evaluate whether an individual needs nursing facility care. The level of care assessment will be based on information obtained from the individual, medical reports from their physician(s) and any other clinical personnel who are familiar with the individual's case and history. The Waiver Care Manager will use form W-1506 "Level of Care Screening" to determine nursing facility level of care. Nursing facility level of care is defined as an individual requiring assistance with three or more critical needs. There are a total of seven critical needs that qualify for nursing facility level of care: bathing, dressing, toileting, and transferring, eating/feeding, meal preparation, and medication administration. Additionally, cognitive status and behavioral problems are part of the health screen. Applicants with four or more cognitive deficits and behavioral challenges may qualify for the waiver with two critical needs in addition to the cognitive deficits and behavioral challenges. Cognitive deficits may include: orientation, concentration, abstract reasoning, comprehension, planning, judgment, attention, and memory.

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.

In addition to the information contained in the W-1506, further information is required for the department to authorize Medicaid payment for nursing facility level of care. Waiver Care Managers also complete a comprehensive skills assessment and psychosocial assessment and history. The skills assessment explores an array of functional domains including personal care, independent living skills, safety, interpersonal communication skills, health awareness, coping skills and cognitive functioning.

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 purpose of determining level of care, the Waiver Care Manager, who is a licensed, or license eligible, mental health professional, will perform the nursing facility level of care evaluation for each applicant. Information gathered for the evaluation/re-evaluation of care is derived from a face-to-face interview and includes a thorough assessment of the applicant's individual circumstances. The level of care outcome form will be used to summarize the information and confirm the level of care. 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):*

Waiver Care Managers will perform the re-evaluation on an annual basis or more frequently if necessary. DMHAS will use an electronic tracking system in which the evaluation and Recovery Plan review dates are logged. This system will prompt Waiver Care Managers when Recovery Plans are due.

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 or electronic copies of the evaluations, re-evaluations and Recovery Plans will be maintained by DMHAS in conformance with 42CFR 441.303c(3) and 45 CFR 74.53.

Appendix B: Evaluation/Reevaluation of Level of Care

Quality Improvement: Level of Care

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

a. Methods for Discovery: Level of Care Assurance/Sub-assurances

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

i. Sub-Assurances:

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

Performance Measures

For each performance measure the state will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

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

Performance Measure:
Number of individuals who received an initial level of care determination indicating need for institutional level of care, divided by number of individuals for whom there is reasonable indication that services may be needed in the future

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

Responsible Party for data	Frequency of data	Sampling Approach

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 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**

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

b. ***Sub-assurance: The 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.

Performance Measure:
Number of LOC re-assessments completed annually, divided by the number of LOC re-assessments due 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 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:

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 of LOC determinations completed using the approved tools, divided by the number of LOC determinations completed by a Waiver Care Manager

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 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:

Performance Measure:
Number of LOC determinations completed using the approved processes, divided by the number of LOC determinations completed by a Waiver Care Manager

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

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

Contracted entity		
	☑ **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.

LOC determination is determined by Waiver Care Managers using standardized assessment tools and documented using W-1506 screening form. All initial screening tools are submitted to the State Medicaid agency for review and authorization prior to provision of services. DMHAS or FI reviews all records to ensure timeliness and appropriateness of all tools used.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the state's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction and the state's method for analyzing information from individual problems, identifying systemic deficiencies, and implementing remediation actions. In

addition, provide information on the methods used by the state to document these items.

The Mental Health Waiver Manager or designated staff notifies the Waiver Care Managers in writing of findings from individual initial enrollment document reviews and record audits. Corrective actions are completed by the Waiver Care Managers within 30 days and results reported back to the Mental Health Waiver Manager. If action is not corrected, staff performing LOC will be retrained on time frames and/or LOC instrument.

ii. Remediation Data Aggregation

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

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

c. Timelines

When the state does not have all elements of the quality improvement strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of 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 the screening for eligibility to participate in the waiver, the Waiver Care Manager informs the potential participant of their option of receiving services in a nursing facility or through the waiver. The individual is also advised of their rights to a fair hearing. This is documented on an Informed Consent form. This form will be maintained by the Waiver Care Manager in the participant's case file as well as in the electronic record.

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.

Written copies or electronic facsimiles of the Informed Consent forms documenting freedom of choice will be maintained by DMHAS in the participant's case file for a minimum period of 3 years as required by 45 CFR 74.53.

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 will have access to services without undue hardship. The Waiver Care Managers will make arrangements to provide interpretation or translation services to potential and active waiver participants who need them. This will be 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 evaluation and Recovery Plan meetings. They will not be required to bring their own interpreter. No person will be denied access to the waiver 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	**Community Support Program**		
Statutory Service	**Supported Employment**		
Other Service	**Assisted Living**		
Other Service	**Assistive Technology**		
Other Service	**Brief Episode Stabilization**		
Other Service	**Chore Services**		
Other Service	**Home Accessibility Adaptations**		
Other Service	**Home Delivered Meals**		
Other Service	**Interpreter**		
Other Service	**Mental Health Counseling**		
Other Service	**Non-Medical Transportation**		
Other Service	**Overnight Recovery Assistant**		
Other Service	**Peer Support**		
Other Service	**Personal Emergency Response Systems**		
Other Service	**Recovery Assistant**		
Other Service	**Specialized Medical Equipment**		
Other Service	**Transitional Case Management**		

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Statutory Service

Service:

Adult Day Health

Alternate Service Title (if any):

HCBS Taxonomy:

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

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

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

Service Definition *(Scope):*

The service is provided four or more hours per day on a regularly scheduled basis for one or more days per week, or as specified in the service plan, in a non-institutional, community-based setting and shall encompass both health and social services needed to ensure the optimal functioning of the participant. Transportation to and from the center is included in the service definition and in the rate structure. Meals provided as part of these services shall not constitute a full nutritional regimen. Claims will denied by any Adult Day Health provider attempting to bill for transportation procedure codes. These procedure codes are not included on the Adult Day Health fee schedule and will deny as edits are built into the claims processing system to prevent duplicative transportation services for Adult Day Health from occurring.

Services Covered and Limitations

A program nurse shall be available on site for not less than 50% 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 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.
Assistance with ADL needs shall be provided as specified in the individual plan of care, including, but not limited to, bathing and transferring. Facilities for bathing are available as part of the physical plant.

Ongoing training shall be available to the staff on a regular basis including, but not 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.

To be considered a medical model, the provider shall provide the above services and have nursing available the entire day. Additionally, the center shall have the capacity to provide therapeutic and rehabilitation 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 the 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. Individual therapeutic and rehabilitation services are provided as part of state plan services and may be billed accordingly.

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

May be provided up to seven times per week.

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

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**
- ☐ **Remote/via Telehealth**

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	Provider agency

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Adult Day Health

Provider Category:

Agency

Provider Type:

Provider agency

Provider Qualifications

License *(specify):*

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

operate the program including: a full-time program administrator; nursing consultation during the full operating day by a Registered Nurse (RN) licensed in the State of Connecticut; and the direct care staff-to-participant ratio shall be a minimum of one to seven. Staffing shall be adequate to meet the needs of the client base. Volunteers shall be included in the ratio only when they conform to the same standards and requirements as paid staff.

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

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

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

Certificate *(specify):*

Certification required by the Connecticut Association of Adult Day Centers, Inc. Certification is for three years.

Other Standard *(specify):*

n/a

Verification of Provider Qualifications

Entity Responsible for Verification:

The fiscal intermediary under contract to DSS and DMHAS enrolling the provider must ensure that the adult day program is certified by the association.

Frequency of Verification:

At start of service and every two years

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Statutory Service

Service:

Psychosocial Rehabilitation

Alternate Service Title (if any):

Community Support Program

HCBS Taxonomy:

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

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

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

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

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

Service Definition *(Scope):*

Community Support Program (CSP) services consist of mental health and substance abuse rehabilitation services and supports necessary to assist the individual in achieving and maintaining the highest degree of independent functioning. The service utilizes a team approach to provide intensive, rehabilitative community support, crisis intervention, group and individual psychoeducation, and skill building for activities of daily living.

CSP includes a comprehensive array of rehabilitation services most of which are provided in non-office settings by a mobile team. Services are focused on skill building with a goal of maximizing independence. Interventions include skill building and support for activities of daily living and self-care skills; activities directed at reducing disability, restoring functioning, increasing participation in social, interpersonal, family or community activities; teaching recovery skills in order to prevent relapse; development of self-advocacy skills; and health and wellness education. Community-based treatment enables the team to become intimately familiar with the participant's surroundings, strengths and challenges, and to assist the participant in learning skills applicable to their living environment. The services and interventions are highly individualized and tailored to the needs and preferences of the individual.

CSP is more intensive than Peer Support. Compared with Peer Support, CSP provides more concentrated and frequent rehabilitative services and supports.

CSP interventions exclude activities that are duplicative of Supported Employment services.

CSP is subject to service volume (number of 1/4 hours service units per day and/or week) and duration (number of months or specified service end date) limits established in the waiver Recovery Plan approved by DMHAS and DSS.

Therapeutic and rehab services for behavioral health under the state plan are primarily provided in clinic settings. The CSP is home and community-based unlike the state plan services and facilitates the generalizing of skills learned in the clinic setting into day-to-day activities in the community.

Services are provided on a face-to-face basis except in extenuating circumstances, as described below.

If the face-to-face service requirement is waived due to an extenuating circumstance such as a pandemic, epidemic, natural disaster, or other temporary cause preventing the safe provision of in-person services (i.e., recipient suffers a contagious illness but would benefit from telephonic monitoring, recipient experiences a bedbug infestation, etc.), services may be provided via alternate means. Allowing services to be delivered in an alternative way when it is not safe to provide services in the home enables individuals to continue to receive supportive skill-building services seamlessly, rather than experiencing an interruption in services. The telehealth option will only be initiated if there is a temporary health and safety concern that creates an unsafe environment for in-person services (i.e., contagious illness, infestation, etc). Therefore, the telehealth service delivery method will only be allowed on a temporary basis during these specific circumstances, and thus no face-to-face services will be required during this time.

Waiver Care Managers will be responsible for approving the alternate means of service provision and will authorize said service in the care plan. Provider reports will indicate how the service was delivered, and a billing procedure code modifier will indicate the alternative means of service delivery. Ongoing monitoring and evaluation will be in place to confirm ongoing need for remote monitoring vs. in-person services.

Delivering services through alternate means can ensure continued teaching of skills that are important for community integration, independence, and assuring health and safety. Allowing telehealth (phone or virtual) service provision while someone is suffering a temporary contagious illness, bedbug infestation, or other issue that precludes their staff from entering their home temporarily will allow them to continue receiving limited support (prompts, cues, psychoeducation), as opposed to having these services placed completely on hold as in the current situation with regards to the face-to-face requirements. Allowing telehealth (phone or virtual) service provision while someone is suffering a temporary contagious illness, bedbug infestation, or other issue that precludes their staff from entering their home temporarily will allow the Mental Health waiver provider staff to be able to check in by phone or virtually in order to monitor health and safety; whereas the current face-to-face requirement would mean that providers are unable to provide any service and thus they cannot monitor health and safety at all in these situations currently.
Either telephonic or virtual technology with 2-way video capability will be used. The virtual platforms utilized by the mental health waiver have been vetted and approved by the DMHAS Agency Compliance Officer
For virtual services, the individual will need to attest that they are in a private place in their environment and that they consent to the alternatively-delivered service, and this will be documented in the provider's report.
No remote monitoring will take place.
Any equipment used by the individual will be the individual's own personal equipment (telephone, cell phone, laptop/computer, tablet, etc.). Thus, the individual will know when their equipment is on or in use. They will have the ability to relocate their own equipment to the setting in their environment in which they are most comfortable completing the visit.
Mental Health waiver services do not include hands-on assistance with bathing, dressing, toileting, etc. Any assistive technology provided to the participant by a mental health waiver assistive technology provider will come with tech support and education about setup and use of the device.
Face-to-face services will be encouraged to resume as soon as the extenuating circumstances causing in-person services to be unsafe have been resolved.

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

Service is limited to no more than 24 hours in a day and is subject to approved cost cap.

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

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**
- ☑ **Remote/via Telehealth**

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: Community Support Program

Provider Category:

Agency

Provider Type:

Provider Agency

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Commission on Accreditation of Rehabilitation Facilities (CARF), The Joint Commission (TJC), other accrediting body approved by DMHAS, or can demonstrate to the satisfaction of DMHAS that it is in the active process of becoming accredited by any of these approved entities.

Other Standard *(specify):*

CSP staff shall hold either a bachelor's degree in a behavioral health-related specialty (may include special education or rehabilitation) OR have two years' experience in the provision of mental health services (may include special education and/or services to persons with developmental disabilities) OR be a Certified Peer Support and Recovery Professional.

A CSP provider must meet the State of Connecticut certification standards to provide CSP services as defined by the Department of Mental Health and Addiction Services (DMHAS).

Verification of Provider Qualifications

Entity Responsible for Verification:

Fiscal intermediary under contract to DSS and DMHAS

Frequency of Verification:

At start of service and at re-accreditation

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Statutory Service

Service:

Supported Employment

Alternate Service Title (if any):

Supported Employment

HCBS Taxonomy:

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

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

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

Service Definition *(Scope):*

Supported employment services consists of intensive, ongoing supports that enable participants, for whom competitive employment at or above the minimum wage is unlikely absent the provision of supports, and who, because of their disabilities, need supports to perform in a regular work setting. Supported employment may include assisting the participant to locate a job or develop a job on behalf of the participant. Supported employment is conducted in a variety of settings, particularly work sites where persons without disabilities are employed. Supported employment includes activities needed to sustain paid work by participants, including supervision and training. When supported employment services are provided at a work site where persons without disabilities are employed, payment is made only for the adaptations, supervision and training required by participants receiving waiver services as a result of their disabilities but does not include payment for the supervisory activities rendered as a normal part of the business setting.

Supported Employment is subject to service volume (number of 1/4 hours service units per day and/or week) and duration (number of months or specified service end date) limits established in the waiver Recovery Plan approved by DMHAS and DSS.

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**
- ☐ **Remote/via Telehealth**

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	Agency Provider

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Supported Employment

Provider Category:

Agency

Provider Type:

Agency Provider

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Commission on Accreditation of Rehabilitation Facilities (CARF), The Joint Commission (TJC), or meets general certification requirements set by DMHAS.

Other Standard *(specify):*

Meet the State of CT Standard to provide rehabilitation services for the Bureau of Rehabilitation Services (BRS), Department of Developmental Services (DDS), and Department of Mental Health and Addiction Services (DMHAS).

Verification of Provider Qualifications

Entity Responsible for Verification:

Fiscal intermediary under contract to DSS and DMHAS

Frequency of Verification:

At start of service or recertification

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Assisted Living

HCBS Taxonomy:

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

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

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

Service Definition *(Scope):*

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

Participants will have access to all medically necessary HCBS waiver services, such as Community Support, Peer Supports, and the Personal Emergency Response System that do not duplicate the supports provided by assisted living service providers. Nursing and skilled therapy services are incidental rather than integral to the provision of assisted living services. Payment is not made for 24-hour skilled care. Federal financial participation is not available for room and board, items of comfort or convenience, or the costs of facility maintenance, upkeep and improvement.

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

Recovery plans will be developed based on the individual's service needs. There are five levels of service provided in assisted living facilities based on the consumer's combined needs for personal care and nursing services. The five levels are: 1) occasional, which is 1-3.75 hours per week of service; 2) limited, which is 4-8.75 hours per week of service; 3) moderate, which is 9-14.75 hours per week of service; 4) extensive, which is 15-25.75 hours per week of service; and 5) significant, which is 26-40 hours per week of service. Level of service assigned depends upon the volume and extent of services needed by each individual and is not a limitation of service.

Assisted Living services are provided under the waiver statewide in private assisted living facilities under CGS 17b-365 and in 17 state-funded congregate and 4 HUD facilities under CGS 8-206e(e). Additionally, Assisted Living services are provided in 4 demonstration sites under section 19-13-D105 of the Regulations of Connecticut State Agencies.

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**
- ☐ **Remote/via Telehealth**

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	Assisted Living Service Agency

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Assisted Living

Provider Category:

Agency

Provider Type:

Assisted Living Service Agency

Provider Qualifications

License *(specify):*

The Assisted Living Service Agency (ALSA) is licensed by the CT Department of Public Health in accordance with chapter 368v. Regulations regarding a managed residential community and the ALSA are found in Regulations of Connecticut State Agencies, section 19-13-D105.

Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

Fiscal intermediary under contract to DSS and DMHAS

Frequency of Verification:

At start of service and at recertification

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Assistive Technology

HCBS Taxonomy:

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

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

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

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

Service Definition *(Scope):*

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

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

Care plans will be developed based on the needs identified in the comprehensive assessment. The cost of the Assistive Technology cannot exceed the yearly cost of the service it replaces. When an assistive technology device is identified that will support the waiver participant's independent functioning, the services will be reduced commensurate with the cost of the service it replaces. This reduction will be made with consideration of the waiver participant's health and safety needs. The service shall be capped at an annual cost of $2,000.

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

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**
- ☐ **Remote/via Telehealth**

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
Agency	Pharmacy

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Assistive Technology

Provider Category:

Agency

Provider Type:

Provider 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) of section 19a-490 of the Connecticut General Statutes.

Certificate *(specify):*

Other Standard *(specify):*

Medicaid provider status for assistive technology and supplies or agency that obtains Medicaid performing provider status

Verification of Provider Qualifications

Entity Responsible for Verification:

Fiscal intermediary

Frequency of Verification:

At the initiation of service and every two years thereafter

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Assistive Technology

Provider Category:

Agency

Provider Type:

Pharmacy

Provider Qualifications

License *(specify):*

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

Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

Fiscal intermediary

Frequency of Verification:

At the initiation of the service

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Brief Episode Stabilization

HCBS Taxonomy:

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

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

- (•) **Service is included in approved waiver. There is no change in service specifications.**
- ( ) **Service is included in approved waiver. The service specifications have been modified.**
- ( ) **Service is not included in the approved waiver.**

Service Definition *(Scope):*

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

Brief Episode Stabilization services are provided to restore a participant's ability to manage their illness and their ability to utilize treatment. These services are designed to restore prior functional level and reduce the likelihood of crisis recurrence. Interventions include practical problem-solving advice and assistance designed to address and remediate the antecedent causes of an emerging psychiatric or behavioral crisis, or to manage stressors related to exacerbation of ongoing medical conditions.

Services take place in the participant's home or in other community (non-residential) settings. This intervention typically takes place in 4- to 8-hour blocks of time, and might last up to 24 or 48 hours. If the individual cannot be stabilized within this time period, a more intensive intervention is usually needed.

Brief Episode Stabilization is subject to service volume (number of 1/4 hours service units per day and/or week) and duration (number of months or specified service end date) limits established in the waiver Recovery Plan approved by DMHAS and DSS.

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**
- ☐ **Remote/via Telehealth**

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: Brief Episode Stabilization

Provider Category:

Agency

Provider Type:

Provider Agency

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Commission on Accreditation of Rehabilitation Facilities (CARF), The Joint Commission (TJC) or other accrediting body approved by DMHAS, or is a DMHAS-designated Local Mental Health Authority (LMHA), or is a contracted affiliate of an LMHA, or certified waiver service provider.

Other Standard *(specify):*

Brief episode stabilization staff shall have two years experience in the provision of mental health services (may include special education and/or services to persons with developmental disabilities)

Verification of Provider Qualifications

Entity Responsible for Verification:

Fiscal intermediary under contract to DSS and DMHAS

Frequency of Verification:

At start of service and at recertification

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the

Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

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

Service Title:

Chore Services

HCBS Taxonomy:

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

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

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

Service Definition *(Scope):*

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

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

When an individual requires one-time only unique or specialized services in order to maintain a healthy and safe environment, they may receive highly skilled chore services which include, but are not limited to, moving, extensive cleaning or extermination services. Highly skilled chore services are subject to prior authorization by the department and must fit within the established annual cost cap. Requests for highly skilled chore services do not have a defined maximum allowable amount and are approved on an "as needed" basis.

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

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**
- ☐ **Remote/via Telehealth**

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: Chore Services

Provider Category:

Agency

Provider Type:

Provider Agency

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

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

Verification of Provider Qualifications

Entity Responsible for Verification:

Fiscal intermediary

Frequency of Verification:

At start of service and at recertification

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Home Accessibility Adaptations

HCBS Taxonomy:

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

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

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

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

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

- (•) **Service is included in approved waiver. There is no change in service specifications.**
- ( ) **Service is included in approved waiver. The service specifications have been modified.**
- ( ) **Service is not included in the approved waiver.**

Service Definition *(Scope):*

Those physical adaptations to the 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 that are necessary for the welfare of the participant. 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).

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

This service will be limited to $10,000 per waiver participant annually and subject to prior authorization. Home accessibility adaptations may not be furnished to adapt living arrangements that are owned or leased by providers of waiver services.

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

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**
- ☐ **Remote/via Telehealth**

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	Private contractor/business

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Home Accessibility Adaptations

Provider Category:

Agency

Provider Type:

Private contractor/business

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Meet the State of CT Standard to provide Environmental Accessibility Adaptations through BRS and Home Improvement Registration by the Department of Consumer Protection; Adhere to state/local building codes

Verification of Provider Qualifications

Entity Responsible for Verification:

Fiscal intermediary under contract to DSS and DMHAS

Frequency of Verification:

At time of service

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Home Delivered Meals

HCBS Taxonomy:

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

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

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

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

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

Service Definition *(Scope):*

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 services 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 Research Council. Special diet meals are available such as diabetic, cardiac, low sodium and renal as are ethnic meals such as Hispanic and Kosher meals.

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.

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

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**
- ☐ **Remote/via Telehealth**

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	Home Delivered Meal Providers

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Home Delivered Meals

Provider Category:

Agency

Provider Type:

Home Delivered Meal Providers

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Reimbursement for home delivered meals shall be available only to providers which provide meals that meet a minimum of one-third of the current daily recommended dietary allowance and requirements as established by the Food and Nutrition Board of the National Academy of Sciences National Research Council.

All "meals on wheels" providers shall provide their menus to the department, contracted agencies or department designee for review and approval. Quality assurance and quality control shall be performed by the department's contracted providers to ensure that the "meals on wheels" service providers are in compliance with the dietary requirements and the requirements for the preparation and storage and delivery of food based on the department policies for the elderly nutrition program and Title (III) of the Older American's Act.

Verification of Provider Qualifications

Entity Responsible for Verification:

Fiscal intermediary under contract to DSS and DMHAS

Frequency of Verification:

At time of enrollment as a provider 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:

Interpreter

HCBS Taxonomy:

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

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

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

Service Definition *(Scope):*

Service of an interpreter to provide accurate, effective, and impartial communication where the waiver recipient or representative is deaf or hard of hearing or where the individual does not understand spoken English. Services under the Interpreter service are limited to additional services not otherwise covered under the state plan, including EPSDT, but consistent with waiver objectives of avoiding institutionalization.

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**
- ☐ **Remote/via Telehealth**

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	Private or public translation agencies

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Interpreter

Provider Category:

Agency

Provider Type:

Private or public translation agencies

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Certified to provide Interpreter services by DMHAS

Sign language interpreter: Certified by National Assn. of the Deaf or national Registry of Interpreters for the Deaf. Sign language interpreters must be registered with the Bureau of Rehabilitation Services.

Other Standard (specify): For any other language interpreter the agency will verify that the person meets the following

qualifications:

Other Standard *(specify):*

For any other language interpreter the agency will verify that the person meets the following qualifications prior to employment:

- 21 years of age
- criminal background check
- registry check
- ability to communicate effectively with the individual/family
- proficient in both languages
- committed to confidentiality
- understands cultural nuances and emblems
- understands the interpreter's role to provide accurate interpretation

Verification of Provider Qualifications

Entity Responsible for Verification:

Fiscal intermediary

Frequency of Verification:

Initial 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:

Mental Health Counseling

HCBS Taxonomy:

Category 1:	Sub-Category 1:
10 Other Mental Health and Behavioral Services	10060 counseling
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

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

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

Service Definition *(Scope):*

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 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 counseling 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 services can be provided in the participant's home or the home of a family member.

Services are provided on a face-to-face basis except in extenuating circumstances, as described below.

If the face-to-face service requirement is waived due to an extenuating circumstance such as a pandemic, epidemic, natural disaster, or other temporary cause preventing the safe provision of in-person services (i.e., recipient suffers a contagious illness but would benefit from telephonic monitoring, recipient experiences a bedbug infestation, etc.), services may be provided via alternate means. Allowing services to be delivered in an alternative way when it is not safe to provide services in the home enables individuals to continue to receive supportive mental health counseling, rather than experiencing an interruption in services. The telehealth option will only be initiated if there is a temporary health and safety concern that creates an unsafe environment for in-person services (i.e., contagious illness, infestation, etc). Therefore, the telehealth service delivery method will only be allowed on a temporary basis during these specific circumstances, and thus no face-to-face services will be required during this time. Allowing telehealth (phone or virtual) service provision while someone is suffering a temporary contagious illness, bedbug infestation, or other issue that precludes their staff from entering their home temporarily will allow them to continue receiving limited support (prompts, cues, psychoeducation), as opposed to having these services placed completely on hold as in the current situation with regards to the face-to-face requirements. Allowing telehealth (phone or virtual) service provision while someone is suffering a temporary contagious illness, bedbug infestation, or other issue that precludes their staff from entering their home temporarily will allow mental health waiver provider staff to be able to check in by phone or virtually in order to monitor health and safety, whereas the current face-to-face requirement would mean that providers are unable to provide any service and thus they cannot monitor health and safety at all in these situations currently.

Waiver Care Managers will be responsible for approving the alternate means of service provision and will authorize said service in the care plan. Provider reports will indicate how the service was delivered, and a billing procedure code modifier will indicate the alternative means of service delivery. Ongoing monitoring and evaluation will be in place to confirm the ongoing need for remote monitoring vs. in-person services.

Delivering services through alternate means can ensure continued teaching of skills that are important for community integration, independence, and assuring health and safety. Either telephonic or virtual technology with 2-way video capability will be used. The virtual platforms utilized by the mental health waiver have been vetted and approved by the DMHAS Agency Compliance Officer
For virtual services, the individual will need to attest that they are in a private place in their environment and that they consent to the alternatively-delivered service, and this will be documented in the provider's report. The Mental Health waiver does not provide hands on/physical assistance.

No remote monitoring will take place. Any equipment used in the individual's home will be the individual's own personal equipment (telephone, cell phone, laptop/computer, tablet, etc.). Thus, the individual will know when their equipment is on or in use. They will have the ability to relocate their own equipment to the setting in their environment in which they are

most comfortable completing the visit. Any assistive technology provided to the participant by a mental health waiver assistive technology provider will come with tech support and education about setup and use of the device.

Face-to-face services will be encouraged to resume as soon as the extenuating circumstances causing in-person services to be unsafe have been resolved.

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**
- ☐ **Remote/via Telehealth**

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	Community Agency

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 provider agency may provide this service using licensed providers. For the purpose of receiving reimbursement under the Mental Health waiver, the agency must utilize a mental health counseling provider who is a Licensed Clinical Social Worker (LCSW) or Licensed Master Social Worker (LMSW) as defined in Connecticut General Statutes section 20-195m, a Licensed Marital and Family Therapist (LMFT) or Licensed Marital and Family Therapist Associate (LMFT-A) as defined in Connecticut General Statutes section 20-195a, or as a Licensed Professional Counselor (LPC) or Licensed Professional Counselor Associate (LPC-A) as defined in Connecticut General Statutes section 20-195aa, 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:

Non-Medical Transportation

HCBS Taxonomy:

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

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

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

Service Definition *(Scope):*

Service offered in order to enable waiver participants to gain access to waiver and other community services, activities and resources, as specified by the service plan.

This service is offered in addition to medical transportation offered by DSS.

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

This service will be limited to $1,000 per waiver participant annually.

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

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

☑ **Provider managed**

☐ **Remote/via Telehealth**

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

☐ **Legally Responsible Person**

☑ **Relative**

☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Individual	Individual Provider
Agency	Private transportation service

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Non-Medical Transportation

Provider Category:

Individual

Provider Type:

Individual Provider

Provider Qualifications

License *(specify):*

Valid driver's license

Certificate *(specify):*

Other Standard *(specify):*

Proof of current vehicle insurance

Verification of Provider Qualifications

Entity Responsible for Verification:

Fiscal intermediary under contract to DSS and DMHAS

Frequency of Verification:

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

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Non-Medical Transportation

Provider Category:

Agency

Provider Type:

Private transportation service

Provider Qualifications

License *(specify):*

DOT livery license

Certificate *(specify):*

Other Standard *(specify):*

Subcontractor for Medicaid Transportation Broker

Verification of Provider Qualifications

Entity Responsible for Verification:

Fiscal intermediary under contract to DSS and DMHAS

Frequency of Verification:

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

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:

Overnight Recovery Assistant

HCBS Taxonomy:

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

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

- (●) **Service is included in approved waiver. There is no change in service specifications.**

○ **Service is included in approved waiver. The service specifications have been modified.**

○ **Service is not included in the approved waiver.**

Service Definition *(Scope):*

Service provides support necessary to enable an individual to live in a community-based residence within walking distance from the overnight staff. Overnight Recovery Assistant services provide opportunities for individuals that require overnight staff access due to health and safety issues to live independently in the community. Determination of need is established by the Waiver Care Manager through functional skills assessment and development of an individual Recovery Plan. Overnight Recovery Assistant services are provided to ensure individual health and wellness and may include supervision of and assistance with: self-care; communication and interpersonal skills; socialization; problem-solving skills; and ability to manage activities safely in an independent setting.

Overnight Recovery Assistant services will not duplicate personal care services that are included in the state plan.

Services may be provided for up to six individuals in dwellings clustered within walking distance of overnight staff, with no greater than four unrelated individuals sharing a single dwelling. Unlike traditional Recovery Assistant services, Overnight Recovery Assistant service provides access to support and does not require all billable time to be provided face-to-face, but rather that staff be available to provide support during the overnight hours. Service may be provided for less than 12-hour increments and in more than one dwelling.

Services purchased by 15-minute increment. Staff may provide support for up to six participants during the overnight period, not to exceed twelve hours (i.e., 8:00 p.m. through 8:00 a.m.). Staff will be awake during the period billed. The amount of service billed overnight is divided by the number of individuals utilizing the service during the time period rather than by the intensity of service provided to any one individual (e.g., for a 12-hour period, one staff member serving six clients would bill two hours for each client, three hours for each of four clients, etc.)

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**

☐ **Remote/via Telehealth**

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
Individual	Certified Individual

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Overnight Recovery Assistant

Provider Category:

Agency

Provider Type:

Provider Agency

Provider Qualifications

License *(specify):*

Certificate *(specify):*

The agency must:
Meet general certification conditions established by DMHAS;
Demonstrate that its training of individuals providing Overnight Recovery Assistant services meet minimum requirements established by DMHAS;
Maintain proper documentation that all staff who provide Overnight Recovery Assistant services have completed required training and meet any continuing education and/or training requirements set by DMHAS;
Maintain accurate and complete personnel records for individuals providing Overnight Recovery Assistant services;
Retain the aforementioned documentation and records for a period specified by DMHAS, and ensure that such materials are available for inspection by DMHAS or its designee at any time during normal business hours; and
Attest in writing that training and related documentation complies with guidelines established by DMHAS for individuals providing Overnight Recovery Assistant services.

Other Standard *(specify):*

An Overnight Recovery Assistant shall:
Be at least 18 years old;
Possess at least a high school diploma or GED and a valid government ID; and
Comply with training requirements by satisfactorily completing training programs that address abilities to:
Follow instructions given by the participant or the participant's conservator;
Report changes in the participant's condition or needs;
Maintain confidentiality;
Meet the participant's needs as delineated in the waiver Recovery Plan;
Implement cognitive and behavioral strategies;
Function as a member of an interdisciplinary team;
Respond to fire and emergency situations;
Accept supervision in a manner prescribed by the department or its designated agent;
Maintain accurate, complete and timely records that meet Medicaid requirements;
Use crisis intervention and de-escalation techniques; and
Provide services in a respectful, culturally competent manner.

Verification of Provider Qualifications

Entity Responsible for Verification:

Fiscal intermediary under contract to DSS and DMHAS

Frequency of Verification:

At start of service and every two years thereafter

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Overnight Recovery Assistant

Provider Category:

Individual

Provider Type:

Certified Individual

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

An Overnight Recovery Assistant shall:
Be at least 18 years old;
Possess at least a high school diploma or GED; and valid government ID;
Be registered with DMHAS as having completed an approved Recovery Assistant training program and meet any continuing education and/or training requirements set by DMHAS, and
Comply with training requirements by satisfactorily completing training programs that address abilities to:
Follow instructions given by the participant or the participant's conservator;
Report changes in the participant's condition or needs;
Maintain confidentiality;
Meet the participant's needs as delineated in the waiver Recovery Plan;
Implement cognitive and behavioral strategies;
Function as a member of an interdisciplinary team;
Respond to fire and emergency situations;
Accept supervision in a manner prescribed by the department or its designated agent;
Maintain accurate, complete and timely records that meet Medicaid requirements;
Use crisis intervention and de-escalation techniques; and
Provide services in a respectful, culturally competent manner.

Verification of Provider Qualifications

Entity Responsible for Verification:

Fiscal intermediary under contract to DSS and DMHAS

Frequency of Verification:

At start of services and annually thereafter

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Peer Support

HCBS Taxonomy:

Category 1:	Sub-Category 1:

Category 2:	Sub-Category 2:

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

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

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

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

Service Definition *(Scope):*

Peer Support can be used as a free-standing service or a supplement to more intensive waiver services such as Community Support Program. Peer support includes face-to-face interactions that are designed to promote ongoing engagement of persons covered under the waiver in addressing residual problems resulting from psychiatric and substance use disorders, as well as promoting the individual's strengths and abilities to continue improving socialization, recovery, self-advocacy, development of natural supports, and maintenance of community living skills. Peer Support also includes communication and coordination with behavioral health services providers and others in support of the participant.

Peer Support is least intensive of the rehabilitative services. The Peer Support worker uses their first-hand knowledge about mental illness and how to overcome the disabling effects of these disorders to engage the participant and to continually reinforce and maintain the psychosocial rehabilitation skills acquired by the participant.

Peer Support interventions exclude activities that are duplicative of Supported Employment services.

Peer Support is subject to service volume (number of 1/4 hours service units per day and/or week) and duration (number of months or specified service end date) limits established in the waiver Recovery Plan approved by DMHAS and DSS.

Services are provided on a face-to-face basis except in extenuating circumstances, as described below.

If the face-to-face service requirement is waived due to an extenuating circumstance such as a pandemic, epidemic, natural disaster, or other temporary cause preventing the safe provision of in-person services (i.e., recipient suffers a contagious illness but would benefit from telephonic monitoring, recipient experiences a bedbug infestation, etc.), services may be provided via alternate means. Allowing services to be delivered in an alternative way when it is not safe to provide services in the home enables individuals to continue to receive supportive skill-building services seamlessly, rather than experiencing an interruption in services. The telehealth option will only be initiated if there is a temporary health and safety concern that creates an unsafe environment for in-person services (i.e., contagious illness, infestation, etc). Therefore, the telehealth service delivery method will only be allowed on a temporary basis during these specific circumstances, and thus no face-to-face services will be required during this time. Allowing telehealth (phone or virtual) service provision while someone is suffering a temporary contagious illness, bedbug infestation, or other issue that precludes their staff from entering their home temporarily will allow them to continue receiving limited support (prompts, cues, psychoeducation), as opposed to having these services placed completely on hold as in the current situation with regards to the face-to-face requirements. Allowing telehealth (phone or virtual) service provision while someone is suffering a temporary contagious illness, bedbug infestation, or other issue that precludes their staff from entering their home temporarily will allow mental health waiver provider staff to be able to check-in by phone or virtually in order to monitor health and safety, whereas the current face-to-face requirement would mean that providers are unable to provide any service and thus they cannot monitor health and safety at all in these situations currently.

Waiver Care Managers will be responsible for approving the alternate means of service provision and will authorize said service in the care plan. Provider reports will indicate how the service was delivered, and a billing procedure code modifier will indicate the alternative means of service delivery. Ongoing monitoring and evaluation will be in place to confirm ongoing need for remote monitoring vs. in-person services.

Delivering services through alternate means can ensure continued teaching of skills that are important for community integration, independence, and assuring health and safety. Either telephonic or virtual technology with 2-way video

capability will be used. The virtual platforms utilized by the mental health waiver have been vetted and approved by the DMHAS Agency Compliance Officer.

For virtual services, the individual will need to attest that they are in a private place in their environment and that they consent to the alternatively-delivered service, and this will be documented in the provider's report. Mental Health waiver services do not include hands-on assistance with bathing, dressing, toileting, etc.

No remote monitoring will take place. Any equipment used by the individual will be the individual's own personal equipment (telephone, cell phone, laptop/computer, tablet, etc.). Thus, the individual will know when their equipment is on or in use. They will have the ability to relocate their own equipment to the setting in their environment in which they are most comfortable completing the visit. Any assistive technology provided to the participant by a mental health waiver assistive technology provider will come with tech support and education about setup and use of the device.

Face-to-face services will be encouraged to resume as soon as the extenuating circumstances causing in-person services to be unsafe have been resolved.

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**
- ☑ **Remote/via Telehealth**

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: Peer Support

Provider Category:

Agency

Provider Type:

Provider Agency

Provider Qualifications

License *(specify):*

Certificate *(specify):*

The agency must:
Meet general certification conditions established by DMHAS;
Demonstrate that its training of individuals providing Peer Support services (also know as "Recovery Support Specialists" services) meets minimum requirements established by DMHAS.
The certification program for Peer Support Specialist includes the following competency areas:

Effective, empathetic communication skills
Legal and ethical practice, boundaries, client rights
Introduction to mental health, substance abuse, and co-occurring disorders
Principles of psychiatric rehabilitation
Using your recovery story, role of peer supports on teams, recovery culture
Role challenges, conflict resolution, self-care
Recovery planning and documentation
Entitlements and benefits management
Cultural awareness
Maintain proper documentation that all staff who provide Peer Support services have completed required training;
Maintain accurate and complete personnel records for individuals providing Peer Support services;
The training accepts applications from individuals in recovery from psychiatric disabilities and co-occurring disorders;
Work is provided with supervision by a mental health professional;
Retain the aforementioned documentation and records for a period specified by DMHAS, and ensure that such materials are available for inspection by DMHAS or its designee at any time during normal business hours; and
Attest in writing that training and related documentation complies with guidelines established by DMHAS for individuals providing Peer Support services.

Other Standard *(specify):*

A Peer Support Specialist shall:
Be at least 18 years old;
Possess at least a high school diploma or GED;
Possess a valid government ID;
Be a Certified Peer Support and Recovery Professional in accordance with requirements set by DMHAS;
Meet requirements for ongoing continuing education set by DMHAS;
Demonstrate ability to support the recovery of others from mental illness and/or substance abuse; and
Comply with training requirements by satisfactorily completing training programs that address abilities to:
Follow instructions given by the participant or the participant's conservator;
Report changes in the participant's condition or needs;
Maintain confidentiality;
Meet the participant's needs as delineated in the waiver Recovery Plan;
Function as a member of an interdisciplinary team;
Respond to fire and emergency situations;
Accept supervision in a manner prescribed by the department or its designated agent;
Maintain accurate, complete and timely records that meet Medicaid requirements;
Provide services in a respectful, culturally competent manner; and
Use effective Peer Support practices.

Verification of Provider Qualifications

Entity Responsible for Verification:

Fiscal intermediary under contract to DSS and DMHAS

Frequency of Verification:

At start of service 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:

Personal Emergency Response Systems

HCBS Taxonomy:

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

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

- (•) **Service is included in approved waiver. There is no change in service specifications.**
- ( ) **Service is included in approved waiver. The service specifications have been modified.**
- ( ) **Service is not included in the approved waiver.**

Service Definition *(Scope):*

Personal Emergency Response Systems (PERS) is an electronic device that enables waiver participants to secure help in an emergency. The participant 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 are provided.
This service may also be provided in combination with an electronic medication management system.

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**
- ☐ **Remote/via Telehealth**

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	Vendors who sell and install appropriate PERS equipment

Appendix C: Participant Services

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

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

Provider Category:

Agency

Provider Type:

Vendors who sell and install appropriate PERS equipment

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Vendor that has an approved contract through DSS as a performing provider

Verification of Provider Qualifications

Entity Responsible for Verification:

Fiscal intermediary under contract to DSS and DMHAS

Frequency of Verification:

At start of service

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Recovery Assistant

HCBS Taxonomy:

Category 1:	Sub-Category 1:

Category 2:	Sub-Category 2:

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

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

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

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

Service Definition *(Scope):*

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

Recovery Assistant services can be received individually or in a group of up to four individuals. Provider agencies will bill for services involving more than one participant utilizing a modifier which will allow for an increased rate. This payment will either be the same or more than the previous billing method depending on the number of participants.

Recovery Assistant services is subject to service volume (number of 1/4 hours service units per day and/or week) and duration (number of months or specified service end date) limits established in the waiver Recovery Plan approved by DMHAS and DSS. Recovery Assistant services will not duplicate personal care services that are included in the state plan.

Services are provided on a face-to-face basis except in extenuating circumstances, as described below.

If the face-to-face service requirement is waived due to an extenuating circumstance such as a pandemic, epidemic, natural disaster, or other temporary cause preventing the safe provision of in-person services (i.e., recipient suffers a contagious illness but would benefit from telephonic monitoring, recipient experiences a bedbug infestation, etc.), services may be provided via alternate means. Allowing services to be delivered in an alternative way when it is not safe to provide services in the home enables individuals to continue to receive supportive skill-building services seamlessly, rather than experiencing an interruption in services. The telehealth option will only be initiated if there is a temporary health and safety concern that creates an unsafe environment for in-person services (i.e., contagious illness, infestation, etc). Therefore, the telehealth service delivery method will only be allowed on a temporary basis during these specific circumstances, and thus no face-to-face services will be required during this time. Allowing telehealth (phone or virtual) service provision while someone is suffering a temporary contagious illness, bedbug infestation, or other issue that precludes their staff from entering their home temporarily will allow them to continue receiving limited support (prompts, cues, psychoeducation), as opposed to having these services placed completely on hold as in the current situation with regards to the face-to-face requirements. Allowing telehealth (phone or virtual) service provision while someone is suffering a temporary contagious illness, bedbug infestation, or other issue that precludes their staff from entering their home temporarily will allow mental health waiver provider staff to be able to check in by phone or virtually in order to monitor health and safety, whereas the current face-to-face requirement would mean that providers are unable to provide any service and thus they cannot monitor health and safety at all in these situations currently.

Waiver Care Managers will be responsible for approving the alternate means of service provision and will authorize said service in the care plan. Provider reports will indicate how the service was delivered, and a billing procedure code modifier will indicate the alternative means of service delivery. Ongoing monitoring and evaluation will be in place to confirm ongoing need for remote monitoring vs. in-person services.

Delivering services through alternate means can ensure continued teaching of skills that are important for community

integration, independence, and assuring health and safety. Either telephonic or virtual technology with 2-way video capability will be used. The virtual platforms utilized by the mental health waiver have been vetted and approved by the DMHAS Agency Compliance Officer.

For virtual services, the individual will need to attest that they are in a private place in their environment and that they consent to the alternatively-delivered service, and this will be documented in the provider's report. Mental Health waiver services do not include hands-on assistance with bathing, dressing, toileting, etc.

No remote monitoring will take place. Any equipment used by the individual will be the individual's own personal equipment (telephone, cell phone, laptop/computer, tablet, etc.). Thus, the individual will know when their equipment is on or in use. They will have the ability to relocate their own equipment to the setting in their environment in which they are most comfortable completing the visit. Any assistive technology provided to the participant by a mental health waiver assistive technology provider will come with tech support and education about setup and use of the device.

Face-to-face services will be encouraged to resume as soon as the extenuating circumstances causing in-person services to be unsafe have been resolved.

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**
- ☑ **Remote/via Telehealth**

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
Individual	Certified Individual

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Recovery Assistant

Provider Category:

Agency

Provider Type:

Provider Agency

Provider Qualifications

License *(specify):*

Certificate *(specify):*

The agency must:
Meet general certification conditions established by DMHAS;
Demonstrate that its training of individuals providing Recovery Assistant services meets minimum requirements established

by DMHAS;
Maintain proper documentation that all staff who provide Recovery Assistant services have completed required training and meet any continuing education and/or training requirements set by DMHAS;
Maintain accurate and complete personnel records for individuals providing Recovery Assistant services;
Retain the aforementioned documentation and records for a period specified by DMHAS, and ensure that such materials are available for inspection by DMHAS or its designee at any time during normal business hours; and
Attest in writing that training and related documentation complies with guidelines established by DMHAS for individuals providing Recovery Assistant services.

Other Standard *(specify):*

A Recovery Assistant shall:
Be at least 18 years old;
Possess at least a high school diploma or GED; and a valid government ID
Training requirement: Training programs will address abilities to:
Follow instructions given by the participant or the participant's conservator;
Report changes in the participant's condition or needs;
Maintain confidentiality;
Meet the participant's needs as delineated in the waiver Recovery Plan;
Implement cognitive and behavioral strategies;
Function as a member of an interdisciplinary team;
Respond to fire and emergency situations;
Accept supervision in a manner prescribed by the department or its designated agent;
Maintain accurate, complete and timely records that meet Medicaid requirements;
Use crisis intervention and de-escalation techniques; and
Provide services in a respectful, culturally competent manner.

Verification of Provider Qualifications

Entity Responsible for Verification:

Fiscal intermediary under contract to DSS and DMHAS

Frequency of Verification:

At start of service and every two years thereafter

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Recovery Assistant

Provider Category:

Individual

Provider Type:

Certified Individual

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

A Recovery Assistant shall:
Be at least 18 years old;
Possess at least a high school diploma or GED; and
Be registered with the Department of Mental Health and Addiction Services (DMHAS) as having completed an approved Recovery Assistant training program and meet any continuing education and/or training requirements set by DMHAS.
Training requirement: Training programs will address abilities to:

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

Verification of Provider Qualifications

Entity Responsible for Verification:

Fiscal Intermediary under contract to DSS and DMHAS

Frequency of Verification:

At start of services and annually thereafter

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Specialized Medical Equipment

HCBS Taxonomy:

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

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

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

Service Definition *(Scope):*

Specialized Medical Equipment includes:
(a) Devices, controls, or appliances, specified in the plan of care, that enable participants to increase their ability to perform activities of daily living;
(b) Devices, controls, or appliances that enable the participant to perceive, control, or communicate with the environment in which they live;
(c) Items necessary for life support or to address physical conditions along with ancillary supplies and equipment necessary to the proper functioning of such items;
(d) Such other durable and non-durable medical equipment not available under the state plan that is necessary to address participant functional limitations; and
(e) Necessary medical supplies not available under the state plan.

Items reimbursed with waiver funds are in addition to any medical equipment and supplies furnished under the state plan and exclude those items that are not of direct medical or remedial benefit to the participant. All items shall meet applicable standards of manufacture, design and installation.

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

This service will be limited to $10,000 per waiver participant annually with prior authorization.

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

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**
- ☐ **Remote/via Telehealth**

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	Medical Equipment Vendor
Agency	DME

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Specialized Medical Equipment

Provider Category:

Agency

Provider Type:

Medical Equipment Vendor

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Meet the State of CT Standard to provide medical equipment or supplies for the Bureau of Rehabilitation Services (BRS), Department of Developmental Services (DDS), or Bureau of Education and Services for the Blind (BESB) or Medicaid provider for specialized medical equipment and supplies

Verification of Provider Qualifications

Entity Responsible for Verification:

Fiscal Intermediary under contract to DSS and DMHAS

Frequency of Verification:

At start of services

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Specialized Medical Equipment

Provider Category:

Agency

Provider Type:

DME

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Meet the State of CT Standard to provide medical equipment or supplies for the Bureau of Rehabilitation Services (BRS), Department of Developmental Services (DDS), or Bureau of Education and Services for the Blind (BESB) or Medicaid provider for specialized medical equipment and supplies

Verification of Provider Qualifications

Entity Responsible for Verification:

Fiscal intermediary under contract to DSS and DMHAS

Frequency of Verification:

At start of services

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Transitional Case Management

HCBS Taxonomy:

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

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

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

Service Definition *(Scope):*

Services provided to persons residing in institutional settings prior to their transition to the waiver to prepare them for discharge, or during the adjustment period immediately following discharge from an institution to stabilize them in a community setting, and to assist them with other aspects of the transition to community life by helping them gain access to needed waiver and other state plan services, as well as medical, social, housing, educational and other services and supports, regardless of the funding source for the services or supports to which access is gained. Transitional Case Management may also be provided to individuals following admission to the waiver during periods of brief institutionalization to prepare for return to the community and to assure continuity of care. The state shall claim the cost of case management services provided to institutionalized persons prior to their transition to the waiver for a period not to exceed 180 days or following admission to the waiver during brief institutional stays for a period not to exceed 90 days.

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

Transitional Case Management services are limited to a period of 180 days of initial enrollment onto the waiver and 100 1/4 hour service units. For services provided during a brief institutionalization following enrollment onto the waiver, services are limited to a period of 90 days and 100 1/4 hour service units during a single episode of care. However, additional limitations on the volume and duration of these services may be specified in the waiver Recovery Plan approved by DMHAS and DSS.

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

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**
- ☑ **Remote/via Telehealth**

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: Other Service
Service Name: Transitional Case Management

Provider Category:

Agency

Provider Type:

Agency Provider

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Commission on Accreditation of Rehabilitation Facilities (CARF), The Joint Commission (TJC) or other accrediting body approved by DMHAS, or can demonstrate to the satisfaction of DMHAS that it is in the active process of becoming accredited by any of theses approved entities.

Other Standard *(specify):*

Transitional Case Management staff shall hold either a bachelor's degree in a behavioral health-related specialty (may include special education or rehabilitation) OR have two years' experience in the provision of mental health services (may include special education and/or services to persons with developmental disabilities) OR be a Certified Peer Support and Recovery Professional.

Must be a fully credentialed provider of Community Support waiver service.

Verification of Provider Qualifications

Entity Responsible for Verification:

Fiscal intermediary under contract to DSS and DMHAS

Frequency of Verification:

At start of services and at recertification

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 section 1915(i) of the Act (HCBS as a State Plan Option).** *Complete*

item C-1-c.

☐ **As a Medicaid state plan service under section 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.*

☐ **As a Medicaid state plan service under section 1945 and/or section 1945A of the Act (Health Homes Comprehensive Care Management).** *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 and the requirements for their training on the HCBS settings regulation and person-centered planning requirements:

Care management is provided by Waiver Care Managers who complete assessments, develop service plans and monitor the effectiveness of the service plans.
The care management that is included as a waiver service is limited to transitional case management.

d. Remote/Telehealth Delivery of Waiver Services. Specify whether each waiver service that is specified in Appendix C-1/C-3 can be delivered remotely/via telehealth.

Service
Community Support Program
Peer Support
Recovery Assistant
Transitional Case Management

1. Will any in-person visits be required?

◉ **Yes.**

○ **No.**

2. *By checking each box below, the state assures that it will address the following when delivering the service remotely/via telehealth.*

☑ **The remote service will be delivered in a way that respects privacy of the individual especially in instances of toileting, dressing, etc.** ***Explain:***

Telehealth for these services is provided via telephone call, and any monitoring of I/ADLs is done with verbal prompts and cues by the provider and receiving the participant's verbal response of what was completed.

☐ **How the telehealth service delivery will facilitate community integration.** ***Explain:***

☑ **How the telehealth will ensure the successful delivery of services for individuals who need hands on assistance/physical assistance, including whether the service can be rendered without someone who is physically present or is separated from the individual.** ***Explain:***

In this waiver, telehealth is only approved for use on a temporary basis should an urgent or emergent barrier to face-to-face service provision of Community Support Program, Peer Supports, Recovery Assistant or Transitional Case Management services arise, such as an infestation in the home, contagious illness/global pandemic, etc. In this scenario, the provision of telehealth services must be approved in advance by the Waiver Care Manager and will be monitored closely to ensure that face-to-face services resume as soon as safely possible. Telehealth is a way to offer guidance and monitoring of health and safety when services would otherwise be paused altogether.

☑ **How the state will support individuals who need assistance with using the technology required for telehealth delivery of the service.** ***Explain:***

Telehealth of these waiver services is generally provided via phone contact with the waiver participant, so no technological assistance is needed.

☑ **How the telehealth will ensure the health and safety of an individual.** ***Explain:***

On this waiver, telehealth is only utilized in the event that face-to-face services cannot be safely provided. Therefore, telehealth is a way to offer guidance and monitoring of health and safety via telephone when services would otherwise be paused altogether.

Appendix C: Participant Services

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

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

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

● **Yes. Criminal history and/or background investigations are required.**

Specify: (a) the types of positions (e.g., personal assistants, attendants) for which such investigations must be conducted; (b) the scope of such investigations (e.g., state, national); and, (c) the process for ensuring that mandatory investigations have been conducted. State laws, regulations and policies referenced in this description are available to CMS upon request through the Medicaid or the operating agency (if applicable):

DSS and DMHAS will require any person serving as a household employee (recovery assistant) to a participant in the waiver to submit to a State of Connecticut criminal background check. DSS will have the discretion to refuse payments for household employees performing services who have been convicted of a felony, as defined in section 53a-25 of the Connecticut General Statutes; larceny under sections 53a-119, 53a-122, 53a-123 and 53a-124 of the Connecticut General Statutes; or a violation under section 53a-290 to 53a-295, inclusive, of the Connecticut General Statutes involving vendor fraud, section 53-20 of the Connecticut General Statutes involving cruelty to persons, sections 53a-70, 53a-70a, 53a-70b, or 53a-73a of the Connecticut General Statutes involving sexual assault, section 53a-59 of the Connecticut General Statutes involving assault, section 53a-59a of the Connecticut General Statutes involving assault of an elderly, blind, disabled, or pregnant person or a person with intellectual disability and section 53a-320 to 53a-323, inclusive, of the Connecticut General Statutes involving abuse of an elderly, blind, disabled, or pregnant person or a person with intellectual disability.

The review is carried out by the fiscal intermediary as a part of consideration for employment; the FI will process background checks for household employee applicants upon submission of a provider application. The nature of the criminal activity will be revealed by the background check, including, but not limited to, check fraud, theft, abuse, or assault and may result in the disqualifications from enrollment or continued enrollment in the waiver program and consideration for employment by any waiver participant. DMHAS will conduct an annual audit involving a sample of FI records to ensure criminal background checks and other required documents are on file.

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; (c) the process for ensuring that mandatory screenings have been conducted; and (d) the process for ensuring continuity of care for a waiver participant whose service provider was added to the abuse registry. 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 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 or regulations to care for another person (e.g., the parent (biological or adoptive) of a minor child or the guardian of a minor child who must provide care to the child). At the option of the state and under extraordinary circumstances specified by the state, payment may be made to a legally responsible individual for the provision of personal care or similar services. *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 types of legally responsible individuals who may be paid to furnish such services and the services they may provide; (b) the method for determining that the amount of personal care or similar services provided by a legally responsible individual is ***"extraordinary care"***, exceeding the ordinary care that would be provided to a person without a disability or chronic illness of the same age, and which are necessary to assure the health and welfare of the participant and avoid institutionalization; (c) the state policies to determine that the provision of services by a legally responsible individual is in the best interest of the participant; (d) the state processes to ensure that legally responsible individuals who have decision-making authority over the selection of waiver service providers use substituted judgement on behalf of the individual; (e) any limitations on the circumstances under which payment will be authorized or the amount of personal care or similar services for which payment may be made; (f) any additional safeguards the state implements when legally responsible individuals provide personal care or similar services; and, (g) the procedures that are used to implement required state oversight, such as ensuring 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.*

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 types of relatives/legal guardians to whom payment may be made, the services for which payment may be made, the specific circumstances under which payment is made, and the method of determining that such circumstances apply. Also specify any limitations on the amount of services that may be furnished by a relative or legal guardian, and any additional safeguards the state implements when relatives/legal guardians provide waiver services. Specify the state policies to determine that that the provision of services by a relative/legal guardian is in the best interests of the individual. When the relative/legal guardian has decision-making authority over the selection of providers of waiver services, specify the state's process for ensuring that the relative/legal guardian uses substituted judgement on behalf of the individual. Specify the procedures 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.*

  Payment to relatives for furnishing Recovery Assistant services must be approved by the Waiver Care Manager. The Waiver Care Manager evaluates whether provision of services by a family member is in the best interest of the participant. The state does not pay legally liable relatives or relatives of Conservators of Person (COP) or Conservators of Estate (COE) to provide care. The participant or their conservator must sign timesheets to confirm the dates and times services were performed. Family members must meet the same qualifications, including DMHAS required training, as unrelated providers. Any reported concerns regarding fraudulent billing are addressed as they would be with other service vendors (e.g., investigation, provider termination, etc.) Payment to family members is only made when the service provided is not a function that a family member would normally provide for the individual without charge as a matter of course in the usual relationship among members of a nuclear family and the service would otherwise need to be provided by a qualified provider.

  Non-Medical Transportation may also be provided by relatives, as individual providers, as long as they meet the provider qualifications as outlined in Appendix C-3, and the service is specified in the Recovery Plan and authorized by the Waiver Care Manager.

  Recovery Assistant and Non-Medical Transportation are the only waiver services that can be provided by a relative.

- **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:

Open enrollment is applied to all providers of waiver services. DSS and DMHAS jointly contract with a fiscal intermediary to conduct outreach activities in order to increase awareness of the Mental Health waiver program within the provider community and to recruit qualified providers to serve waiver participants. Recruitment activities include: 1) describing the purpose of the waiver, services to be covered, and expectations for the performance of those services; 2) promoting awareness among potential providers regarding the open enrollment opportunity; 3) sharing details about how to apply; and 4) specifying provider certification requirements.

DMHAS establishes qualifications for each provider type. The fiscal intermediary will accept applications from any provider who seeks to provide waiver service(s). The fiscal intermediary will complete the review of the provider qualifications. Any provider applicant who submits proper documentation of qualifications to perform a particular waiver service will be enrolled and certified to perform that service. Provider application and all related instructions will be available for download on the FI website. The provider is given a specific list of accompanying required documentation with their provider enrollment application. FI staff attempt to make the process as efficient as possible and provide providers with assistance during the enrollment process.

All waiver service providers hold Medicaid provider agreements directly with the state.

g. State Option to Provide HCBS in Acute Care Hospitals in accordance with Section 1902(h)(1) of the Act. Specify whether the state chooses the option to provide waiver HCBS in acute care hospitals. *Select one*:

- ○ **No, the state does not choose the option to provide HCBS in acute care hospitals.**
- ● **Yes, the state chooses the option to provide HCBS in acute care hospitals under the following conditions.** *By checking the boxes below, the state assures:*
  - ☑ **The HCBS are provided to meet the needs of the individual that are not met through the provision of acute care hospital services;**
  - ☑ **The HCBS are in addition to, and may not substitute for, the services the acute care hospital is obligated to provide;**
  - ☑ **The HCBS must be identified in the individual's person-centered service plan; and**
  - ☑ **The HCBS will be used to ensure smooth transitions between acute care setting and community-based settings and to preserve the individual's functional abilities.**

*And specify:***(a) The 1915(c) HCBS in this waiver that can be provided by the 1915(c) HCBS provider that are not duplicative of services available in the acute care hospital setting;(b) How the 1915(c) HCBS will assist the individual in returning to the community; and(c) Whether there is any difference from the typically billed rate for these HCBS provided during a hospitalization. If yes, please specify the rate methodology in Appendix I-2-a.**

Transitional Case Management services may be provided in an acute care setting for brief periods in order to assist the individual in transitioning back to the community. The staff will coordinate discharge planning with acute care staff and assure continuity of care for the return home. There is no difference in the billing rate during a hospitalization.

Appendix C: Participant Services

Quality Improvement: Qualified Providers

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

a. Methods for Discovery: Qualified Providers

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

i. Sub-Assurances:

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

Performance Measures

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

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

Performance Measure:
Number of approved provider applications, by provider type, that satisfied all licensure and/or certification standards as outlined in the application at time of re-credentialing, divided by the total number of approved provider applications with license/certification requirement due for re-credentialing during audit period.

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: Fiscl Intermediary	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Number of providers that conducted background checks as required by the state, divided by the total number of providers required to conduct background checks

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 of approved provider applications , by provider type, that satisfied all initial

licensure and/or certification standards as outlined in the application prior to provision of services, divided by the total number of approved provider applications with license/certification requirement

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**

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

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

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

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

Performance Measure:
Number of approved applications for non-licensed/non-credentialed providers, by provider type, who satisfied requirements at time of re-credentialing as outlined in the application, divided by the total number of approved provider applications with license/certification requirement due for re-credentialing during audit period.

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: 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 of approved applications for non-licensed/non-credentialed providers, by provider type, who met initial Waiver provider qualification, divided by total number of approved applications for non-licensed/non-credentialed providers

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

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

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☑ **Other** Specify: 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:
Number of approved providers, by provider type, that meet provider training requirements, divided by total number of approved providers required to meeting training obligations

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

Data Aggregation and Analysis:

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

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the

state to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the state's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction and the state's method for analyzing information from individual problems, identifying systemic deficiencies, and implementing remediation actions. In addition, provide information on the methods used by the state to document these items.

Waiver leadership staff from DSS, DMHAS, and the FI meet at least quarterly to review operational issues. At this time any questions or issues raised through monitoring and monthly/quarterly reporting are addressed. When provider issues are identified, qualified providers are required to submit a plan of correction with timeframes for completion. If a provider continues to have less than acceptable performance they can be put on enhanced monitoring, can be prohibited from serving any new participants until their performance has reached an acceptable level of quality, can lose their status as a qualified provider for the service(s) with less than acceptable quality, and/or can be removed as a qualified provider altogether.

ii. Remediation Data Aggregation

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

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

c. Timelines

When the state does not have all elements of the quality improvement strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Qualified Providers that are currently non-operational.

◉ **No**

○ **Yes**

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

Appendix C: Participant Services

C-3: Waiver Services Specifications

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

Appendix C: Participant Services

C-4: Additional Limits on Amount of Waiver Services

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

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

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

☐ **Limit(s) on Set(s) of Services.** There is a limit on the maximum dollar amount of waiver services that is authorized for one or more sets of services offered under the waiver.
Furnish the information specified above.

☐ **Prospective Individual Budget Amount.** There is a limit on the maximum dollar amount of waiver services authorized for each specific participant.
Furnish the information specified above.

☐ **Budget Limits by Level of Support.** Based on an assessment process and/or other factors, participants are assigned to funding levels that are limits on the maximum dollar amount of waiver services.
Furnish the information specified above.

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

The budget limit applies to the total waiver plan budget. Connecticut utilizes 125% of institutional care as a budgetary limit on the Mental Health waiver program. Participants are notified of budget limits during service planning/plan revision team meetings.

This limit applies to all waiver services.

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 in which 1915(c) HCBS are recieved. *(Specify and describe the types of settings in which waiver services are received.)*

At the time of submission, all provider owned and controlled settings that support waiver participants were reviewed, assessed, and determined to meet the HCB settings requirements in accordance with 42 CFR 441.301(c)(4)-(5) and associated CMS guidance. This includes all of the settings in the HCBS program, as offered through this waiver. DSS continues to work with qualified providers to confirm continued compliance across all DSS Medicaid settings and to ensure awareness of the settings rule expectations through numerous communications, trainings, and presentations. DSS staff work with providers to ensure participation in a continued and ongoing person-centered service planning process is occurring. A review of the person-centered plan is done at least annually and any time there is a significant status change or hospitalization. The level of care and psychosocial assessment are the functional assessment tools that cover multiple domains, including setting, choice and control. These assessments are completed with the participant annually and as needed.

The one exception is facility-based respite, which is excluded from assessment since this service is a time-limited service and therefore does not require an assessment of the settings in which it is provided. It is not the institutional nature of the setting that excludes the settings from site-specific assessment; it is the nature of time-limited respite service.

As part of the ongoing monitoring process to measure and document that a provider setting is meeting and continues to meet all settings criteria as outlined in the HCBS final rule, DSS will look at all settings-based criteria, including, but not limited to: how settings establish opportunities for individuals to participate in services and/or activities in the community, outside the walls of the setting; how settings ensure that participants are made aware of these opportunities; how settings ensure that individuals can freely choose from these services and/or activities; and how these services and/or activities are consistent with individual needs, as noted in the person-centered service plan. Non-compliant providers will be expected to remediate identified issues in a timely manner and document that all issues are addressed in order to continue to provide HCBS.

For individual, privately-owned homes, the state will monitor compliance of this category with HCB settings requirements over time through the level of care assessment, which includes questions asked of the participant about their home on an annual and ongoing basis and is conducted during a home visit.

Regarding residential care homes, RCHs in general are not required to meet the HCB settings rule but they are required to meet the rule if a waiver participant resides in the home. At this time, all RCHs with waiver participants are compliant and will be monitored annually at a minimum and subject to visits and compliance checks upon complaints from other state agencies, members, or families.

Case manager on-site touch point meetings will be used as the primary source to determine directly from members if they are residing in privately-owned settings that are institutional in nature. If identified, these providers will be non-compliant providers and will be expected to remediate identified issues in a timely manner and document that all issues are addressed in order to continue to provide HCBS. This may be done through a Corrective Action Plan or the enhanced monitoring process.

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 in the future as part of ongoing monitoring. *(Describe the process that the state will use to assess each setting including a detailed explanation of how the state will perform on-going monitoring across residential and non-residential settings in which waiver HCBS are received.)*

DSS has a continuous process to work with qualified providers to ensure continued compliance with CMS' final rule on HCB settings. The Department conducts assessments, audits, and unannounced visits of all providers to ensure compliance.

3. *By checking each box below, the state assures that the process will ensure that each setting will meet each requirement:*

☑ **The setting is integrated in and supports full access of individuals receiving Medicaid HCBS to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community, to the same degree of access**

as individuals not receiving Medicaid HCBS.

☑ **The setting is selected by the individual from among setting options including non-disability specific settings and an option for a private unit in a residential setting. The setting options are identified and documented in the person-centered service plan and are based on the individual's needs, preferences, and, for residential settings, resources available for room and board.** ***(see Appendix D-1-d-ii)***

☑ **Ensures an individual's rights of privacy, dignity and respect, and freedom from coercion and restraint.**

☑ **Optimizes, but does not regiment, individual initiative, autonomy, and independence in making life choices, including but not limited to, daily activities, physical environment, and with whom to interact.**

☑ **Facilitates individual choice regarding services and supports, and who provides them.**

☑ **Home and community-based settings do not include a nursing facility, an institution for mental diseases, an intermediate care facility for individuals with intellectual disabilities, a hospital; or any other locations that have qualities of an institutional setting.**

Provider-owned or controlled residential settings. (*Specify whether the waiver includes provider-owned or controlled settings*.)

○ **No, the waiver does not include provider-owned or controlled settings.**

● **Yes, the waiver includes provider-owned or controlled settings.** (By checking each box below, the state assures that each setting, *in addition to meeting the above requirements, will meet the following additional conditions*):

☑ **The unit or dwelling is a specific physical place that can be owned, rented, or occupied under a legally enforceable agreement by the individual receiving services, and the individual has, at a minimum, the same responsibilities and protections from eviction that tenants have under the landlord/tenant law of the state, county, city, or other designated entity. For settings in which landlord tenant laws do not apply, the state must ensure that a lease, residency agreement or other form of written agreement will be in place for each HCBS participant, and that the document provides protections that address eviction processes and appeals comparable to those provided under the jurisdiction's landlord tenant law.**

☑ **Each individual has privacy in their sleeping or living unit:**

- ☑ **Units have entrance doors lockable by the individual.**
- ☑ **Only appropriate staff have keys to unit entrance doors.**
- ☑ **Individuals sharing units have a choice of roommates in that setting.**
- ☑ **Individuals have the freedom to furnish and decorate their sleeping or living units within the lease or other agreement.**

☑ **Individuals have the freedom and support to control their own schedules and activities.**

☑ **Individuals have access to food at any time.**

☑ **Individuals are able to have visitors of their choosing at any time.**

☑ **The setting is physically accessible to the individual.**

☑ **Any modification of these additional conditions for provider-owned or controlled settings, under § 441.301(c)(4)(vi)(A) through (D), must be supported by a specific assessed need and justified in the person-centered service plan*(see Appendix D-1-d-ii of this waiver application).***

Appendix D: Participant-Centered Planning and Service Delivery

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

State Participant-Centered Service Plan Title:

Recovery 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. Given the importance of the role of the person-centered service plan in HCBS provision, the qualifications should include the training or competency requirements for the HCBS settings criteria and person-centered service plan development. *(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:

A licensed, or license eligible, mental health professional, including a registered nurse, psychologist, clinical social worker, marriage and family therapist, professional counselor, and psychiatrist, with at least three years experience.

Appendix D: Participant-Centered Planning and Service Delivery

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

b. Service Plan Development Safeguards. Providers of HCBS for the individual, or those who have interest in or are employed by a provider of HCBS; are not permitted to have responsibility for service plan development except, at the option of the state, when providers are given responsibility to perform assessments and plans of care because such individuals are the only willing and qualified entity in a geographic area, and the state devises conflict of interest protections. *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.** ***Explain how the HCBS waiver service provider is the only willing and qualified entity in a geographic area who can develop the service plan:***

(Complete only if the second option is selected) The state has established the following safeguards to mitigate the potential for conflict of interest in service plan development. *By checking each box, the state attests to having a process in place to ensure:*

☐ **Full disclosure to participants and assurance that participants are supported in exercising their right to free choice of providers and are provided information about the full range of waiver services, not just the services furnished by the entity that is responsible for the person-centered service plan development;**

☐ **An opportunity for the participant to dispute the state's assertion that there is not another entity or individual that is not that individual's provider to develop the person-centered service plan through a clear and accessible alternative dispute resolution process;**

☐ **Direct oversight of the process or periodic evaluation by a state agency;**

☐ **Restriction of the entity that develops the person-centered service plan from providing services without the direct approval of the state; and**

☐ **Requirement for the agency that develops the person-centered service plan to administratively separate the plan development function from the direct service provider functions.**

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.

Once an individual is deemed eligible for waiver services, but prior to actual enrollment, the individual will work with a Waiver Care Manager who will assist them in completing a person-centered assessment and developing an initial Recovery Plan. The participant will have the authority to determine who is included in the development of the Recovery Plan. Family, friends, and anyone of the individual's choosing may participate in developing the Recovery Plan. The individual will be informed of services which are available as part of the waiver and how the Recovery Plan will be used to guide all supports and services provided to them. Services and supports will be identified to meet the person's unique desires and needs, regardless of funding source and may include state plan services, general community resources, and natural support networks.

The Recovery Plan process will promote and encourage the person and those people who know and care for them to take the lead in directing this process and in planning, choosing, managing, and evaluating supports and services. The Recovery Plan process will offer people the opportunities to lead self-determined lifestyles and exercise greater control in their lives. The person will be viewed holistically to develop a plan of supports and services that is meaningful to them.

Appendix D: Participant-Centered Planning and Service Delivery

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

d. i. 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; (g) how and when the plan is updated, including when the participant's needs changed; (h) how the participant engages in and/or directs the planning process; and (i) how the state documents consent of the person-centered service plan from the waiver participant or their legal representative. State laws, regulations, and policies cited that affect the service plan development process are available to CMS upon request through the Medicaid agency or the operating agency (if applicable):

The Waiver Care Manager will be responsible for assisting the participant in developing the Recovery Plan. The Recovery Plan will outline in writing the services that will be provided to the participant to meet their identified needs, taking into account their individual strengths, capacities, preferences, and desired outcomes.

Prior to the development of the Recovery Plan, the Waiver Care Manager will complete an assessment of the participant. The assessment, at a minimum, will include the following components:

1. Psychosocial history including:
   a. behavioral health treatment history
   b. behavioral risk factors
   c. psychiatric symptoms and behaviors
   d. current mental status
   e. alcohol/drug history
   f. natural supports
   g. diagnosis

2. Functional Skills Assessment including:
   a. personal care
   b. independent living skills
   c. safety
   d. money management
   e. interpersonal communication skills
   f. health awareness
   g. coping skills
   h. cognitive functioning
   i. assessment of health care needs.

Once the assessment is completed, the Recovery Plan process will commence. Participants will develop their Recovery Plan with the Waiver Care Manager. The participant will have the authority to determine who is included in the development of the Recovery Plan. Family, friends, and anyone of the individual's choosing may participate in developing the Recovery Plan. The Waiver Care Manager will maximize the extent to which the individual participates by:

-Explaining the Recovery Plan process;
-Assisting the participant to explore and identify their preferences, strengths and capacities, desired outcomes, goals, and the services and supports that will assist them in achieving desired outcomes;
-Identifying and reviewing with the participant issues to be discussed during the Recovery Plan process;
-Providing information regarding the participant's choice to self-direct his or her care;
-Sharing the description of service information with participants so that they are informed about the array of supports that are available; and
-Giving each participant the opportunity to determine the location and time of planning meetings, participants attending the meetings, and frequency and length of the meetings.

The participant, with the assistance of family, friends, the Waiver Care Manager, and others of the individual's choosing will develop an initial Recovery Plan. The initial Recovery Plan will include identified strengths and barriers, the participant's desired goals, and specific short-term objectives. In addition, the Recovery Plan will include the specific services to be provided and the frequency, intensity and duration of services. The plan will identify all services and supports needed by the individual including services included in the Medicaid state plan as well as services offered by other state agencies, general community resources, and natural supports. It will also identify (when applicable) the specific organization that will be requested to offer more formal treatment and support services. Once the Recovery Plan is developed, the participant and/or their representative are asked to sign off on the plan indicating their approval and/or agreement with it.

The Waiver Care Manager will be responsible for monitoring the Recovery Plan semi-annually or more frequently if needed. The frequency with which monitoring will be performed may vary based on risk factors that are identified during the assessment and Recovery Plan development process and during subsequent reviews.

After the Recovery Plan has been developed and care plan costs generated, the Waiver Care Manager will review the cost sheet. The cost sheet will also be reviewed when the Recovery Plan is significantly revised.

ii. HCBS Settings Requirements for the Service Plan. *By checking these boxes, the state assures that the following will be included in the service plan:*

☑ **The setting options are identified and documented in the person-centered service plan and are based on the individual's needs, preferences, and, for residential settings, resources available for room and board.**

☑ **For provider owned or controlled settings, any modification of the additional conditions under 42 CFR § 441.301(c)(4)(vi)(A) through (D) must be supported by a specific assessed need and justified in the person-centered service plan and the following will be documented in the person-centered service plan:**

- ☑ **A specific and individualized assessed need for the modification.**
- ☑ **Positive interventions and supports used prior to any modifications to the person-centered service plan.**
- ☑ **Less intrusive methods of meeting the need that have been tried but did not work.**
- ☑ **A clear description of the condition that is directly proportionate to the specific assessed need.**
- ☑ **Regular collection and review of data to measure the ongoing effectiveness of the modification.**
- ☑ **Established time limits for periodic reviews to determine if the modification is still necessary or can be terminated.**
- ☑ **Informed consent of the individual.**
- ☑ **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 choose their services and their providers. It is imperative to accurately identify the services and supports that are needed to ensure the health and welfare of the waiver participant. During the service plan development process, the Waiver Care Manager, the participant and their representative, and any other person identified by the participant collaborate to assess individuals from a multidimensional perspective as well as any risk factors including: inadequate supervision, social isolation, cognitive impairment, fall risk, inability to summon assistance, emotional and behavioral issues, and communication capabilities. This information is used to provide the background necessary to identify areas of potential risk to the waiver participant.

When risk issues are identified, the Waiver Care Manager provides feedback to the waiver participant regarding the area(s) of concern. This allows the participant and the Waiver Care Manager to have a dialogue and exchange of ideas on how to mitigate the risk by developing a back up plan in collaboration with the participant and/or their representative. An Emergency Backup Plan identifies informal, in-kind support from family, friends, or neighbors, and formal support provided by the service agency. Each contracted agency is responsible for providing backup services for clients identified as being at risk in the absence of formal waiver services being provided for a specified period of time. All participants are reviewed for the need for a backup plan. The waiver participant has the right to accept, reject or modify recommendations that address risk.

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

Appendix D: Participant-Centered Planning and Service Delivery

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

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

During the development of the Recovery Plan, participants will select providers from a list prepared by the fiscal intermediary. DMHAS will maintain the list of waiver providers according to geographic areas within the state, and the list may vary by geographic area. The Community Support Clinician will describe the services available from providers on the list. Participants will choose providers from the list and their signature on the Recovery Plan acknowledges freedom of choice.

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):

DSS staff review 100% of all new service plans and must authorize them in order to initiate service. DSS staff also review all revisions of service plans resulting from annual re-evaluations. DSS Utilization Review Nurses match identified needs with services to ensure all health and safety needs are being met. DMHAS and DSS will determine if the cost of the waiver services necessary to ensure the participant's health and safety exceeds the cost limit established by the state.

DMHAS or its designee conducts a quarterly Quality Review of a randomly selected sample of Recovery Plans. The review includes the following:
-Completeness of plan which includes all necessary services (waiver and non-waiver services) being listed in terms of amount, frequency, duration and planned provider(s), including assurances of the consumers' freedom of choice of waiver and non-waiver providers;
-Consistency of the plan with assessment information regarding consumers' needs.

Summary reports including discovery and remediation are submitted quarterly to DSS for review and comment.

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, when the individual's circumstances or needs change significantly, or at the request of the individual, 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, participant health and welfare, and adherence to the HCBS settings requirements under 42 CFR §§ 441.301(c)(4)-(5); (b) the monitoring and follow-up method(s) that are used; and, (c) the frequency with which monitoring is performed.

Recovery Plan Implementation
The Waiver Care Managers are responsible for monitoring the implementation of the Recovery Plan and participant health and welfare. The Waiver Care Managers will contact the participant, and any organizations that are identified in the Recovery Plan to discuss implementation.

Monitoring of the Recovery Plan
The purpose of monitoring will be to ensure that waiver services are furnished in accordance with the Recovery Plan, meet the participant's needs and achieve their intended outcomes. Monitoring will also be conducted to identify any problems related to the participant's health and welfare that may require action.

The Waiver Care Manager will be responsible for monitoring the Recovery Plan semi-annually or more frequently if needed. The frequency with which monitoring will be performed may vary based on risk factors that are identified during the assessment and Recovery Plan development process and during subsequent reviews. The Waiver Care Manager will use interviews (e.g., with principal clinician), provider progress notes, chart reviews and other data to determine whether:
-Services are furnished in accordance with the Recovery Plan;
-Participants have access to waiver services identified in the Recovery Plan
-Services continue to meet the needs of the participant;
-Back-up plans are effective;
-Participant health and welfare is assured;
-Participants continue to be offered and exercise free choice of providers; and,
-Participants have access to non-waiver services identified in the Recovery Plan, including access to health services.

These semi-annual meetings will be face-to-face and include the participant, key providers and other individuals chosen by the participant. The meetings will also review the service implementation status, care efficacy, and participant progress. Participant safety, and health and welfare also will be reviewed. At these meetings, Recovery Plans will be adjusted congruent with consumer's needs.

The participant, caregiver(s), or service providers experiencing or identifying a problem with the implementation of a Recovery Plan will also immediately contact the participant's Waiver Care Manager. The Waiver Care Manager will then contact the participant, providers and/or caregiver(s) to assess the problem and strategize possible solutions. Solutions may include:
-Conducting a meeting to revise the Recovery Plan if the scope or amount of services are not appropriate for the participant
-Contacting the necessary providers regarding any engagement and performance issues.
-On-site reviews to assess and resolve any health and safety issues.

Recovery Plans are also reviewed as part of ongoing Quality Assurance efforts. Results are summarized as part of a Quarterly Quality Review report. Individual issues identified are brought to the attention of the DMHAS Waiver Manager for remediation as appropriate.

b. Monitoring Safeguard. Providers of HCBS for the individual, or those who have interest in or are employed by a provider of HCBS; are not permitted to have responsibility for monitoring the implementation of the service plan except, at the option of the state, when providers are given this responsibility because such individuals are the only willing and qualified entity in a geographic area, and the state devises conflict of interest protections. *Select one:*

- ○ **Entities and/or individuals that have responsibility to monitor service plan implementation, participant health and welfare, and adherence to the HCBS settings requirements may not provide other direct waiver services to the participant.**
- ● **Entities and/or individuals that have responsibility to monitor service plan implementation, participant health and welfare, and adherence to the HCBS settings requirements may provide other direct waiver services to the participant because they are the only the only willing and qualified entity in a geographic area who can monitor service plan implementation.** *(Explain how the HCBS waiver service provider is the only willing and qualified entity in a geographic area who can monitor service plan implementation).*

The waiver currently employs staff from state agencies, private non-profit organizations and staff that may have outside employment in agencies that may intersect with their work on the waiver. This therefore could pose a conflict of interest for staff. As a result, the program instituted an ethics policy that outlines acceptable practice within the waiver. Client choice is the guiding principal under which Mental Health waiver services are provided and staff may not direct participants to select services from an agency with whom the employee has a paid professional relationship. If a participant chooses services at an agency with whom an employee has such a relationship, they must clearly document the participant's choice in the client record with notification to their immediate supervisor.

Annually, staff will be required to review the policy and sign a statement attesting to their paid professional relationship with outside employers.

The fiscal intermediary will conduct quarterly audits of staff from private non-profit agencies as well as staff with dual employment relationships. The results of these audits will be shared with the Mental Health Waiver Manager for discussion during combined operating agency leadership meetings.

(Complete only if the second option is selected) The state has established the following safeguards to mitigate the potential for conflict of interest in monitoring of service plan implementation, participant health and welfare, and adherence to the HCBS settings requirements. *By checking each box, the state attests to having a process in place to ensure:*

☑ **Full disclosure to participants and assurance that participants are supported in exercising their right to free choice of providers and are provided information about the full range of waiver services, not just the services furnished by the entity that is responsible for the person-centered service plan development;**

☑ **An opportunity for the participant to dispute the state's assertion that there is not another entity or individual that is not that individual's provider to develop the person-centered service plan through a clear and accessible alternative dispute resolution process;**

☑ **Direct oversight of the process or periodic evaluation by a state agency;**

☑ **Restriction of the entity that develops the person-centered service plan from providing services without the direct approval of the state; and**

☑ **Requirement for the agency that develops the person-centered service plan to administratively separate the plan development function from the direct service provider functions.**

Appendix D: Participant-Centered Planning and Service Delivery

Quality Improvement: Service Plan

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

a. Methods for Discovery: Service Plan Assurance/Sub-assurances

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

i. Sub-Assurances:

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

Performance Measures

For each performance measure the state will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

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

identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Number of participants who have Recovery Plans that are adequate and appropriate to their needs as addressed in the assessment, including health and safety risk factors, divided by total number of approved Recovery Plans in effect during audit period

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 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:

Performance Measure:
Number of participant case records that include a risk mitigation strategy, divided by total number of active cases during audit period

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 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:

Performance Measure:
Number of Recovery Plans that address participant identified goals, divided by total number of approved Recovery Plans effective during audit period

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

Responsible Party for data collection/generation*(check*	**Frequency of data collection/generation***(check*	**Sampling Approach** *(check each that*

each that applies):	*each that applies):*	*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 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**

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

b. ***Sub-assurance: Service plans are updated/revised at least annually, when the individual's circumstances or needs change significantly, or at the request of the individual.***

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 Recovery Plans that are updated/revised at least annually or when warranted by changes in participant needs, divided by total number of approved Recovery plans active during audit period

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**	☑ **Annually**	☐ **Stratified**

Specify: Contracted Entity		Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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

Performance Measures

For each performance measure the state will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

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

Performance Measure:
Number and percentage of 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):
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 Agency	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

Performance Measure:
Number and percentage of waiver participants who report via HCBS CAHPS survey that their staff come to work on time. Numerator is number of survey respondents who report their staff come to work on time and denominator is number of participants who completed the HCBS CAHPS survey

Data Source (Select one):
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**	☐ **Annually**	☐ **Stratified**

Specify: Contracted Entity		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:

d. ***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:
Number of waiver participants with a signed recovery plan demonstrating a choice in providers, divided by number of recovery plans 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 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:

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

Performance Measures

For each performance measure the state will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

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

Performance Measure:
Number of recovery plans that are revised and signed, divided by number of recovery plans 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 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):*

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 Mental Health Waiver Manager or designated staff conducts record audits on a random sample of case records to ensure compliance with performance measures outlined in the waiver. Reviews are summarized in a Quarterly Quality Improvement Report. All Recovery Plans are submitted to the state Medicaid agency for authorization.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the state's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction and the state's method for analyzing information from individual problems, identifying systemic deficiencies, and implementing remediation actions. In addition, provide information on the methods used by the state to document these items.

The Mental Health Waiver Manager or designated staff notifies the Waiver Care Managers in writing of findings from record audits. Corrective actions are completed by the Waiver Care Managers within 30 days and results reported back to the Waiver Manager or designee.

ii. Remediation Data Aggregation

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

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

c. Timelines

When the state does not have all elements of the quality improvement strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of 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.

Appendix E: Participant Direction of Services

E-1: Overview (1 of 13)

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

The waiver will provide participant-directed options for individuals who choose to direct the development of their Recovery Plans and to have choice and control over the selection and management of Recovery Assistant and Overnight Recovery Assistant services. Individuals will have employer authority for those services they choose to self-direct.

The development of the Recovery Plan will be participant led. During the planning process, services and supports will be identified to meet the person's unique desires and needs, regardless of funding source and may include state plan services, generic resources, and natural support networks. At the time of the planning process, the Waiver Care Manager will ensure the person and/or representative has sufficient information available to make informed choices about the option to self-direct Recovery Assistant and Overnight Recovery Assistant services. The Waiver Care Manager will also ensure the individual has the information to make informed selections of qualified waiver providers. Waiver Care Managers will also notify individuals about their ability to change providers when they are not satisfied with a provider's performance.

Self-direction will be included in the Recovery Plan to the extent the individual and/or representative wishes to directly manage services and supports. Participants can self-direct individuals that provide Recovery Assistant and Overnight Recovery Assistant Services. Participants who choose to self-direct these services will be referred to a fiscal intermediary (FI) that will function as their agent to carry out the role of common-law employer. The participant will be the employer of record for employees hired to provide Recovery Assistant and/or Overnight Recovery Assistant Services and maintains the ability to select, schedule and supervise those workers.
The FI provides training and support to the participant, describing in detail the participant's responsibility as a household employer and reviews the roles of hiring, recruiting, supervising and managing the Recovery Assistant and Overnight Recovery Assistant. As part of this process the FI advises the participant of the potential liabilities associated with employer authority. Specific tasks performed by the FI include:

-Assist the participant to identify and recruit qualified employees that can provide these services;
-Developing a registry of individuals that provide these services;
-Developing an enrollment packet for individuals that will provide these services;
-Performing background checks on prospective individuals who will provide these services:
-Providing information and training materials to assist in employment and training of workers;
-Facilitating the meeting with the participant and the individual providing these services;
-Managing, on a monthly basis, all invoices from individual employees who provide Recovery Assistant services against the amount of services authorized in a participant's Recovery Plan;
-Developing fiscal accounting and expenditure reports; and
-Reporting on problems regarding participant-directed services to the Waiver Care Manager.

The FI will work on behalf of waiver participants for the purpose of managing the payroll task for the participant's employees who provide Recovery Assistant and/or Overnight Recovery Assistant services. In addition, the FI will be responsible to individuals that provide these services for the following activities:
-Withholding federal, state and local tax payments, including FICA and FUTA;
-Filing the necessary tax forms with the IRS and the State of Connecticut;
-Providing individuals with the necessary tax information on a timely basis;
-Filing and withholding state unemployment insurance tax; and
-Making payment for invoices submitted by individuals providing these services.

The FI does not provide any services directly. The FI service is delivered as an administrative cost to the state and is not included in individual budgets.

Appendix E: Participant Direction of Services

E-1: Overview (2 of 13)

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

- ◉ **Participant: Employer Authority.** As specified in ***Appendix E-2, Item a***, the participant (or the participant's representative) has decision-making authority over workers who provide waiver services. The participant may function as the common law employer or the co-employer of workers. Supports and protections are available for participants who exercise this authority.

- **Participant: Budget Authority.** As specified in ***Appendix E-2, Item b***, the participant (or the participant's representative) has decision-making authority over a budget for waiver services. Supports and protections are available for participants who have authority over a budget.
- **Both Authorities.** The waiver provides for both participant direction opportunities as specified in ***Appendix E-2***. Supports and protections are available for participants who exercise these authorities.

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

☑ **Participant direction opportunities are available to participants who live in their own private residence or the home of a family member.**

☐ **Participant direction opportunities are available to individuals who reside in other living arrangements where services (regardless of funding source) are furnished to fewer than four persons unrelated to the proprietor.**

☐ **The participant direction opportunities are available to persons in the following other living arrangements**

Specify these living arrangements:

Appendix E: Participant Direction of Services

E-1: Overview (3 of 13)

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

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

Specify the criteria

Appendix E: Participant Direction of Services

E-1: Overview (4 of 13)

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

The Waiver Care Managers and the fiscal intermediary will provide information to waiver participants regarding participant direction of Recovery Assistant and Overnight Recovery Assistant services. Individuals will be informed of participant-directed services during the assessment and Recovery Plan process. After completing the assessment, the Waiver Care Manager will coordinate the Recovery Plan process and provide a continuing source of supports to participants after the Recovery Plan has been developed. The members of the Recovery Plan team include the participant, the Waiver Care Manager and any other persons chosen by the participant. At this meeting, and in subsequent meetings to revise the Recovery Plan, the Waiver Care Manager will provide information to the participant regarding the opportunity to direct their own care and assume employer authority of Recovery Assistant and Overnight Recovery Assistant services. An individual may also have a representative do this on their behalf.

If an individual chooses to direct their own Recovery Assistant and/or Overnight Recovery Assistant services, they will be connected with the fiscal intermediary by the Waiver Care Manager. The FI will provide training to the participant and/or their representative regarding employer responsibilities and will provide step-by-step explanations that include examples of required forms. The FI describes in detail the participant's responsibility as a household employer and reviews the roles of hiring, recruiting, supervising and managing the Recovery Assistant. As part of this process, the FI will advise the participant of the potential liabilities associated with employer authority.

Appendix E: Participant Direction of Services

E-1: Overview (5 of 13)

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

○ **The state does not provide for the direction of waiver services by a representative.**

◉ **The state provides for the direction of waiver services by representatives.**

Specify the representatives who may direct waiver services: *(check each that applies)*:

☑ **Waiver services may be directed by a legal representative of the participant.**

☑ **Waiver services may be directed by a non-legal representative freely chosen by an adult participant.**
Specify the policies that apply regarding the direction of waiver services by participant-appointed representatives, including safeguards to ensure that the representative functions in the best interest of the participant:

Legal representatives and other representatives may be appointed by a waiver participant to assist them in directing certain services. These representatives will only assist individuals to manage participant-directed services. The appointment of the representative will be done during the Recovery Plan process or during their participation in the waiver. The Waiver Care Manager will review the participant's request for appointing a representative to assist with directing their care and ensure that this appointment does not present a conflict of interest. In addition, these representatives will not be allowed to provide a waiver service. Waiver recipients will be encouraged, but not required, to execute a limited power of attorney to allow other representatives to manage their participant-directed services.

Appendix E: Participant Direction of Services

E-1: Overview (6 of 13)

g. Participant-Directed Services. Specify the participant direction opportunity (or opportunities) available for each waiver service that is specified as participant-directed in Appendix C-1/C-3.

Waiver Service	Employer Authority	Budget Authority
Recovery Assistant	☑	☐
Overnight Recovery Assistant	☑	☐

Appendix E: Participant Direction of Services

E-1: Overview (7 of 13)

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

- (●) **Yes. Financial Management Services are furnished through a third party entity.** *(Complete item E-1-i).*

  Specify whether governmental and/or private entities furnish these services. *Check each that applies*:

  - ☐ **Governmental entities**
  - ☑ **Private entities**

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

Appendix E: Participant Direction of Services

E-1: Overview (8 of 13)

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

- ( ) **FMS are covered as the waiver service specified in Appendix C-1/C-3**

  The waiver service entitled:

- (●) **FMS are provided as an administrative activity.**

Provide the following information

i. Types of Entities: Specify the types of entities that furnish FMS and the method of procuring these services:

DSS and DMHAS will competitively procure the services of a fiscal intermediary to coordinate Recovery Assistants and Overnight Recovery Assistants.

ii. Payment for FMS. Specify how FMS entities are compensated for the administrative activities that they perform:

The fiscal intermediary will be paid quarterly for activities set forth in the contract with DSS and DMHAS. The fiscal intermediary is paid a flat rate for all services rendered which include administrative activity for provision of financial management services.

iii. Scope of FMS. Specify the scope of the supports that FMS entities provide *(check each that applies)*:

Supports furnished when the participant is the employer of direct support workers:

- ☑ **Assist participant in verifying support worker citizenship status**
- ☑ **Collect and process timesheets of support workers**
- ☑ **Process payroll, withholding, filing and payment of applicable federal, state and local employment-related taxes and insurance**
- ☑ **Other**

  Specify:

-Identifies and recruits individuals that can provide Recovery Assistant and Overnight Recovery Assistant services;
-Develops a registry of individuals that provide Recovery Assistant and Overnight Recovery Assistant services;
-Develops an enrollment packet for individuals that will provide Recovery Assistant and Overnight Recovery Assistant services;
-Performs background checks on prospective individuals who will provide Recovery Assistant and Overnight Recovery Assistant services:
-Provides information and training materials to assist in employment and training of workers, including problem solving, ongoing performance evaluation and termination;
-Facilitates the meeting with the participant and the individual providing Recovery Assistant and/or Overnight Recovery Assistant services;
-Manages, on a monthly basis, all invoices for Recovery Assistant and Overnight Recovery Assistant services against the amount of Recovery Assistant and Overnight Recovery Assistant services authorized in a participant's Recovery Plan; and
-Develops fiscal accounting and expenditure reports.

Supports furnished when the participant exercises budget authority:

- ☐ **Maintain a separate account for each participant's participant-directed budget**
- ☐ **Track and report participant funds, disbursements and the balance of participant funds**
- ☐ **Process and pay invoices for goods and services approved in the service plan**
- ☐ **Provide participant with periodic reports of expenditures and the status of the participant-directed budget**
- ☐ **Other services and supports**

Specify:

Additional functions/activities:

- ☐ **Execute and hold Medicaid provider agreements as authorized under a written agreement with the Medicaid agency**
- ☑ **Receive and disburse funds for the payment of participant-directed services under an agreement with the Medicaid agency or operating agency**
- ☐ **Provide other entities specified by the state with periodic reports of expenditures and the status of the participant-directed budget**
- ☐ **Other**

Specify:

iv. Oversight of FMS Entities. Specify the methods that are employed to: (a) monitor and assess the performance of FMS entities, including ensuring the integrity of the financial transactions that they perform; (b) the entity (or entities) responsible for this monitoring; and, (c) how frequently performance is assessed.

DSS and DMHAS will assess the performance of the functions that will be performed by the fiscal intermediary. The methods and frequency of this review are as follows:

1) The fiscal intermediary will provide DSS and DMHAS with quarterly and ad hoc reports
2) DSS and DMHAS will perform on-site administrative and operational reviews
3) DSS and DMHAS will attend trainings administered or approved by the fiscal intermediary to assess content and quality
4) DSS and DMHAS will collect information from participants and providers regarding the satisfaction with the fiscal intermediary's performance; this may include focus groups, phone and face-to-face interviews
5) Ongoing correspondence between the fiscal intermediary and DSS staff regarding progress on deliverables (e.g. claims processing).

Appendix E: Participant Direction of Services

E-1: Overview (9 of 13)

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

☐ **Case Management Activity.** Information and assistance in support of participant direction are furnished as an element of Medicaid case management services.

Specify in detail the information and assistance that are furnished through case management for each participant direction opportunity under the waiver:

☐ **Waiver Service Coverage.**

Information and assistance in support of participant direction are provided through the following waiver service coverage(s) specified in Appendix C-1/C-3 (check each that applies):

Participant-Directed Waiver Service	Information and Assistance Provided through this Waiver Service Coverage
Chore Services	☐
Mental Health Counseling	☐
Specialized Medical Equipment	☐
Home Accessibility Adaptations	☐
Home Delivered Meals	☐
Personal Emergency Response Systems	☐
Supported Employment	☐
Peer Support	☐
Community Support Program	☐
Recovery Assistant	☐

Participant-Directed Waiver Service	Information and Assistance Provided through this Waiver Service Coverage
Assistive Technology	☐
Brief Episode Stabilization	☐
Transitional Case Management	☐
Overnight Recovery Assistant	☐
Interpreter	☐
Adult Day Health	☐
Assisted Living	☐
Non-Medical Transportation	☐

☑ **Administrative Activity.** Information and assistance in support of participant direction are furnished as an administrative activity.

Specify (a) the types of entities that furnish these supports; (b) how the supports are procured and compensated; (c) describe in detail the supports that are furnished for each participant direction opportunity under the waiver; (d) the methods and frequency of assessing the performance of the entities that furnish these supports; and, (e) the entity or entities responsible for assessing performance:

The Waiver Care Manager, in DMHAS or under contract with DMHAS, will provide information to the waiver participant to support their efforts to direct their own services. This will occur during the initial Recovery Plan process and during reviews and updates to the plan. If the individual elects to direct their own services, they will be referred to the fiscal intermediary to provide employer-related services. These include:

-Identifying and recruiting individuals that can provide Recovery Assistant and Overnight Recovery Assistant services;
-Maintaining a registry of individuals that provide Recovery Assistant and Overnight Recovery Assistant services;
-Providing an enrollment packet for individuals that will provide Recovery Assistant and Overnight Recovery Assistant services;
-Performing background checks on prospective individuals who will provide Recovery Assistant and Overnight Recovery Assistant services:
-Providing information and training materials to assist in employment and training of workers;
-Facilitating the meeting with the participant and the individual providing Recovery Assistant and Overnight Recovery Assistant services;
-Managing, on a monthly basis, all invoices for Recovery Assistant and Overnight Recovery Assistant services against the amount of Recovery Assistant and Overnight Recovery Assistant services authorized in a participant's Recovery Plan; and
-Developing fiscal accounting and expenditure reports.

The fiscal intermediary will be competitively procured by DSS and DMHAS. DSS and DMHAS will review the performance of the fiscal intermediary on a quarterly basis. The methods and frequency of this review will be as follows:

-The fiscal intermediary will provide DSS and DMHAS quarterly ad hoc reports
-DSS and DMHAS will perform on-site administrative and operational reviews
-DSS and DMHAS will attend trainings administered or approved by the fiscal intermediary to assess content and quality
-DSS and DMHAS will collect information from participants and providers regarding the satisfaction with the fiscal intermediary's performance; this may include focus groups, phone and face-to-face interviews.

Appendix E: Participant Direction of Services

E-1: Overview (10 of 13)

k. Independent Advocacy *(select one).*

- ○ **No. Arrangements have not been made for independent advocacy.**
- ◉ **Yes. Independent advocacy is available to participants who direct their services.**

Describe the nature of this independent advocacy and how participants may access this advocacy:

DMHAS will refer individuals to independent organizations that will provide consultation, advocacy, resource facilitation, support, information, and training to waiver participants. Types of independent advocacy organizations include private non-profit agencies funded specifically to assist adults with serious mental illness access and utilize services to aid in their recovery. These organizations are intended to enable participants to advocate for themselves for access to services and supports. This will be provided through face-to-face and telephonic support as well as mailings and web-based information dissemination. The independent advocacy organization will be available by telephone and internet. The organizations providing the advocacy function will not provide direct services, perform assessments or have monitoring oversight or fiscal responsibilities.

Appendix E: Participant Direction of Services

E-1: Overview (11 of 13)

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

Participant direction of self-directed waiver services may be voluntarily terminated. All waiver services will be available through waiver agency providers. If a participant chooses to terminate self-direction, the Waiver Care Manager will aid in the identification of a provider agency to support the participant's needs. The Recovery Plan will be revised and the Waiver Care Manager will ensure linkages to the appropriate provider in a timely manner.

Appendix E: Participant Direction of Services

E-1: Overview (12 of 13)

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

Participant direction of self-directed waiver services may be involuntarily terminated when a participant does not demonstrate the ability to manage their Recovery Assistant. When an involuntary termination of participant-directed services occurs, the participant will be issued a Notice of Action and the individual has the right to a fair hearing pursuant to current DSS Medicaid rules. If a participant's self-direction is involuntarily terminated, the Waiver Care Manager will aid in the identification of a provider agency to support the consumer's need. The Recovery Plan will be revised and the Waiver Care Manager will ensure linkages to the appropriate provider in a timely manner.

Appendix E: Participant Direction of Services

E-1: Overview (13 of 13)

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

Table E-1-n

	Employer Authority Only	Budget Authority Only or Budget Authority in Combination with Employer Authority
Waiver Year	**Number of Participants**	**Number of Participants**
Year 1	8	
Year 2	10	
Year 3	15	
Year 4	20	
Year 5	25	

Appendix E: Participant Direction of Services

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

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

i. Participant Employer Status. Specify the participant's employer status under the waiver. *Select one or both*:

☐ **Participant/Co-Employer.** The participant (or the participant's representative) functions as the co-employer (managing employer) of workers who provide waiver services. An agency is the common law employer of participant-selected/recruited staff and performs necessary payroll and human resources functions. Supports are available to assist the participant in conducting employer-related functions.

Specify the types of agencies (a.k.a., agencies with choice) that serve as co-employers of participant-selected staff:

☑ **Participant/Common Law Employer.** The participant (or the participant's representative) is the common law employer of workers who provide waiver services. An IRS-approved Fiscal/Employer Agent functions as the participant's agent in performing payroll and other employer responsibilities that are required by federal and state law. Supports are available to assist the participant in conducting employer-related functions.

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

☑ **Recruit staff**

☐ **Refer staff to agency for hiring (co-employer)**

☑ **Select staff from worker registry**

☑ **Hire staff common law employer**

☐ **Verify staff qualifications**

☑ **Obtain criminal history and/or background investigation of staff**

Specify how the costs of such investigations are compensated:

The fiscal intermediary performs this function on behalf of the participant. The cost is included in their administrative reimbursement.

☐ **Specify additional staff qualifications based on participant needs and preferences so long as such**

qualifications are consistent with the qualifications specified in Appendix C-1/C-3.

Specify the state's method to conduct background checks if it varies from Appendix C-2-a:

☑ **Determine staff duties consistent with the service specifications in Appendix C-1/C-3.**
☐ **Determine staff wages and benefits subject to state limits**
☑ **Schedule staff**
☑ **Orient and instruct staff in duties**
☑ **Supervise staff**
☑ **Evaluate staff performance**
☑ **Verify time worked by staff and approve time sheets**
☑ **Discharge staff (common law employer)**
☐ **Discharge staff from providing services (co-employer)**
☐ **Other**

Specify:

Appendix E: Participant Direction of Services

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

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

Answers provided in Appendix E-1-b indicate that you do not need to complete this section.

i. Participant Decision Making Authority. When the participant has budget authority, indicate the decision-making authority that the participant may exercise over the budget. *Select one or more*:

☐ **Reallocate funds among services included in the budget**
☐ **Determine the amount paid for services within the state's established limits**
☐ **Substitute service providers**
☐ **Schedule the provision of services**
☐ **Specify additional service provider qualifications consistent with the qualifications specified in Appendix C-1/C-3**
☐ **Specify how services are provided, consistent with the service specifications contained in Appendix C-1/C-3**
☐ **Identify service providers and refer for provider enrollment**
☐ **Authorize payment for waiver goods and services**
☐ **Review and approve provider invoices for services rendered**
☐ **Other**

Specify:

Appendix E: Participant Direction of Services

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

b. Participant - Budget Authority

Answers provided in Appendix E-1-b indicate that you do not need to complete this section.

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

Appendix E: Participant Direction of Services

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

b. Participant - Budget Authority

Answers provided in Appendix E-1-b indicate that you do not need to complete this section.

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

Appendix E: Participant Direction of Services

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

b. Participant - Budget Authority

Answers provided in Appendix E-1-b indicate that you do not need to complete this section.

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

- **Modifications to the participant directed budget must be preceded by a change in the service plan.**
- **The participant has the authority to modify the services included in the participant directed budget without prior approval.**

Specify how changes in the participant-directed budget are documented, including updating the service plan. When prior review of changes is required in certain circumstances, describe the circumstances and specify the entity that reviews the proposed change:

Appendix E: Participant Direction of Services

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

b. Participant - Budget Authority

Answers provided in Appendix E-1-b indicate that you do not need to complete this section.

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

Appendix F: Participant Rights

Appendix F-1: Opportunity to Request a Fair Hearing

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

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

Applicants for and participants under this waiver may request and receive a fair hearing in accordance with the rules under DSS' Medicaid program. Applicants will receive a copy of the Informed Consent Form during the first visit with the Waiver Care Manager.

Participants are eligible for fair hearings in the following circumstances:

-Participant was not offered the choice of home and community-based services as an alternative to institutional care;
-DSS does not reach a determination of financial eligibility within standards of promptness;
-DSS denies the application for any reasons other than limitations on the number of individuals that can be served and/or funding limitations as established under this waiver;
-DSS denies the application for the individual not meeting the level of care or other eligibility criteria;
-DSS disapproves the individual's Recovery Plan;
-DSS denies or terminates a service of the individual's choice;
-DSS denies or terminates a payment to a provider of the individual's choice; or
-DSS discharges an individual from this waiver.

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

During the enrollment process, participants will be informed of their rights and provided information about the fair hearing and grievance processes. At that time, participants will be informed that, if they file a grievance or appeal, services will continue while the grievance or appeal is under consideration.

Notices of adverse action and forms for fair hearing requests are kept at the DSS alternate care unit and are sent to the participant in the case of an adverse determination. Fair hearing requests are submitted by the participant to the DSS Office of Administrative Hearings. The DSS Office of Legal Counsel, Regulations and Administrative Hearings retains all documentation pertaining to fair hearings.

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**

- **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.

Do not complete this item.

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**

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

Do not complete this item.

• **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).

Do not complete this item.

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).

Reporting and review of critical incidents is an important component of the ongoing evaluation and improvement of the quality of care and services offered under the waiver.

Critical incidents are defined as incidents that may have a serious or potential serious impact on waiver participants, staff, facilities, funded agencies, or the public or may bring about adverse publicity. The requirement to report a critical incident apply under the following circumstances: the incident involves a waiver participant and/or an agency or individual serving a waiver participant. The following events are considered critical incidents:

a. The death of a waiver participant, on-duty staff member, or visitor to the facility/agency, which is related to a critical incident, suicide, accident, unexplained circumstance or appearance of negligence, including client deaths that occur up to 30 days after discharge (from any program level), if known;
b. Any incident involving a waiver participant or the agency where it appears reasonable to expect that media coverage will or is likely to occur;
c. Threats by a waiver participant who has been assessed by agency staff to represent a serious risk to the staff, other clients, or others;
d. Any serious suicide attempt resulting in an admission to a medical/surgical inpatient unit or a psychiatric inpatient unit, including suicide attempts that occur up to 30 days after discharge (from any program level), if known;
e. Serious behaviors, that are committed or allegedly committed on or by waiver participants, on-duty staff, or visitors to a facility or program that have resulted or may result in a felony arrest, e.g., arson, assault, armed robbery, bomb threat, hostage taking, sexual assault, sale of illegal substances on program premises;
f. Allegations of client abuse, neglect, exploitation, injury, or violation of confidentiality that have serious consequences or potentially serious consequences;
g. Significant loss or allegations of theft of property or property damage that have or could compromise staff or participant safety; and
h. Emergency situations resulting in the notification of federal offices (e.g., FBI, U.S. Secret Service) in conformance with the incident reporting requirements of the respective agency.

All critical incidents will be reported, up to the Supervisor of the waiver provider agency and the DMHAS Mental Health Waiver Manager and/or designee. Such reporting will be the responsibility of the primary contact person of the agency providing the waiver service or individual providing self-directed waiver services.

Notification:

1. When a critical incident becomes known, verbal notification will be required to be provided by the agency primary contact person or individual providing self-directed waiver services to the Supervisor of the provider agency and the DMHAS Mental Health Waiver Manager and/or designee immediately upon discovery. Required information for the verbal and written/faxed notification is listed in Required Information for Notification section below.

2. All members of the Medicaid waiver participant's Recovery Plan team and service agency staff members will be required to report critical incidents.

Required Information for Notification:

1. Verbal notification minimally includes:
a. A brief description of the incident, including the date, time and place of occurrence;
b. Person(s) involved;
c. Action already taken and/or immediate follow-up steps planned; and
d. Any other information that may be of immediate significance or importance regarding the situation.

2.Written notification must be submitted within one business day and will be made using the Mental Health Waiver Critical Incident Report Form, and minimally includes the following information:
a. Waiver services and DMHAS program involved, as applicable;
b. Last time of services or program/participant contact;
c. Services participant was receiving at time of incident;
d. Date of incident;
e. Time of incident;
f. Location of incident;

g. Type of incident;
h. Name of person(s) involved in incident;
i. Role of involved person in terms of the incident, i.e., victim, alleged perpetrator, other;
j. Any injuries relating to the critical incident;
k. Immediate actions taken at incident and up to notification;
l. Brief narrative description of incident, including if charges and arrests have occurred; and
m. Name and title of person reporting incident.

Abuse and Neglect

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

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.

Waiver Care Managers will provide information to participants and their representatives at various times during their waiver tenure regarding the reporting of potential abuse, neglect and exploitation. Waiver Care Managers will provide written and verbal information regarding protections from abuse, neglect, and exploitation, including how participants can notify appropriate authorities or entities when the participant may have experienced abuse, neglect or exploitation during initial enrollment onto the waiver and during the annual re-assessment process. In addition, DMHAS will provide ongoing training and education to providers at the Provider Update meetings regarding identifying and reporting abuse, neglect or exploitation.

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

Critical Incident Review

1. Critical incidents will be reviewed by Mental Health waiver leadership staff within 21 days of the incident. This review will focus on causative factors and will, when indicated, result in the development of a corrective action plan that would reduce the risk of reoccurrence of a similar event.

2. The nature of a critical incident investigation and review may vary based upon the type and seriousness of the incident and/or the potential impact of the incident on the program and on the service recipients in general. Other factors that may influence the investigation and review will be the context within which the incident occurred, such as the program's recent history of critical incidents, previously identified issues or trends, the individual client's history, etc. However, all critical incident reviews, at a minimum, will address the following areas:

a. Factual description of the incident, including persons involved, date, time and location;
b. Context in which the incident occurred, including precipitating and contributing factors;
c. A review of possible root causes of the incident,
d. Actions taken at time of the incident; and
e. Impact of incident upon persons, program, system, etc.

Incident Review Closure
Within 15 days following the critical incident review(s), the completed critical incident review, conveying the outcome of the review and the corrective action plan proposed, will be presented to the waiver leadership team. At a minimum, the report will include the following information:

a. Incident date
b. Date of critical incident review;
c. Brief summary of the findings of the review;
d. Corrective action plan with date(s) to be completed; and
e. The recommended date of incident closure.

The DMHAS Waiver Manager and/or designee will review the critical incident review report, the corrective action plan and recommended date of incident completion. Findings will be summarized in the quarterly QA report forwarded to DSS and presented to the Quarterly Waiver Advisory Council. Where indicated, participants (or family or legal representative as appropriate) and other relevant parties will be informed of the outcomes of the investigation/ incident review.

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.

DMHAS will be responsible for overseeing the reporting and response to all critical incidents or events that affect waiver participants.

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 client, community provider or private citizen can report to Mental Health waiver staff the suspected use of restraints or seclusion. Suspected use of restraints or seclusion which occurs in the home or community is considered a reportable incident and would be investigated according to the protocol as noted above.
Waiver Care Manager visits, observations and interviews are an additional methodology utilized to detect any suspected use of restraints or seclusion.

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

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

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

Appendix G: Participant Safeguards

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

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

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

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

At any time, a client, community provider or private citizen can report to Mental Health waiver staff the suspected use of restraints or seclusion. Suspected use of restraints or seclusion which occurs in the home or community is considered a reportable incident and would be investigated according to the protocol as noted above.
Waiver Care Manager visits, observations and interviews are an additional methodology utilized to detect any suspected use of restraints or seclusion.

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

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

ii. State Oversight Responsibility. Specify the state agency (or agencies) responsible for monitoring and

overseeing the use of restrictive interventions and how this oversight is conducted and its frequency:

Appendix G: Participant Safeguards

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

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

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

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

  At any time, a client, community provider or private citizen can report to Mental Health waiver staff the suspected use of restraints or seclusion. Suspected use of restraints or seclusion which occurs in the home or community is considered a reportable incident and would be investigated according to the protocol as noted above.
  Waiver Care Manager visits, observations and interviews are an additional methodology utilized to detect any suspected use of restraints or seclusion.

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

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

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

Appendix G: Participant Safeguards

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

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

a. Applicability. Select one:

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

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

- **Medication Management and Follow-Up**

Do not complete this section

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)*

- **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).

- **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:

- **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 state's quality improvement strategy, provide information in the following fields to detail the state's 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.

i. Sub-Assurances:

a. ***Sub-assurance: The state demonstrates on an ongoing basis that it identifies, addresses and seeks to prevent instances of abuse, neglect, exploitation and unexplained death.***

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 case records that include a risk mitigation strategy, divided by total number of active clients during audit period

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 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**

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

Performance Measure:
Number of participants who received information about how to identify and report abuse, neglect, and exploitation, divided by total number of active clients during audit period

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 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:

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 of critical incidents reviewed by DMHAS within required time frame that comply with critical incident reporting process and standards in Appendix G-1b of Waiver application, divided by number of critical incidents received during reporting period

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 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: Contracted Entity	☐ **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 participants assessed who reported the use of restrictive interventions, restraints and/or seclusion were not used. Numerator: number of participants assessed who reported the use of restrictive interventions, restraints and/or seclusion were not used. Denominator: number of assessments complete

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 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 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):*

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 of waiver participants whose plan of care includes intervention(s) for age-appropriate preventive health care, divided by total number of active participants during audit period

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 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:

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.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the state's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction and the state's method for analyzing information from individual problems, identifying systemic deficiencies, and implementing remediation actions. In addition, provide information on the methods used by the state to document these items.

When incidents are brought to the attention of the DMHAS Waiver Manager or designee, he/she will consult with the Waiver Care Manager who is monitoring the participants Recovery Plan to assure appropriate services are in place and at the scope and frequency necessary to assure health and safety. If additional services are required, the Waiver Care Manager will make needed changes to the Recovery Plan. The incident review process will investigate possible causes of the incident

and request corrective action as indicated. Corrective actions will be made as soon as possible.
Waiver leadership staff from DSS, DMHAS, and the FI meet at least quarterly to review operational issues. At this time any questions or issues raised through monitoring and monthly/quarterly reporting are addressed.

ii. Remediation Data Aggregation

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

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

c. Timelines

When the state does not have all elements of the quality improvement strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of 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 Section 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 (QIS) 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 QIS is not fully developed at the time the waiver application is submitted, the state may provide a work plan to fully develop its QIS, 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 QIS 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 QIS. 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.

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

Administrative Authority

The Department of Social Services, as the state Medicaid Agency, is responsible for directly administering or overseeing all Waiver functions. The CT Department of Mental Health and Addiction Services is the operating agency under the supervision of DSS as outlined in a Memorandum of Understanding. DSS ensures that all waiver operational and administrative functions are performed in accordance with the requirements set forth in this waiver. DSS conducts initial and annual reviews of plans to evaluate compliance with Waiver requirements regarding Level of Care determinations and re-determinations; individual choice between HCBS and institutional services; assessment and service planning.

As part of the ongoing Quality Management Strategy for the Waiver, an Advisory Council was developed and meets biannually. Membership includes service recipients, family members, service providers and representatives from DSS and DMHAS. The purpose of the Waiver Advisory Council is to provide opportunity for input from individuals and families receiving waiver supports and services as well as other interested parties, to review key quality findings and data trends in order to make recommendations for system improvement. The Council also reviews and offer input for the annual Quality Improvement Plan.

DSS and DMHAS jointly contracts with a fiscal intermediary to conduct provider recruitment, training, engage in fiscal monitoring, claims processing and reporting. Quarterly reports, at a minimum are submitted to the Departments to facilitate state oversight of the waiver program.

DSS, DMHAS, and the FI meet at least quarterly to review operational issues. At this time any questions or issues raised through monitoring and monthly reporting are addressed.

Level of Care

Applicants are screened for eligibility using the Nursing Facility LOC Screening W1506-MH. This initial level of care determination is verified through face to face assessment by a licensed, or licensed eligible Waiver Care Manager. The level of care assessment is based on information obtained from the individual, medical reports from their physician(s) and any other clinical providers. DMHAS has standardized the use of program forms that collect information necessary to determine reasonable indication of applicant eligibility. The Waiver Care Managers conduct annual reassessments using the same process used to determine eligibility. DMHAS tracks annual due dates using an internal data base.
DSS verifies and authorizes 100% of initial and annual LOC and recovery plans submitted prior to service delivery.

DMHAS audits 100% of records for completeness to assure all tools are utilized to make LOC determinations as well as for timeliness to assure they were completed within timeframes required. Remediation is ongoing and continuous. Findings from the case record check list are summarized and incorporated into the quarterly Quality Improvement Report for review.

Qualified Providers

DSS and DMHAS jointly engage a Fiscal Intermediary who is contractually obligated to credential waiver service providers and assure they meet criteria set forth in the program regulations and all applicable state and federal regulations, and establish provider contracts that meet all the criteria set forth in the DSS's Provider Agreement Guidelines. All providers complete the standard DSS Medicaid Performing Provider Agreement. The FI provides monthly and quarterly reports to DSS and DMHAS, documenting the credentialing process, Provider Performance Measures, and ongoing provider audits and site visits.

DMHAS will incorporate an expanded administrative review of audits to include verification that licensure, certification and qualifications are monitored and documented as required through contracts, policies and procedures.

Service Plan

The Waiver Care Manager completes a series of individual assessments to identify participants' needs and preferences, including health and safety risk factors. This culminates in development of a comprehensive Recovery Plan that outlines the type, amount, duration and frequency of services provided, and participant selection of provider. Waiver Care Managers review Recovery Plans with participants every six months, or more frequently if needed, to assure services are furnished in accordance with the Recovery Plan, meet the participant's needs and achieve their intended outcomes.

DSS Utilization Review Nurse reviews 100% of all new recovery plans and must authorize them in order to initiate service. The DSS Utilization Review Nurse matches needs with services to ensure all health and safety needs are being met.

As part of the DMHAS Quality Assurance Program a designated QA specialist conducts ongoing record reviews to assess appropriateness of Recovery Plans and to assure they are based on skills assessments and reflect the needs and preferences of participants and to ensure compliance with CMS requirements outlined in the approved waiver. Audits are submitted to the DMHAS Mental Health Waiver Manager or designee for review and remediation as necessary. Audits are summarized as part of a Quarterly Quality Improvement Report and submitted to DSS for review at the DSS/DMHAS Quarterly QA meeting. In addition; the Fiscal Intermediary conducts random encounter note and monthly progress note audits to ensure provider adherence to Recovery Plans. The FI also provide a report of all waiver service providers' compliance with documentation requirements (i.e. submit monthly notes by required deadline). These activities are summarized in monthly reports submitted to DSS and DMHAS.

Health and Welfare

Critical Incidents are tracked as part of the Mental Health Waiver Quality Assurance Program. A Critical Incident Log is utilized to record and monitor any critical incidents relative to safety and overall well-being of participants. Incidents reported are reviewed to identify any potential trends and identify potential need for remediation and improvement. These activities are summarized and included in the Quarterly Quality Improvement Report submitted to DSS for review at the DSS/DMHAS Quarterly QA meeting. In addition, DMHAS and DSS through their contract Fiscal Intermediary provide training and education to its providers regarding identifying and reporting abuse and neglect. This training is provided to both participant directed and non participant directed providers. As part of their Provider Agreement all waiver service providers agree to report critical incidents.

Financial Accountability

The State of Connecticut contracts with a Medicaid Management Information System (MMIS) to provide claims processing function to ensure reimbursement consistent with waiver requirements. The DSS provider relations unit oversees the contract with the State's MMIS contractor, as part of the medical operations process. They can make changes to procedure codes, edits and audits. Clients are identified by Medical Eligibility or Benefit Plan code. Providers are based on type and specialty. The system is designed to make sure it can be billed only for what is allowed through the edits and audits system.

DSS and DMHAS jointly engage a Fiscal Intermediary to maintain the authorizations on services received and billed under the waiver. The fiscal intermediary submits appropriate claims to the State's MMIS contractor for processing as required that are not billed by Provider Agency directly. The fiscal intermediary ensures that all billed services are within a participant's approved Recovery Plan.

DSS and DMHAS have also implemented Electronic Visit Verification through Sandata to be utilized with face-to-face Mental Health waiver services as another measure of accountability.

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: Fiscal Intermediary	☑ **Other** Specify: Critical Incident Review - ongoing

b. System Design Changes

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

The DMHAS waiver leadership team is responsible for trending, prioritizing, and recommending improvement strategies and system changes prompted as a result of analysis of auditing and remediation information.

The DMHAS waiver leadership team meets at least weekly and is comprised of leadership from the DMHAS Division of Statewide Services as well as representatives from the fiscal intermediary dedicated to waiver operations. The purpose of this group is to monitor compliance with the six HCBS waiver assurances and other federal, state, and agency requirements. Their responsibilities include a routine administrative review of key organizational and programmatic issues and data trends associated with the department's quality management system in order to determine and/or recommend changes in agency policy, program, infrastructure, and funding levels. The DMHAS waiver leadership team ensures that all changes in program and practice are appropriately reflected in the agency policy, procedure, and operations manuals and communicated to stakeholders. This group works in conjunction with DSS to make final decisions on improvement and implementation strategies. The group will review findings from quality audits, critical incidents and FI reports to monitor compliance with waiver assurances. Discovery data and the progress and success of remediation strategies from various reports outlined in Appendices A, B, C, D, G, and I will be aggregated and shared at least quarterly as part of the ongoing QA/QI strategy. Findings will be presented as a quarterly Quality Improvement Report and procedural changes implemented as appropriate by the waiver leadership staff. This will be shared with the Waiver Advisory Council.

ii. Describe the process to periodically evaluate, as appropriate, the quality improvement strategy.

Evaluation of the Quality Improvement Strategy is continuous and ongoing. As reports from the FI are generated on all of the aggregated, analyzed data, they are scrutinized for trends and potential process improvements.

Waiver leadership staff from DSS, DMHAS, and the FI meet at least quarterly to review operational issues. At this time any questions or issues raised through monitoring and monthly/quarterly reporting are addressed.

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 Medicaid Management Information System (MMIS) contractor to serve as the claims payment subcontractor for waiver and state plan services. The state's MMIS contractor reviews claims for Medicaid eligibility and other elements (e.g. spend-down requirements) before reimbursing providers. Any claims paid by the fiscal intermediary for waiver services will be submitted to the state's MMIS for adjudication and are subject to the same financial audit requirements as for other waiver services. The DSS Office of Quality Assurance (QA) conducts financial audits of Medicaid providers and issues exceptions when it identifies areas of non-compliance with the state's policy requirements. All waiver providers are subject to audits performed by the QA Office. Overall audit demands and audit resources available to DSS QA impact the frequency of audit of waiver providers. The frequency of audits is determined by DSS' Director of Quality Assurance who oversees audits for the Department's programs. There is no specified frequency, however the frequency is similar to other providers of Medicaid services which is determined by the Director as he identifies the need.

The DSS Provider Relations Unit monitors provider enrollment to assure that the state's MMIS is collecting and verifying required provider documentation prior to enrolling participating providers.

Appendix I: Financial Accountability

Quality Improvement: Financial Accountability

As a distinct component of the state's quality improvement strategy, provide information in the following fields to detail the state's 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.

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

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 claims paid in accordance with waiver reimbursement strategy, divided by total number of claims paid

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:* *Gainwell Technologies*	☑ ***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:
Total number of claims reviewed by QA department that are supported by documentation that services were provided, divided by total number of claims reviewed

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:*	☐ ***Annually***	☐ ***Stratified*** *Describe Group:*

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

Data Aggregation and Analysis:

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

b. Sub-assurance: The state provides evidence that rates remain consistent with the approved rate methodology throughout the five year waiver cycle.

Performance Measures

For each performance measure the state will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

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

identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Number and percent of rates that remained consistent with the approved rate methodology specified in the waiver. Numerator: number of rates that remained consistent with the approved rate methodology specified in the waiver. Denominator: number of rates.

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

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

b. Methods for Remediation/Fixing Individual Problems

i. *Describe the state's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction and the state's method for analyzing information from individual problems, identifying systemic deficiencies, and implementing remediation actions. In addition, provide information on the methods used by the state to document these items.*

Waiver leadership staff from DSS, DMHAS, and the FI meet at least quarterly to review operational issues. At this time any questions or issues raised through monitoring and monthly/quarterly reporting are addressed.

The FI is in regular contact with DSS to correct issues as they arise. Billing irregularities are analyzed and necessary action is taken to correct the problem. The FI receives remittance advice from the state's MMIS indicating all claims submitted, claim status (paid, denied, suspended, recoupment, mass adjustment). The state's MMIS has a dedicated EDI Help Desk for providers, including the FI acting as fiscal agent, experiencing difficulties with electronic claim submissions. All interaction with the state's MMIS is documented through the Contact Tracking Management System (CTMS) which logs the date, provider, reason for the call and resolution of the problem.

ii. Remediation Data Aggregation

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

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

Responsible Party*(check each that applies):*	***Frequency of data aggregation and analysis*** *(check each that applies):*
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 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 the Connecticut Department of Social Services Provider Manual, all schedules of payment for covered Medical Assistance Program goods and services shall be established by the Commissioner of Social Services and paid by the Department of Social Services in accordance with applicable federal and state statutes and regulations. Waiver service rates are based on direct and indirect costs of providing waiver services. Consumers, provider organizations and DMHAS staff have had the opportunity to review the waiver application and rates pursuant to the public notice. The waiver application was also reviewed by the committees of cognizance of the Connecticut state legislature. The rate structure for the program consists of fee-for-service billing from an established fee schedule that pays uniform rates across providers and "up to max" rates that are used for specialized medical equipment or other services such as home modifications that require manual pricing.

The following services price at max fee: Community Support, Supported Employment, Adult Day Health, Brief Episode Stabilization, Home Delivered Meals, Non-Medical Transportation, Overnight Recovery Assistant, Peer Supports, Personal Emergency Response Systems, Recovery Assistant and Transitional Case Management.

Rates for Community Support, Supported Employment, Brief Episode Stabilization, Peer Supports, Recovery Assistant and Transitional Case Management services were developed by DMHAS fiscal unit and DSS based on the direct support hourly wage, information drawn from Connecticut Department of Labor wage statistics, salary surveys, and the additional components of supervision required at the provider level, and the number of clients per the direct care staffing ratio and approved by the DSS rate setting unit.

The service rates for Assisted Living, Non-Medical Transportation, Personal Emergency Response Systems (install and monitoring), Adult Day Health and Home Delivered Meals utilize the DSS promulgated rates.

The rate for Assistive Technology is priced up to max and equal to the reimbursement rate for Assistive Technology services on the fee schedule for the Connecticut Home Care Program for Elders.

The rate for the Chore services is equal to the reimbursement rate for Chore services on the fee schedule for the ABI 2 waiver.

Waiver rates are uniform for every provider of a waiver service and do not vary between private and state-operated facilities. During the life of this waiver, service rates may be adjusted based on legislatively approved increases or decreases to the Department's appropriation. The rate for Interpreter services is equal to the reimbursement rate for Interpreter services under the fee schedule for the ABI 2 waiver. The rate for Mental Health Counseling services is equal to the reimbursement rate for Mental Health Counseling services on the Connecticut Home Care Program for Elders.

Performance Supplemental Payments will be paid to eligible providers who meet Department objectives related to decrease in avoidable hospitalization; and increase the number of members meeting their person-centered goals. Payments range from 2% to 4% of expenditures and are based on the availability of program funds in the budget. All provider types covered under the waiver active as of the issuance date of the respective payment and participating in the state's VBP as defined above are eligible for payments other than those provider types and services specifically excluded. Excluded providers and services: Assistive Technology; Environmental Accessibility Modifications, Personal Emergency Response System, skilled Chore Service, Specialized Medical Equipment, individual goods and services, and all self-directed services.

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 state plan services through the state's Medicaid Management Information System (MMIS). There are provider agreements between DSS and each provider of state plan services under the waiver. Payment for waiver services will either made by the Medicaid agency directly or be administered by the fiscal intermediary, depending on the service. The fiscal intermediary acts as the billing provider and submits claims on behalf of the performing provider for the following services: Assistive Technology, Specialized Medical Equipment, highly skilled Chore Service, Home Accessibility Adaptations, Interpreter, and self-directed Recovery Assistant. DSS has a provider agreement with the fiscal intermediary for waiver services such that the fiscal intermediary will also submit its claims for adjudication through the the state's MMIS contractor. Consequently, payments for all waiver and state plan services will be made through the the state's MMIS contractor. DSS will pay the fiscal intermediary for waiver services through the same fiscal agent as used in the rest of the Medicaid program.

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.)

The Department of Mental Health and Addiction Services (DMHAS) certifies public expenditures for waiver services provided by DMHAS state-operated Local Mental Health Authorities (LMHA). The public funds appropriated to DMHAS are not federal funds. The state assures that the CPE is based on the total computable costs for waiver services by paying the same rates for all waiver services, whether provided by private or DMHAS state-operated providers. Claims for services provided by DMHAS state-operated providers will be processed by the the state's MMIS contractor prior to inclusion in DSS' federal Medicaid claim. Waiver services are uniform for every provider of a waiver service and do not vary between private providers and state-operated facilities.

☐ ***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 state plan services through the state's MMIS contractor. There are provider agreements between DSS and each provider of state plan services under the waiver. The state's MMIS contractor ensures that the individual was eligible for Medicaid waiver payment on the date of service. In addition, for those state plan services that are included in a participant's approved service plan and are subject to prior authorization under existing Medicaid policy, the authorized limits will be entered into the MMIS and thus will prevent expenditures in excess of the service plan.

Payment for waiver services will be administered either by the Medicaid agency or the fiscal intermediary, depending on the service. DSS will have a provider agreement with the fiscal intermediary for waiver services such that the fiscal intermediary will also submit its claims for adjudication through the MMIS. The fiscal intermediary will enter the service plan limits into its claims system and thus prevent expenditures in excess of the service plan. The fiscal intermediary will in turn submit waiver service claims for adjudication through the DSS MMIS. The MMIS claims processing system will verify that the participant was Medicaid eligible on the date of service delivery specified in the request for reimbursement and will allow payment only on claims for services provided within the eligibility period.

Claims and service records for all waiver and state plan services will be subject to audit through the DSS Office of Quality Assurance. This will ensure that service billed were in fact provided and documented.

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:

Payments will be made by the MMIS directly to providers of state plan services. Payments for waiver services will be made either by the MMIS directly or the fiscal intermediary (FI) depending on the service. The FI serves as the fiscal or billing agent for providers of waiver services and will submit claims on behalf of waiver service providers to the MMIS. The MMIS will adjudicate claims on a cash basis for services provided by private non-profit performing providers and will adjudicate claims on a non-cash basis for claims submitted on behalf of state-operated performing providers.

The fiscal intermediary will ensure that claims for waiver services provided by individuals will be subject to the limitations established in the approved service plan. The fiscal intermediary will also request formal documentation (e.g., timesheets) from these individual providers regarding the amount of services provided. The fiscal intermediary will generate claims from this documentation and will also be responsible for reconciling any claim that was submitted but not paid by the MMIS.

DSS and DMHAS competitively procured a fiscal intermediary to act as the limited fiscal agent. The state oversees the fiscal intermediary through regularly scheduled meetings, audits and reporting as set forth in this waiver's Appendix A.

☐ ***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.

Performance Supplemental Payments will be paid to eligible providers who meet Department objectives related to decrease in avoidable hospitalization and increase in the number of members meeting their person-centered goals. Payments range from 2% to 4% of expenditures and are based on the availability of program funds in the budget. All provider types covered under the waiver active as of the issuance date of the respective payment and participating in the state's VBP as defined above are eligible for payments other than those provider types and services specifically excluded. Excluded providers and services: Assistive Technology; Environmental Accessibility Modifications, Personal Emergency Response System, skilled Chore Service, Specialized Medical Equipment, individual goods and services, and all self-directed services.

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:

DMHAS state-operated Local Mental Health Authorities (LMHA) may provide certain waiver services including: Community Support Program, Recovery Assistants, Supported Employment, Brief Episode Stabilization, Transitional Case Management and Peer Supports.

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:

- ***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 section 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 section 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 section 1915(b)/section 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 section 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 section 1115/section 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 section 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 text box below, indicate the contract authorities. In addition, if the state contracts with MCOs, PIHPs, or PAHPs under the provisions of section 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 section 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:

Funds are appropriated to DSS for waiver and state plan services provided by private non-profit providers. Funds are appropriated to DMHAS as a CPE for the provision of those waiver services that are provided by DMHAS state-operated Local Mental Health Authorities (LMHAs). The State Department of Administrative Services (DAS) submits claims on behalf of the LMHAs to the MMIS, and the MMIS will adjudicate these claims on a non-cash basis. Rates paid for waiver services are uniform for every provider of a waiver service and do not vary between private and state-operated facilities.

☐ ***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:*

Do not complete this item.

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	28249.93	28225.00	56474.93	127268.00	15442.00	142710.00	86235.07
2	31281.07	38289.00	69570.07	133632.00	17095.00	150727.00	81156.93
3	34576.10	42386.00	76962.10	140313.00	18924.00	159237.00	82274.90
4	38254.70	46922.00	85176.70	147329.00	20948.00	168277.00	83100.30
5	42360.09	51942.00	94302.09	154696.00	23190.00	177886.00	83583.91

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	714	714
Year 2	770	770
Year 3	819	819
Year 4	873	873
Year 5	925	925

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (2 of 9)

b. Average Length of Stay. *Describe the basis of the estimate of the average length of stay on the waiver by participants in item J-2-a.*

The projected average length of stay for each of the five renewal years is the same as that reported on the CMS-372(S) Initial report for April 1, 2024 - March 31, 2025, and is consistent with the historical trend for this waiver.

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (3 of 9)

c. Derivation of Estimates for Each Factor. *Provide a narrative description for the derivation of the estimates of the following factors.*

i. Factor D Derivation. *The estimates of Factor D for each waiver year are located in Item J-2-d. The basis and methodology for these estimates is as follows:*

The beginning caseload for April 1, 2027 was projected based on the actual billing caseload as of August 1, 2026 and the net growth projected for the succeeding 8 month period. The projection is based on the April 1, 2024 - March 31, 2025 actual caseload intake and discharges. The projected intake for Year 1 was added to the projected beginning caseload for April 1, 2027 to obtain the unduplicated recipient count for Year 1. The beginning caseload for each year was projected based on the actual net growth experienced April 1, 2024 - March 31, 2025.
The source of users for each service used to calculate Factor D is the same as the percentage of total users for each service reported in the CMS-372(S) Initial report for April 1, 2024 - March 31, 2025. The units per user is the same as reported in the CMS-372(S) Lag report for April 1, 2024 - March 31, 2025. The average cost per unit for Year 1 is based on the data reported on the CMS-372(S) for April 1, 2024 - March 31, 2025 and adjusted for any legislatively approved rate increases effective prior to the renewal period. The average cost per unit for Years 2-5 is trended at 10.7% based on the published June 2026 Consumer Price Index for Home Health Care found in Table 7.

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

The factor D' was calculated by applying CPI to the utilization data in the CMS-372(S) Lag report for April 1, 2024 - March 31, 2025. The historical cost data were trended forward for each renewal year using 10.7% based on the published June 2026 Consumer Price index for Medical Care. Factor D' was based on 372 reports that exclude dual eligible client's pharmacy expenditures; therefore, Factor D' did not require additional adjustment.

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

The factor G was calculated by applying CPI to the CMS-372(T) Lag report utilization for April 1, 2024 - March 31, 2025. The annual inflation projection for Factor G is based on the published June 2026 Consumer Price Index for Home Health Care at 10.7%.

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

The factor G' was calculated by applying CPI to the CMS-372(S) Lag report utilization for April 1, 2024 - March 31, 2025. The historical cost data were trended forward by 5.0% for each renewal year, based on the published June 2026 Consumer Price index for Nursing Home 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	
Community Support Program	
Supported Employment	
Assisted Living	
Assistive Technology	
Brief Episode Stabilization	
Chore Services	
Home Accessibility Adaptations	
Home Delivered Meals	
Interpreter	
Mental Health Counseling	
Non-Medical Transportation	
Overnight Recovery Assistant	
Peer Support	
Personal Emergency Response Systems	
Recovery Assistant	
Specialized Medical Equipment	
Transitional Case Management	

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (5 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. *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. 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	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Day Health Total:						**11928.54**
Adult Day Health	Per day	1	123.00	96.98	**11928.54**	
Community Support Program Total:						**4815124.65**
Community Support Program - individual	Per 15 Min	581	315.00	26.31	**4815124.65**	
Supported Employment Total:						**23789.28**
Supported Employment Individual	Per 15 Min	3	464.00	17.09	**23789.28**	
Assisted Living Total:						**250033.60**
Assisted Living	per day	10	496.00	50.41	**250033.60**	
Assistive Technology Total:						**32109.80**
Assistive Technology	per unit	31	1.00	1035.80	**32109.80**	
Brief Episode Stabilization Total:						**228.80**
Brief Episode Stabilization	per 15 Min	5	4.00	11.44	**228.80**	
Chore Services Total:						**277704.00**
Chore Services	per 15 min	112	450.00	5.51	**277704.00**	
Home Accessibility Adaptations Total:						**11070.00**
Home Accessibility Adaptations	Per Service	1	1.00	11070.00	**11070.00**	
Home Delivered Meals Total:						**608767.68**
Home Delivered Meals	per unit	349	276.00	6.32	**608767.68**	
Interpreter Total:						**1599.00**
Interpreter	Per 15 min	5	20.00	15.99	**1599.00**	
Mental Health Counseling Total:						**119749.50**
Mental Health Counseling	Per unit	46	45.00	57.85	**119749.50**	

GRAND TOTAL: 20170450.52

Total Estimated Unduplicated Participants: 714

Factor D (Divide total by number of participants): 28249.93

Average Length of Stay on the Waiver: 321

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Non-Medical Transportation Total:						**126.85**
Non-Medical Transportation	per mile	1	5.00	25.37	**126.85**	
Overnight Recovery Assistant Total:						**671.44**
Overnight Recovery Assistant	per 15 min	1	88.00	7.63	**671.44**	
Peer Support Total:						**52027.92**
Peer Support	Per 15 Min	27	148.00	13.02	**52027.92**	
Personal Emergency Response Systems Total:						**241561.80**
Personal Emergency Response Systems	per month	402	10.00	60.09	**241561.80**	
Recovery Assistant Total:						**13658310.40**
Recovery Assistant	per 15 minutes	640	2797.00	7.63	**13658310.40**	
Specialized Medical Equipment Total:						**37175.32**
Specialized Medical Equipment	Per unit	182	1.00	204.26	**37175.32**	
Transitional Case Management Total:						**28471.94**
Transitional Case Management	Per 15 Min	49	34.00	17.09	**28471.94**	

GRAND TOTAL: 20170450.52

Total Estimated Unduplicated Participants: 714

Factor D (Divide total by number of participants): 28249.93

Average Length of Stay on the Waiver: 321

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (6 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. *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. 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	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Day Health						**13205.28**

GRAND TOTAL: 24086427.71

Total Estimated Unduplicated Participants: 770

Factor D (Divide total by number of participants): 31281.07

Average Length of Stay on the Waiver: 321

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Total:						
Adult Day Health	Per day	1	123.00	107.36	**13205.28**	
Community Support Program Total:						**5753320.65**
Community Support Program - individual	Per 15 Min	627	315.00	29.13	**5753320.65**	
Supported Employment Total:						**35115.52**
Supported Employment Individual	Per 15 Min	4	464.00	18.92	**35115.52**	
Assisted Living Total:						**304444.80**
Assisted Living	per day	11	496.00	55.80	**304444.80**	
Assistive Technology Total:						**37838.79**
Assistive Technology	per unit	33	1.00	1146.63	**37838.79**	
Brief Episode Stabilization Total:						**253.20**
Brief Episode Stabilization	per 15 Min	5	4.00	12.66	**253.20**	
Chore Services Total:						**332145.00**
Chore Services	per 15 min	121	450.00	6.10	**332145.00**	
Home Accessibility Adaptations Total:						**12254.49**
Home Accessibility Adaptations	Per Service	1	1.00	12254.49	**12254.49**	
Home Delivered Meals Total:						**726432.00**
Home Delivered Meals	per unit	376	276.00	7.00	**726432.00**	
Interpreter Total:						**1770.00**
Interpreter	Per 15 min	5	20.00	17.70	**1770.00**	
Mental Health Counseling Total:						**132562.80**
Mental Health Counseling	Per unit	46	45.00	64.04	**132562.80**	
Non-Medical Transportation Total:						**140.40**
Non-Medical Transportation	per trip	1	5.00	28.08	**140.40**	
Overnight Recovery Assistant Total:						**743.60**

GRAND TOTAL: 24086427.71

Total Estimated Unduplicated Participants: 770

Factor D (Divide total by number of participants): 31281.07

Average Length of Stay on the Waiver: 321

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Overnight Recovery Assistant	Per 15 minutes	1	88.00	8.45	743.60	
Peer Support Total:						61847.72
Peer Support	Per 15 Minutes	29	148.00	14.41	61847.72	
Personal Emergency Response Systems Total:						288031.60
Personal Emergency Response Systems	per month	433	10.00	66.52	288031.60	
Recovery Assistant Total:						16307908.50
Recovery Assistant	per 15 minutes	690	2797.00	8.45	16307908.50	
Specialized Medical Equipment Total:						44319.52
Specialized Medical Equipment	Per Service	196	1.00	226.12	44319.52	
Transitional Case Management Total:						34093.84
Transitional Case Management	Per 15 Min	53	34.00	18.92	34093.84	

GRAND TOTAL: 24086427.71
Total Estimated Unduplicated Participants: 770
Factor D (Divide total by number of participants): 31281.07
Average Length of Stay on the Waiver: 321

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (7 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. *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. 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	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Day Health Total:						14618.55
Adult Day Health	Per day	1	123.00	118.85	14618.55	
Community Support Program Total:						6775886.25
Community					6775886.25	

GRAND TOTAL: 28317827.48
Total Estimated Unduplicated Participants: 819
Factor D (Divide total by number of participants): 34576.10
Average Length of Stay on the Waiver: 321

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Support Program - individual	Per 15 Min	667	315.00	32.25		
Supported Employment Total:						**38864.64**
Supported Employment Individual	Per 15 Min	4	464.00	20.94	**38864.64**	
Assisted Living Total:						**337017.12**
Assisted Living	per day	11	496.00	61.77	**337017.12**	
Assistive Technology Total:						**45695.52**
Assistive Technology	per unit	36	1.00	1269.32	**45695.52**	
Brief Episode Stabilization Total:						**336.24**
Brief Episode Stabilization	per 15 Min	6	4.00	14.01	**336.24**	
Chore Services Total:						**388800.00**
Chore Services	per 15 min	128	450.00	6.75	**388800.00**	
Home Accessibility Adaptations Total:						**13565.72**
Home Accessibility Adaptations	Per Service	1	1.00	13565.72	**13565.72**	
Home Delivered Meals Total:						**855600.00**
Home Delivered Meals	per unit	400	276.00	7.75	**855600.00**	
Interpreter Total:						**1959.00**
Interpreter	Per 15 min	5	20.00	19.59	**1959.00**	
Mental Health Counseling Total:						**146742.30**
Mental Health Counseling	Per unit	46	45.00	70.89	**146742.30**	
Non-Medical Transportation Total:						**155.40**
Non-Medical Transportation	per trip	1	5.00	31.08	**155.40**	
Overnight Recovery Assistant Total:						**822.80**
Overnight Recovery Assistant	per 15 minutes	1	88.00	9.35	**822.80**	
Peer Support Total:						**70818.00**
Peer Support	Per 15 Min	30	148.00	15.95	**70818.00**	

GRAND TOTAL: 28317827.48

Total Estimated Unduplicated Participants: 819

Factor D (Divide total by number of participants): 34576.10

Average Length of Stay on the Waiver: 321

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Personal Emergency Response Systems Total:						**339480.40**
Personal Emergency Response Systems	per month	461	10.00	73.64	**339480.40**	
Recovery Assistant Total:						**19195531.30**
Recovery Assistant	per 15 minutes	734	2797.00	9.35	**19195531.30**	
Specialized Medical Equipment Total:						**52064.48**
Specialized Medical Equipment	Per Service	208	1.00	250.31	**52064.48**	
Transitional Case Management Total:						**39869.76**
Transitional Case Management	Per 15 Min	56	34.00	20.94	**39869.76**	

GRAND TOTAL: 28317827.48

Total Estimated Unduplicated Participants: 819

Factor D (Divide total by number of participants): 34576.10

Average Length of Stay on the Waiver: 321

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (8 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver.*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. 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	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Day Health Total:						**16183.11**
Adult Day Health	Per day	1	123.00	131.57	**16183.11**	
Community Support Program Total:						**7995550.50**
Community Support Program - individual	Per 15 Min	711	315.00	35.70	**7995550.50**	
Supported Employment Total:						**43022.08**
Supported Employment Individual	Per 15 Min	4	464.00	23.18	**43022.08**	

GRAND TOTAL: 33396352.33

Total Estimated Unduplicated Participants: 873

Factor D (Divide total by number of participants): 38254.70

Average Length of Stay on the Waiver: 321

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Assisted Living Total:						**406997.76**
Assisted Living	per day	12	496.00	68.38	**406997.76**	
Assistive Technology Total:						**53395.32**
Assistive Technology	per unit	38	1.00	1405.14	**53395.32**	
Brief Episode Stabilization Total:						**372.24**
Brief Episode Stabilization	per 15 Min	6	4.00	15.51	**372.24**	
Chore Services Total:						**460525.50**
Chore Services	per 15 min	137	450.00	7.47	**460525.50**	
Home Accessibility Adaptations Total:						**15017.25**
Home Accessibility Adaptations	Per Service	1	1.00	15017.25	**15017.25**	
Home Delivered Meals Total:						**1008802.08**
Home Delivered Meals	per unit	426	276.00	8.58	**1008802.08**	
Interpreter Total:						**2169.00**
Interpreter	Per 15 min	5	20.00	21.69	**2169.00**	
Mental Health Counseling Total:						**162453.60**
Mental Health Counseling	Per unit	46	45.00	78.48	**162453.60**	
Non-Medical Transportation Total:						**172.05**
Non-Medical Transportation	per trip	1	5.00	34.41	**172.05**	
Overnight Recovery Assistant Total:						**910.80**
Overnight Recovery Assistant	per 15 minutes	1	88.00	10.35	**910.80**	
Peer Support Total:						**83637.76**
Peer Support	Per 15 Min	32	148.00	17.66	**83637.76**	
Personal Emergency Response Systems Total:						**400263.20**
Personal Emergency Response Systems	per month	491	10.00	81.52	**400263.20**	
Recovery Assistant						**22638078.90**

GRAND TOTAL: 33396352.33

Total Estimated Unduplicated Participants: 873

Factor D (Divide total by number of participants): 38254.70

Average Length of Stay on the Waiver: 321

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Total:						
Recovery Assistant	per 15 minutes	782	2797.00	10.35	**22638078.90**	
Specialized Medical Equipment Total:						**61513.98**
Specialized Medical Equipment	Per Service	222	1.00	277.09	**61513.98**	
Transitional Case Management Total:						**47287.20**
Transitional Case Management	Per 15 Min	60	34.00	23.18	**47287.20**	

GRAND TOTAL: 33396352.33
Total Estimated Unduplicated Participants: 873
Factor D (Divide total by number of participants): 38254.70
Average Length of Stay on the Waiver: 321

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (9 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. *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. 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	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Day Health Total:						**17914.95**
Adult Day Health	Per day	1	123.00	145.65	**17914.95**	
Community Support Program Total:						**9373946.40**
Community Support Program - individual	Per 15 Min	753	315.00	39.52	**9373946.40**	
Supported Employment Total:						**47624.96**
Supported Employment Individual	Per 15 Min	4	464.00	25.66	**47624.96**	
Assisted Living Total:						**488113.60**
Assisted Living	per day	13	496.00	75.70	**488113.60**	
Assistive Technology Total:						**62219.60**

GRAND TOTAL: 39183083.32
Total Estimated Unduplicated Participants: 925
Factor D (Divide total by number of participants): 42360.09
Average Length of Stay on the Waiver: 321

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Assistive Technology	per unit	40	1.00	1555.49	62219.60	
Brief Episode Stabilization Total:						412.08
Brief Episode Stabilization	per 15 Min	6	4.00	17.17	412.08	
Chore Services Total:						539617.50
Chore Services	per 15 min	145	450.00	8.27	539617.50	
Home Accessibility Adaptations Total:						16624.10
Home Accessibility Adaptations	Per Service	1	1.00	16624.10	16624.10	
Home Delivered Meals Total:						1185144.00
Home Delivered Meals	per unit	452	276.00	9.50	1185144.00	
Interpreter Total:						2401.00
Interpreter	Per 15 min	5	20.00	24.01	2401.00	
Mental Health Counseling Total:						179841.60
Mental Health Counseling	Per unit	46	45.00	86.88	179841.60	
Non-Medical Transportation Total:						190.45
Non-Medical Transportation	per trip	1	5.00	38.09	190.45	
Overnight Recovery Assistant Total:						1008.48
Overnight Recovery Assistant	per 15 minutes	1	88.00	11.46	1008.48	
Peer Support Total:						98375.60
Peer Support	Per 15 Min	34	148.00	19.55	98375.60	
Personal Emergency Response Systems Total:						470150.40
Personal Emergency Response Systems	per month	521	10.00	90.24	470150.40	
Recovery Assistant Total:						26572450.98
Recovery Assistant	per 15 minutes	829	2797.00	11.46	26572450.98	
Specialized Medical Equipment Total:						72083.90
Specialized					72083.90	

GRAND TOTAL: 39183083.32

Total Estimated Unduplicated Participants: 925

Factor D (Divide total by number of participants): 42360.09

Average Length of Stay on the Waiver: 321

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Medical Equipment	Per Service	235	1.00	306.74		
Transitional Case Management Total:						**54963.72**
Transitional Case Management	Per 15 Min	63	34.00	25.66	**54963.72**	

GRAND TOTAL: ***39183083.32***

Total Estimated Unduplicated Participants: ***925***

Factor D (Divide total by number of participants): ***42360.09***

Average Length of Stay on the Waiver: 321