



## **CT Department of Mental Retardation**

### **HCBS Waivers Operations Manual**

#### **Individual and Family Support Waiver And Comprehensive Support Waiver**

**Effective October 1, 2005**

**Issued October 11, 2005**

Version 1

# **HCBS Consolidated Waiver Manual**

## **ABOUT THIS MANUAL**

The HCBS Waiver Operations Manual encompasses the operational guidance for both DMR waivers. The Individual and Family Support Waiver (IFS) Manual has been modified to reflect the addition of the Comprehensive Support waiver effective October 1, 2005. Both DMR waivers are implemented in the same manner, so much of the original IFS Waiver Manual has remained unchanged in process.

The primary changes in this manual include the addition of new waiver services available under the Comprehensive Support waiver and more detailed instructions and information regarding the Level of Need process, service packages and limitations, Utilization Review and the approval of waiver applications and services. The Table of Contents is shaded in gray where there are significant changes or additions to the IFS Waiver Manual as a result of either the initiation of Comprehensive Support waiver, or based on revisions to the manual where more clarification was needed.

This manual will continue to be updated as our collective experiences with operating under the new waivers leads to new or improved practices or identifies areas that require further explanation. Future revisions will be distributed through a notice to replace pages of this manual accordingly. Notices will be communicated through the DMR web site, Provider Trade Associations, Family Support Networks and Self-Advocacy groups.

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## 1. Introduction and Overview of the DMR Waivers

Waivers granted by the Centers for Medicare & Medicaid Services (CMS) under Section 1915 (c) of the Social Security Act authorize the Individual and Family Support Waiver (IFS) and the Comprehensive Support Waivers. The IFS waiver is also designated as an *Independence Plus* Waiver by CMS because it provides the authority for individuals to self-direct a number of services and supports to the extent desired. This waiver was approved effective February 1, 2005 for a period of three years. The Comprehensive Supports waiver was approved effective October 1, 2005 for a period of three years. It also permits self-direction for the majority of services and supports, but is not designated as an *Independence Plus* waiver. Both offer specific services and supports in the community for individuals age three and above who require ICF/MR level of care.

The Individual and Family Support Waiver is authorized to provide direct services and supports to people who live in his or her own or family home. It is approved for individuals who do not require 24- hour paid supports. Services and supports are organized in four categories:

Home and Community Supports – Personal Assistance, Adult Companion, Supported Living, Individual Habilitation, Personal Emergency Response Systems, and Respite;  
Day/Vocational Supports – Group Day, Individualized Day, and Supported Employment;  
Ancillary Supports – Consultative Therapies, Specialized Medical Equipment and Supplies, and non-medical Transportation; and,  
Additional support services including Home and Vehicle Modifications, Interpreter Services, Family Training, and Family and Individual Consultation and Support.

The Comprehensive Supports waiver is authorized to provide direct services and supports for people who live in licensed settings, and those who live in his/her own or family home who require a level of support not available under the IFS waiver, usually due to significant behavioral, medical and/or physical support needs and/or the absence of available natural supports. Services and Supports are organized in three categories:

Residential Supports – Personal Assistance, Adult Companion, Respite, Supported Living, Res Hab (CLA and CTH), Assisted Living, Personal Emergency Response Systems, Consultative Therapies, Specialized Medical Equipment and Supplies, Transportation, Interpreter, and Family and Individual Consultation and Support.  
Day/Vocational Supports – Group Day, Supported Employment, Individualized Day, Transportation, Consultative Therapies, Interpreter, Specialized Medical Equipment and Supplies, and Family and Individual Support and Consultation.  
Other – Home and Vehicle Modifications.

Both waivers further set specific dollar limits of services and supports that can be offered based on an individuals assessed level of support need.

The requirements for the administration of the IFS and Comprehensive Support waivers are established in the approved HCBS Waiver applications. CMS negotiates the content of the application with the state. Once approved, the waiver specifies the following:

- The target population and related eligibility criteria;
- Lists the services to be provided, including the service definition, Vendor requirements, direct service employee competencies, and expected utilization of each service;
- Estimates the number of people to be served each year with associated costs, and specifies maximum number of individuals who can be enrolled in each year
- Describes the Plan of Care requirements [Individual Plan (IP)] and Individual Budgeting methodology;
- Describes and provides assurances for assuring the quality of services;

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- Demonstrates cost neutrality; and,
- Describes the payment and audit mechanisms.

These elements may only be changed by CMS review and approval of amendments to the waiver.

## 1.1 Waiver Administration

The Department of Mental Retardation (DMR) is considered the Lead Agency for day-to-day operations of the IFS and Comprehensive Supports waivers. The Department of Social Services (DSS), as the Single State Medicaid Agency, oversees DMR's operation of the waivers. The departments cooperate in the operation of the waiver under a Memorandum of Understanding that delineates each department's responsibilities.

### 1.1.1 DMR Responsibilities

As the implementing agency, DMR is responsible for the following components of the program:

1. Conducts initial assessments and required re-assessments of potential waiver enrollees/recipients using uniform assessment instrument(s), documentation and procedure to establish whether an individual meets all eligibility criteria including that set forth as part of the evaluation and criteria in 42 CFR Sec. 441.302;
2. Documents individual plans of care for waiver recipients in format(s) approved by DSS, which set forth: (1) individual service needs, (2) waiver services necessary to meet such needs, (3) the authorized service provider(s), and (4) the amount of waiver services authorized for the individual;
3. Establishes and maintains quality assurance and improvement systems designed to assure the ongoing recruitment of qualified providers of waiver services and documents adherence to all applicable state and federal laws and regulations pertaining to health and welfare consistent with the assurance made in the approved waiver application(s);
4. Develops and amends as necessary, training materials, activities, and initiatives sufficient to provide relevant DMR staff, waiver recipients, and potential waiver recipients, information and instruction related to participation in the waiver program;
5. Maintains and enhances, as necessary, a billing system which:
  - a. Identifies the source documents that providers use to verify service delivery in accordance with individual plans of care;
  - b. Assures that the data elements required by CMS for Federal Financial Participation (FFP) are collected and maintained at the time of service delivery;
  - c. Provides computerized billing system(s) with audit capacity to identify problems and permit timely resolution; and
  - d. Issues complete and accurate billing information and data to DSS in accordance with the schedules mutually established by the departments;
6. Maintains service delivery records in sufficient detail to assure that waiver services provided were authorized by individual plans of care and delivered by qualified providers in accordance with the waiver(s);
7. Provides ongoing support and performs periodic audit and assessment of providers of waiver services;

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8. Establishes and maintains a person-centered component to the evaluation and improvement activities associated with waiver services;
9. Establishes, maintains and documents the delivery of “case management” and “broker” services as indicated in the individual plan of care;
10. Establishes and maintains a system that provides for continuous monitoring of the provision of waiver services to assure compliance with applicable health and welfare standards and evaluates individual outcomes and satisfaction;
11. Approves the waiver services and settings in which such services are provided;
12. Provides payment for such services from the annual budget allocation to DMR;
13. Assists DSS in establishing and maintaining rates of reimbursement for waiver services;
14. Assists DSS in the preparation of all waiver-related reports and communications with CMS; and,
15. Consults with DSS regarding all waiver-related activities and initiatives including but not limited to waiver applications and waiver amendments.

### 1.1.2 DSS Responsibilities

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

1. Coordinates communication with federal officials concerning the waiver;
2. Specifies and approves policies and procedures and consults with DMR 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;
3. 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;
4. Determines Medicaid eligibility for potential waiver recipients/enrollees and calculate applied income as appropriate;
5. Establishes, in consultation and cooperation with DMR, the rates of reimbursement for services provided under the waiver;
6. Assists with the billing process for waiver services, complete billing process and claims for FFP for such services;
7. Prepares and submits, with assistance from DMR, all reports required by CMS or other federal agencies regarding the waiver;
8. 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; and,

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## 1.2 DMR Operating Units for Waiver Administration

### 1.2.1 Central Office Medicaid Operations Unit

#### 1.2.1.1 Waiver Section

This unit is responsible for the development of policies and procedures, processing of waiver applications, providing notification to applicants and participants of eligibility decisions and service reduction or denial decisions, maintaining current data on the number of waiver participants, collaborating with DSS to resolve Medicaid eligibility issues, conducting waiver quality assurance audits, and the provision of training and technical assistance. This unit participates with DSS in the development of waiver applications and amendments to CMS, and in the development of required quality monitoring reports to CMS.

#### 1.2.1.2 Billing Section

This unit is responsible for the processing of attendance and billing reports for submission to DAS for Medicaid billing to CMS, participating in Medicaid Rate Setting with DSS, maintaining records of federal financial reimbursement, resolving rejected Medicaid claims, and participating in audits of service utilization and billing.

### 1.2.2 Operations Center

This unit is responsible for the certification and enrollment of private providers, participation in the rate setting process, management of the Master Contract system of payment and cost reporting for private providers, management of the Fiscal Intermediary contract, and management of the department's fiscal spend plan for private services.

### 1.2.3 Regional Planning and Resource Allocation Teams

This function is responsible for the prioritization of individuals who make application for the either Waiver, recommendations regarding waiver eligibility and enrollment, service authorization/utilization management functions, and regional management of the number of enrolled participants.

### 1.2.4 Quality Management

This unit is responsible for the overall establishment and maintenance of a system that provides for continuous monitoring of the provision of waiver services to assure compliance with applicable health and welfare standards and evaluate individual outcomes and satisfaction. This system is implemented in collaboration with Regional Quality Improvement Divisions.

### 1.2.5 Regional Resource Administration

This unit in each region is responsible for providing oversight and technical assistance to private providers of services and supports, and coordinating payments for services to private providers through Master Contracts and Fiscal Intermediary services. The Resource Administration unit coordinates with the Regional PRAT on resource allocation management.

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## 1.2.6 Regional Administration/Case Management

The DMR Regional Administration is responsible for the delivery of case management services for individuals enrolled in both waivers. Once an individual is enrolled, case management is responsible for the completion of service needs assessments, the development and implementation of the Individual Plan, the effective use of waiver services as well as other available services and natural supports, the coordination and linkages of services, and the monitoring of the delivery of services and supports as described in the Individual Plan.

## 1.3 Waiver Eligibility

### 1.3.1 IFS Waiver

The following requirements determine if an individual is eligible to apply for the IFS Waiver program:

- Individual lives in his/her own or family home;
- Individual is eligible for Medicaid (Title 19) as a child or adult regardless of enrollment in the waiver; or
- Individual is eligible for Medicaid (Title 19) by virtue of enrollment in a DMR HCBS Waiver due to increased income limits or waiving spouse/parent income (deeming);
- The individual requires the level of care provided by an ICF/MR facility;
- The individual's health and safety can be reasonably assured through a combination of: the appropriate type, duration and amount of IFS waiver services based on an individual's level of need not to exceed \$52,000; Medicaid State Plan services; DMR state-funded services and supports; community/generic services; and natural supports;
- The state has sufficient allocations to fund those waiver and state-funded supports;
- There is an available opening under the approved cap on the number of individuals who may participate in the waiver at the time of application.

### 1.3.2 Comprehensive Supports Waiver

The following eligibility requirements determine if an individual is eligible to apply for the Comprehensive Support Waiver program:

- Individual lives in his/her own or family home, or, will reside in a licensed setting;
- Individual is eligible for Medicaid (Title 19) as a child or adult regardless of enrollment in the waiver; or
- Individual is eligible for Medicaid (Title 19) by virtue of enrollment in the Comprehensive Support Waiver due to increased income limits, asset limits or waiving spouse/parent income (deeming);
- The individual requires the level of care provided by an ICF/MR facility;
- The individual requires a level of support not available under the DMR IFS Waiver 0426(IP) due to intensive medical, physical and/or behavioral conditions, and/or insufficient availability of natural supports, as determined by a DMR Level of Need assessment.
- The state has sufficient allocations to fund the waiver opening;
- There is an available opening under the approved cap on the number of individuals who may participate in the waiver at the time of application.

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## 1.4 Process Overview and General Principles

How an individual and his/her family will experience participation in a waiver is broadly described in the following sections. Detailed instructions and guidance follows in each Section area of the Manual.

### 1.4.1 Initial Resource Allocation and Individual Planning

Through the Regional Planning and Resource Allocation Team process, individuals identified through the prioritization process are provided a resource funding range or Individual Budget limit based on his/her assessed level of need. The individual, case manager, and other members of the planning and support team will initiate the person-centered planning process to identify needs, preferences and desired personal outcomes. An Individual Budget in an amount up to the allocated resource range or Individual Budget limit will be developed by choosing the type, amount and duration of services and supports from the list of waiver service and support options that meet the identified personal outcomes.

### 1.4.2 Service Arrangement and Provider Choice

Upon approval of the Individual Budget, which provides authorization to initiate and purchase approved services and supports, the individual may choose from any qualified vendor to deliver the services and supports specified in the Individual Budget. Individuals and families are offered options on how much control and flexibility they choose to have over their supports. They may choose to hire their own staff to provide a number of services in this waiver, choose a vendor agency to deliver the service, select an Agency with Choice option, or choose a combination of vendor delivered and self-directed service options. The case manager will provide vendor agency lists, information and assistance as requested to ensure that the individual and other members of the planning and support team successfully arrange the initiation of approved services.

### 1.4.3 Consumer Direction

Individuals who self-direct their service options and request enhanced assistance to manage the Individual Budget, hire and manage staff, support self-advocacy or provide enhanced service coordination may request that a DMR Broker provide case management and enhanced information and support services, or may choose to purchase Family and Individual Support and Consultation services from a qualified vendor or direct hire. In the case of the latter, a DMR case manager continues to deliver Targeted Case Management services to ensure the delivery of services and supports, overall implementation of the Individual Plan, and provide general information and referral services.

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## 2. Services

This section describes the services that are covered under the IFS and the Comprehensive Supports Waivers. When reviewing these services, the following apply:

- These services as defined in this manual are for Waiver recipients only;
- How much of each service a person will receive, how often it will be provided, and how long it will be provided must be specified in the person's Individual Plan and approved by the region before payment is available;
- Payment may not be made for Specialized Medical Equipment and Supplies when the cost triggers prior approval requirements until such approval is obtained.
- Only one service that directly involves the person is provided at a time unless specifically permitted in the definition;
- Waiver funding may only be used to purchase or acquire service definitions as defined in this section;
- The definitions of waiver services do not specify any named technique or therapy. These definitions have been written to meet general best practice habilitation principles and not to approve/deny any type of training. The decisions regarding techniques should be based on the needs/preferences of the person, the development of the Individual Plan, and Service Authorization;
- As a Medicaid recipient, the individual is also eligible to receive regular Medicaid services in addition to waiver services according to Medicaid policies and procedures;
- Payment will not be made waiver services when a person is a patient or resides in a hospital, nursing facility, or ICF-MR facility.

### Individual/Group Services

- Services that have a group rate are Supported Employment Services, Group Day, Res Hab and Respite. Group Services apply to situations involving the provision of services by one staff to two or more waiver recipients;
- All waiver services/supports are to be provided with a staffing ratio of one direct service employee to the person unless otherwise provided in the service definition unless the service is provided in accordance with a group rate; (exceptions can be made if consumer-directed, such as if two individuals agree to share a support provider and the total rate paid for the service does not exceed the published vendor rate)
- If a waiver recipient receives a service with a group rate in a setting where two or more individuals receive that service at the same time of day, then the presumption is that the person will receive the service at the group rate;
- If the person normally receives a group rate, then that rate must be billed regardless of the attendance of the other individuals in the group;
- When services are provided to a group of individuals, back-up staff must be available in the event of an emergency.

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## 2.1 IFS Residential Habilitation (Supported Living)

### Definition

Assistance with the acquisition, retention, or improvement in skills related to activities of daily living, such as personal grooming and cleanliness, bed making and household chores, eating and the preparation of food, and the social and adaptive skills necessary to enable the individual to reside in a non-institutional setting. This service is comprised of a combination of habilitative and personal support activities delivered on a flexible basis in response to the individual's needs.

### Examples

- Provide instruction and training in one or more need areas to enhance the person's ability to live independently in their own home, and enhance the individual's ability to access and use the community;
- Implement strategies to address behavioral, medical or other needs identified in the Individual Plan;
- Implement all therapeutic recommendations including speech, O.T., P.T., and assist in following special diets and other therapeutic routines;
- Provide training or practice in basic consumer skills such as banking.
- Assist the individual to complete daily living activities, or to access the community.

### Service Settings

Provision of services is limited to the person's own home and/or in their community.

### General Service Limitations

Payments for residential habilitation are not made for room and board, the cost of facility maintenance, upkeep and improvement. It is limited to adults who live in their own home and are supported by a Supported Living agency and, cannot be used in combination with Respite, IS Habilitation, Personal Support, or Adult Companion services. Self-direction is not available for IFS Residential Habilitation (Supported Living).

### Service Utilization

Typical utilization is five to 20 hours per week.

### Qualified Vendor Requirements

Has an executed DMR standard contract under C.G.S. 17a-227 State Administrative Code 17a-227-31 to 17a-227-37.

Public Supported Living services must follow all DMR policies and procedures.

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## **Qualified Vendor Direct Service Staff Requirements**

Standards as described in current contract or DMR employee training requirements, and:

### Prior to Employment

- 18 yrs of age
- Criminal background check
- Abuse Registry check
- Ability to communicate effectively with individual/family
- Ability to complete necessary documentation.

### Prior to being alone with the Individual:

Training w/in 60 days (cannot work alone until training completed)

- Medication Administration if required by the IP
- Communicable disease/OSHA
- First Aid and CPR
- Abuse and Neglect
- Sexual Abuse Prevention
- Emergency Procedures
- Confidentiality
- Human Rights
- Incident Reporting
- Planning and Provision of services
- Recognition of Approved and Prohibited Physical Management Techniques
- Behavioral techniques based on individual needs
- Additional training as required by the team/circle specific to support the individual's health, welfare, and personal outcomes as described in the IP.

## **Unit of Service and Method of Payment: Qualified Vendor**

### Hourly Fee

The basis of payment for services is an hourly unit of direct service time. Billing should be rounded to the nearest hour.

### Per Diem

The basis for payment is based on a negotiated daily rate when paid under a master contract.

## **Qualified Vendor Provided Rate for Services**

DMR Master Contract.

# HCBS Consolidated Waiver Operations Manual

## 2.2 Personal Support

### Definition

Assistance necessary to meet the individual's day-to-day activity and daily living needs and to reasonably assure adequate support at home and in the community to carry out personal outcomes. Cueing and supervision of activities is included. This service may be self-directed.

### Examples

- Provide assistance to maintain activities of daily living that may include:
  - Personal hygiene
  - Dressing
  - Eating and meal prep
- Provide assistance to attain and maintain safe and sanitary living conditions and managing a household that may include:
  - General housekeeping
  - Washing and drying laundry
  - Shopping
- Provide assistance to access and attend community activities that may include:
  - Accompanying the individual while traveling to community activities
  - Accessing leisure activities such as the library, fitness center, self-advocacy meeting, and community events.

### Service Settings

Provision of services is limited to the person's own or family home and/or in their community. This service shall not be provided while the consumer is attending day program.

### General Services Limitations

This service may not be used in place of eligible Medicaid State Plan Home Health Care services or be used in combination with residential habilitation. This service should not supplant the care provided by the consumer's natural supports. Personal care providers may be members of the individual's family with prior approval from DMR. Payment will not be made for services furnished to a minor by the child's parent (or step-parent), or to an individual by that person's spouse. For other family members, payment is made only when the service is not a function that a family member normally provides 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. Family members who provide personal care services must meet the same standards as providers who are unrelated to the individual.

This service may not be used in combination with (as part of the same plan) residential habilitation.

### Service Utilization

Typical utilization is seven to 20 hours per week.

# HCBS Consolidated Waiver Operations Manual

## Qualified Vendor Direct Service Staff Requirements

### Prior to Employment

- 18 yrs of age
- Criminal background check
- Abuse Registry check
- Have ability to communicate effectively with the individual/family
- Have ability to complete record keeping as required by the employer

### Prior to being alone with the Individual:

- Demonstrate competence and knowledge of DMR policies and procedures in: abuse/neglect; incident reporting; human rights; confidentiality; handling fire and other emergencies, prevention of sexual abuse; knowledge of approved and prohibited physical management techniques;
- Demonstrate competence in their role necessary to safely support the individual as described in the Individual Plan;
- Medication Administration, if required in the Individual's Plan.

## Unit of Service and Method of Payment: Qualified Vendor

### Hourly Fee

The basis of payment for services is a quarter-hour unit of direct service time. Billing should be rounded to the nearest quarter hour.

## Qualified Vendor Rate for Services

See Rate Table

**Self-directed:** Negotiated Rate. Prior approval must be obtained from the DMR to exceed published waiver rate (Procedure: I.C.2.PR 009). Allowable costs are based on *The Department of Mental Retardation Individual Support Agreements Accounting and Reporting Requirements (COST STANDARDS) 4/29/04*.

# HCBS Consolidated Waiver Operations Manual

## 2.3 IFS Individual Support (IS) and Habilitation

### Definition

Assist with the acquisition, improvement and/or retention of skills and provide necessary support to achieve personal outcomes that enhance an individual's ability to live in their community as specified in the plan of care. This service is specifically designed to result in learned outcomes, but can also include elements of personal support that occurs naturally during the course of the day. This service may be self-directed.

### Examples

- Provide Instruction and training in one or more need areas to enhance the person's ability to live independently in their own home, a family home, and enhance the individual's ability to access and use the community;
- Implement strategies to address behavioral, medical or other needs identified in the Individual Plan;
- Implement all therapeutic recommendations including speech, O.T., P.T. and assist in following special diets and other therapeutic routines;
- Mobility training;
- Adaptive communication training;
- Provide training or practice in basic consumer skills such as banking, budgeting, and shopping.

### Service Settings

This service is not available for use in CLA or CTH settings. .  
Provision of services is limited to the person's own or family home and/or in their community.

### General Service Limitations

Payments for IS habilitation are not made for room and board.  
A qualified family member or relative, independent contractor or service agency may provide services. In the case of providers who are family members, federal financial participation is excluded when the provider is a parent providing services for a minor child under the age of 18, a participant's spouse, conservator, or a relative of a conservator. For other family members, payment 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. DMR prior approval is required for family members.

This service may not be used in combination with (as part of the same plan) residential habilitation.

### Service Utilization

Typical utilization of five to 10 hours per week.

# HCBS Consolidated Waiver Operations Manual

## **Qualified Vendor or Self-directed Direct Service Staff Requirements**

### Prior to Employment:

- 18 yrs of age
- Criminal background check
- Abuse Registry check
- Ability to communicate effectively with individual/family
- Ability to complete necessary documentation.

### Prior to being alone with the Individual:

- Demonstrate competence in knowledge of DMR policies and procedures: abuse/neglect; incident reporting; client rights and confidentiality; handling fire and other emergencies, prevention of sexual abuse, knowledge of approved and prohibited physical management techniques;
- Demonstrate competence/knowledge in areas described in the Individual Plan to support the health and welfare of the individual;
- Demonstrate competence, skills, abilities, education, and/or experience necessary to achieve the specific training outcomes as described in the Individual Plan;
- Ability to participate as a member of the circle if requested by the individual;
- Demonstrate understanding of Person-Centered Planning;
- Medication Administration, if required in the Individual's Plan.

## **Unit of Service and Method of Payment: Qualified Vendor**

### Hourly Fee

The basis of payment for services is a quarter-hour unit of direct service time. Billing should be rounded to the nearest quarter hour.

## **Qualified Vendor Rate for Services**

See Rate Table

**Self-Directed:** Negotiated Rate. Prior approval must be obtained from the DMR to exceed published waiver rate (Procedure: I.C.2.PR 009). Allowable costs are based on *The Department of Mental Retardation Individual Support Agreements Accounting and Reporting Requirements (COST STANDARDS) 4/29/04*.

# HCBS Consolidated Waiver Operations Manual

## 2.4 Adult Companion Services

### Definition

Non-medical care, supervision, and socialization provided to an adult. Service may include assistance with meals and basic activities of daily living incidental to the care and supervision of the individual. Providers may also perform light housekeeping tasks, which are incidental to the care and supervision of the individual. This service is provided to carry out personal outcomes identified in the Individual Plan. This service does not entail hands-on nursing care, except as permitted under the *Nurse Practice Act (CGS 20-101)*. This service may be self-directed.

### Examples

- Provide companionship and social interactions;
- Companions may assist or supervise the individual with such tasks as light housekeeping, meal preparation, laundry and shopping, but do not perform these activities as discrete services or more than 20% of time worked.

### Service Settings

Provision of services is limited to the person's own or family home and/or in their community. This service shall not be provided while the consumer is attending day program.

### General Service Limitations

Adult Companion Services payments are not made for room and board, the cost of facility maintenance, upkeep and improvement. A qualified family member or relative, independent contractor or service agency may provide services. In the case of providers who are family members, federal financial participation is excluded when the provider is a parent providing services for a minor child under the age of 18, a participant's spouse, conservator, or a relative of a conservator. For other family members, payment 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. Prior approval from DMR is required for family members to qualify. This service may not be used in combination with (as part of the same plan) residential habilitation.

### Service Utilization

Two to 16 hours per day.

# HCBS Consolidated Waiver Operations Manual

## **Qualified Vendor or Self-directed Direct Service Staff Requirements**

### Prior to Employment

- 18 yrs of age
- Criminal background check
- Abuse Registry check
- Have ability to communicate effectively with the individual/family
- Have ability to complete record keeping as required by the employer.

### Prior to being alone with the Individual:

- Demonstrate competence in knowledge of DMR policies and procedures: abuse/neglect; incident reporting; human rights and confidentiality; handling fire and other emergencies, prevention of sexual abuse; and knowledge of approved and prohibited physical management techniques;
- Demonstrate competence in their role necessary to safely support the individual as described in the Individual Plan;
- Medication Administration if required by the Individual Plan.

## **Unit of Service and Method of Payment: Qualified Vendor**

### **Qualified Vendor Rate for Services**

See Rate Table

**Self-directed:** Negotiated Rate. Prior approval must be obtained from the DMR to exceed published waiver rate (Procedure: I.C.2.PR 009). Allowable costs are based on *The Department of Mental Retardation Individual Support Agreements Accounting and Reporting Requirements (COST STANDARDS) 4/29/04.*

# HCBS Consolidated Waiver Operations Manual

## 2.5 Supported Employment Services

### Definition

Services and supports to assist the individual to obtain and maintain paid employment in a work place where individuals without disabilities are employed. This service may be self-directed.

### Examples

- Supported employment includes activities needed to sustain paid work by individuals receiving waiver services, including supervision and training;
- Evaluate the Individual's appropriateness, desire, strengths, and abilities for supported employment;
- Develop a plan for job development;
- Assist in finding employment;
- Provide job coaching/teaching;
- Monitor job performance;
- Support work crews and teams;

### Service Settings

Supported employment is conducted in a variety of settings.

### General Service Limitations

When supported employment services are provided at a work site in which persons without disabilities are employed, payment will be made only for the adaptations, supervision, and training required by individuals receiving waiver services as a result of their disabilities, and will not include payment for the supervisory activities rendered as a normal part of the business setting. This service is not for use to provide ongoing long-term 1:1 support to enable an individual to complete work activities. This service may only be used when the individual is not eligible for state Vocational Rehabilitation services. A qualified family member or relative, independent contractor or service agency may provide services. In the case of providers who are family members, federal financial participation is excluded when the provider is a parent providing services for a minor child under the age of 18, a participant's spouse, conservator, or a relative of a conservator. For other family members, payment 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. Prior approval from DMR is required for family members to qualify.

### Service Utilization

Individual Supported Employment services will vary in the intensity of initial job development, intensive training, and decreasing periodic monitoring. Typical Group Supported Employment ranges from six to eight hours per day for small groups consumers.

# HCBS Consolidated Waiver Operations Manual

## **Qualified Vendor or Direct Hire Direct Service Staff Requirements**

### Prior to Employment:

- 18 yrs of age
- Criminal background check
- Abuse Registry check
- Have ability to communicate effectively with the individual/family
- Have ability to complete record keeping as required by the employer.

### Prior to being alone with the Individual:

- Demonstrate competence in knowledge of DMR policies and procedures: abuse/neglect; incident reporting; human rights and confidentiality; handling fire and other emergencies, prevention of sexual abuse; knowledge of approved and prohibited physical management techniques;
- Demonstrate competence in their role necessary to safely support the individual as described in the Individual Plan;
- Demonstrate competence, skills, abilities, education, and/or experience necessary to achieve the specific outcomes as described in the Individual Plan;
- Ability to participate as a member of the circle if requested by the individual.

## **Unit of Service and Method of Payment Qualified Vendor**

### Hourly Fee

The basis of payment for services is a quarter-hour unit of direct service time. Billing should be rounded to the nearest quarter hour.

## **Qualified Vendor Rate for Services**

### ***Individual***

See Rate Table

**Self-directed:** Negotiated Rate. Prior approval must be obtained from the DMR to exceed the published waiver rate (Procedure: I.C.2.PR 009). Allowable costs are based on *The Department of Mental Retardation Individual Support Agreements Accounting and Reporting Requirements (COST STANDARDS) 4/29/04.*

### **Group**

See Rate Table 1:4 ratio on average

# HCBS Consolidated Waiver Operations Manual

## 2.6 Group Day Service

### Definition

Sheltered Workshops and Group Day Support Options provided outside of the home. Services and supports lead to the acquisition, improvement, and/or retention of skills and abilities to prepare an individual for work and/or community participation, or support meaningful socialization, leisure, and retirement activities.

### Examples

- Develop and implement an individualized support plan;
- Develop, maintain or enhance independent functioning skills in the areas of sensory-motor, cognition, personal grooming, hygiene, toileting, etc.;
- Assist in developing and maintaining friendships of choice and skills to use in daily interactions;
- Develop work skills;
- Provide opportunities to earn money;
- Provide opportunities to participate in community activities.

### Service Settings

These services are delivered in or from a facility-based program.

### General Service Limitations

Facility-based service only provided by an enrolled vendor. Transportation time or cost is not included as part of this service. This service may not be self-directed.

### Service Utilization

Five to eight hours per day.

# HCBS Consolidated Waiver Operations Manual

## Qualified Vendor Requirements and Individual Provider Qualifications

Has an executed DMR standard contract under CGS 17a-227 State Administrative Code 17a-227-31 to 17a-227-37.

### Prior to Employment:

- 18 yrs of age
- Criminal background check
- Abuse Registry check
- Ability to communicate effectively with individual/family
- Ability to complete necessary documentation.

Training w/in 60 days (cannot work alone until training completed)

- Medication Administration, if required in the Individual's Plan
- Communicable disease/OSHA
- FA and CPR
- Abuse and Neglect
- Sexual Abuse Prevention
- Confidentiality
- Human Rights
- Incident Reporting
- Planning and Provision of services
- Behavioral techniques based on the individual(s) supported and knowledge of approved and prohibited physical management techniques.
- Additional training as required by the team/circle specific to support the individual's health, welfare and personal outcomes as described in the Individual Plan.

<b>Unit of Service and Method of Payment: Qualified Vendor</b>
Hourly Fee
The basis of payment for services is a quarter-hour unit of direct service time. Billing should be rounded to the nearest quarter hour.
<b>Qualified Vendor Rate</b>
Sheltered Workshop
See Rate Table 1:8 ratio on average
Day Support Options
See Rate Table 1:3 ratio on average
<i>See Intensive Supports Definition for additional rate options</i>

# HCBS Consolidated Waiver Operations Manual

## 2.7 Individualized Day Support

### Definition

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

### Examples

- Develop and implement an individualized support plan;
- Develop, maintain or enhance independent functioning skills in the areas of sensory-motor, cognition, personal grooming, hygiene, toileting, etc.;
- Assist in developing and maintaining friendships of choice and skills to use in daily interactions;
- Provide support to explore job interests, retirement options;
- Provide opportunities to participate in community activities;
- Provide support to complete work or business activities;
- Training and supervision to increase or maintain self-help, socialization, and adaptive skills to participate in own community.

### Service Settings

This service originates from the home and is generally delivered in the community.

### General Service Limitations

This service is not provided in or from a facility-based day program.

A qualified family member or relative, independent contractor or service agency may provide services. In the case of providers who are family members, federal financial participation is excluded when the provider is a parent providing services for a minor child under the age of 18, a participant's spouse, conservator, or a relative of a conservator. For other family members payment is only made when the service provided is not a function 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. DMR Prior Approval required for family members.

### Service Utilization

Five to eight hours per day.

# HCBS Consolidated Waiver Operations Manual

## **Qualified Vendor or Self-directed Direct Service Staff Requirements**

### Prior to Employment:

- 18 yrs of age
- Criminal background check
- Abuse Registry check
- Have ability to communicate effectively with the individual/family
- Have ability to complete record keeping as required by the employer

### Prior to being alone with the Individual:

- Demonstrate competence in knowledge of DMR policies and procedures: abuse/neglect; incident reporting; human rights and confidentiality; handling fire and other emergencies, prevention of sexual abuse; knowledge of approved and prohibited physical management techniques;
- Demonstrate competence in their role necessary to safely support the individual as described in the Individual Plan;
- Demonstrate competence, skills, abilities, education, and/or experience necessary to achieve the specific training outcomes as described in the Individual Plan;
- Demonstrate understanding of Person-Centered Planning.

## **Unit of Service and Method of Payment**

### Hourly Fee

The basis of payment for services is an hourly unit of direct service time. Billing should be rounded to the nearest hour.

## **Qualified Vendor or Self-directed Rate for Service**

Negotiated rate.

(Procedure: I.C.2.PR 009). Allowable costs are based on *The Department of Mental Retardation Individual Support Agreements Accounting and Reporting Requirements (COST STANDARDS) 4/29/04*.

# HCBS Consolidated Waiver Operations Manual

## 2.8 Respite

### Definition

Services provided to individuals unable to care for themselves; furnished on a short-term basis because of the absence or need for relief of those persons normally providing the care. This service may be self-directed.

### Examples

Weekend stay at certified respite provider's home, four hours of in-home respite relief for parents, Saturday group respite at a community center, and attendance at approved respite/camp facilities.

### Service Settings

Consumer's home, home of Qualified Respite Provider, Medicaid certified ICF/MR, DMR operated Respite Centers, Private Certified Respite Homes, community locations, approved respite facilities.

### General Service Limitations

Stay in respite home/center cannot exceed 30 consecutive days. Family members who reside in the same household as the individual may not provide respite.

### Service Utilization

More than 13 hours in a given day the basis of payment is a daily unit of direct service. Less than 13 hours per day the basis of payment for services is a quarter-hour unit of direct service time. Billing should be rounded to the nearest quarter hour.

#### Qualified Vendor Requirements

##### Out of Home Respite Home/Center/Facility

Meets all requirements under CT General Statute (CGS) CGS 17a-218 and State Administrative Code 17a-218-1 to 17a-218-17.

Approved facilities licensed by Department of Public Health, Department of Education or other state licensing entity.

#### Self –Directed Requirements

##### Out of Home Respite

###### Prior to Employment

- 18 yrs of age
- Criminal background
- Abuse Registry check
- Have ability to communicate effectively with the individual/family
- Have ability to complete record keeping as required by the employer.

###### Prior to being alone with the Individual:

- Demonstrate competence in knowledge of DMR policies and procedures: abuse/neglect; incident reporting; human rights and confidentiality; handling fire and other emergencies, prevention of sexual abuse; knowledge of approved and prohibited physical management techniques;
- Demonstrate competence in their role necessary to safely support the individual as described in the Individual Plan;
- Medication Administration, if required in the Individual's Plan.

# HCBS Consolidated Waiver Operations Manual

## **In Home/Community Respite**

### Prior to Employment

- 18 yrs of age
- Criminal background check
- Abuse Registry check
- Have ability to communicate effectively with the individual/family
- Have ability to complete record keeping as required by the employer

### Prior to being alone with the Individual:

- Demonstrate competence and knowledge of DMR policies and procedures in: abuse/neglect; incident reporting; human rights; confidentiality; handling fire and other emergencies, prevention of sexual abuse; knowledge of approved and prohibited physical management techniques;
- Demonstrate competence in their role necessary to safely support the individual as described in the Individual Plan
- Medication Administration, if required in the Individual's Plan.

## **Unit of Service and Method of Payment Qualified Vendor**

### Daily Fee

The basis of payment for services is a daily unit after 13 hours in one 24-hour period

### Hourly Fee of direct service

The basis of payment for services is a quarter-hour unit of direct service time. Billing should be rounded to the nearest hour.

## **All Respite Rates Out of Home Respite Home/Center/Facility, In-home Respite**

### Daily

Individual	Group
See Rate Table	

### Hourly

Individual	Group
See Rate Table	

## **In Home/Community Respite**

### Prior to Employment

- 16 yrs of age (IFS Waiver Only)
- 18 yrs of age
- Abuse Registry check
- Have ability to communicate effectively with the individual/family
- Have ability to complete record keeping as required by the employer

### Prior to being alone with the Individual:

- Demonstrate competence and knowledge of DMR policies and procedures in: abuse/neglect; incident reporting; human rights; confidentiality; handling fire and other emergencies, prevention of sexual abuse; knowledge of approved and prohibited physical management techniques;
- Demonstrate competence in their role necessary to safely support the individual as described in the Individual Plan
- Medication Administration, if required in the Individual's Plan.

## **Unit of Service and Method of Payment Self-Directed**

### Daily Fee

The basis of payment for services is a daily unit after 13 hours in one 24- hour period

### Hourly Fee of direct service

The basis of payment for services is a quarter-hour unit of direct service time. Billing should be rounded to the nearest hour.

## **Self-Directed Rates**

Prior approval must be obtained from The DMR to exceed published waiver rate. (Procedure: I.C.2.PR 009). Allowable costs are based on *The Department of Mental Retardation Individual Support Agreements Accounting and Reporting Requirements (COST STANDARDS) 4/29/04.*

# HCBS Consolidated Waiver Operations Manual

## 2.9 Personal Emergency Response Systems (PERS)

### Definition

PERS is an electronic device, which enables certain individuals at high risk of institutionalization to secure help in an emergency.

### Examples

The individual wears a portable "help" button to allow for mobility.

### Service Settings

The system is connected to the person's phone and programmed to signal a response center once a "help" button is activated.

### General Service Limitations

Trained professionals staff the response center. PER's 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.

### Service Utilization

Ongoing service billed on a monthly basis.

### Qualified Vendor Direct Service Staff Requirements

N/A

### Unit of Service and Method of Payment Qualified Vendor

Installation

Monthly Fee

### Qualified Vendor Rate for Service

Installation See Rate Table

Two-way See Rate Table

# HCBS Consolidated Waiver Operations Manual

## 2.10 Transportation

### Definition

Service offered in order to enable individuals served under the IFS Waiver to gain access to waiver and other community services, activities and resources, specified by the plan of care. This service may be self-directed.

Transportation services under the waiver shall be offered in accordance with the individual's plan of care.

### Examples

Travel to and from day program, travel for shopping or recreation.  
In group transportation models the rate includes the driver of the vehicle

### Service Settings

N/A

### General Service Limitations

This service is offered in addition to medical transportation required under 42 CFR 431.53 and transportation services under the State Plan, defined at 42 CFR 440.170(a) (if applicable), and shall not replace them. Whenever possible, family, neighbors, friends, or community agencies that can provide this service without charge will be utilized. Payment for service may not be made when provided by the parent of a minor child or the individual's spouse, or when delivered by other family members who would normally provide the service for the individual without charge as a matter of course in the usual relationship among members of a nuclear family.

### Service Utilization

N/A

### Qualified Vendor or Self-directed Direct-Service Staff Requirements

Valid CT driver's license  
Criminal Background Check

### Unit of Service and Method of Payment Qualified Vendor

- Per Mile Fee/Per trip Fee upon receipt of invoice
- Signed Provider Agreement

### Qualified Vendor Rate for Service

See Rate Table

**Self-directed:** Negotiated Rate. Prior approval must be obtained from the DMR to exceed published waiver rate (Procedure: I.C.2.PR 009). Allowable costs are based on *The Department of Mental Retardation Individual Support Agreements Accounting and Reporting Requirements (COST STANDARDS) 4/29/04.*

# HCBS Consolidated Waiver Operations Manual

## 2.11 Environmental Modifications

### Definition

Those physical adaptations to the home which are necessary to ensure the health, welfare, and safety of the individual, or which enable the individual to function with greater independence in the home, and without which, the individual would require institutionalization.

### Examples

Such adaptations may include the installation of ramps and grab-bars, widening of doorways, modification of bathroom facilities, or installation of specialized electric and plumbing systems, which are necessary to accommodate the medical equipment and supplies, which are necessary for the welfare of the individual.

### Service Settings

The individual's or individual's family home.

### General Provider/Service Limitations

Excluded are those adaptations or improvements to the home that are of general utility and are not of direct medical or remedial benefit to the individual, such as carpeting, roof repair, central air conditioning, etc. This service is not self-directed.

### Service Utilization

Up to \$10,000 over the term of this waiver (three years).

### Unit of Service and Method of Payment Qualified Vendor

Vendor paid through the FI upon receipt of invoice and signed Provider Agreement.

### Qualified Vendor Rate for Service

Lowest of three bids. Documentation of bids is required.  
Payment based on lowest bid.

# HCBS Consolidated Waiver Operations Manual

## 2.12 Vehicle Modification Services

### Definition

Alterations made to a vehicle that is the individual's primary means of transportation when such modifications are necessary to improve the individual's independence and inclusion in the community, and to avoid institutionalization. **The vehicle may be owned by the individual, a family member with whom the individual lives or has consistent and on-going contact, or a non-relative who provides primary long-term support to the individual and is not a paid provider of such services. This service explicitly excludes: 1) adaptations or improvements to the vehicle that are of general utility, and are not of direct medical or remedial benefit of the individual; 2) purchase or lease of a vehicle; 3) regular scheduled upkeep and maintenance of a vehicle except upkeep and maintenance of the modifications.**

### Examples

Wheelchair lift, wheelchair tie downs, grab bar.

### Service Settings

The vehicle may be owned by the individual, a family member with whom the individual lives or has consistent and ongoing contact, or a non-relative who provides primary long-term support to the individual and is not a paid provider of such services.

### General Provider Limitations

This service is not self-directed.

### Service Utilization

Up to \$10,000 over the term of this waiver (three years).

### Qualified Vendor Direct Service Staff Requirements

N/A

### Unit of Service and Method of Payment Qualified Vendor

Vendor paid through the FI upon receipt of invoice and signed Provider Agreement.

### Qualified Vendor Rate for Service

Lowest of three bids. Documentation of bids is required.  
Payment based on lowest bid.

# HCBS Consolidated Waiver Operations Manual

## 2.13 Specialized Medical Equipment and Supplies

### Definition

Devices, controls or appliances specified in the Individual Plan, which enable individuals to increase their abilities to perform activities of daily living or to perceive, control, or communicate with the environment in which they live.

This service also includes items necessary for life support, ancillary supplies, and equipment necessary to the proper functioning of such items, and durable and non-durable medical equipment not available under the Medicaid State Plan. **Examples**

### Service Settings

N/A

### General Service Limitations

Items reimbursed with waiver funds shall be in addition to any medical equipment and supplies furnished under the State Plan and shall exclude those items that are not of direct medical or remedial benefit to the individual. Prior approval required for single items that cost more than \$750. This service is not self-directed.

All items shall meet applicable standards of manufacture, design, and installation.

### Service Utilization

\$750/yr., with prior approval \$3,000/three yrs.

### Qualified Vendor Direct Service Staff Requirements

N/A

### Unit of Service and Method of Payment Qualified Vendor

Item or supply upon receipt of invoice and signed Provider Agreement. Must follow DMR Cost Standards and provide notice of denial from DSS.

# HCBS Consolidated Waiver Operations Manual

## 2.14 IFS Family Training

### Definition

Training and counseling services for the families of individuals served on this waiver.

### Examples

Training includes instruction about treatment regimens and use of equipment specified in the Individual Plan, and shall include updates as necessary to safely maintain the individual at home.

### Service Settings

For purposes of this service, "family" is defined as the persons who live with or provide care to a person served on the waiver and may include a parent, spouse, children, relatives, foster family, or in-laws. "Family" does not include individuals who are employed to care for the consumer.

All family training must be included in the individual's written Individual Plan.

### General Service Limitations

This service is limited to the Department of Mental Retardation. This service may not be self-directed.

### Service Utilization

#### Qualified Vendor Direct Service Staff Requirements

#### Unit of Service and Method of Payment Qualified Vendor

N/A

#### Qualified Vendor Rate for Service

N//A

# HCBS Consolidated Waiver Operations Manual

## 2.15 Consultative Services

### Definition

Services that assist natural support persons and/or paid support staff in carrying out individual treatment/support plans, which are not covered by the Medicaid State Plan, necessary to improve the individual's independence and inclusion in their community. This service may be self-directed.

### Examples

Professionals in psychology, nutrition, counseling, and behavior management provide consultation activities. The service may include the development of a home treatment/support plan, training to carry out the plan and monitoring of the individual and the provider in the implementation of the plan.

### Service Settings

This service may only be delivered in the individual's home or in the community as described in the treatment/support plan.

### General Service Limitations

This service may be delivered at the same time as IS Habilitation, Personal Support, Adult Companion and Individualized Day services

### Service Utilization

Service limited to \$1,200 per year for this service. Prior approval required for additional services in a plan year.

### Qualified Vendor Direct Service Staff Requirements

Psychology	Licensure per CGS Chapter 383
Dietitian/Nutrition	Licensure per CGS Chapter 384b
Counseling	Licensure per CGS Chapter 383a or 383c (Marriage and Family Therapist or Professional Counselor)
Behavior Management	Licensed psychologist or appropriate training: Masters degree in psychology, special education or applied behavior analysis and course work in human behavior and at least one-year experience working with people with mental retardation.

### Unit of Service and Method of Payment Qualified Vendor

Quarter hour (15-minute) unit.

The basis of payment for services is an hourly unit of direct service time. Billing should be rounded to the nearest 15-minute interval.

### Qualified Vendor Rate for Service

Self-directed may negotiate a rate

See Rate Table

# HCBS Consolidated Waiver Operations Manual

## 2.16 Interpreter Services

### Definition

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. This service may be self-directed.

### Examples

Interpretation at community activities to access generic services and supports, to receive training, etc.

### Service Settings

This service may only be delivered in the individual's home, or in the community as described in the Individual Plan.

### General Service Limitations

None

### Qualified Vendor Direct Service Staff and Self-Directed Requirements

#### Prior to Employment:

- 18 yrs of age
- Criminal background if required by participant
- Abuse Registry check if required by participant
- Have ability to communicate effectively with the individual/family
- Be proficient in both languages
- Be committed to confidentiality
- Understand cultural nuances and emblems
- Understand the interpreter's role to provide accurate interpretation.

### Sign language interpreter:

Certified by National Assn. Of the Deaf or National registry of Interpreters for the Deaf and must be registered with the Commission on the Deaf and Hearing Impaired.

### Service Utilization

Typical utilization will be to attend meetings, provide orientation to employer responsibilities, etc.

### Unit of Service and Method of Payment Qualified Vendor

Quarter-Hour Unit.

The basis of payment for services is an hourly unit of direct service time. Billing should be rounded to the nearest 15-minute interval. Provider Agreement required.

### Qualified Vendor Rate for Service

See Rate Table *Self-directed participants may negotiate rate.*

# HCBS Consolidated Waiver Operations Manual

## 2.17 Family and Individual Consultation and Support (FICS)

### Definition

Support and Consultation provided to individuals and/or their families to assist them in directing their own plans of individual support. This service may be self-directed.

### Examples

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

### Service Settings

This service may only be delivered in the individual's home, meeting locations or in the community as described in the Individual Plan.

### General Service Limitations

Qualified Vendor cannot be a direct provider of services for the individual. This service is limited to those who direct their own supports. Individual support person may participate in emergency back up plan. Cannot be a guardian of the person or an immediate relative (mother, father, sibling).

### Service Utilization

Utilization will vary in intensity depending upon the stage of the implementation of the Individual Plan.

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## Provider Requirements

### Prior to Employment:

- 21 yrs of age
- Criminal background check
- Abuse Registry check
- Demonstrated ability, experience and/or education to assist the individual and/or family in the specific areas of support as described by the circle in the Individual Plan.
- Five years experience in working with people with mental retardation involving participation in an interdisciplinary team process and the development, review and/or implementation of elements in an individual's plan of care.
- One year of the experience must have involved supervision of direct care staff in OR responsibility for developing, implementing and evaluating individualized supports for people with mental retardation in the areas of behavior, education or rehabilitation.

**Substitutions Allowed:** College training in programs related to supporting people with disabilities (social service, education, psychology, rehabilitation, etc.) may be substituted for the experience on the basis of 15 semester hours equaling one-half year of experience to a maximum of four years.

- Demonstrate competence in knowledge of DMR policies and procedures: abuse/neglect; incident reporting; human rights and confidentiality; handling fire and other emergencies, prevention of sexual abuse; knowledge of approved and prohibited physical management techniques;
- Demonstrate understanding of the role of the service, of advocacy, person-centered planning, and community services;
- Demonstrate understanding of individual budgets and DMR fiscal management policies.

## Unit of Service and Method of Payment Qualified Vendor

### Hourly Fee

The basis of payment for services is an hourly unit of direct service time. Billing should be rounded to the nearest hour.

## Qualified Vendor Rate for Services

See Rate Table

**Self-directed:** Negotiated Rate. Prior approval must be obtained from the DMR to exceed published waiver rate (Procedure: I.C.2.PR 009). Allowable costs are based on *The Department of Mental Retardation Individual Support Agreements Accounting and Reporting Requirements (COST STANDARDS) 4/29/04.*

# HCBS Consolidated Waiver Operations Manual

## 2.18 Intensive Staffing Support

### Definition

Intensive Staffing Supports are offered to individuals, who are in Supported Employment (Group) or Group Day services and require additional direct staffing support above the standard staffing ratio for that service.

### Examples

Additional staffing for severe behavior management  
Additional staffing for feeding

### Service Settings

This service may only be delivered as part of the individual's group day program.

### Service Utilization

The service must be preauthorized by the PRAT on a time-limited basis and reauthorized on a pre-established schedule. The regional PRAT will approve reauthorization.

### Unit of Service and Method of Payment Qualified Vendor

#### Hourly Fee

The basis of payment for services is an hourly unit of direct service time. Billing should be rounded to the nearest quarter hour. Payment for Intensive Staffing Support services will be made on top of or in addition to the payment for the basic Day service. Enrolled Vendors will bill for the standard service and for the Intensive Staffing Supports service.

### Rate

See Rate Table

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## 2.19 Comprehensive Support Waiver- Residential Habilitation (CLA and CTH)

### Definition

Assistance with acquisition, retention, or improvement in skills related to activities of daily living, such as personal grooming and cleanliness, bed making and household chores, eating and the preparation of food, and the social and adaptive skills necessary to enable the individual to reside in a non-institutional setting.

### Examples

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

### Service Settings

Provision of services is limited to licensed CLA and CTH settings.

### General Service Limitations

Payments for residential habilitation are not made for room and board, the cost of facility maintenance, upkeep and improvement.

### Service Utilization

24 Hour Services available.

### Qualified Vendor Requirements

Has an executed DMR standard contract.

C.G.S. 17a-227 State Administrative Code 17a-227-31 to 17a-227-37.

Public services must follow all DMR policies and procedures.

### Qualified Vendor Direct Service Staff Requirements

Standards as described in current contract, DMR Licensing regulations or DMR employee training requirements, and:

### Unit of Service and Method of Payment: Qualified Vendor

Daily Per Diem

### Qualified Vendor Provided Rate for Services

DMR Master Contract.

# HCBS Consolidated Waiver Operations Manual

## 2.20 Comprehensive Support Waiver Supported Living

### Definition

Assist with the acquisition, improvement and/or retention of skills and provide necessary support to achieve personal outcomes that enhance an individual's ability to live in their community as specified in the plan of care. This service is specifically designed to results in learned outcomes, but can also include elements of personal support that occurs naturally during the course of the day.

### Examples

- Provide Instruction and training in one or more need areas to enhance the person's ability to live independently in their own home, a family home, and enhance the individual's ability to access and use the community;
- Implement strategies to address behavioral, medical or other needs identified in the Individual Plan;
- Implement all therapeutic recommendations including speech, O.T., P.T. and assist in following special diets and other therapeutic routines;
- Provide assistance with personal care or activities of daily living;
- Provide training or practice in basic consumer skills such as banking, budgeting, and shopping.

### Service Settings

This service is not available for use in licensed settings.

Provision of services is limited to the person's own or family home and/or in their community.

### General Service Limitations

Payments for Supported Living are not made for room and board.

A qualified family member or relative, independent contractor or service agency may provide services. In the case of providers who are family members, federal financial participation is excluded when the provider is a parent providing services for a minor child under the age of 18, a participant's spouse, conservator, or a relative of a conservator. For other family members payment is only made when: the service provided is not a function, 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. DMR prior approval is required for family members.

This service may not be used in combination with (as part of the same plan) residential habilitation.

### Service Utilization

Typical utilization of five to 40 hours per week.

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## **Qualified Vendor or Self-directed Direct Service Staff Requirements**

### Prior to Employment:

- 18 yrs of age
- Criminal background check
- Abuse Registry check
- Ability to communicate effectively with individual/family
- Ability to complete necessary documentation.

### Prior to being alone with the Individual:

- Demonstrate competence in knowledge of DMR policies and procedures: abuse/neglect; incident reporting; client rights and confidentiality; handling fire and other emergencies, prevention of sexual abuse, knowledge of approved and prohibited physical management techniques;
- Demonstrate competence/knowledge in areas described in the Individual Plan to support the health and welfare of the individual;
- Demonstrate competence, skills, abilities, education, and/or experience necessary to achieve the specific training outcomes as described in the Individual Plan;
- Ability to participate as a member of the circle if requested by the individual;
- Demonstrate understanding of Person-Centered Planning;
- Medication Administration, if required in the Individual's Plan.

## **Unit of Service and Method of Payment: Qualified Vendor**

### Hourly Fee

The basis of payment for services is a quarter-hour unit of direct service time. Billing should be rounded to the nearest quarter hour.

## **Qualified Vendor Rate for Services**

See Rate Table

**Self-Directed:** Negotiated Rate. Prior approval must be obtained from the DMR to exceed published waiver rate (Procedure: I.C.2.PR 009). Allowable costs are based on *The Department of Mental Retardation Individual Support Agreements Accounting and Reporting Requirements (COST STANDARDS) 4/29/04*.

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## 2.21 Comprehensive Support Waiver only -Assisted Living

### Definition

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, in conjunction with residing in 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.

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 may or may not include kitchenette and/or living rooms and which contain bedrooms and toilet facilities. The consumer has a right to privacy. Living units may be locked at the discretion of the consumer, except when a physician or mental health professional has certified in writing that the consumer is sufficiently cognitively impaired as to be a danger to self or others if given the opportunity to lock the door. (This requirement does not apply where it conflicts with fire code.) 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 consumer retains the right to assume risk, tempered only by the individual's ability to assume responsibility for that risk. Care must be furnished in a way that fosters the independence of each consumer to facilitate aging in place. Routines of care provision and service delivery must be consumer-driven to the maximum extent possible, and treat each person with dignity and respect.

Assisted living services may also include (Check all that apply):

Home health care     Medication administration  
 Intermittent skilled nursing services     Transportation specified in the plan of care

### Provider Qualifications

ALSA License from the Dept of Public Health Public Health Code 19-13-D105 and Enrolled as a Qualified Provider of Assisted Living with DMR.

#### A. Service Level Packages (Rates: see Rate Table)

##### SP-1 per Diem

Occasional Personal Service - 1 hour per week, up to 3.75 hours per week of personal services plus nursing visits as needed.

##### SP-2 per Diem

Limited Personal Service - 4 hours per week, up to 8.75 hours per week of personal services plus nursing visits as needed

##### SP-3 per Diem

Moderate Personal Service - 9 hours per week, up to 14.75 hours per week of personal services plus nursing visits as needed.

##### SP-4 per Diem

Extensive Personal Services - 15 hours per week, up to 25 hours per week of personal services plus nursing visits as needed.

#### B. Core Assisted Living Services

##### Additional Core Services: per Diem

Additional Basic Core Services e.g. housekeeping, laundry and meal preparation, beyond the level provided by the MRC under its core services will also be allowed.

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## 2.21 Comprehensive Support Waiver only- Individual Directed Goods and Services

### Definition

Services, equipment or supplies that will provide direct benefit to the individual and support specific outcomes identified in the Individual Plan. The service, equipment or supply must either reduce the reliance of the individual on other paid supports, be directly related to the health and/or safety of the individual in his/her home, be habilitative in nature and contribute to a therapeutic goal, enhance the individual's ability to be integrated into the community, provide resources to expand self-advocacy skills and knowledge, and, the individual has no other funds to purchase the described goods or services.

### Examples

Examples would include cleaning services, specialized clothing for work or safety for the individual, public speaking training, and specialized therapies.

### Service Settings

May be delivered in the individual's home, at work, vocational or retirement location, or in the community.

### Service Utilization

Must be pre-approved by DMR and follow DMR Cost Standards.

### Service/Provider Limitations

Experimental and prohibited treatments are excluded. This service is only available for individuals who self-direct his/her own supports; DMR applies consistent guidelines in respect to the appropriateness of the services or items to be approved in this service definition. This service may not duplicate any Medicaid State Plan service.

### Unit of Service and Method of Payment

All services or items are pre-approved by DMR and follow DMR Cost Standards. Unit may be an item, or hourly, ½ hour, or daily service unit. Costs and rates are negotiable.

### Provider/Service Qualifications

Supplier or Individual selected by participant and approved by DMR including signed Medicaid Provider agreement. Meets any applicable state regulations for the type of supply or service as described in the Individual Plan approved by DMR.

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## 3. Application and Enrollment

Individuals seeking services and supports that are covered under a DMR HCBS waiver must agree to participate in the waiver application and enrollment process at the time DMR determines it has the resources and waiver slots available to deliver such services/supports (see also **Public Act 05-280**)

Waiver enrollment enables the State to bill Medicaid and receive federal assistance in funding waiver services, and thereby assists the State of Connecticut in its goal of supporting all citizens with Mental Retardation to safely and successfully live in their communities.

At least annually, consumers/families/guardians/representatives will be provided with information about the DMR waivers that includes a summary of approved waiver services, the application and enrollment process, and hearing rights for decisions related to waiver(s).

When an individual, his/her family/guardian, or his/her planning and support team initiates a request for covered services, the DMR case manager will follow DMR Procedure No: I.B.1.PR.001, Administration of Requests for Day and Residential Supports and Services. A Level of Need Assessment must be completed at that time if one is not on file and current.

### 3.1 Referral for Services and Support

When the individual, his or her family or planning and support team identifies a need for service(s), the request is submitted to the region's PRAT following the process outlined in DMR Procedure I.B.1.PR.001 - Administration of Requests for Day and Residential Supports and Services.

#### 3.1.1 The individual's case manager submits a request for services consisting of:

- a. PRAT "Request for Services" Form
- b. Level of Need Assessment
- c. Priority checklist
- d. The individual's current Individual Plan or FAP and projected budget, if available
- e. Resources currently available to the individual
- f.

#### 3.1.2 Priority Assignment

PRAT assigns the individual a Priority status using the Priority Checklist, which determines whether he or she is assigned to the Waiting List (Emergency or Priority 1) or Planning List (Priority 2 or 3). The Priority Checklist is located in Appendix A.

### 3.2 Planning and Resource Allocation Team (PRAT)

Each DMR region has a PRAT responsible for: the prioritization of individuals who seek to make an application to a DMR HCBS waiver; recommendations regarding waiver eligibility and enrollment; service authorization/utilization management functions; and regional management of the number of enrolled participants in each waiver. The PRAT activities follow the process outlined in DMR Procedure I.B.1.PR.001 - Administration of Requests for Day and Residential Supports and Services, and in DMR Procedure I.B.2. PR 001- Application for New or Additional Waiver Services and Enrollment Procedures for DMR HCBS Waivers.

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## 3.2.1 PRAT Data Maintenance

Each region, using the department's statewide Planning and Resource Allocation Tracking database, shall maintain data about the individuals who request waiver enrollment or new service requests, their priority and level of need, the estimated and actual costs of the service and the nature of the request (new service or enhancement).

## 3.2.2 Waiver Slot Authorization

Waiver applications are not accepted for determination of eligibility by DMR unless the individual has been notified that a waiver slot has been awarded to the individual. The PRAT maintains data regarding the availability of waiver slots in the region, manages available resources and awards funded waiver slots to individuals based on:

- a. Any restrictions placed upon the funding resource, e.g. DMR budget allocation specifies people living at home with elderly caregivers
- b. The length of time the person has been a Priority 1
- c. The urgency of the individual's need for services
- d. The availability of funding/resource sufficient to meet the person's needs, and
- e. The person's personal resources and preferences.

If both DMR waivers have available slots at the time of the referral or resource allocation award, the application will be guided by the target criteria in the DMR waivers defined in Section 1 of this Manual. The PRAT notifies the case manager of the availability of a waiver opening and initial resource allocation or referral(s). The case manager notifies the individual/family of the initial allocation or referral(s) and of the HCBS Waiver enrollment requirements, at this time, in accordance with Procedure I.B.2.PR.001 The Notification Letter and the Acknowledgement Form described in that procedure are located in Appendix B.

Emergency service authorization can occur outside of this process if time sensitive health and safety concerns exist, such as the department is directed to take custody of an individual by a court or the Office of Protection and Advocacy, or the individual has experienced a sudden loss of his/her home. These cases are reviewed at the first PRAT meeting following the authorization of services covered by a waiver..

## 3.2.3 Resource Allocation, the Level of Need and Service Limits

The DMR HCBS waivers cover a level of services for an individual as determined by an individual's assessed Level of Need. The level of services is governed by the dollar limits approved for the individual's Level of Need.

### Resource Allocation:

When an individual is notified that they may apply for one of the HCBS waivers as described in the preceding sub-section, the PRAT will also inform the individual and his/her planning and support team of either:

- The range of resources available to design a plan of supports (Individual Budget) based on the outcome of the Individual Plan (e.g. \$5,000 to \$20,000 for Home and Community Supports) as determined by his/her assessed Level of Need; or,
- The maximum Individual Budget amount available to design a plan of supports (Individual Budget) based on the outcome of the Individual Plan

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(e.g. \$60,000 for annualized Residential and Day/Vocational Supports) as determined by his/her assessed Level Of Need.

### **Level of Need:**

An individual's Level of Need is determined based on the results of a completed assessment tool. The current assessment results in an assignment to one of three levels of support; Minimum, Moderate or Comprehensive. A new assessment tool under development through the CMS *Independence Plus* Grant Level Of Need project will result in five to six levels of support. That tool will improve the department's capability to determine individual support needs equitably and consistently across the state even further.

The Level Of Need assessment is then correlated to an amount of funding. The funding levels are determined through analysis of historical service utilization, meaning, that service types and costs for services for individuals already receiving services is evaluated and correlated to their corresponding Level of Need results. This analysis is done each year and may result in an adjustment to the funding amounts accordingly. The new Level of Need tool will also be correlated to historical service and funding levels. At this time the department utilizes a range of resources method for residential and day/vocational services, treating each separately. A combined Individual Budget limit method will also be introduced in FY 06.

### **Service Limits**

The DMR waivers further set upper limits for the level of services covered as expressed through a dollar limit.

The IFS Waiver prescribes three broad categories of support services: Home and Community Supports, Day and Vocational Supports, and Ancillary Supports. Each category separately ...” is limited to up to \$x amount per participant per year based on assessed level of need (underline\_added), unless the CT Department of Mental Retardation approves an exception to this service limit” (CT IFS Waiver 04261P, Page B-1). The specific dollar limits and services for each support category are found in Section 4 of the Manual. The IFS Waiver in total is approved to cover annualized service needs for each individual up to a maximum of \$52,000 per year, as determined by the assessed Level of Need, effective in the first year of the approved waiver, and adjusted thereafter for cost of living increases. Service costs that may be incurred on a one time basis such as Home and Vehicle Modifications, may be approved in any plan year beyond the annualized service limit per the service definition limits as described in Section 2 of the Manual.

The Comprehensive Supports Waiver prescribes two broad categories of annualized support services: Residential/Home and Community Supports, and Day and Vocational Supports. Home and Vehicle modifications are included as an Other category with distinct service limitations as described in the Service Definitions in Section 2 of this Manual. The Comprehensive Waiver also sets funding limits ... “Each service package is limited to a specific range of funding based on the results of an individual's Level of Need (underline added) Assessment”, with specific upper limits set by Level of Need for **each category (CT Comprehensive Supports Waiver 0437, page B-1 and B-2). The specific dollar limits and services designated for each support category by Level of Need are found in Section 4 of this Manual.** The funding range limits apply to each participant on an annualized basis, unless the CT DMR approves an exception to this limit through Utilization Review. Criteria for Utilization

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Review approval as prescribed in the waiver application are also found in Section 4 of the Manual.

## 3.2.4 Administrative Review Process and Fair Hearing Rights

If an individual/family does not agree with the priority status determination they may request a Programmatic Administrative Review or an Administrative Hearing with DMR. The case manager will assist in making this request as needed.

If an individual is denied access to a preferred waiver program (DMR's IFS or Comprehensive waiver), or denied requested services as a result of a Level of Need Determination, a notice of denial and fair hearing rights will be provided to the applicant by the CO Waiver Unit.

## 3.2.5 Regional Audit

Each region will conduct an internal audit at least annually. The audit addresses areas such as consistency in prioritization and resource allocation as well as the removal from the list of individuals no longer interested in obtaining services and supports from DMR. The DMR Division of Strategic Leadership Planning Unit will conduct quality audits on an annual basis to assess consistency with these practices across the department.

## 3.3 Waiver Application

The DMR case manager coordinates the completion of the waiver Application with the individual/legal representative. It includes the following components:

### 3.3.1 ICF/MR Level of Care Determination

Individuals who seek to enroll in a DMR Waiver must meet the ICF/MR level of care determination. In Connecticut, that determination is based on the following:

1. The individual has mental retardation or a related condition,
  - a. Mental Retardation as defined in Connecticut General Statute 1-1g, or otherwise eligible for services from CT DMR under state law, Con Gen Stat Sec 17a-210. Also included are those determined eligible for DMR services as a result of a hearing conducted by DMR according to the Uniform Administrative Procedures Act or administrative determination of the Commissioner
  - b. Related condition - limited to persons who currently reside in general nursing facilities, but who have been shown, as a result of the Pre-Admission Screening and Annual Resident Review process mandated by P.L. 100-203 to require active treatment at the level of care of an ICF/MR. Also included are young children between age three and seven years of age; and
2. There is a reasonable indication that the person, but for the provision of waiver services coupled with other available supports, would need services in an ICF/MR or NF, as evidenced by one or more of the following:
  - a. The services/support provided and sought (including state-funded, generic/community, natural and family supports) is critical to maintaining the individual in his or her current living situation,
  - b. Without such services/support, the individual would require the level of care provided in an ICF/MR institutional setting,
  - c. In the absence of such services/support, the individual would present an immediate need for an ICF/MR institutional placement, OR,

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- d. There are other compelling indications of an immediate risk of institutional placement.

It is not expected that the profile of participants in the waiver program match that of current residents in the ICF/MR program.

This determination is documented on **DMR Form # 219, HCBS ICF/MR Level of Care Form**, and submitted to the regional Planning and Resource Allocation Team (PRAT).

### 3.3.2 Waiver Application Packet

Since waiver services are provided under a Medicaid program, the individual must be a current Medicaid beneficiary (have Title 19) or be willing to apply for Medicaid and agree to continue to maintain eligibility. Under the DMR waivers, persons not otherwise eligible for Medicaid may qualify for Medicaid so long as their income is less than three times the monthly SSI amount. In addition, family income is not taken into account when determining Medicaid eligibility under a DMR waiver. Individuals who are employed and eligible for Medicaid through the Medicaid for the Working Disabled, or SO5, program are also eligible for enrollment in the DMR Comprehensive waiver at this time. The SO5 eligibility for the IFS Waiver is pending CMS review and approval of a waiver amendment.

The case manager coordinates the Individual Plan process and completes the waiver application and enrollment packet with the individual, family or legal representative.

The packet contains:

- a. **DMR 219**, Level of Care Form, initially completed.
- b. Medicaid (Title 19) Application, if needed.
- c. **DMR 222**, Service Selection, which documents that the individual was informed of the feasible alternatives for available services and chose home, and community-based services.
- d. **DMR 223 IFS**, Notification of Waiver Services that lists the individual's waiver services at enrollment.
- e. **DSS W-1518 (Rev. 2/05)**, HCBS Referral to Regional DSS Office, which summarizes information required by the Department of Social Services in order to enroll them in the DMR IFS Waiver.
- f. The Individual Plan and proposed Individual Budget.

This packet must be submitted with the completed Individual Plan and Budget to the case management supervisor for quality review. Once the CM Supervisor has reviewed the Individual Plan and Budget, these are forwarded to the Regional Resource Management Unit for review and service approval. Once service authorization is completed, the Resource Management unit will forward the waiver application and Individual Budget to PRAT. The PRAT reviews the waiver packet and records the formal enrollment recommendation (approve or deny) for enrollment in either the IFS or Comprehensive waiver based on the outcome of the planning and budgeting process. This recommendation is recorded on the **DMR 225, PRAT HCBS Waiver Recommendation** and is sent to the DMR Central Office Waiver Unit with the entire waiver packet.

All forms described in this section are located in Appendix C.

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### 3.3.3 Waiver Enrollment Eligibility Decision

The CO Waiver Unit records the receipt of the application, reviews the contents of the packet and issues the final decision on enrollment. The approval or denial and due process notice is then sent to the individual/legal representative with a copy forwarded to the case manager. The approval letter is located in Appendix D.

A person may be denied enrollment in a DMR waiver based on any one of the following circumstances: the individual is determined by DSS to be ineligible for Medicaid; the individual fails to complete the Medicaid application process for eligibility; the initial Individual Plan and Budget exceeds the allowable service/dollar limits prescribed in the waiver and is subsequently not approved through the Utilization Review process; or, the individual is determined by the PRAT to not be eligible for a waiver slot based on the established priority of need system.

### 3.3.4 DSS Appeals

All determinations by the Waiver Unit to deny waiver eligibility or deny additional requested waiver services are subject to a request for a hearing before the Department of Social Services in accordance with the Uniform Administrative Procedures Act. The DMR Division of Legal and Governmental Affairs will coordinate the hearing process and present the department's position at such hearings. See Section 11.

If an applicant/waiver participant prevails at the DSS hearing, the DMR regional office will be notified and DMR shall implement the hearing decision as soon as possible thereafter.

### 3.3.5 Refusal or Inability to Enroll in a DMR HCBS Waiver

When individuals are seeking new or additional supports but are not eligible for Medicaid due to excess income and/or assets, or the individual / legal representative declines to apply for Medicaid and/or complete the enrollment process for a DMR HCBS waiver, the DMR case manager must complete **DMR Form 224, Reasons for Declining to Submit Medicaid and/or DMR HCBS Waiver Applications**, and return to the PRAT for submission to the CO Waiver Unit.

The PRAT will suspend consideration for services/supports for the individual until notified by the CO Waiver Unit of a final determination of eligibility for DMR funded services/supports. The CO Waiver unit will make a formal written request to the individual, guardian, and legal/personal representative to explain the basis for refusal and review documentation in support of the refusal.

After review the waiver unit will issue their findings and notify the individual, guardian, and legal/personal representative. Individuals and families who are seeking new supports will be advised of their right to a Programmatic Administrative Review at the Regional Level if they do not agree with the findings.

### 3.3.6 Annual Re-determinations

All individuals who are enrolled in the DMR waiver must be reviewed annually for re-determination of continued eligibility for waiver status at the time of their individual plan review by the case manager. Annual re-determination should be

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recorded in the Individual Plan or Form 219 ICF/MR Level of Care and kept in the case record. A copy is not sent to the waiver unit.

### 3.3.7 Changes in Individual Plan

Any changes in waiver services at the time of the annual review, or at any time during the year, will be reported by the case manager to the waiver unit on **Form 223 Notification of Waiver Services** and updated in CAMRIS within 5 business days.

### 3.3.8 Change in Eligibility

**Any change such as:**

- a. A change in residence to an institutional setting (ICF/MR or nursing facility)
- b. Increase in monthly earned and unearned income above the waiver limit
- c. Moving out of state
- d. Refusal of waiver services

which effects waiver eligibility should be reported to the waiver unit.

The **Form DSS 1576 DMR Waiver Change Report Form** should be completed by the case manager and submitted to the PRAT for review and submission to the CO Waiver Unit. The waiver unit will review the Form 1576 and forward it to the Department of Social Services and the Department of Administrative Services to assure correct Medicaid status and billing in a timely manner. If it is determined that the reported change will result in the individual's no longer being eligible for the waiver, the waiver unit will contact the case manager to review the information and resulting disqualification. The case manager will discuss this with the individual/family and advise them of the review process and document this in their record/notes. The waiver unit will send notification to inform the individual and family of their discontinuance from the waiver and their right to a hearing with DSS, the State Medicaid agency. (See Section 11)

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## 4. Individual Planning

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

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

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

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

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

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

DMR recognizes there are many established approaches to Person-Centered Planning such as Essential Lifestyle Planning, Circles, MAPS, Personal Futures Planning, Individual Service Design, and Lifestyle Planning. Any of these planning models may be used to supplement the planning process and incorporated into the person’s Individual Plan. The department’s Individual Plan format will be the document used for all individuals in the IFS Waiver.

### 4.1 Individual Planning Process

For additional information regarding the following sections, please refer to the following DMR policies and procedures:

Individual Planning Policy, Policy No. I.C.1.PO.002

Planning and Support Team Procedure, Procedure No. I.C.1.PR.002.b

Components of an Individual Plan Procedure, Procedure No. I.C.1.PR.002.a

Following are the major steps of the Individual Planning process:

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## 4.1.1 Prepare to plan.

The case manager should develop strategies to assist the person and his or her family to be actively involved in the planning process. The case manager and other team members should assemble as much information as possible before the meeting to assist the individual and his or her family to prepare for the meeting and helps the meeting to be shorter, more focused on decision making, and more efficient. Before the meeting, the case manager or another team member may assist the individual and his or her family to begin to update the Information Profile and develop the Personal Profile, Future Vision, and the Health and Safety Screening. The case manager should provide a copy of "My Health and Safety Screening" to the individual or his or her family so they may identify health and safety concerns they want to be sure are addressed in the plan if desired. It is also helpful before the meeting to ensure that the person and his or her family has a chance to review the information in current Assessments, Reports, and Evaluations that will be discussed at the meeting. Supporting the individual to prepare for the meeting offers an opportunity to express his or her desires or concerns to the case manager or another team member with whom he or she is comfortable and who can assist the individual to share these issues with the larger group.

There may be circumstances when the individual does not want to discuss something in a meeting. This preference should be respected when possible, however, personal information that affects supports or impacts the individual's health or safety should be addressed. In these circumstances, the topic should be acknowledged and dealt with respectfully and privately outside of the meeting with the person and with others who need to know this information to provide appropriate supports.

## 4.1.2 Gather a good understanding of the individual.

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

- Information Profile
- Personal Profile
- Health and Safety Screening
- Future Vision
- Assessment Review.

## 4.1.3 Develop an action plan to achieve desired outcomes.

The action plan should include desired outcomes, needs or issues addressed, actions and steps, responsible person(s), and by when and should consider the individual's choices and preferences. The section of the plan completed during this stage of plan development includes the:

- Action Plan

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## **4.1.4 Summarize the plan of supports and services.**

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

- Summary of Agencies and/or Individuals Who Will Provide Supports or Services.

## **4.1.5 Identify how progress on the individual's plan will be monitored.**

During the planning meeting, the individual and planning and support team should discuss plans to monitor progress and to evaluate whether the supports are helping the person to reach desired outcomes. At a minimum, the plan should be reviewed quarterly and may be reviewed sooner if the individual experiences a life change, identifies a need to change supports, or requests a review. The section of the plan completed during this stage of plan development includes the:

- Summary of Monitoring and Evaluation of the Plan

## **4.1.6 Agreement with the Individual Plan.**

Once the plan is completed and the individual and planning and support team agrees with the plan, the case manager should ensure the plan is documented on the appropriate forms and obtain the necessary signatures and approvals on the:

- Signature Sheet

## **4.1.7 Staff Qualifications**

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

- Provider Qualifications and Training Form

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## **4.1.8 Put the plan into action.**

Every effort should be made to arrange for needed supports and to implement the plan as soon as possible after the final approval is obtained as outlined in Sections 4.7 through 4.10. Supports and services are expected to be implemented within 45 days of plan approval and should be provided as described in the Individual Plan.

## **4.1.9 Monitor and revise the Individual Plan as needed.**

The team shall review all areas of the individual plan when there are any changes in the individual's life situation and at least every six months, or more frequently as required by state or federal regulations.

## **4.2 Role of Case Manager**

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

The case manager ensures the plan is documented on the Individual Plan forms, though other team members or clerical staff may do the actual transcription of the plan. He or she ensures the plan is distributed to all team members, though this task may also be assumed by another team member or clerical staff.

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

## **4.3 Participants in the Person-Centered Planning Process**

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

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

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

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## **4.4 Scheduling the planning meeting**

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

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

## **4.5 Completing the Individual Plan**

At a minimum, all individuals enrolled in a DMR waiver will have an Individual Plan developed on a yearly basis. The Individual Plan is the document that guides the supports and services provided to the individual. The individual plan should accurately reflect the individual's current life situation and address their specific supports and services. The Individual Plan Forms are found in Appendix E.

### **4.5.1 Information Profile**

The Information Profile, IP.3, is a form to update and document basic demographic information about the individual. After the meeting, any updated information should be entered into the department's automated data system, CAMRIS.

### **4.5.2 Personal Profile**

The Personal Profile, IP.1 – Section 1, describes information that members of the planning and support team and other support providers need to know in order to assist the individual to achieve what is important to him or her and to stay healthy and safe. The Personal Profile includes information about the individual's significant life history; accomplishments and strengths; relationships; home life; work, day, retirement, or school situation; leisure and community life; health and wellness; and finances. The Health and Safety Screening and all other relevant assessments are completed and the information is available during the planning process.

### **4.5.3 Future Vision**

Within the Future Vision section of the Individual Plan, IP.1 – Section 2, the individual and his or her planning and support team describe his or her hopes and dreams for one to three years into the future and for the coming year.

### **4.5.4 Assessments**

The Assessments section of the Individual Plan, IP.1 – Section 3, lists the current assessments, screenings, evaluations, and reports that are available or needed by the individual. Any assessments or reviews identified as needed must be referenced in IP.1 - Section 4 – the Action Plan and should be done within three months. However, any issue or concern that poses an immediate risk must be addressed immediately. Once the assessments and reviews are completed, all recommended supports or procedures identified must also be referenced in the

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action plan. The action plan may reference documents such as specific service plans, health care plans, guidelines, procedures, or protocols that describe the detailed supports to be provided. The planning and support team is responsible to ensure that recommended supports and procedures are in place, required staff training is completed and documented, and ongoing supervision provided.

### **4.5.5 Health and Safety Screening – IP.6**

The Health and Safety Screening, IP.6, should be completed prior to developing the other sections of the individual plan. The screening should be completed at the time of the initial plan and updated annually or more often as needed to identify and document concerns or issues that may pose a health and safety risk to the individual. It is recommended that the case manager or other team member begin to update the Health and Safety Screening prior to the meeting and should ensure the screening is completed and reviewed at the Individual Plan meeting.

An optional format, My Health and Safety Screening – IP.6a, is a screening tool designed to help individuals and their families identify risk issues of concern to them prior to the individual plan being developed. If available, this information should be incorporated in health and safety screening and individual plan developed by the planning and support team.

Some issues or concerns identified in the Health and Safety Screening may require a formal assessment by a licensed professional with specialized expertise such as a physician, nurse, physical therapist, occupational therapist, psychologist, or speech and language pathologist. The planning and support team may review other issues with input from people who know the person well and are familiar with the person's history and current situation. These reviews should be documented in the form of a report. In either case, an assessment or review must be completed for each area identified. All assessments and reviews should contain specific recommendations for supports or procedures to minimize risk to the person.

### **4.5.6 Action Plan - Individual Plan – IP.1 – Section 4**

The Action Plan, Section 4 of the Individual Plan – IP.1, should identify the desired outcome and the needs that will be addressed by the action and steps. The Action and Steps section should be specific and should indicate all actions to be taken to address the need or should reference a teaching strategy, specific service plan, guideline, procedure, protocol, health care plan, behavior plan, or other document that contains the step by step actions to take.

### **4.5.7 Summary of Representation, Participation & Plan Monitoring**

Section 5 of the Individual Plan – IP.1, Summary of Representation, Participation & Plan Monitoring summarizes four areas: the person's understanding and capacity to make important decisions/choices, accept assistance from others, and possible need for guardian/advocate/legal or personal representative; the team's efforts to involve the person in planning, the person's actual participation in the planning process, and planned efforts to enhance the person's future participation in planning; the team's efforts to involve the person's family/guardian/advocate/legal or personal representative in the planning process; and the team's plans to ensure that the Individual Plan will be implemented and that progress is made toward achieving desired outcomes.

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## **4.5.8 Summary of Agencies and/or Individuals Who Will Provide Supports or Services**

Section 6 of the Individual Plan – IP.1, Summary of Agencies and/or Individuals Who Will Provide Supports or Services, identifies the individual's support providers. The information documented in the plan should include the agency or individual who will provide support, the type of service or support, and the amount of service or support. Included in this information is the type and frequency of contact the case manager will have with the person.

## **4.5.9 Provider Qualifications and Training Form – IP.7**

The Provider Qualifications and Training Form – IP.7 is to be used for individuals enrolled in a DMR HCBS waiver who require specially qualified or trained support staff. Each waiver service identifies standard qualifications that employee(s) who provide the service must meet. During the planning meeting, the Planning and Support team may identify additional or specific qualifications (expertise, competence, and or training) that staff should possess to effectively support the individual to achieve personal outcomes and maintain a healthy and safe lifestyle. The additional qualifications or training requirements should be documented on this form.

## **4.5.10 Emergency Back Up Support Plan – IP.8**

The Emergency Back Up Support Plan – IP.8 is to be used for individuals who are enrolled in both the Comprehensive Waiver and the IFS Waiver. This form is to be completed for individuals on the waivers who live in their own or family homes and who receive personal care and/or supervision supports that must be available as described in the Individual Plan or it would lead to an immediate risk to the individual's health and/or safety. The form documents specific protocols to follow in the event that these needed supports are not available.

## **4.5.11 P.4 HCBS Re-determination**

At the time of the Individual Planning meeting the planning and support team should also complete the IP.4 HCBS Re-determination form to indicate whether there is a reasonable indication that the person, but for the provision of waiver services would need services in an ICF/MR or NF.

## **4.5.12 P.2 Individual Plan Signature Sheet**

Once the plan is completed and the individual and planning and support team approves of the plan, the case manager should ensure the plan is documented on the appropriate forms and obtain the necessary signatures and approvals on the Individual Plan Signature Sheet, IP.2. The Signature Sheet includes the names of those who attended the meeting or reviewed the plan and a place for each to indicate their approval of the plan.

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## 4.6 Changes to the Individual Plan

The Individual Planning process is an ongoing process that changes as the needs and circumstances of the individual change. The individual or his or her legal representative may request a meeting to revise the Individual Plan at any time.

### 4.6.1 Periodic Review of the Plan – IP.5

For individuals who are enrolled in a waiver, the case manager monitors the supports and services the person is receiving on at least a quarterly basis and reviews progress reports completed by support providers to determine if desired outcomes are being addressed. Case managers should sign and date the progress reports and file them with the Individual Plan in the Individual Record. For individuals with Individual Support Agreements (ISAs) including those who are hiring their own staff, the case manager should also review the quarterly fiscal intermediary reports that indicate what supports have been provided and billed for as a method to monitor the actual delivery of services and supports as prescribed in the Individual Plan. At least once every six months, case managers should convene the planning and support team to review the Individual Plan using the Periodic Review of the Plan – IP.5. The following areas should be included in the review of Individual Plans:

- Overview of the person's current life situation
- Identification and documentation of any changes, progress, and accomplishments
- Determination that supports and services authorized in the Individual Plan have been provided
- Review of the individual's satisfaction with supports and providers
- Review of the individual's current needs, preferences and desired outcomes
- Review and/or develop strategies and action plans to ensure specific needs, preferences and desired outcomes are being addressed.
- Identification of the frequency of future individual plan reviews.

Individual service providers should provide specific review documents detailing progress on specific personal outcomes and actions for which they are responsible. These progress reports should be attached to the Periodic Review Form in the Individual Record. When the Team reviews the Individual Plan, the review form should reflect the review of the plan and progress on the Action Plan.

If the plan needs to be modified, the Area Reviewed section on the form should indicate the desired outcome, issue, or the need area that is to be modified. The Summary of Progress section of the Periodic Review form should include the rationale for the change in the plan. The Plan Modifications section should detail the new actions and steps, and any changes in responsible persons or timeframes.

Individuals who have ISA's and/or are enrolled in a waiver, should have a revised budget completed at the time of the Periodic Review if there are changes to the existing budget.

### 4.6.2 Service and/or Provider Changes to the Plan

If changes are made to types of or providers of supports and services, a revised Summary of Individuals or Agencies Who Will Provide Supports or Services – IP.1 - Section 6, and an Individual Budget, should be completed. At the time of the Periodic Review, the Signature Sheet – IP.2, should also be completed and initialed by the individual or his or her family or guardian and the other planning

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and support team members. If the changes do not result in an increase in the approved Individual Budget, submit a copy of the Summary and Individual Budget to the Resource Administrator or designee who will issue new service authorizations to the Vendor and FI as needed. See Section 4.10 for more about service authorization.

If a change in services will exceed the dollar limit in the approved Individual Budget, the case manager must submit a Request for Services to the PRAT detailing the type and amount of services requested and the reasons for the requested services. The PRAT is responsible to approve increased service requests based on identified needs and any Utilization Review criteria if applicable. See Sections 4.7 through 4.10 for plan approval.

### **4.7 Individual and Family Support (IFS) Budget (Form found in Appendix IFS FGP2)**

The IFS Budget is used if the individual is purchasing all services and supports from qualified vendors at the established rates for each service, and/or will utilize an individualized rate for specialized medical or behavioral day services paid through a Master Contract. If the individual will be hiring his/her own staff directly or negotiating rates with qualified vendors for any of the selected services and supports, the ISA Budget is used as described in section 4.10. The ISA Budget and IFS Budget will be replaced in FY 06 by an integrated Individual Budget data system.

**4.7.1 IFS Budget Instructions** Detailed instructions are found in the Excel file containing the IFS Individual Budget located in Appendix IFS FGP2.

### **4.8 Comprehensive Support Budget (Form found in Appendix Comp FGP1)**

Individuals who are eligible for the Comprehensive Supports waiver will prepare an Individual Budget using the Comprehensive Supports Budget if all services will be delivered at the established rates from qualified vendors and/or will utilize an individualized rate for specialized medical or behavioral day services paid through a Master Contract. Individuals who will be residing in a licensed CLA or CTH setting will record the annual budget amount on the budget form. If the individual will be hiring his/her own staff directly or negotiating rates with qualified vendors for any of the selected services and supports, the ISA Budget is used as described in section 4.10. The ISA Budget and Comprehensive Budget will be replaced in FY 06 by an integrated Individual Budget data system.

#### **4.8.1 Comprehensive Support Individual Budget Instructions**

Detailed instructions are found in the Excel file containing the Comprehensive Support Individual Budget located in Appendix Comp FGP1.

### **4.9 Plan and Budget Approval Process**

Based on the outcome of the Individual Plan, supports are crafted with a combination of natural supports, community supports, and DMR funded (waiver and state only) supports.

Each waiver prescribes packages of services and supports with associated dollar limits for each package, as described in the next two pages.

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- 4.9.1** The **IFS Waiver** covers the following service packages and associated service limits defined by total cost for groups of waiver services and supports. IFS Waiver Service Packages and Limits: total amount of available services within each package is based first on the individual's assessed level of need, and, for any individual may not exceed without prior approval, the following limits:

<b>Home/Community Package to \$24,000</b>	<b>Day/Vocational Package to \$23,000</b>	<b>Ancillary Package to \$5,000</b>	<b>Other -require individual approvals</b>
Supported Living	Group Day Options	Adaptive Equipment	Home Modification
Personal Support	Individualized Day	Consultative Therapies up to \$1,250 per year	Vehicle Modifications
Individual Habilitation	Individual SE	Interpreter Services	Family/ Individual consultation/support
Adult Companion	Group SE	Transportation	Family Training
Respite			
PERS			

The total amount of services within each package that is available to an individual is based first on the individual's assessed level of need. Then, each service package is further limited to a specific range of funding. For example, and adult is assessed as having a Minimum Support Need for Day and Vocational Services, and is authorized to plan for day and vocational services up to \$12,500. Funding beyond that amount is subject to Utilization Review described in Section 4.9.4. Additionally, with prior approval, service package limits for each group (e.g. Home/Community Package to \$24,000) may be exceeded based on identified needs. The overall amount of services that can be approved on an annualized basis from all Packages (Home, Day, Ancillary and Other) covered by the IFS Waiver may not exceed the sum of the total, \$52,000.

The Individual Budget may exceed \$52,000 at any one point during the plan year as a result of specific services that have been authorized from the Other Category as a result of Utilization Review approval. Examples of this would include: Home or Vehicle Modifications resulting in a one time increase in the Individual Budget; Individuals Self-Directing services may require a higher amount of Family/Individual Consultation and Support when initially selecting and training staff that will decrease over time; or, a need for extra Family and Individual Consultation and Support is required due to a change in the individual status of a person who self-directs their own supports that creates potential risk to the individual's health and safety until effectively resolved. Individual Budgets may also exceed \$52,000 during the course of a plan year the due to a temporary change in the person's status, such as a significant illness, or temporary loss of a caregiver as an example. A procedure governing DMR's obligation if an individual can no longer be supported under the IFS Waiver as a result of on-going health and safety needs is described in Section 4.9.5.

Individual package limits will increase over the term of the approved waiver as a result of cost of living adjustments and service utilization studies. Increases to the service limits can occur at any time during the term of the waiver.

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- 4.9.2** The **Comprehensive Supports Waiver** covers the following service packages and associated service limits defined by total cost for groups of waiver services and supports. This waiver is intended to support individuals who: utilize or require structured comprehensive group residential settings; individuals who use the Community Training Home (Foster Care) model for support; and, for those who choose and are able to live in his/her own or family home with a more comprehensive amount and/or array of waiver services than is available in the Individual and Family Support waiver, in combination with his/her State Plan services and natural supports.

<b>Residential/Home and Community Supports</b>	<b>Day and Vocational Supports</b>	<b>Other Services</b>
Residential Hab <sup>1</sup>	Group Day Supports	Home Modifications <sup>2</sup>
Assisted Living <sup>1</sup>	Supported Employment	Vehicle Modifications <sup>2</sup>
Supported Living	Individualized Day Support	
Personal Support	Transportation	
Adult Companion	Consultative Services	
Respite	Interpreter	
Transportation	Medical Equipment and Supplies	
Consultative Services	Family and Individual Consultation and Support	
Interpreter	Individual Directed Goods and Services	
Medical Equipment and Supplies		
PERS		
Family and Individual Consultation and Support		
Individual Directed Goods and Services		

<sup>1</sup>Res Habilitation and Assisted Living may not be utilized at the same time,

<sup>2</sup>Can be authorized as separate service costs above the Residential and Day/Vocational Package funding level limits, see also service definition limitations.

### Funding Limits by Level of Need

<b>Service Package</b>	<b>Minimum</b>	<b>Moderate</b>	<b>Comprehensive</b>
<b>Res/Home and Community Supports</b>	up to \$30,000	up to \$60,000	up to \$90,000
<b>Day and Vocational Supports</b>	up to \$19,500	up to \$24,000	up to \$35,000
<b>Home and Vehicle Modifications</b>	up to \$10,000 for each service in a three year period	up to \$10,000 for each service in a three year period	up to \$10,000 for each service in a three year period

The total amount of services within each package that is available to each individual is based first on the individual's assessed level of need.

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Then, each service package is further limited to a specific range of funding based on the results of an individual's Level of Need Assessment. This funding range is used to build the Individual Budget that meets the needs of the individual as determined by the plan of care. For example, an individual is assessed as having Moderate Support needs and is provided an Individual Budget limit of \$65,000 for combined Residential and Day/Vocational services based on the Level of Need assessment findings. The individual and his/her planning and support team then initiate the person-centered planning process and build an Individual Budget up to the \$65,000 limit to carry out the Individual Plan. Funding levels may exceed \$65,000 at any time during a plan year if Home and Vehicle Modifications services authorizations occur as one-time service costs. Requests to exceed \$65,000 of annualized supports and services, in this example, are addressed through Utilization Review detailed in Section 4.9.4.

Changes to these budget limits will be made based on analysis of actual utilization relative to Level of Need, and on COLA increases, for each year of the waiver. Increases to the service limits can occur at any time during the term of the waiver.

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## 4.9.3 Plan and Individual Budget Approval

When the Individual Plan is completed, the case manager, individual, family, and planning and support team develop an individual budget to address the services and supports needs identified in the plan as outlined below:

- The type and amount of waiver services to be purchased based on the identified needs and desired outcomes in the Individual Plan is entered into the budget form;
- Individuals and families choose vendors from the qualified vendor list at DMR established rates;
- After vendors have been chosen, the Individual and Family Support budget (IFS budget) or the Comprehensive Support budget is completed with the vendor name, the type of support, the hours of support per week and per month;
- If the total cost of DMR funded waiver services is within the original assigned PRAT resource allocation range, the case manager submits a signed copy of the Individual Plan and Budget with the waiver application packet to his/her case manager supervisor;
- Individual Budgets exceeding the original resource allocation range are submitted back to PRAT with the Individual Plan and waiver application packet for further utilization management review as described in 4.9.4;
- Following CM supervisor or designee approval verifying planning and budget standards are met, the Individual Plan checklist, Individual Budget and waiver application packet is submitted to the Resource Administration Unit;
- The Operations Center, (860) 418-6029, assigns a fiscal intermediary to manage the IFS or Comprehensive budget funds and vendor payments that are managed through a Fiscal Intermediary;
- The regional Resource Administration office prepares a contract or contract amendment for the selected vendor if needed;
- The regional Fiscal office enters the budget into the spend plan;
- The resource administrator or designee authorizes the release of funds to the fiscal intermediary or to the contract after the Individual budget is reviewed for accuracy and the annualized and current fiscal year funding amounts meet the PRAT authorized funding amount;
- The approved Individual Budget is forwarded to the FI if applicable, and the case manager. A copy of the Individual Budget is returned with the waiver application packet to the PRAT for waiver application processing, and a copy of the Individual Budget is submitted to the CO Operations Center.
- The regional Fiscal office issues the payments to the Fiscal intermediary quarterly prospectively.
- The FI sends periodic expenditure reports to the individual and family to review with a copy to the case manager.

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## 4.9.4 Utilization Review

Individual Plans and budgets exceeding the overall original resource allocations or Individual Budget limits based on the Level of Need Assessment proceed through utilization review. Individual Plans and budgets are reviewed to evaluate the amount, type, frequency, and intensity of services directly related to health and safety needs of the individual, and desired outcomes based on the individual's preferences and needs. Utilization review consists of regional and state level review processes outlined below:

- a) Requests for resource allocations exceeding original range or Individual Budget limit by the Regional PRAT are made to the PRAT. PRAT has up to 10 business days to issue a decision on the request.
- b) The Regional Director is required to review and approve PRAT decisions that exceed PRAT approval limits and will do so within 5 business days.
- c) The State UR Committee is required to review and approve Regional Director decisions that exceed the Regional approval limits and will do so within 25 business days.
- d) Regional Directors may provide immediate temporary approval for requests to address immediate threats to the individual's health and/or safety.

Each waiver has specific established limits and Utilization Review criteria.

### **IFS Waiver**

Regional Utilization Review may approve service packages up to \$30,000 in Day and Vocational Services and up to \$30,000 in Home and Community Services, when considered separately. State Utilization Review is required beyond those amounts. Such approvals are made based on the existence of health and safety needs that could not be addressed within the original Level of Need allocation for that individual. The total annualized cost of the individual's services and supports may not exceed the current IFS Waiver covered services limit described in Section 4.9.1 (this section will be updated through the term of the waiver to reflect increases in service limits).

### **Comprehensive Supports Waiver**

Regional Utilization Review is required for any service package that exceeds the initial allocation range or Individual Budget limit as determined through the Level of Need assessment outcome. Regional Utilization may approve up to the established limits found in Section 4.9.2 for each Level of Need in total (e.g. Moderate up to \$84,000 for Residential/Home and Community Supports and Day/Vocational Supports combined on an annualized basis at the time of this publication). Such approvals are made based on the existence of health and safety needs that could not be addressed within the original Level of Need allocation for that individual.

State Utilization Review is required for any service package that exceeds the identified total limits for each Level of Need range. Specific criteria for approval of such requests are:

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- Funding, or allowable, service costs which exceed those amounts may be permitted if necessary to access 24-hour supervised "group living" arrangements; and/or,
- To access specialized day/vocational supports due to specific and identified behavioral, medical, and physical support needs; and/or,
- For specialized service costs for individuals who may present threats of harm to others, as assessed on an individual basis; and/or,
- When needed to assure the health and welfare of a self-directed participant, the funding limit may be exceeded if needed to approve additional Family and Individual Consultation and Support services. (DMR Comprehensive Supports Waiver 0437 page B: 2)

Individuals transferred from DMR waiver # 0153 who currently receive a level of support in excess of the defined Funding Limits will continue to receive such services at the time of the transition to this waiver.

Individuals who are seeking enrollment in a DMR HCBS waiver whose service package exceeds the prescribed allocation range or Individual Budget limits may not initiate services until the application has been accepted and approved through either Utilization Review or through the determination of a DSS Appeal Process.

Requests for additional services later in a plan year that exceed the previously approved Individual Plan and Budget are submitted to the Regional PRAT following a review of an individual's plan, and are subject to the same approval and/or Utilization Review process and criteria as described in this sub-section.

### **4.9.5 Denial of Services and/or Enrollment and Notice of Appeal**

Any PRAT or Utilization review resulting in a recommendation to deny an initial Individual Plan and Budget, or an additional service request in whole or part is submitted to the Central Office Waiver Unit. The Waiver Unit will review the request and issue a final decision. If the initial Individual Plan and Budget, or additional service request, is approved following a Central Office Case review, the reasons for the approval are documented in a Utilization Review summary and returned to the Regional office for processing and service authorization. If denied, the Waiver Unit will issue a denial with notice of appeal rights to the individual, responsible person and case manager. For any determinations of the CO Waiver Unit that constitute a denial of or reduction in a waiver service, the CO Waiver Unit will provide information and forms to initiate an administrative hearing through the Department of Social Services. The Appeal process is further outlined in Section 10 of this Manual.

### **4.9.6 IFS Waiver- Exceeding the IFS Waiver Limits**

Individuals participating in this (IFS) waiver will not lose their eligibility for the waiver due an increase in the need for covered service that causes the total need for the relevant service(s) to exceed the maximum permitted amounts established by the state, unless the state has evaluated the individual and determined that the individual's health and welfare cannot be assured by any one or any combination of the following:

- Adding more available natural supports; and/or,

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- Accessing available non-waiver services, other than natural supports; and/or,
- Accessing funds held in CT DMR Regional risk funds on a non-annualized basis.

To the extent that the above efforts are unsuccessful, and the state finds that the absence of sufficient service(s) prevents the state from being able to assure the individual's health and welfare, the following shall apply:

- Individuals will be given the opportunity to apply for an alternative CT MR HCBS waiver for which the individual is eligible that may more adequately respond to the service needs of the individual, to the extent that such waiver openings exist. Individuals in emergency situations are permitted to access services on a priority basis before other individuals on the waiting list per DMR Procedure I. B. PR. 002.
- Individuals will be afforded an opportunity for placement in an ICF/MR including a state operated Regional Center.
- Individuals will be informed and given the opportunity to request a fair hearing if the state proposes to terminate the individual's waiver eligibility consistent with the requirements under 42 CFR 431.210, .211, .221 and .430 subpart D. Waiver services will be continued during the pendency of a timely requested hearing including the provision of any emergency services available within the DMR Regional Risk Pool, even if the services exceed the total benefit package limitation in this waiver.  
(DMR IFS Waiver 0426IP, page D: 6-7)

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## 4.10 Service Authorization Procedure

Upon final approval of the Individual Plan and Budget, the resource administrator/designee authorizes release of DMR funds for the Individual budget to the fiscal intermediary and sends a service authorization form to the vendor (Vendor Service Authorization), or finalizes the DMR Master Contract amendment.

### 4.10.1 Vendor Service Authorization Form – Instructions (Form found in Appendix G)

- The Resource Administrator fills out the Service Authorization Form with information from the Individual budget;
- The Service Authorization Form includes the individual's name, the authorized services including amount, duration, and/or frequency, unit rate, the fiscal intermediary, the case manager, case manager phone number, the region, and the effective date;
- The vendor provides services as authorized in the Vendor Service Authorization Form and documents the date of service, type of service, and the number of units and/or costs;
- The vendor submits the monthly Vendor Billing Invoice Form for each person served, with the dates, number of units and/or costs, vendor billing information, and consumer information;
- The fiscal intermediary makes payment up to the amounts authorized in the Individual Budget to the vendor.

## 4.11 Consumer-Directed Options

Individuals and families can choose the level of control and flexibility they want to exercise over their supports. The options for self-direction include:

- Choosing qualified vendors and negotiating rates below the established DMR rates;
- Agency with Choice, the vendor provides the individual and family an opportunity to participate in selecting and dismissing staff;
- Hiring individual providers, with the individual or family as the employer of record)
- A combination of vendor services and hiring individual providers.

The case manager/support broker will provide information and assistance to ensure that the individual and his/her planning and support team successfully arrange the initiation of approved services in the desired approach.

Individuals who choose to manage his/her supports through the direct hiring of support staff can utilize up to \$500 per year of his/her annual resource allocation to purchase non-waiver supports. Requests for non-waiver services/supports in excess of this amount may only be made through the one-time funding procedures managed by the PRAT.

Individuals who create consumer-directed plans and budgets including the direct hiring of staff are subject to The *Department of Mental Retardation Individual Support Agreements Accounting and Reporting Requirements (COST STANDARDS) 4/29/04*. For individuals who self-direct services and supports through an Consumer Directed Agreement, the Medicaid Agency (DSS) has designated the Fiscal Intermediary to obtain and hold individual Medicaid Provider Agreements. Cost Standards found in Appendix H.

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Individuals who only select the Agency with Choice Option use the Individual Budget and process described in section 4.7 through 4.9.

### 4.11.1 Consumer Directed Agreement Instruction (Form found in Appendix I)

The case manager/support broker will review the requirements for self-direction and the Consumer-Directed Services Agreement with the individual and family. The requirements for self-direction are: the sponsoring person signs the Self-Directed Service Agreement with DMR, demonstrates the ability to manage supports, and selects an approved fiscal intermediary or has one assigned. The sponsoring person may need assistance with managing their supports as identified in the Individual Plan. Individuals who seek additional assistance may request a DMR broker who will provide both Targeted Case Management and the additional support functions to effectively self-direct services. The waiver Service, Individual Family Consultation Support, can also be used to assist the sponsoring person with the management of supports. The sponsoring person can be the individual receiving services, a family member, or a member of the planning and support team, with the exception of the case manager/support broker.

### 4.11.2 Instructions ISA Budget

- The Individual Budget System was designed to allow automated budgeting of individual support budgets. This version allows budgets to span two fiscal years and provides detail for Day and Residential Services. It will allow the use of 620 for residential, 617 for day, and one other account for both day and residential.
- Data entry fields are colored green. All entries should be rounded to the nearest dollar. Wages, Benefits, and Agency costs carry forward from previous worksheets. In Funding Account section it will default to 620 for residential and 617 for day. You may choose one other account. Enter the SID and distribute funds to it. The annualization section provides an annualized number based on the last month and the day rate for your information. You must enter an annualized number in the data entry field. If the entered annualized is very different from the annualized based on day rate or monthly amount, there is a field for an explanation.

### 4.11.3 Individual Plan and Budget Approval Process

- The case manager/support broker assist the individual, family, and planning and support team to complete the person centered planning process and the Individual Plan;
- Supports are crafted with a combination of natural supports, community supports, and DMR supports;
- The case manager/support broker build an ISA budget that captures the DMR supports within the DMR Cost Standards and Cost Guidelines; t
- If the total cost of DMR funded services is within the original assigned PRAT resource allocation range, the case manager submits a signed copy of the Individual Plan and Budget with the waiver application packet to his/her case management supervisor;
- Individual Budgets exceeding the original resource allocation range are submitted back to PRAT with the Individual Plan and waiver application

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packet for further utilization management review as described in Section 4.9.4;

- Following case management supervisor approval verifying planning and budget standards are met, the Individual Plan checklist, Individual Budget and waiver application packet is submitted to the Self-Determination Director or designee;
- The Self-Determination director/designee reviews the ISA budget for accuracy and compliance with all DMR procedures ( Waiver requirements, Cost Standards, Cost Guidelines, and qualified vendors);
- The Self-Determination director/designee authorizes release of funds to the fiscal intermediary when the ISA budget and plan meet all DMR procedures and the annualized and current fiscal year funding amounts meet the PRAT authorized funding amount;
- The approved Individual Budget is forwarded to the Fiscal Intermediary and the case manager. A copy of the Individual Budget is returned with the waiver application packet to the PRAT for waiver application processing, and a copy of the Individual Budget is sent to the CO Operations Center.
- The regional fiscal office enters the budget into the spend plan;
- Funds are paid to the Fiscal Intermediary quarterly, in advance;
- The **Fiscal Intermediary** sends periodic expenditure reports to the individual and family to review with a copy to the case manager. The individual and family have flexibility to make changes in their budget according to the DMR IS Fiscal Management Procedure No. I.C.2.PR.008.

### 4.11.4 Service Authorization

The individual or sponsoring person of the ISA completes agreements with all qualified vendors and individual providers. (Individual/ Family Agreement with Vendor and Individual /Family Agreement with Employee) These agreements reflect the type and amount support, any special conditions, and the effective date.

### 4.11.5 Individual /Family Vendor Agreement Form Instructions –(Form found in Appendix J)

Individuals who self-direct their services and choose vendors and/or negotiate rates are required to complete an Individual/ Family Vendor Agreement. The agreement includes the type of Waiver support, the hours per week and schedule of support, agency with choice arrangements, the negotiated rate when below the DMR established rate, the billing method, terms for discontinuation, and the effective date.

The Fiscal Intermediary sends a confirmation to the Vendor when the authorized budget and vendor agreement are received from the individual.

### 4.11.6 Individual/ Family Employee Agreement Instructions- (Form found in Appendix K)

Individuals who hire their own staff are required to have an agreement with each employee. The agreement (Individual/ Family Employee Agreement) includes the type of Waiver support, the hours per week and the schedule of hours, the hourly rate of pay (within DMR Cost Guidelines), employee information, a commitment to complete training requirements, and work rules as determined by the individual or family.

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## 5 Case Manager Responsibilities

During the Individual Planning process, the case manager is responsible to ensure the HCBS waiver application has been completed and been included in the Individual Plan and Budget package submitted for authorization.

The case manager has overall responsibility for ensuring that Waiver services are coordinated with other services, resources, and supports available the person, including state plan, generic, and informal services and supports. The case manager also has responsibility to ensure approved waiver services are delivered according to the Individual Plan, and to routinely review and monitor all aspects of service delivery.

The individual and his or her planning and support team, including his or her family or legal representative and support providers, also have roles in assuring that services are delivered as described in the plan to meet the person's needs. The individual and planning and support team members should inform the case manager of any changes in the person's situation or needs and provide access to locations and information that will enable the case manager to monitor supports and services.

Case managers specifically carry out the following requirements under a DMR HCBS waiver.

### 5.1 Choice of Service Options

The case manager is responsible to ensure that the individual and his or her family or legal representative have sufficient information about support and service options to make informed choices during the planning process. Individuals may self-direct their supports and services, may select to have services delivered by qualified vendors, or a combination of both options. To the extent that they choose, individuals will be supported to self-direct and manage the supports and services identified in their individual plans.

### 5.2 Arranging Services and Free Choice of Providers

Case managers should assist individuals to obtain supports and services identified in their individual plans to the extent that individuals request their assistance. This may include assisting the individual to gain access to supports and services from qualified vendors or from other sources including state plan, generic, and informal supports and services.

For those individuals who self-direct a plan of supports that includes the hiring of staff, the individual and his or her family or legal representative may request the additional support offered by a DMR Broker, or choose to obtain assistance from an independent broker under the Family and Individual Consultative Service (FICS) option. In these cases, the broker will assume responsibility to fully arrange and coordinate consumer-directed services and supports. In these cases, the individual will continue to also receive DMR Targeted Case Management services.

Individuals will be offered choices of qualified vendors and fully informed of their right to freely select among qualified vendors. Case managers will ensure that individuals have sufficient information about qualified vendors to make informed choices. Case managers will refer the individuals who request supports and services from vendors to the directory of qualified vendors within that region. Case managers may accompany individuals to interviews, tours, and initial visits. Case managers may also assist individuals and their families or legal representatives to evaluate several different options and providers to ensure the best selection.

Supports and services should be implemented within 45 days of plan approval and should be provided as described in the Individual Plan. If supports and services cannot be promptly

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implemented, the case manager, individual and planning and support team should consider the need to revise the Individual Plan to meet the person's needs.

### 5.3 Coordination

Case managers will assist individuals to coordinate the services identified in the individual plan and will promote cooperative communication among support providers.

### 5.4 Monitoring

Case managers will engage in activities to evaluate whether supports and services are meeting the desired outcomes for the individual and will continue to work with the individual and his or her family or legal representative to make adaptations to plans and service arrangements as needed. The case manager must have a face-to-face contact with individuals enrolled in the IFS Waiver at least quarterly. At least quarterly, the case manager is responsible to ensure supports are provided as described in the plan, to review all service provider progress reports and sign, date, and file them with the Individual Plan, to review reports from Fiscal Intermediaries (FIs) as applicable, and to document his or her activities in the case management running notes. Case Management running notes should include the date and a description of the Case Management and should be signed and dated.

Monitoring of supports and services will include input from the individual and implementation of Case Manager Quality Reviews. Within six months of the development of the Individual Plan, the case manager will visit the individual at locations where IFS Waiver supports and services are provided to conduct the Case Manager Quality Reviews. The Quality Reviews include an interview with the individual, observation of support providers, and a review of provider documentation. Case managers document their reviews on the case manager quality review forms.

When a case manager identifies or is notified that an individual may be in need of additional support, is at risk, or may be entering a crisis, the case manager shall take steps to notify appropriate parties, convene the planning and support team to make needed support changes, make referrals to the region's Planning and Resource Allocation Team (PRAT), implement appropriate practices or procedures, or manage the crisis as appropriate to respond to the situation. If the issue is related to the individual's program or plan the case manager should bring the issue to the planning and support team and may schedule a periodic review of the plan.

### 5.5 Maintaining Medicaid Eligibility

The individual and his or her family or legal representative will maintain Medicaid eligibility and submit required documents to the Medicaid agency. The case manager is responsible for verifying a person's continuing eligibility for Medicaid. During the Case Manager Quality Review, the case manager will review documents to ensure the individual and his or her family or legal representative have submitted required information and may ask to view the person's Medicaid card. On an annual basis, the case manager coordinates the completion of a Level of Care re-determination for continued waiver eligibility.

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## 6. Provider Options

### 6.1 Qualified Vendor Requirements

Private agencies/organizations seeking enrollment as a qualified vendor to deliver services and supports in this waiver will meet the following requirements through demonstration of knowledge, policy and practice, and agreement to assurances as part of the DMR vendor enrollment process. Each agency upon approval by DMR will enter into a Provider Agreement with the Medicaid Agency (DSS). DMR will hold the Provider Agreements and will make payments on behalf of the Medicaid agency (DSS). Vendor Application Form is located in Appendix L.

- Meets all applicable federal and state regulations;
- Meets and keeps current all state licensing/certification;
- Understands and follows all applicable DMR policies and procedures (see Vendor Qualification Grid, Appendix B);
- Is able to communicate clearly and effectively with individuals and their families;
- Protects the confidentiality of the individual and family's information;
- Operates a drug-free workplace;
- Bills only for services that are actually provided;
- Submits billing documents after service is provided and within 90 days;
- Accepts payment from DMR as payment in full
- Retains financial and statistical records for six years from date of service provision;
- Allows state and federal offices responsible for program administration and audit to review service records and have access to program sites;
- Assure it will carry sufficient general liability insurance;
- To comply with State of Connecticut Ethics Protocols;
- When transporting a consumer as part of the service: the vehicle in which the transportation is provided must have valid license plates and at a minimum the State of CT required level of liability insurance; vehicles must be maintained in safe working order; consumers with special mobility needs shall be provided transportation in a vehicle adapted to those needs as required to facilitate adequate access to services; and, if the vehicle is used to transport consumers in wheel chairs, it should be equipped with floor mounted seat belts and wheel chair lock downs for each wheel chair it transports;
- Demonstrate in its policies and procedures that criminal background, abuse and neglect (Registry), driver's license checks, and any future pre-employment requirements are completed and updated as required for all direct service employees prior to employment;
- Will not discriminate against any employee, applicant for employment or participant because of race, age, color, religion, sex, handicap, national origin or sexual orientation;
- Demonstrate that it can train Direct Service staff in required areas;
- Demonstrate competence and knowledge of DMR policies and procedures in: abuse/neglect; incident reporting; human rights; confidentiality; handling fire and other emergencies, prevention of sexual abuse; knowledge of approved and prohibited physical management techniques; all required DMR policies and procedures as they apply to the services;
- Demonstrate that it can make information about staff qualifications and training records and Direct Service staff's time and attendance records available to DMR;
- Demonstrate that Direct Service staff receive supervision;
- Demonstrate the capacity to:
  - Assume responsibility
  - Respond to emergency situations and follow emergency procedures
  - Assure that the in the delivery of services, specific service related activities as well as staffing are:
    - Available and provided at any time as specified in the individual's Individual Plan

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- Delivered in a manner that takes into consideration the primary language of the consumer and their representatives as well as cultural diversity issues;
- Demonstrate that it can provide back up staff when the lack of immediate care poses a threat to the individual's health and welfare;
- Demonstrate that it will participate in individual's person-centered planning if requested by the individual;
- Demonstrate that it can obtain adequate information necessary to meet the needs of the individual;
- Demonstrate that it can observe and report all changes, which affect the individual and take action if necessary;
- Assure it will sign a provider agreement with the individual and family;
- Assure it will not require a participant to sign an agreement that they will not change agencies as a condition of providing services;
- Assure it will not sub-contract services;
- Demonstrates a commitment to Quality Improvement;
- Demonstrates financial stability.

### 6.2 Self-Directed Options

Individuals and families are offered options on how much control and flexibility they choose to have over their supports. They may choose a vendor agency to deliver the service, choose an Agency with Choice option, hire their own staff through the use of an approved Fiscal Intermediary to provide a number of services in this waiver, choose an agency and negotiate the rate below the DMR established rate, or choose a combination of vendor delivered and self-directed service options. This process is described in section 4.10. The case manager will provide vendor agency lists, information and assistance as requested to ensure that the individual and his/her circle successfully select and arrange the initiation of approved services in his/her desired approach.

### 6.3 Agency with Choice

Agencies with Choice are those agencies that provide individuals and families with a choice of choosing and dismissing staff. This provides families with a role in self-directing their services without the responsibilities of becoming an employer. The staffs are employed by the agency, but the individual and family participate in choosing staff. Individuals and families who select an agency with choice option are required to fill out an Individual/Family Vendor Agreement, which identifies the role of the individual and family in choosing and dismissing staff. The Individual/Family Vendor Agreement is located in Appendix J.

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## 7. Provider Qualifications and Training

Each Waiver Service identifies the standard qualifications that the employee(s) must meet prior to employment and prior to being alone with the individual for whom the service is being provided. The Provider Qualifications are listed for each service in Section 2 of this manual.

It is also necessary for the planning and support team to identify the **additional or specific qualifications** (expertise, competence, and or training) required to effectively support the individual to **achieve the personal outcomes** identified in his or her plan and to maintain a **healthy and safe lifestyle**.

Based on the preferences and support needs of the individual, the following information is documented for each employee who may require additional or specific qualifications in the Individual Plan form IP.7 Provider Qualifications and Training: (See IP Forms in Appendix E)

- The **additional or specific qualifications** (expertise, competence, and or training) required to effectively support the individual to **achieve personal outcomes** and maintain a **healthy and safe lifestyle**
- The timeframe in which the specific qualification(s) must be met.

Employers (vendor agencies or individuals/families) are responsible to ensure that employees meet the standard and specific qualifications identified. Employers must provide the necessary training and support for employees to acquire identified competencies and verify that all qualifications are met within required timeframes.

### 7.1 Provider Standard Qualifications and Training

QUALIFICATION/ TRAINING AREA	KNOWLEDGE, COMPETENCIES, OR EXPERTISE REQUIRED (Prior to being alone/within 30 days)	AVAILABLE TRAINING RESOURCES
<b>ABUSE AND NEGLECT (INCLUDING SEXUAL ABUSE)</b>	<ul style="list-style-type: none"> <li>✓ Understand the definitions of abuse (including sexual abuse) and neglect</li> <li>✓ Know the signs of possible abuse and neglect</li> <li>✓ Understand conditions that may lead to abuse and neglect</li> <li>✓ Understand strategies for preventing abuse and neglect</li> <li>✓ Know how to respond if abuse or neglect is suspected or reported</li> </ul>	Abuse and Neglect Policy and Procedures Abuse and Neglect Direct Hire Training Material

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<p><b>HUMAN RIGHTS</b></p>	<ul style="list-style-type: none"> <li>✓ Understand that people with disabilities are entitled to the same rights afforded to all citizens</li> <li>✓ Understand their responsibility to assist the person they support to understand and exercise their rights</li> <li>✓ Understands guardianship role and responsibilities</li> <li>✓ Understand and can use processes designed to safeguard rights, i.e., human rights committees</li> </ul>	<p>Human Rights Policy and Procedures Abuse and Neglect Direct Hire Training Material</p>
<p><b>CONFIDENTIALITY</b></p>	<ul style="list-style-type: none"> <li>✓ Understand that any individual identifiable health information is kept private</li> <li>✓ Understand that confidential information cannot be disclosed without written, informed consent</li> </ul>	<p>HIPAA Policy and Procedure HIPAA Fact Sheet Confidentiality Direct Hire Training Material</p>
<p><b>HANDLING FIRE AND OTHER EMERGENCIES</b></p>	<ul style="list-style-type: none"> <li>✓ Understand basic principles of fire prevention and personal safety</li> <li>✓ Know the appropriate actions to take in response to fire emergencies</li> <li>✓ Know the appropriate actions to take in response to other emergencies, such as severe weather, hazardous materials, missing person and others</li> </ul>	<p>DMR Fire Safety Guidelines Websites or pamphlets on fire safety or emergency management Handling Fire and Other Emergencies Direct Hire Training Material</p>
<p><b>PHYSICAL MANAGEMENT</b></p>	<ul style="list-style-type: none"> <li>✓ Understand the limitations placed on the use of involuntary physical restraint by Connecticut state law and DMR regulations, policies and procedures</li> <li>✓ Understand what constitutes life-threatening physical restraint, and that its use is prohibited under any circumstances</li> <li>✓ Understand that physical management techniques may only be applied by individuals who are certified through DMR-approved training programs</li> </ul>	<p>Policy and Procedure Physical Management Direct Hire Training Material</p>

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<b>INCIDENT REPORTING</b>	<ul style="list-style-type: none"> <li>✓ Know incidents and accidents to be reported</li> <li>✓ Understand required timelines for incident and accident reporting</li> <li>✓ Understand employer protocol for reporting incidents and accidents</li> </ul>	Incident Policy and Procedures Family Fact Sheets
<b>MEDICATION ADMINISTRATION</b>	<ul style="list-style-type: none"> <li>✓ Completion of DMR certified Medication Administration training if required by DMR regulations and the individual's specific support needs.</li> </ul>	DMR
<b>INDIVIDUAL PLANNING AND PERSON-CENTERED SERVICES</b>	<ul style="list-style-type: none"> <li>✓ Understands the DMR Individual Planning Process</li> <li>✓ Understand the importance of language that demonstrates respect, shared control, and use of "person first language"</li> <li>✓ Understand the basic philosophy of person centered planning</li> <li>✓ Understand the methods for gathering information about the person</li> <li>✓ Understand support staff roles and responsibilities in developing and implementing a plan with the person, his or her family, and circle or team</li> <li>✓ Understand that the plan changes as the person's life circumstances change</li> </ul>	Individual Planning Policy and Procedure PPT Presentation on Individual Person-centered Planning Direct Hire Training Material
<b>PARTICIPATION IN A PLANNING AND SUPPORT TEAM OR CIRCLE OF SUPPORT</b>	<ul style="list-style-type: none"> <li>✓ Understand the importance of listening, and takes direction from the person, identifying and building upon strengths and talents, and working as an effective, collaborative member of the person's circle or team.</li> </ul>	Individual Planning Policy and Procedure PPT Presentation on Individual Planning Person-centered Planning Direct Hire Training Material

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## 7.2 Documentation of Qualifications and Training

Vendor agencies must have a system to verify employee qualifications, screenings and training required by the waivers. Department staff will conduct periodic audits of provider records.

Individuals or families hiring employees will use the Provider Qualifications and Training Verification Record to document that each employee meets the standard and additional provider qualifications, screenings and training requirements. See Form in Appendix M. Upon verifying that all qualifications, screenings and training have met, the verification form will be attached to the Individual/Family Agreement with the Employee and forwarded to the Fiscal Intermediary. The Fiscal Intermediary will assist the individual or families with obtaining needed screenings and may provide assistance with arranging staff training. The FI is not authorized to make any payments for services until the individual provider has met the initial entry qualifications and screening requirements. Department staff will conduct periodic audits of employee records on file with the Fiscal Intermediary.

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## 8. Service Documentation and Records

Qualified Vendor staff and individual employees hired by individuals who self-direct must document services and keep records according to Medicaid requirements as well as DMR Policies and Procedures. A Qualified Vendor staff person or individual employee must document the provision of a service before seeking Medicaid payment.

The Medicaid requirements for specific services are outlined in this section. Qualified Vendors and individuals and/or their legal representatives who self-direct services must also keep related personnel, financial and other management records as required by the Medicaid Provider Participation Agreement, the policies and procedures in this manual, Medicaid rules, and state and federal law.

### 8.1 How Long Records Must Be Kept

The records must be maintained for six years from the date of service. For individuals who self-direct services and hire his or her own staff through a Fiscal Intermediary, that service documentation should be collected by the DMR case manager during the six month and annual plan reviews for inclusion in the individual's permanent record with the Individual Plan and Periodic Review forms.

### 8.2 Availability of Records

The Qualified Vendor or the individual and his or her legal representative who self-directs services must furnish information regarding its Medicaid payments upon request by DMR and its agents, the Office of the Attorney General, the Department of Social Services, the Centers for Medicare and Medicaid Services, and any other entities specified in the Medicaid Provider Participation Agreement.

In addition the DMR Case Manager, DMR Staff, DSS, and/or CMS must be permitted to review the documentation that supports a claim for Waiver services rendered and billed. Requested documents must be mailed or delivered to designated sites during state and/or federal reviews.

### 8.3 What the Qualified Vendor or the Individual who self-directs services keeps

- Copy of the Individual Plan, including current outcomes;
- Service documentation;
- Vendor Service Authorization, or approved ISA Budget; and
- Vendor copies of claims submitted to Fiscal Intermediary or individual/family as well as related correspondence.

In addition, the information needed in all records includes:

- The person 's name and DMR Number;
- What service was provided;
- The date that the service was provided;
- Duration of service, if applicable;
- Where the service was provided;
- Signature of the person providing the service; and

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## 8.4 Service Documentation

Documentation requirements differ according to the service. Note that DMR only considers that a service is provided if there is documentation of the service. The minimum service documentation requirements for Waiver services are listed in the following parts of this section. Examples of documentation forms may be found in Appendix N.

### 8.4.1 IFS Residential Habilitation (Supported Living)

Maintain service note documentation signed and dated by the individual providing the service that documents the date of the service; the amount of time involved in the service and a description of the activities related to outcomes/goals/objectives, care or transportation provided to the person.

For Daily Supported Living, the Qualified Vendor documents that one daily unit of service was provided to the person rather than the amount of time involved in the service. If the Qualified Vendor provides less than the average hours for the level of the Daily Supported Living Services on a given day, that is noted on the documentation form with the reason for the deviation in hours of scheduled service provision.

### 8.4.2 Personal Support

Maintain time logs kept by each direct service employee that provides services. After providing the service, the direct service employee enters the date of service, the time the service begins, the time it ends, and the tasks performed. The person/responsible party signs and dates the log to certify that the tasks were performed satisfactorily and the time is correct.

### 8.4.3 (IFS) IS Habilitation

Maintain time logs kept by each direct service employee that provides services. After providing the service, the direct service employee enters the date of service, the time the service begins, the time it ends, and the tasks performed. The direct service employee signs and dates the log to certify that he/she worked the time and dates listed, and performed the indicated tasks. The person /responsible party must sign the log to certify that the tasks were performed satisfactorily and the time is correct.

### 8.4.4 Adult Companion Services

Maintain time logs kept by each direct service employee that provides services. After providing the service, the direct service employee enters the date of service, the time the service begins, the time it ends, and the tasks performed. The person/responsible party signs and dates the log to certify that the tasks were performed satisfactorily and the time is correct.

### 8.4.5 Supported Employment Services

Maintain service note documentation signed and dated by the individual providing the service that documents the date of the service; the amount of time involved in the service, and a description of the activities related to outcomes/goals/objectives provided to the person.

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## **8.4.6 Group Day Service**

Maintain service note documentation signed and dated for each daily unit provided. If the individual arrives more than one hour after the usual start time or leaves more than one hour before the usual end time, the actual amount of time the individual is in service is recorded. The Group Day provider will maintain service records related to the acquisition of outcomes/goals/objectives, provided to the person.

## **8.4.7 Individualized Day Support**

Maintain service note documentation signed and dated by the individual providing the service that documents the date of the service; the amount of time involved in the service; and a description of the activities related to outcomes/goals/objectives provided to the person.

## **8.4.8 Respite**

Maintain a record of the dates and times that the care was provided, where it was provided, and the signature of who provided the care. Daily respite is recorded by date and location.

## **8.4.9 Environmental Modifications**

All home improvements and renovation projects must document through a submission of a proposal that includes, (1) the disclosure of the full scope of the project including a budget that identifies the cost for the entire project, (2) documentation that the project has the approvals from local building inspectors and fire marshals, (3) the documentation that the project has been competitively bid with the documentation of bids are from three qualified bidders, that each bidder is currently licensed with the State of Connecticut's Department of Consumer Protection to perform the work, craft, or skill for the portion of the project they are bidding, that the bidders are insured, and that all bids must be competitive and the bids are comparable. A signed Provider Agreement is required before payment is made.

## **8.4.10 Vehicle Modification Services**

All vehicle modifications must document through a submission of a proposal that includes, (1) the disclosure of the full scope of the project including a budget that identifies the cost for the entire project, (2) the documentation that the project has been competitively bid with the documentation of bids are from three qualified bidders, that each bidder is currently licensed with the State of Connecticut's Department of Consumer Protection to perform the work, craft, or skill for the portion of the project they are bidding, that the bidders are insured, and that all bids must be competitive and the bids are comparable. A signed Provider Agreement is required before payment is made.

## **8.4.11 Transportation**

Maintain a record that documents the date that the service is provided, the specific activity that the person is being transported to/from, and the mileage related to transporting the person. The signature of a representative from the

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Qualified Vendor or the directly hired employee providing the transportation is required.

### **8.4.12 Specialized Medical Equipment and Supplies**

The Qualified Vendor that provides an invoice that documents the date the item was provided to the person, a description of the item, and the cost of the item, including charges for delivery, supplies medical Supplies. A signed Provider Agreement is required before payment is made.

### **8.4.13 Personal Emergency Response Systems (PERS)**

Maintain a record that documents the date service is started, the dates that it is provided, and the date it is terminated.

### **8.4.14 (IFS) Family Training**

Maintain service documentation for each service event, including a description of activities completed related to outcomes/goals/objectives identified in the Individual Plan. Maintain a record of the dates and times that the service was provided, where it was provided, and the signature of who provided the service. Professional standards apply.

### **8.4.15 Consultative Services**

Maintain progress notes signed by the individual providing the service that document the date of the service, the amount of time involved in the service, and a description of the activities related to outcomes/goals/objectives as described in the Individual Plan.

### **8.4.16 Interpreter Services**

Maintain service documentation signed and dated by the interpreter providing the service that documents the date of the service; the amount of time involved in the service, and a description of the activities related to interpreter services.

### **8.4.17 Family and Individual Consultation and Support (FICS)**

Maintain progress notes signed by the individual providing the service that document the date of the service, the amount of time involved in the service, and a description of the activities related to outcomes/goals/objectives.

### **8.4.18 Comprehensive Residential Habilitation (CLA and CTH)**

Documentation maintained as directed in CLA and CTH regulations.

### **8.4.19 Assisted Living**

Maintain attendance records and service documentation notes signed by the individual provider if applicable.

### **8.4.20 Individual Directed Goods and Services**

Documentation requirements are set at the time of the service authorization.

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## 8.5 Periodic Review Reporting

Providers of service are expected to prepare periodic summary reports of the service provided specific to the outcomes identified in the Individual Plan. Providers of service should prepare at minimum a summary report to the case manager at the 6 month review and the annual review.

## 9. Invoices, Billing, Payments

The Vendor on a monthly basis will provide billing for the services rendered during the previous month. Billing will be sent to the following:

- For Individuals with an Individual Family Support Budget or a Comprehensive Support Individual Budget that includes Vendor fee for service:  
The appropriate Fiscal Intermediary listed on the individual's **IFS Vendor Service Authorization** form.
- For Individuals with an Individual Support Agreement:  
Whoever is designated on the **Individual/Family Vendor Agreement**.

Billing should specify the following:

- Qualified Vendor name and Address
- Federal Taxpayer ID number
- Medicaid Vendor Number
- Service month
- Individual's name and DMR number
- Service code
- Number of service units provided for each date of service

Direct service time is the period of time spent with the consumer and verified by the consumer or their family when required.

When billing, the Qualified Vendor should use the procedure code for the specific service that is authorized on the consumer's **IFS or Comprehensive Supports Vendor Authorization or Individual /Family Agreement –Vendor**. Each waiver service has a specific procedure code. The DMR Waiver Services: Codes-Units-Rates table is located in Appendix O. The Comprehensive Support Waiver Services: Codes and Units are located in Appendix S.

When billing, the Qualified Vendors should submit the number of units (hours, days, miles) for each service provided. Each service has a specific unit of service that is the minimum amount of direct service time that can be billed. Direct service time is the period of time spent face to face with the consumer. Qualified Vendors should round their direct service time to the nearest unit increment.

For example, when billing for **Personal Supports** the basis for payment is a quarter-hour unit; therefore, the Qualified Vendor should round its direct service time to the nearest 15-minute increment.

- If services were provided for **67** minutes, bill for **1** hour.
- If services were provided for **68** minutes, bill for **1.25** hours.
- If services were provided for **50** minutes, bill for **.75** hours.

Absences do not constitute a billable unit. The DMR will not compensate a Qualified Vendor for absences.

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For a Qualified Vendor of group day services, billing may include up to one (1) hour per day if the consumer arrives after or departs before his/her scheduled arrival or departure time. In no event shall the Qualified Vendor submit a bill for more than the number of hours authorized for that consumer.

If a consumer permanently stops attending the Qualified Vendor's program, they shall notify their Regional Contract Manager and the consumer's F.I.

Services authorized for payment through a Master Contract require that monthly attendance records be submitted to the Central Office Medicaid Operations Unit. Payments are made per the Master Contract agreement in place.

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## 9.1 Instruction for completing Vendor Billing Invoice Form (Form found in Appendix P)

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**Consumer Name:** Individual's name as it appears on the **Vendor Service Authorization**

**DMR Number:** Consumer's Department of Mental Retardation Identification number;

**Vendor Name/ Address:** name and address as listed on the Qualified Vendor application

**Vendor EIN#:** Federal Tax Identification Number

**T-XIX Provider #:** Department of Social Services Medicaid Vendor Number

**F.I.:** Fiscal Intermediary used by that consumer

**Billing Month:** Month that the services were provided for example- October 2005

**Date:** Date that the service was provided, for example 12 twelve day of month

**Service/Commodity Type:** The authorized service listed on the individual's **Vendor Service Authorization**

**Procedure Code:** Code that corresponds to the authorized service listed on the individual's **Vendor Service Authorization** (see **Individual and Family Waiver Service: Codes-Units-Rates** table and **Comprehensive Supports Waiver Service: Codes-Units** table)

**Service Units:** Unit of service that corresponds with that service code (see : **Codes-Units-Rates** tables)

**# Units:** The number of units provided for that particular date for that service. Units (hours, days, miles) should be entered in whole numbers or whole numbers with decimals. For example 6 and a half hours of DSO support would be recorded as **6.5** in the unit column.

**Unit Rate:** The fee set by the DMR for one unit of the corresponding service.

**Total:** The # of units times the Unit Rate (# Unit X Unit Rate)

**Subtotal:** Total of Column Total

**Grand Total:** The total of all Subtotals for that Individual for that month if more than one Billing Invoice Form is used

Qualified Vendor Certification

**Signature:** Signature of the staff of the Qualified Vendor authorized to certify the accuracy and authenticity of the billing

**Printed Name:** Print or type name of individual's signature

**Date:** Date of signature

**Telephone:** Telephone number of the individual who signed the **Request for Payment**

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## 9.2 Medicaid Billing

DMR serves as the billing provider for the DMR HCBS Waiver. Medicaid billing is received at DMR Central Office Medicaid Operations is reviewed and processed through the Department of Administrative Services Financial Services Center. The fiscal intermediaries will prepare the Fiscal Intermediary Waiver Service Documentation Form on a monthly basis for all waiver services received by the individuals they serve. The completed forms will be sent to DMR Central Office Medicaid Operations Unit. The form is located in Appendix Q. The fiscal intermediary will only report services that are:

- a. Provided according to the individual's plan of care.
- b. Provided by qualified providers who are enrolled with DMR and have a Medicaid performing provider number. Or,
- c. Provided through an approved consumer-directed Individual Support Agreement, Individual Plan and budget, and the provider has signed a Medicaid Provider Agreement. The Fiscal Intermediary has been deemed by the Medicaid Agency (DSS) as the entity authorized to obtain and hold those Provider Agreements.

Master Contract authorized services submit monthly attendance records.

## 9.3 Documentation for Medicaid Billing

Services provided under a DMR HCBS Waiver are billed to Medicaid and any provider accepting payment for those services will sign a Medicaid Provider Agreement found in Appendix R, which requires them to do the following:

- a. Accept payment, in form of check(s), from the fiscal intermediary.
- b. Agree to keep records of the service(s) or purchase(s).
- c. Provide only the service(s) or item(s) authorized on the check(s).
- d. Accept the check(s) as payment in full for the service(s) or item(s) purchased.
- e. No additional charges will be made or accepted from clients.
- f. Upon request, provide DSS or its designee information regarding the service(s) or purchase(s) for which payment was made.

### 9.3.1 Performing Provider Agreement

Vendors who register with DMR as providers of CLA and CTH services will complete an application for a Medicaid performing provider number from DSS prior to receiving any payment for services. Other Vendors who are approved to provide services under the a DMR Waiver may be required to obtain a Medicaid Performing Provider Number before they may bill for services. In these cases, the enrollment procedure is:

- a. Vendors who apply to the DMR Operation Center to be providers for the Waiver who must also obtain a Medicaid Billing Provider number will be referred to the Medicaid Operations Unit in order to obtain a number. The Operations Center will inform the Medicaid Operations Unit when they have approved a vendor to provide waiver services. Information will include the services the vendor is authorized to provide.
- b. DMR Medicaid Operations Unit will complete specific information pertaining to the vendor on the Waiver Performing Provider Registration Form.

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- c. A Provider Registration packet will be sent to the vendor along with instructions and guidelines for completion.
- d. The vendor will complete the packet and send it back to the DMR Medicaid Operations Unit within 10 working days.
- e. The DMR Medicaid Operations Unit forwards the Registration Form to the DSS Provider Relations Unit requesting Medicaid Performing Provider Number along with the procedure codes relating to the services the vendor is authorized to provide.
- f. DSS sends DMR Medicaid Operations Unit Performing Provider Number.
- g. DMR Medicaid Operations Unit tracks progress of Provider Enrollment from date sent to Provider through date EDS loads approved rates and procedure codes.

### 9.3.2 Qualified Vendor Documentation

The vendor will maintain the following:

- a. A record of the type of service, date of service, units of service and the name of the person performing the service.
- b. A record of the training and qualifications of anyone providing services.
- c. A record of any licenses or certifications of persons providing services
- d. Documentation that services are provided in accordance with an Individual Plan approved by the DMR Region.
- e. Records will be maintained for a minimum of six years.

### 9.3.3 Self-Directed Employee Documentation

Where services are provided by a person hired directly by the waiver recipient, the Fiscal Intermediary will maintain the following documentation: Medicaid Provider Agreement signed by the employee, copy of the criminal history background check, copy of the registry check, a copy of the provider qualification verification record, copy of licenses or certifications, the employment application form, the Individual/Family Employee Agreement, all federal and state employment related forms, payroll records and time sheets, quarterly expenditure reports, and Medicaid monthly billing reports.

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## 10. Appeals

Individuals have a right to request an evidentiary hearing from the Department of Social Services (The State Medicaid Agency) if they are aggrieved by a decision concerning their participation in the Home and Community-Based Services Waiver. This may be as a result of denied enrollment in a waiver or a denial of or reduction in waiver services.

### 10.1 Enrollment Denial

Once an individual has formally applied for enrollment in a DMR HCBS Waiver, the application is processed through the region's PRAT team and sent with a recommendation to the Central Office Waiver Unit. The Waiver Unit will review the PRAT recommendation and available documentation and then render a decision. If the decision is to deny enrollment, the individual will be notified in writing along with their right to request an Administrative Hearing from DSS. Typical reasons why a person may be denied enrollment are:

- a. The individual's income or assets exceed the waiver limit.
- b. The person does not meet the ICF/MR level of care requirement.
- c. The person's service needs exceed the covered waiver service limits.
- d. The individual does not need waiver services covered by the waiver.
- e. There is no available funded waiver opening.
- f. The individual plan budget exceeds approved limits, has been denied by Utilization Review to exceed limits, and subsequently denied enrollment by the CO Waiver Unit.
- g. The individual has not met the priority requirements to access waiver services.
- h. The department does not have sufficient funds to meet the individual's Level of Need requirements.

### 10.2 Service Denial

Individuals may also request an Administrative Hearing if a request for increased services provided in the waiver is denied. This is usually the result of a determination that current services are adequate to meet the individual's needs. The Utilization Review process is followed as detailed in Section 4.9.4. The Central Office Waiver Unit will make a final determination and notify the individual. The individual will also be notified of their right to request an Administrative Hearing from DSS at that time.

### 10.3 Request for Hearing

If a service is formally denied, the Central Office Waiver Unit will provide a written notice to the person along with a form to request an Administrative Hearing from the Department of Social Services. The individual will have 60 days from the date of the notice to request a hearing. The DSS Office of Legal Counsel, Regulations and Administrative Hearings will schedule and conduct the hearing. The DMR Region will be expected to provide any necessary documentation and testimony for the hearing.

## 11. Quality Management

The Connecticut Department of Mental Retardation has designed an enhanced system of quality assurance and improvement to support individuals to lead self-determined lives, and receives services and supports from the department in their own or family homes if desired. This system begins with core values to integrate the department's mission, the principles of self-determination, and the department's responsibility to design and implement a systemic and individualized approach of quality assurance and improvement. The department's approach to quality is designed to assure that individual participants achieve meaningful personal outcomes, have the supports necessary to make choices, informed decisions, experience community opportunities and individual relationships, benefit from system safeguards, and experience satisfaction with their services, supports and desired lifestyle. These values can be described in turn by the quality indicators outlined below:

### **Attitudes and Values**

- All individuals served by the department understand and can effectively apply the DMR Mission and the Self Determination Principles to their daily lives

### **Person-Centered Planning**

- All individuals served by the department make progress toward achieving desired outcomes through effective implementation of Person-Centered Planning

### **Freedom** (*Choice, Informed Decision-Making, Reasonable Risks*)

- All individuals served by the department have sufficient opportunities to make choices through exploration of lifestyle possibilities
- All individuals served by the department have sufficient supports needed to make informed decisions
- All individuals served by the department have sufficient supports needed to take reasonable risks, as desired

### **Authority** (*Self Advocacy, Control, Fiscal Conservatism*)

- All individuals served by the department are able to Self Advocate for themselves to the greatest degree possible
- All individuals served by the department are able to control their resources to the greatest degree possible
- All individuals served by the department use the resources provided to them in a fiscally conservative and responsible manner

### **Support** (*Roles & Responsibilities, Relationships, Reciprocal Community Contributions*)

- Individuals are able to identify the roles & responsibilities required to attain and sustain a desired lifestyle

- Individuals are able to develop and maintain the relationships required to attain and sustain a desired lifestyle
- Individuals are able to benefit from their local community through reciprocal contributions

**Responsibility** (*Planning & Goal Setting, Problem-Solving, Self Esteem*)

- All individuals served by the department are actively involved in planning & setting individual goals for themselves
- All individuals served by the department are actively involved in problem solving barriers that prevent attainment of a desired lifestyle
- All individuals served by the department have opportunities to increase self-esteem through activities that demonstrate their individual strengths

**11.1 Person-centered Planning**

Quality assurance begins with the person-centered planning process. CT DMR provides training and supports to case managers and brokers in a variety of person-centered planning tools such as Personal Futures Planning (PFP), Essential Lifestyles Planning (ELP), PATH and MAPS. CT DMR has revised its' Individual Planning process to enhance the focus on consumer-direction. The department has incorporated new approaches to risk management in the Individual Planning process, to identify through an organized health and safety screening process with the individual and his or her planning and support team, specific areas where education, clinical evaluation and support, and/or resources can address identified health, welfare and environmental concerns. The system of quality is predicated on the belief that quality begins by assuring that the individual and his or her planning and support team have available to them a thorough process of assessment, planning, training and education, and informed decision-making, at the core of the person-centered planning process.

**11.2 Qualified Provider Network**

A second key component of quality assurance and improvement is the development of a qualified provider network, and processes of monitoring compliance with policies and procedures designed to support the achievement of personal outcomes, the assurance of health and welfare, and is reflected in the individual participant's satisfaction with services and supports. Providers, whether individuals or agencies, must enroll with the department to provide specified services and supports. In so doing, the Provider must agree, within the mission and scope of the service(s) offered, the following:

- To safeguard the health, safety and well-being of individuals receiving services from the Provider;
- To assist people in the achievement of personal outcomes in the areas of Planning and Personal Achievement; Relationships and Community Connections; Choice and Control; Rights, Respect and Dignity; Safety; and, Health and Wellness. and Satisfaction;
- To participate in and support the Department's Quality Improvement Process;
- To provide information about the individual to assist in the development of the individual's plan and to attend the planning meeting if desired by the participant;
- To participate in discussions about the individual's progress, the extent to which the individual's needs are being met or any need for modifications in the support plan;
- To provide the individual with relevant training to achieve their personal goals and opportunities to expand their life experiences in the community through the provision of

person-centered supports and services. Services will be provided within the scope, intensity and duration specified in the individual's support plan and within approved funding;

- To abide by state and federal laws governing the use or disclosure of individually identifiable health information;
- To assure that any employee who observes abusive treatment or neglect of an individual will intervene immediately on the individual's behalf and immediately report the situation according to procedures established by the Department;
- To maintain books, records, documents, program and individual records for a period of six (6) years, and other evidence of accounting and billing procedures and practices which sufficiently and properly reflect all direct and indirect costs of any nature incurred in the performance of the services and supports rendered, and maintain such records for a period of three (3) years after the completion and submission of any financial audits;
- To provide for an annual financial audit acceptable to the Department for any expenditure of state-awarded funds made by the Provider;
- To participate in performance reviews and meetings as scheduled by the Department;
- To ensure that all employees receive the specific training required to successfully serve each person and meet the specific training required under provider qualifications for each service it has been authorized to provide;
- To notify the Department of any issues concerning the individual's continued eligibility for waiver services;
- To immediately notify the Department of any emergency or of an unusual occurrence or circumstances per Department Incident Management policies and procedures;
- To maintain on file and make available on request documentation that background screening, staff training and other qualifications as required by state law or specified in DMR policies and procedures, including copies of licenses and certifications;
- To provide appropriate billing for services rendered per Department policies and procedures, and maintain records and receipts for expenditures made in the delivery of services rendered in accordance with Generally Accepted Accounting Principles;
- To comply with Department policies and procedures pertaining to the handling of individual funds as applicable to the service(s) provided;
- To carry sufficient general liability insurance; and,
- To comply with State of Connecticut Ethics Protocols.

Individuals who choose to hire their own support staff must enter into a Consumer Directed Agreement with the Department, and utilize an approved Fiscal Intermediary of their choosing. The Fiscal Intermediary is responsible for ensuring that any individual support worker hired directly by the individual has completed the required Criminal Background check and CT Abuse Registry check, meets age requirements, and completes necessary employment paperwork. The individual, his or her planning and support team, DMR Case Manager, and personal support broker if applicable, are responsible for assisting the individual, and their family if applicable, with the coordination of any specific training, orientation and demonstrated competencies as required by the associated provider qualifications.

### **11.3 Quality Service Reviews**

The *Quality Service Review (QSR)* is the process by which the Department conducts formal reviews of Qualified Providers and the systems processes associated with supporting individuals who hire their own support staff. Formal re-certification of Qualified Providers occurs at least once every two (2) years. Systems processes associated with individuals who hire their own support staff occur annually. Sampling techniques draw individuals for review who are supported by the provider agency in each service type. Sampling represents 5-10% of the population depending upon the total numbers of individuals supported in each service type. Individuals who hire their own supports are samples when the Department's Regional operations and Case Management services are reviewed annually.

The content of the *Quality Service Review* is built around seven focus areas: Planning and Personal Achievement; Relationships and Community Connections; Choice and Control; Rights, Respect and Dignity; Safety; Health and Wellness; and, Satisfaction. Within these seven focus areas, Individual Personal Outcomes and Support Expectation Measures are assessed. The review process measures both the individual experiences with the services and supports, and, the Provider and System effectiveness in supporting the individual to achieve positive personal outcomes. Quality indicators are measured utilizing varied review methods including: Consumer Interview (incorporates elements of the National Core Indicators Consumer Interview and additional items for the purpose of the QSR); Support Staff Interview; Observation; Document Review; and, Safety Review.

The results of the review will result in continued certification, conditional certification or suspension of certification of the Provider Agency for each service type depending upon the outcomes of the review. Corrective Action Plans are developed and implemented by the Provider Agency as appropriate in cases of threats to individual health and welfare and Medicaid plan of care deficiencies. Regional and State Quality Review team members conduct on-site follow-up activities to verify Corrective Action Plans. The Department has in place mechanisms to assist individuals to acquire alternative qualified providers if their current provider is de-certified for a service type. Quality Improvement Plans are prepared with the Provider in areas where compliance is met but further quality improvement activities could result in enhanced individual outcomes and satisfaction.

Additionally, the *Quality Service Review* is designed to collect quality indicator data generated through Case Manager and Regional Quality Monitor activities for analysis on a quarterly basis by the Department. This data, along with the routine collection of incident data, abuse and neglect data, mortality review, behavioral program review and medication management review activities, is monitored to identify particular trends or issues that may require interim quality improvement activities, or the initiation of an earlier formal re-certification review.

#### **11.4 Reviews of the Department's Regional Operations and Case Management**

The Department monitors Regional Operations for assurance with policies and procedures governing participant access, person-centered planning and service delivery, participant safeguards, and rights and responsibilities. The Regional Operations are also responsible for oversight of Fiscal Intermediary adherence to policies and procedures. The Department conducts annual reviews of the Regional Operations utilizing the *Quality Service Review* to assess the quality of services and supports for individuals who hire their own supports. The Department also evaluates the broader performance of the Regional Office on an annual basis in the following areas:

- The Region provides the individual and his or her family/legal representative an explanation of all services that may be available to the individual,
- The Region assists the individual with making application for Department funded services and supports, and determines priority for service initiation in a consistent manner;
- The Region provides an explanation of waiver services, documents the individual's choice of waiver or ICF/MR services; and assists the individual in applying for Medicaid and other benefits;
- The Region submits all enrollment requests and completes annual re-certification for waiver eligibility in a timely manner.
- The Region follows a person-centered planning process in assisting individuals and their families/legal representatives in the development of individual plans;
- The Region implements Risk Management procedures and practices;

- The Region informs the individual and family/legal representative of all qualified providers of services and supports outlined in the individual plan, and provides assistance as requested in the selection of qualified providers;
- The Region provides information and support to assist the individual to make decisions regarding the self-direction of services and supports;
- The Region monitors the qualifications of direct hire support staff through oversight of the Fiscal Intermediary and of the individual's DMR case manager/support broker;
- The Region assures the case manager/support broker coordinates and monitors the provision of waiver and non-waiver services and supports;
- The Region assures the case manager/support broker assists individuals in accessing non-waiver services as appropriate;
- The Region informs individuals and their family/legal representative of the processes for changing service providers, reporting complaints, and reporting allegations of abuse and neglect; and of their individual and civil rights and responsibilities;
- The Region responds to all complaints of service delivery, and maintains a written record of all Program Administrative Reviews;
- The Region operates the Program Review Committee and Human Rights Committee according to policies and procedures;
- The Region implements Abuse/Neglect and Incident Management systems according to policies and procedures;
- The Region monitors Medication Management practices, Nursing Delegation and End of Life decisions according to policies and procedures;
- The Region ensures that all personnel receive annual training according to policies and procedures.

The Review Team is comprised of Qualified Mental Retardation Professionals, registered nurses, quality review staff, social workers, planning specialists, and other Mental Retardation professionals. Regions are required to submit plans of correction for any major areas of non-compliance, which are verified during the next review and reporting period, or by an on-site review visit. Quality Improvement Plans are also developed to enhance the performance on a continuous basis.

### **11.5 Individual and Family Participation**

Individuals and family members are represented on Quality Advisory Councils at the Regional and State level of the Department. These councils will review Provider and Regional Review results and make recommendations to the Department on matters where certification is suspended, and for quality improvement efforts. The State Quality Advisory Council will review Departmental system quality performance and data, make recommendations for and participate in continuous quality improvement initiatives.

### **11.6 Oversight by the State Medicaid Agency**

The Department of Social Services participates in quarterly meetings with Department personnel to review quality data, and conduct a sample of 15 –20 individual plan of care reviews. Individual Plans of Correction and system corrections and improvements are prepared as needed with formal written response provided by DMR.

### **11.6.1 DMR Waiver Plan of Care Audits**

The Waiver Management Unit conducts individual record reviews in each region to assure compliance with Medicaid requirements as outlined in DMR Procedure No. I.B.2.PR.004 Waiver Compliance Review. A summary of findings and a regional correction report is issued after each visit. The region completes the report with the corrective action taken and completion dates. The CT Department of Social Services (DSS) Medicaid Waiver Coordinator reviews this process.

### **11.7 System Monitoring**

The Department's Division of Strategic Leadership and Quality Management monitors all quality review activities, implementation of the incident management and abuse/neglect systems, mortality review, behavior modifying intervention systems, human rights review process, medication management systems, complaints, and due process. The Department is developing improved data systems to manage incident reporting, follow-up and analysis, and to enter all Quality Service Review data collected on an on-going basis allowing tracking at the Provider and system levels. Training and technical assistance is provided for Providers and Regional staff based on outcome data. Fiscal oversight occurs through the implementation of Department Cost Standards, quarterly financial reporting by the Fiscal Intermediary, quarterly audits of billing activities compared to the Individual Plan, and annual cost reporting. A Departmental Quality Improvement Committee meets on a quarterly basis to review data and reports. This Committee is charged to recommend to the Commissioner any changes or additions to policy and procedure based on their review outcomes.