

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

### PURPOSE OF THE HCBS WAIVER PROGRAM

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

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

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

### 1. Request Information (1 of 3)

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- A. The **State of Connecticut** requests approval for a Medicaid home and community-based services (HCBS) waiver under the authority of §1915(c) of the Social Security Act (the Act).
- B. **Program Title** (*optional - this title will be used to locate this waiver in the finder*):  
**HCBS Waiver for People with Serious Mental Illness in Nursing Homes**
- C. **Type of Request: new**
- New to replace waiver**  
 Replacing Waiver Number: \_\_\_\_\_
- Migration Waiver** - this is an existing approved waiver  
 Provide the information about the original waiver being migrated
- Base Waiver Number:** \_\_\_\_\_
- Amendment Number**  
 (if applicable): \_\_\_\_\_
- Effective Date:** (*mm/dd/yy*) \_\_\_\_\_
- Waiver Number: CT.0653.R00.00**
- Draft ID: CT.05.00.00**
- D. **Type of Waiver** (*select only one*):
- E. **Proposed Effective Date:** (*mm/dd/yy*)

### 1. Request Information (2 of 3)

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**F. Level(s) of Care.** This waiver is requested in order to provide home and community-based waiver services to individuals who, but for the provision of such services, would require the following level(s) of care, the costs of which would be reimbursed under the approved Medicaid State plan (*check each that applies*):

**Hospital**

Select applicable level of care

**Hospital as defined in 42 CFR §440.10**

If applicable, specify whether the State additionally limits the waiver to subcategories of the hospital level of care:

**Inpatient psychiatric facility for individuals age 21 and under as provided in 42 CFR §440.160**

**Nursing Facility**

Select applicable level of care

**Nursing Facility As defined in 42 CFR §440.40 and 42 CFR §440.155**

If applicable, specify whether the State additionally limits the waiver to subcategories of the nursing facility level of care:

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

**Intermediate Care Facility for the Mentally Retarded (ICF/MR) (as defined in 42 CFR §440.150)**

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

## 1. Request Information (3 of 3)

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

Select one:

**Not applicable**

**Applicable**

Check the applicable authority or authorities:

**Services furnished under the provisions of §1915(a) of the Act and described in Appendix I**

**Waiver(s) authorized under §1915(b) of the Act.**

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

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

**§1915(b)(1) (mandated enrollment to managed care)**

**§1915(b)(2) (central broker)**

**§1915(b)(3) (employ cost savings to furnish additional services)**

**§1915(b)(4) (selective contracting/limit number of providers)**

- A program authorized under §1115 of the Act.**

Specify the program:

## 2. Brief Waiver Description

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**Brief Waiver Description.** *In one page or less*, briefly describe the purpose of the waiver, including its goals, objectives, organizational structure (e.g., the roles of state, local and other entities), and service delivery methods.

This Medicaid Waiver will be for adults with serious mental illness who are being discharged or diverted from nursing home care. This Waiver would provide participants with the medical and psychiatric services and supports necessary to live independently in the community. The Waiver will serve 216 individuals who are currently in nursing facilities or who are at risk for this level of care. Waiver services would be provided face to face, in the participant's home or in other community settings (non-office based). Individualized assessment, Recovery Plan development, and service delivery will emphasize participant strengths and assets, utilization of natural supports and community integration. In other words, service delivery will emphasize recovery from the disabling effects of psychiatric disorders. The Waiver will be operated by the Department of Mental Health and Addiction Services with oversight by the Department of Social Services, Connecticut's Single State Agency for Medicaid. The Waiver, as proposed, will commence on April 1, 2009.

## 3. Components of the Waiver Request

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**The waiver application consists of the following components.** *Note: Item 3-E must be completed.*

- A. Waiver Administration and Operation.** Appendix A specifies the administrative and operational structure of this waiver.
- B. Participant Access and Eligibility.** Appendix B specifies the target group(s) of individuals who are served in this waiver, the number of participants that the State expects to serve during each year that the waiver is in effect, applicable Medicaid eligibility and post-eligibility (if applicable) requirements, and procedures for the evaluation and reevaluation of level of care.
- C. Participant Services.** Appendix C specifies the home and community-based waiver services that are furnished through the waiver, including applicable limitations on such services.
- D. Participant-Centered Service Planning and Delivery.** Appendix D specifies the procedures and methods that the State uses to develop, implement and monitor the participant-centered service plan (of care).
- E. Participant-Direction of Services.** When the State provides for participant direction of services, Appendix E specifies the participant direction opportunities that are offered in the waiver and the supports that are available to participants who direct their services. (*Select one*):
 

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

**No. This waiver does not provide participant direction opportunities.** *Appendix E is not required.*
- F. Participant Rights.** Appendix F specifies how the State informs participants of their Medicaid Fair Hearing rights and other procedures to address participant grievances and complaints.

- G. Participant Safeguards.** Appendix G describes the safeguards that the State has established to assure the health and welfare of waiver participants in specified areas.
- H. Quality Management Strategy.** Appendix H contains the Quality Management Strategy for this waiver.
- I. Financial Accountability.** Appendix I describes the methods by which the State makes payments for waiver services, ensures the integrity of these payments, and complies with applicable federal requirements concerning payments and federal financial participation.
- J. Cost-Neutrality Demonstration.** Appendix J contains the State's demonstration that the waiver is cost-neutral.

## 4. Waiver(s) Requested

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- A. Comparability.** The State requests a waiver of the requirements contained in §1902(a)(10)(B) of the Act in order to provide the services specified in Appendix C that are not otherwise available under the approved Medicaid State plan to individuals who: (a) require the level(s) of care specified in Item 1.F and (b) meet the target group criteria specified in Appendix B.
- B. Income and Resources for the Medically Needy.** Indicate whether the State requests a waiver of §1902(a)(10)(C)(i)(III) of the Act in order to use institutional income and resource rules for the medically needy (*select one*):
- Not Applicable
- No
- Yes
- C. Statewideness.** Indicate whether the State requests a waiver of the statewideness requirements in §1902(a)(1) of the Act (*select one*):
- No
- Yes

If yes, specify the waiver of statewideness that is requested (*check each that applies*):

- Geographic Limitation.** A waiver of statewideness is requested in order to furnish services under this waiver only to individuals who reside in the following geographic areas or political subdivisions of the State.  
*Specify the areas to which this waiver applies and, as applicable, the phase-in schedule of the waiver by geographic area:*
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- Limited Implementation of Participant-Direction.** A waiver of statewideness is requested in order to make *participant-direction of services* as specified in Appendix E available only to individuals who reside in the following geographic areas or political subdivisions of the State. Participants who reside in these areas may elect to direct their services as provided by the State or receive comparable services through the service delivery methods that are in effect elsewhere in the State.  
*Specify the areas of the State affected by this waiver and, as applicable, the phase-in schedule of the waiver by geographic area:*
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## 5. Assurances

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In accordance with 42 CFR §441.302, the State provides the following assurances to CMS:

- A. Health & Welfare:** The State assures that necessary safeguards have been taken to protect the health and welfare of persons receiving services under this waiver. These safeguards include:
1. As specified in **Appendix C**, adequate standards for all types of providers that provide services under this waiver;
  2. Assurance that the standards of any State licensure or certification requirements specified in **Appendix C** are met for services or for individuals furnishing services that are provided under the waiver. The State assures that these requirements are met on the date that the services are furnished; and,
  3. Assurance that all facilities subject to §1616(e) of the Act where home and community-based waiver services are provided comply with the applicable State standards for board and care facilities as specified in **Appendix C**.
- B. Financial Accountability.** The State assures financial accountability for funds expended for home and community-based services and maintains and makes available to the Department of Health and Human Services (including the Office of the Inspector General), the Comptroller General, or other designees, appropriate financial records documenting the cost of services provided under the waiver. Methods of financial accountability are specified in **Appendix I**.
- C. Evaluation of Need:** The State assures that it provides for an initial evaluation (and periodic reevaluations, at least annually) of the need for a level of care specified for this waiver, when there is a reasonable indication that an individual might need such services in the near future (one month or less) but for the receipt of home and community based services under this waiver. The procedures for evaluation and reevaluation of level of care are specified in **Appendix B**.
- D. Choice of Alternatives:** The State assures that when an individual is determined to be likely to require the level of care specified for this waiver and is in a target group specified in **Appendix B**, the individual (or, legal representative, if applicable) is:
1. Informed of any feasible alternatives under the waiver; and,
  2. Given the choice of either institutional or home and community based waiver services. **Appendix B** specifies the procedures that the State employs to ensure that individuals are informed of feasible alternatives under the waiver and given the choice of institutional or home and community-based waiver services.
- E. Average Per Capita Expenditures:** The State assures that, for any year that the waiver is in effect, the average per capita expenditures under the waiver will not exceed 100 percent of the average per capita expenditures that would have been made under the Medicaid State plan for the level(s) of care specified for this waiver had the waiver not been granted. Cost-neutrality is demonstrated in **Appendix J**.
- F. Actual Total Expenditures:** The State assures that the actual total expenditures for home and

community-based waiver and other Medicaid services and its claim for FFP in expenditures for the services provided to individuals under the waiver will not, in any year of the waiver period, exceed 100 percent of the amount that would be incurred in the absence of the waiver by the State's Medicaid program for these individuals in the institutional setting(s) specified for this waiver.

- G. Institutionalization Absent Waiver:** The State assures that, absent the waiver, individuals served in the waiver would receive the appropriate type of Medicaid-funded institutional care for the level of care specified for this waiver.
- H. Reporting:** The State assures that annually it will provide CMS with information concerning the impact of the waiver on the type, amount and cost of services provided under the Medicaid State plan and on the health and welfare of waiver participants. This information will be consistent with a data collection plan designed by CMS.
- I. Habilitation Services.** The State assures that prevocational, educational, or supported employment services, or a combination of these services, if provided as habilitation services under the waiver are: (1) not otherwise available to the individual through a local educational agency under the Individuals with Disabilities Education Act (IDEA) or the Rehabilitation Act of 1973; and, (2) furnished as part of expanded habilitation services.
- J. Services for Individuals with Chronic Mental Illness.** The State assures that federal financial participation (FFP) will not be claimed in expenditures for waiver services including, but not limited to, day treatment or partial hospitalization, psychosocial rehabilitation services, and clinic services provided as home and community-based services to individuals with chronic mental illnesses if these individuals, in the absence of a waiver, would be placed in an IMD and are: (1) age 22 to 64; (2) age 65 and older and the State has not included the optional Medicaid benefit cited in 42 CFR §440.140; or (3) age 21 and under and the State has not included the optional Medicaid benefit cited in 42 CFR § 440.160.

## 6. Additional Requirements

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*Note: Item 6-I must be completed.*

- A. Service Plan.** In accordance with 42 CFR §441.301(b)(1)(i), a participant-centered service plan (of care) is developed for each participant employing the procedures specified in **Appendix D**. All waiver services are furnished pursuant to the service plan. The service plan describes: (a) the waiver services that are furnished to the participant, their projected frequency and the type of provider that furnishes each service and (b) the other services (regardless of funding source, including State plan services) and informal supports that complement waiver services in meeting the needs of the participant. The service plan is subject to the approval of the Medicaid agency. Federal financial participation (FFP) is not claimed for waiver services furnished prior to the development of the service plan or for services that are not included in the service plan.
- B. Inpatients.** In accordance with 42 CFR §441.301(b)(1) (ii), waiver services are not furnished to individuals who are in-patients of a hospital, nursing facility or ICF/MR.
- C. Room and Board.** In accordance with 42 CFR §441.310(a)(2), FFP is not claimed for the cost of room and board except when: (a) provided as part of respite services in a facility approved by the State that is not a private residence or (b) claimed as a portion of the rent and food that may be

reasonably attributed to an unrelated caregiver who resides in the same household as the participant, as provided in **Appendix I**.

- D. Access to Services.** The State does not limit or restrict participant access to waiver services except as provided in **Appendix C**.
- E. Free Choice of Provider.** In accordance with 42 CFR §431.151, a participant may select any willing and qualified provider to furnish waiver services included in the service plan unless the State has received approval to limit the number of providers under the provisions of §1915(b) or another provision of the Act.
- F. FFP Limitation.** In accordance with 42 CFR §433 Subpart D, FFP is not claimed for services when another third-party (e.g., another third party health insurer or other federal or state program) is legally liable and responsible for the provision and payment of the service. FFP also may not be claimed for services that are available without charge, or as free care to the community. Services will not be considered to be without charge, or free care, when (1) the provider establishes a fee schedule for each service available and (2) collects insurance information from all those served (Medicaid, and non-Medicaid), and bills other legally liable third party insurers. Alternatively, if a provider certifies that a particular legally liable third party insurer does not pay for the service(s), the provider may not generate further bills for that insurer for that annual period.
- G. Fair Hearing:** The State provides the opportunity to request a Fair Hearing under 42 CFR §431 Subpart E, to individuals: (a) who are not given the choice of home and community- based waiver services as an alternative to institutional level of care specified for this waiver; (b) who are denied the service(s) of their choice or the provider(s) of their choice; or (c) whose services are denied, suspended, reduced or terminated. **Appendix F** specifies the State's procedures to provide individuals the opportunity to request a Fair Hearing, including providing notice of action as required in 42 CFR §431.210.
- H. Quality Management.** The State operates a formal, comprehensive system to ensure that the waiver meets the assurances and other requirements contained in this application. Through an ongoing process of discovery, remediation and improvement, the State assures the health and welfare of participants by monitoring: (a) level of care determinations; (b) individual plans and services delivery; (c) provider qualifications; (d) participant health and welfare; (e) financial oversight and (f) administrative oversight of the waiver. The State further assures that all problems identified through its discovery processes are addressed in an appropriate and timely manner, consistent with the severity and nature of the problem. During the period that the waiver is in effect, the State will implement the Quality Management Strategy specified in **Appendix H**.
- I. Public Input.** Describe how the State secures public input into the development of the waiver: During the 2005 legislative session the Connecticut General Assembly passed PA 05-280 (HB 7000) "An Act Concerning Social Services and Public Health Budget Implementation Provisions." Section 85 of the act called for the Commissioners of Social Services and Mental Health and Addiction Services to jointly convene a Taskforce to study the feasibility of obtaining a Medicaid Home and Community-Based Services Waiver for adults with serious mental illness being discharged or diverted from nursing home care. The Taskforce was comprised of state legislators, state agency representatives, mental health consumer and provider representatives and other community members. The taskforce reviewed the rationale and recommendations for proposing this HCBS Waiver. The draft HCBS Waiver was disseminated for public comment and was reviewed by the Connecticut General Assembly. These comments were reviewed and incorporated as appropriate into this Waiver document.

**J. Notice to Tribal Governments.** The State assures that it has notified in writing all federally-recognized Tribal Governments that maintain a primary office and/or majority population within the State of the State's intent to submit a Medicaid waiver request or renewal request to CMS at least 60 days before the anticipated submission date is provided by Presidential Executive Order 13175 of November 6, 2000. Evidence of the applicable notice is available through the Medicaid Agency.

**K. Limited English Proficient Persons.** The State assures that it provides meaningful access to waiver services by Limited English Proficient persons in accordance with: (a) Presidential Executive Order 13166 of August 11, 2000 (65 FR 50121) and (b) Department of Health and Human Services "Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons" (68 FR 47311 - August 8, 2003). **Appendix B** describes how the State assures meaningful access to waiver services by Limited English Proficient persons.

## 7. Contact Person(s)

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**A.** The Medicaid agency representative with whom CMS should communicate regarding the waiver is:

**Last Name:** Schaefer  
**First Name:** Mark  
**Title:** Director, Medical Policy and Behavioral Health  
**Agency:** Department of Social Services  
**Address:** 25 Sigourney Street  
**Address 2:**  
**City:** Hartford  
**State:** Connecticut  
**Zip:** 06106  
**Phone:** (860) 424-5067 **Ext:**   TTY  
**Fax:** (860) 424-5799  
**E-mail:** Mark.Schaefer@ct.gov

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

**Last Name:** Rehmer  
**First Name:** Pat  
**Title:** Deputy Commissioner  
**Agency:** Department of Mental Health and Addiction Services  
**Address:** 410 Capitol Avenue  
**Address 2:** 4th floor, MS14COM  
**City:**

**State:** Hartford  
**State:** **Connecticut**  
**Zip:** 06423  
**Phone:** (860) 418-6676 **Ext:**             **TTY**  
**Fax:** (860) 418-6691  
**E-mail:** pat.rehmer@po.state.ct.us

## 8. Authorizing Signature

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

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

**Signature:** David Parrella  
State Medicaid Director or Designee

**Submission Date:** Aug 29, 2008

**Last Name:** Parrella

**First Name:** David

**Title:** Director of Medical Care Administration

**Agency:** Department of Social Services

**Address:** 25 Sigourney Street

**Address 2:**

**City:** Hartford

**State:** **Connecticut**

**Zip:** 06106

**Phone:** (860) 424-5116

**Fax:** (860) 424-5114

**E-mail:** David.Parrella@ct.gov

## Attachment #1: Transition Plan

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Specify the transition plan for the waiver:

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## **Appendix A: Waiver Administration and Operation**

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

- The waiver is operated by the State Medicaid agency.**

Specify the Medicaid agency division/unit that has line authority for the operation of the waiver program (*select one: do not complete Item A-2*):

- The Medical Assistance Unit.**

Specify the unit name:

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

Specify the unit name:

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*Do not complete item A-2.*

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

Specify the unit name:

**Department of Mental Health and Addiction Services**

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

## **Appendix A: Waiver Administration and Operation**

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**2. Medicaid Agency Oversight of Operating Agency Performance.** When the waiver is not operated by the Medicaid agency, specify the methods that the Medicaid agency uses to ensure that the operating agency performs its assigned waiver operational and administrative functions in accordance with waiver requirements. Also specify the frequency of Medicaid agency assessment of operating agency performance:

The CT Department of Mental Health and Addiction Services (DMHAS) will be the operating agency under the supervision of the Single State Medicaid Agency, the Department of Social

Services (DSS). The Department of Social Services will ensure that DMHAS performs its operational and administrative functions in accordance with the requirements set forth in this Waiver. DSS and DMHAS will execute a Memorandum of Understanding (MOU) that outlines this relationship. This MOU will establish the functions DMHAS performs, expectations regarding the performance of these functions and specific reporting requirements. Functions that will be performed by DMHAS are set forth in A.7. These functions will include: level of care assessment; individual planning and service delivery monitoring; recruitment of waiver service providers, maintenance of all service records; service approval; dissemination of Waiver information to potential participants, and quality management functions for certain Quality Framework areas. We expect the DSS-DMHAS Operations MOU to be signed by Sept. 15, 2008. Thereafter, oversight will occur on an ongoing basis with formal quarterly oversight meetings. The MOU will require quarterly reports from DMHAS regarding specific operational activities. This will include quantitative and qualitative information regarding activities performed by DMHAS including assessments and reassessment, service plans, and service plan reviews. These quarterly reports will focus on:

- a) How promptly an initial Waiver eligibility process commences (Application for Title XIX, Level of Care determination, and meets criteria for serious mental illness review) once an initial Waiver application is submitted for an individual.
- b) How promptly an assessment and Recovery Plan is developed once an individual is initially reviewed for potential participation in the Waiver
- c) How promptly DMHAS reviews and makes recommendations to DSS regarding the appropriateness of the Recovery Plan
- d) How promptly a DMHAS Support Coordinator implements the Recovery Plan
- e) Critical events or serious incidents and DMHAS' response to these events/incidents. Information regarding DMHAS' responses to these events/incidents will be reviewed for timely notification to DSS and responses by DMHAS to assure these individual's health and safety.

DSS will review these reports on a quarterly basis.

The MOU will also specify the frequency with which DSS will review documentation completed by DMHAS Support Coordinators for Waiver participants. This will include DSS reviewing the completeness of the Level of Care Assessment, psychosocial assessments and Recovery Plans. In addition, DSS will review the materials and forms developed by DMHAS including: informational material regarding the Waiver, the psychosocial assessment tool, and Recovery Plan format. DSS will also review and approve each participant's initial Recovery Plan and budget and any changes to the Participant's Recovery Plan. DSS will also be responsible for quality management functions for certain Quality Framework areas.

DSS will: coordinate communication with federal officials concerning the waiver; specify policies and procedures and consult with DMHAS in the implementation of such policies and procedures; monitor waiver operations for compliance with federal regulations including but not limited to the areas of waiver eligibility determinations, service quality systems, Recovery Plans, qualification of providers, and fiscal controls and accountability; determine Medicaid eligibility for potential waiver recipients/enrollees and calculate applied income as appropriate; establish, in consultation and cooperation with DMHAS, rates of reimbursement for services provided under the waiver; assist with the billing process for waiver services, complete billing process and claims for F.F.P. for such services; prepare and submit, with assistance from DMHAS, all reports required by CMS or other federal agencies in connection to the waiver; administer the hearing process for any decisions associated with the waiver for which an aggrieved party has hearing

rights under federal law.

DSS and DMHAS will enter into a contract with a fiscal intermediary to perform key administrative and operational functions. DSS will receive quarterly reports from the fiscal intermediary. This contractor will report to DMHAS and DSS information on:

- a) How promptly the fiscal intermediary accepts applications from Waiver providers, verifies information in the Waiver application, renders recommendations to DSS and DMHAS regarding provider enrollment and enrolls providers.
- b) How promptly the fiscal intermediary makes payments to individuals and organizations for Waiver services
- c) Training and education activities performed by the fiscal intermediary regarding provider enrollment, documentation, service standards and quality management.
- d) How promptly the FI submits claims data to the state's MMIS to generate the necessary financial and data reports required under the Waiver.

## Appendix A: Waiver Administration and Operation

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

- Yes. Contracted entities perform waiver operational and administrative functions on behalf of the Medicaid agency and/or operating agency (if applicable).**

Specify the types of contracted entities and briefly describe the functions that they perform. *Complete Items A-5 and A-6.:*

DSS and DMHAS will contract with a fiscal intermediary to perform various administrative functions and assist participants who choose to direct recovery assistant services. The fiscal intermediary (FI) will serve as the Medicaid Billing Provider for all Waiver services. The fiscal intermediary will perform the following functions:

- Provide information and training materials regarding the Waiver, participants, and service delivery.
- Identify and recruit agencies and individuals who can provide Waiver services;
- Develop an enrollment packet for agencies and individuals who will provide Waiver services;
- Accept application and verify the credentials of agencies and individuals that will provide Waiver services. Enroll Waiver agencies and individuals that will provide Waiver services
- Develop a registry of agencies and individuals who provide Waiver services;
- \* Accept and make payment for Waiver services to agencies and individuals who provide Waiver services

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

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

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

## **Appendix A: Waiver Administration and Operation**

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

- Not applicable**
- Applicable** - Local/regional non-state agencies perform waiver operational and administrative functions.

Check each that applies:

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

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

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

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

## **Appendix A: Waiver Administration and Operation**

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- 5. Responsibility for Assessment of Performance of Contracted and/or Local/Regional Non-State Entities.** Specify the state agency or agencies responsible for assessing the performance of contracted and/or local/regional non-state entities in conducting waiver operational and administrative functions:  
DSS and DMHAS will assess the performance of the functions that will be performed by the fiscal intermediary.

## **Appendix A: Waiver Administration and Operation**

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

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

- 1) The fiscal intermediary will provide DSS and DMHAS monthly reports on providers enrolled and expenditures for Waiver services
- 2) DSS and DMHAS will attend trainings administered or approved by the fiscal intermediary to assess content and quality
- 3) DSS and DMHAS will monitor key implementation activities and deliverables during the first 90 days of the contract.

## Appendix A: Waiver Administration and Operation

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- 7. Distribution of Waiver Operational and Administrative Functions.** In the following table, specify the entity or entities that have responsibility for conducting each of the waiver operational and administrative functions listed (*check each that applies*):

In accordance with 42 CFR §431.10, when the Medicaid agency does not directly conduct a function, it supervises the performance of the function and establishes and/or approves policies that affect the function.

Function	Medicaid Agency	Other State Operating Agency	Contracted Entity
Disseminate information concerning the waiver to potential enrollees	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Assist individuals in waiver enrollment	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Manage waiver enrollment against approved limits	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Monitor waiver expenditures against approved levels	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Conduct level of care evaluation activities	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Review participant service plans to ensure that waiver requirements are met	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Perform prior authorization of waiver services	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Conduct utilization management functions	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Recruit providers	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Execute the Medicaid provider agreement	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Determine waiver payment amounts or rates	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Conduct training and technical assistance concerning waiver requirements	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
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## Appendix B: Participant Access and Eligibility

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

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

Target Group	Included	Target SubGroup	Minimum Age	Maximum Age	
				Maximum Age Limit	No Maximum Age Limit
<input type="radio"/> <b>Aged or Disabled, or Both - General</b>					
	<input type="checkbox"/>	Aged			<input type="checkbox"/>
	<input type="checkbox"/>	Disabled (Physical)			
	<input type="checkbox"/>	Disabled (Other)			
<input type="radio"/> <b>Aged or Disabled, or Both - Specific Recognized Subgroups</b>					
	<input type="checkbox"/>	Brain Injury			<input type="checkbox"/>
	<input type="checkbox"/>	HIV/AIDS			<input type="checkbox"/>
	<input type="checkbox"/>	Medically Fragile			<input type="checkbox"/>
	<input type="checkbox"/>	Technology Dependent			<input type="checkbox"/>
<input type="radio"/> <b>Mental Retardation or Developmental Disability, or Both</b>					
	<input type="checkbox"/>	Autism			<input type="checkbox"/>
	<input type="checkbox"/>	Developmental Disability			<input type="checkbox"/>
	<input type="checkbox"/>	Mental Retardation			<input type="checkbox"/>
<input checked="" type="radio"/> <b>Mental Illness</b>					
	<input checked="" type="checkbox"/>	Mental Illness	22		
	<input type="checkbox"/>	Serious Emotional Disturbance			

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

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

Section 1 (all of the following five requirements)

- o An adult, 22 years of age or older;
- o Who is Medicaid-eligible;

- o Meets Medicaid State Plan criteria for nursing home level of care;
- o Voluntarily chooses to participate in the waiver;
- o Has a diagnosis of serious mental illness as defined by State of Connecticut PASRR policy;

Section 2 (one of the following three requirements)

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

1. Has history of:

- Two or more inpatient psychiatric hospitalizations in the past two years; or
  - A single inpatient psychiatric hospitalization lasting 30 consecutive days or more in the past two years; or
  - Three crisis episodes in the past year requiring face-to-face assessment, but not necessarily requiring inpatient hospitalization;

2. Is currently experiencing 2 or more of the following circumstances due to serious mental illness:

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

3. Has level of risk to self or others that a licensed mental health professional has determined can be managed safely in the community.

4. Has the following core services needs if living in the community:

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

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

- Not applicable. There is no maximum age limit**
- The following transition planning procedures are employed for participants who will reach the waiver's maximum age limit.**

*Specify:*

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## **Appendix B: Participant Access and Eligibility**

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**a. Individual Cost Limit.** The following individual cost limit applies when determining whether to deny home and community-based services or entrance to the waiver to an otherwise eligible individual (*select one*):

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

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

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

Specify the percentage:

- Other**

*Specify:*

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

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

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

- The following dollar amount:**

Specify dollar amount:

**The dollar amount (*select one*)**

- Is adjusted each year that the waiver is in effect by applying the following**

**formula:**

Specify the formula:

---



---

- May be adjusted during the period the waiver is in effect. The State will submit a waiver amendment to CMS to adjust the dollar amount.**
- The following percentage that is less than 100% of the institutional average:**

Specify percent: 

- Other:**

Specify:

---

## Appendix B: Participant Access and Eligibility

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

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

Applicants or participants whose health and safety needs cannot be reasonably assured at their current level of assessed care and with the support of home and community based services within the Waiver will not be enrolled (or disenrolled if a current participant) in the Waiver. DMHAS and DSS will determine if the cost of the Waiver services necessary to ensure the participant's health and safety does not exceed the cost limit established by the state. In the event that an individual's service plan cannot be approved because it exceeds the individual cap, the Department shall work with the individual and other members of the person-centered team to determine if revisions can be made that will provide appropriate services at the dollar amount available. If the DMHAS Service Coordinator determines that an applicant's need is more extensive than the services in the Waiver are able to support, the DMHAS Service Coordinator will inform the applicant that their health and safety can not be assured. The plan may be resubmitted in the future if the total average cost of program participation has decreased sufficiently or the needs of the individual are reduced to a sufficient degree. In the event that the Applicant is denied enrollment or a current participant's services are being reduced or terminated, the applicant or participant will receive a Medicaid Notice of Action (NOA) regarding their right to a fair hearing in accordance with the rules of the Medicaid program.

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

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

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

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

The DMHAS Support Coordinator may convene a Recovery Plan Team Meeting in the event of an increased need for service by a Waiver participant. If the team review determines a need for increased intensity of services, the DMHAS Lead Support Coordinator and DSS may approve a time limited increase (less than 90 days) in the intensity of services. If it is determined at the time of the meeting or at the end of 90 days that the participant has an extended need for increased intensity of services, the individuals will be re-assessed by DMHAS Support Coordinator and transitioned to a nursing facility or inpatient hospital if the health and safety of the participant can not be assured.

**Other safeguard(s)**

Specify:

## **Appendix B: Participant Access and Eligibility**

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

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

**Table: B-3-a**

<b>Waiver Year</b>	<b>Unduplicated Number of Participants</b>
Year 1	79
Year 2	169
Year 3	249

- b. Limitation on the Number of Participants Served at Any Point in Time.** Consistent with the unduplicated number of participants specified in Item B-3-a, the State may limit to a lesser number the number of participants who will be served at any point in time during a waiver year. Indicate whether the State limits the number of participants in this way: (*select one*):
- The State does not limit the number of participants that it serves at any point in time during a waiver year.**
- The State limits the number of participants that it serves at any point in time during a waiver year.**

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

**Table: B-3-b**

Waiver Year	Maximum Number of Participants Served At Any Point During the Year
Year 1	72
Year 2	144
Year 3	216

## Appendix B: Participant Access and Eligibility

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

- c. **Reserved Waiver Capacity.** The State may reserve a portion of the participant capacity of the waiver for specified purposes (e.g., provide for the community transition of institutionalized persons or furnish waiver services to individuals experiencing a crisis) subject to CMS review and approval. The State (*select one*):
- Not applicable. The state does not reserve capacity.
  - The State reserves capacity for the following purpose(s).  
Purpose(s) the State reserves capacity for:

Purposes
Reserved Capacity for Money Follows the Person Participants

## Appendix B: Participant Access and Eligibility

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

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

Reserved Capacity for Money Follows the Person Participants

**Purpose** (*describe*):

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

**Describe how the amount of reserved capacity was determined:**

Currently 50 individuals per year will participate in the Money Follows the Person Initiative (MFP). A total of 150 individuals will participate in this initiative. Approximately 30 % of these individuals would meet the criteria established by this Waiver. Therefore 15 slots will be reserved for MFP individuals in Year 1, 41 slots in Year 2 and 44 slots the final year of this Waiver.

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

Waiver Year	Capacity Reserved
Year 1	15
Year 2	41
Year 3	44

## Appendix B: Participant Access and Eligibility

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

- d. Scheduled Phase-In or Phase-Out.** Within a waiver year, the State may make the number of participants who are served subject to a phase-in or phase-out schedule (*select one*):
- The waiver is not subject to a phase-in or a phase-out schedule.**
  - The waiver is subject to a phase-in or phase-out schedule that is included in Attachment #1 to Appendix B-3. This schedule constitutes an intra-year limitation on the number of participants who are served in the waiver.**
- e. Allocation of Waiver Capacity.**

*Select one:*

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

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

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

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

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

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

Entry into the Waiver will be offered to individuals based on their date of application for the Waiver. Individuals who are referred in excess of the allocated Waiver capacity within any given year will be placed on a waiting list. The waiting list will be managed by the Department of Mental Health and Addiction Services Lead Support Coordinator. The Lead Support Coordinator will review individuals on the waiting list on a monthly basis against current capacity.

## Appendix B: Participant Access and Eligibility

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

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

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## Appendix B: Participant Access and Eligibility

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### B-4: Eligibility Groups Served in the Waiver

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

- §1634 State
- SSI Criteria State
- 209(b) State

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

---

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

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- Low income families with children as provided in §1931 of the Act
- SSI recipients
- Aged, blind or disabled in 209(b) states who are eligible under 42 CFR §435.121
- Optional State supplement recipients
- Optional categorically needy aged and/or disabled individuals who have income at:

*Select one:*

- 100% of the Federal poverty level (FPL)
- % of FPL, which is lower than 100% of FPL.

Specify percentage:

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

**Group as provided in §1902(a)(10)(A)(ii)(XV) of the Act)**

- Working individuals with disabilities who buy into Medicaid (TWWIIA Medical Improvement Coverage Group as provided in §1902(a)(10)(A)(ii)(XVI) of the Act)
- Disabled individuals age 18 or younger who would require an institutional level of care (TEFRA 134 eligibility group as provided in §1902(e)(3) of the Act)
- Medically needy
- Other specified groups (include only statutory/regulatory reference to reflect the additional groups in the State plan that may receive services under this waiver)

*Specify:*

- Persons found eligible for Medicaid under provisions of 1902(a)(10)(A) (ii)(XV) of the Social Security Act
- Persons defined as qualified severely impaired individuals in section 1619(b) and 1905(q) of the Social Security Act: and
- Persons found eligible for Medicaid under the provisions of 1902(a)(10)(A)(ii)(XIII), of the Social Security Act.

---

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

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

*Select one and complete Appendix B-5.*

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

*Check each that applies:*

- A special income level equal to:

*Select one:*

- 300% of the SSI Federal Benefit Rate (FBR)
- A percentage of FBR, which is lower than 300% (42 CFR §435.236)

Specify percentage: \_\_\_\_\_

- A dollar amount which is lower than 300%.

Specify dollar amount: \_\_\_\_\_

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

- Medically needy without spenddown in States which also provide Medicaid to recipients of SSI (42 CFR §435.320, §435.322 and §435.324)**
- Medically needy without spend down in 209(b) States (42 CFR §435.330)**
- Aged and disabled individuals who have income at:**

*Select one:*

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

Specify percentage amount: \_\_\_\_\_

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

*Specify:*

## **Appendix B: Participant Access and Eligibility**

### **B-5: Post-Eligibility Treatment of Income (1 of 4)**

*In accordance with 42 CFR §441.303(e), Appendix B-5 must be completed when the State furnishes waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217, as indicated in Appendix B-4. Post-eligibility applies only to the 42 CFR §435.217 group. A State that uses spousal impoverishment rules under §1924 of the Act to determine the eligibility of individuals with a community spouse may elect to use spousal post-eligibility rules under §1924 of the Act to protect a personal needs allowance for a participant with a community spouse.*

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

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

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

- Use spousal post-eligibility rules under §1924 of the Act.**  
(*Complete Item B-5-c (209b State) and Item B-5-d*)
- Use regular post-eligibility rules under 42 CFR §435.726 (SSI State) or under §435.735 (209b State)**  
(*Complete Item B-5-c (209b State) . Do not complete Item B-5-d*)
- Spousal impoverishment rules under §1924 of the Act are not used to determine eligibility of individuals with a community spouse for the special home and community-**

based waiver group. The State uses regular post-eligibility rules for individuals with a community spouse.

(Complete Item B-5-c (209b State) . Do not complete Item B-5-d)

## Appendix B: Participant Access and Eligibility

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### B-5: Post-Eligibility Treatment of Income (2 of 4)

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

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

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## Appendix B: Participant Access and Eligibility

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### B-5: Post-Eligibility Treatment of Income (3 of 4)

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

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

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

- The following standard included under the State plan

(select one):

- The following standard under 42 CFR §435.121

Specify:

- Optional State supplement standard  
 Medically needy income standard  
 The special income level for institutionalized persons

(select one):

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

Specify percentage: \_\_\_\_\_

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

Specify dollar amount: \_\_\_\_\_

**A percentage of the Federal poverty level**

Specify percentage: 200

**Other**

*Specify:*

\_\_\_\_\_

**The following dollar amount**

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

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

*Specify:*

\_\_\_\_\_

---

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

---

**Not Applicable**

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

*Specify:*

\_\_\_\_\_

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

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

*Specify:*

\_\_\_\_\_

**Optional State supplement standard**

**Medically needy income standard**

**The following dollar amount:**

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

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

*Specify:*

\_\_\_\_\_

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

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

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

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

*Specify:*

- Other**

*Specify:*

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

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

Select one:

- Not Applicable (see instructions)**
- The State does not establish reasonable limits.**
- The State establishes the following reasonable limits**

*Specify:*

**Appendix B: Participant Access and Eligibility****B-5: Post-Eligibility Treatment of Income (4 of 4)****d. Post-Eligibility Treatment of Income Using Spousal Impoverishment Rules**

The State uses the post-eligibility rules of §1924(d) of the Act (spousal impoverishment

protection) to determine the contribution of a participant with a community spouse toward the cost of home and community-based care if it determines the individual's eligibility under §1924 of the Act. There is deducted from the participant's monthly income a personal needs allowance (as specified below), a community spouse's allowance, a family allowance, and an amount for incurred expenses for medical or remedial care.

**i. Allowance for the personal needs of the waiver participant**

*(select one):*

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

Specify percentage: 200

- The following dollar amount:

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

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

*Specify formula:*

---

- Other

*Specify:*

---

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

Select one:

- Allowance is the same
- Allowance is different.

*Explanation of difference:*

---

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

- a. Health insurance premiums, deductibles and co-insurance charges
- b. Necessary medical or remedial care expenses recognized under State law but not

covered under the State's Medicaid plan, subject to reasonable limits that the State may establish on the amounts of these expenses.

Select one:

- Not Applicable (see instructions)
- The State does not establish reasonable limits.
- The State uses the same reasonable limits as are used for regular (non-spousal) post-eligibility.

## Appendix B: Participant Access and Eligibility

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### B-6: Evaluation/Reevaluation of Level of Care

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

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

**i. Minimum number of services.**

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

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

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

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

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

- Directly by the Medicaid agency
- By the operating agency specified in Appendix A
- By an entity under contract with the Medicaid agency.

*Specify the entity:*

---

- Other**  
Specify:
- 

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

A Registered Nurse will perform the NF Level of Care evaluation. Determination whether the individual meets the Criteria for Serious Mental Illness will be performed by a licensed mental health professional with at least three years mental health experience. Licensed mental health professionals include registered nurses, psychologist, clinical social worker, professional counselor, marriage and family therapist and psychiatrist. Licensed mental health professionals without the requisite three years experience will be supervised by licensed mental health professionals who meet the experience requirement.

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

DMHAS will conduct level of care assessments to evaluate whether an individual needs nursing facility care. The level of care assessment will be based on information obtained from the individual, medical reports from his or her physician(s) and any other clinical personnel who are familiar with the individual's case and history. DMHAS will use form W-1506 "Level of Care Determination". The individual will be required to meet NF Level of Care and have three or more critical needs/deficits in the following activities of daily living: bathing, dressing, toileting, transfer, meal preparation, administration of medication, ambulating, or four or more cognitive deficits and requires daily supervision for behavioral health problems including wandering, abuse/assaultive behavior, unsafe/unhealthy hygiene or habits, and impaired judgment with threats to health/safety.

- e. Level of Care Instrument(s).** Per 42 CFR §441.303(c)(2), indicate whether the instrument/tool used to evaluate level of care for the waiver differs from the instrument/tool used to evaluate institutional level of care (*select one*):

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

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

---

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

For the purpose of determining level of care, the DMHAS RN and Support Coordinator will

make an evaluation of each applicant. Information gathered for the evaluation/re-evaluation of care is derived from a face to face interview and includes a thorough assessment of the client's individual circumstances. The Level of Care determination form will be used to summarize the information and confirm the level of care. The reevaluation process is the same as the evaluation process.

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

- Every three months**
- Every six months**
- Every twelve months**
- Other schedule**

*Specify the other schedule:*

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

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

*Specify the qualifications:*

DMHAS Support Coordinator will perform the re-evaluation in consultation with a DMHAS R.N. on an annual basis. The qualifications of the DMHAS Support Coordinator are a licensed mental health professional with at least three years mental health experience. Licensed mental health professionals include registered nurses, psychologist, clinical social worker, professional counselor, marriage and family therapist and psychiatrist. The qualifications of the consulting RN are the same as the individual who performs the initial evaluation. Licensed mental health professionals without the requisite 3 years experience will be supervised by licensed mental health professionals who meet the experience requirement.

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

DMHAS Support Coordinator will perform the re-evaluation in consultation with a DMHAS R.N. on an annual basis or more frequently if necessary. DMHAS will use an electronic tracking system in which the evaluation and Recovery Plan review dates are logged. This system will prompt Support Coordinators when Recovery Plans are due.

- j. Maintenance of Evaluation/Reevaluation Records.** Per 42 CFR §441.303(c)(3), the State assures that written and/or electronically retrievable documentation of all evaluations and reevaluations are maintained for a minimum period of 3 years as required in 45 CFR §74.53. Specify the location(s) where records of evaluations and reevaluations of level of care are maintained:

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

## **Appendix B: Participant Access and Eligibility**

## B-7: FREEDOM OF CHOICE

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

- i. *informed of any feasible alternatives under the waiver; and*
  - ii. *given the choice of either institutional or home and community-based services.*
- a. Procedures.** Specify the State's procedures for informing eligible individuals (or their legal representatives) of the feasible alternatives available under the waiver and allowing these individuals to choose either institutional or waiver services. Identify the form(s) that are employed to document freedom of choice. The form or forms are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

At the time of the screening for eligibility to participate in the Waiver, the DMHAS Support Coordinator will inform the potential participant of his or her option of receiving services in a nursing facility or through the Waiver. The individual will also be advised of his/her rights to a Fair Hearing. This will be documented on a form and will be included in the individual's record. This form will be maintained by the DMHAS Support Coordinator in the participant's case file.

- b. Maintenance of Forms.** Per 45 CFR §74.53, written copies or electronically retrievable facsimiles of Freedom of Choice forms are maintained for a minimum of three years. Specify the locations where copies of these forms are maintained.

Written copies or electronic facsimiles of the freedom of choice forms will be maintained for a minimum period of 3 years as required by 45 CFR 74.53 by the Support Coordinator.

## Appendix B: Participant Access and Eligibility

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

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

Potential and active Waiver participants with limited fluency in English will have access to services without undue hardship. Information regarding the Waiver and the Request for Waiver Services will be available in Spanish. DMHAS Support Coordinators will be required to make arrangements to provide interpretation or translation services to potential and active waiver participants who need them. This will be accomplished through the use of bi-lingual staff and or purchasing/contracting for interpreters. Non-English speaking Waiver applicants/participants may bring an interpreter of their choice with them to the evaluation and Recovery Planning meetings. They will not be required to bring their own interpreter. No person will be denied access to the Waiver on the basis of English proficiency.

## Appendix C: Participant Services

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

- a. **Waiver Services Summary.** List the services that are furnished under the waiver in the following table. If case management is not a service under the waiver, complete items C-1-b and C-1-c:

Service Type	Service
Statutory Service	Community Support
Statutory Service	Supported Employment
Other Service	Assertive Community Treatment
Other Service	Home Accessibility Adaptations
Other Service	Non-medical transportation
Other Service	Peer Supports
Other Service	Recovery Assistant
Other Service	Short Term Crisis Stabilization
Other Service	Specialized Medical Equipment
Other Service	Transitional Case Management

## Appendix C: Participant Services

### C-1/C-3: Service Specification

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

**Service Type:**

Statutory Service

**Service:**

Psychosocial Rehabilitation

**Alternate Service Title (if any):**

Community Support

**Service Definition (Scope):**

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

CSP includes a comprehensive array of rehabilitation services most of which are provided in non-office settings by a mobile team. Services are focused on skill building with a goal of maximizing independence. Community-based treatment enables the team to become intimately familiar with the participant's surroundings, strengths and challenges, and to assist the participant in learning skills applicable to his/her living environment. The team services and interventions are highly individualized and tailored to the needs and preferences of the individual.

Community Support Program differs from ACT and Peer Support. CSP is less intensive than ACT, does not include the services of psychiatrists or R.N.s, and does not provide medical oversight. Any necessary medical oversight and medication management is provided by hospital clinics, freestanding clinics or independent practitioners. CSP will often be provided as a step-

down service for individuals who successfully complete an ACT program. CSP is more intensive than Peer Support. Compared with Peer Support, CSP provides more concentrated and frequent rehabilitative services and supports. Peer Support would be offered to individuals that have successfully completed their tenure in a Community Support Program.

Community Support Program (CSP) interventions will exclude activities that are duplicative of Supported Employment services.

Community Support is subject to service volume (number of ¼ hours service units per day and/or week) and duration (number of months or specified service end date) limits established in the waiver Recovery Plan approved by DMHAS and DSS. The departments or their designee will enact these limits.

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

---

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

- Participant-directed as specified in Appendix E  
 Provider managed

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

- Legally Responsible Person  
 Relative  
 Legal Guardian

**Provider Specifications:**

Provider Category	Provider Type Title
Agency	Provider Agency

## Appendix C: Participant Services

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

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**Service Type: Statutory Service**

**Service Name: Community Support**

---

**Provider Category:**

Agency

**Provider Type:**

Provider Agency

**Provider Qualifications**

**License** (*specify*):

**Certificate** (*specify*):

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

**Other Standard** (*specify*):

CSP staff shall hold either a bachelor's degree in a behavioral health-related specialty

(may include special education or rehabilitation) OR have two years experience in the provision of mental health services (may include special education and/or services to persons with developmental disabilities) OR be a Certified Peer Specialist.

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

#### **Verification of Provider Qualifications**

##### **Entity Responsible for Verification:**

Fiscal Intermediary under contract to DSS and DMHAS

##### **Frequency of Verification:**

At start of service and at re-accreditation

## **Appendix C: Participant Services**

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### **C-1/C-3: Service Specification**

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

#### **Service Type:**

Statutory Service

#### **Service:**

Supported Employment

#### **Alternate Service Title (if any):**

Supported Employment

#### **Service Definition (Scope):**

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

Supported Employment is subject to service volume (number of ¼ hours service units per day and/or week) and duration (number of months or specified service end date) limits established in the waiver Recovery Plan approved by DMHAS and DSS. The departments or their designee will enact these limits.

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

---

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

- Participant-directed as specified in Appendix E  
 Provider managed

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

- Legally Responsible Person  
 Relative  
 Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Agency Provider

## Appendix C: Participant Services

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

---

**Service Type: Statutory Service**

**Service Name: Supported Employment**

---

**Provider Category:**

Agency

**Provider Type:**

Agency Provider

**Provider Qualifications**

**License (specify):**

**Certificate (specify):**

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

**Other Standard (specify):**

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

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

Fiscal Intermediary under contract to DSS and DMHAS

**Frequency of Verification:**

At start of service or recertification

## Appendix C: Participant Services

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### C-1/C-3: Service Specification

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

**Service Type:**

Other Service

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

**Service Title:**

Assertive Community Treatment

**Service Definition** (*Scope*):

Assertive Community Treatment (ACT) is a recovery focused, high intensity, community based service for individuals discharged from multiple or extended stays in hospitals, or who are difficult to engage in treatment. The service utilizes an interdisciplinary team to provide intensive, integrated, rehabilitative community support, crisis, and treatment interventions/services that are available 24-hours/7days a week.

ACT includes a comprehensive array of rehabilitative services integrated with medical care, most of which is provided in non-office settings by a mobile multidisciplinary team. The team provides community support services interwoven with treatment and rehabilitative services and regularly scheduled team meetings to no fewer than 60 active participants.

The ACT team provides nearly all the treatment needed by the participant. ACT community and clinical services are guided by the participant's strengths and preferences. The service involves an assertive approach, individually tailored programming, ongoing monitoring, variable support, in vivo service, relating to participants as responsible citizens, utilizing a variety of community resources and collaborating with the family. Community-based treatment enables the team to become intimately familiar with the participant's surroundings, strengths and challenges, and to assist the participant in learning skills applicable to his/her actual living environment. The team is persistent in engaging the participant, doing whatever is necessary to keep the individual involved in community life and active in treatment.

ACT services are targeted to individuals with the most complex and persistent psychiatric problems (including those with co-occurring psychiatric and substance use disorders) seen among persons living outside institutional settings. ACT service recipients also are likely to have interlocking social, economic and legal problems that complicate their behavioral health treatment. ACT service users often have erratic behaviors, are frequent users of crisis services, are often difficult to engage in care, have poor adherence to treatment plans, have had multiple hospitalizations, have not benefited from the traditional array of community-based services and, were it not for ACT care, would likely require hospitalization or care in some other institutional setting.

Assertive Community Treatment (ACT) will exclude activities that are duplicative of Supported Employment services.

Assertive Community Treatment is subject to service volume (number of ¼ hours service units per day and/or week) and duration (number of months or specified service end date) limits established in the waiver Recovery Plan approved by DMHAS and DSS. The departments or their designee will enact these limits.

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

---

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

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

**Provider managed**

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

**Legally Responsible Person**

**Relative**

**Legal Guardian**

**Provider Specifications:**

Provider Category	Provider Type Title
Agency	Agency Provider

## Appendix C: Participant Services

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

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**Service Type: Other Service**

**Service Name: Assertive Community Treatment**

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**Provider Category:**

Agency

**Provider Type:**

Agency Provider

**Provider Qualifications**

**License (specify):**

**Certificate (specify):**

The Commission of Accreditation of Rehabilitation Facilities (CARF), or The Joint Commission (TJC).

**Other Standard (specify):**

ACT clinical staff shall hold either a Master's degree in a behavioral health-related specialty (may include special education or rehabilitation) to function as a licensed clinical ACT provider. Paraprofessionals on an ACT team must have a Bachelor's degree OR have two years experience in the provision of mental health services (may include special education and/or services to persons with developmental disabilities), OR be a Certified Peer Specialist.

As ACT service provider must meet the State of Connecticut certification standards to provide both Clinical Services and ACT services as defined by the Department of Mental Health and Addiction Services (DMHAS).

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

Fiscal Intermediary under contract to DSS and DMHAS

**Frequency of Verification:**

At the start of services and recertification

## Appendix C: Participant Services

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### C-1/C-3: Service Specification

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

**Service Type:**

Other Service

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

**Service Title:**

Home Accessibility Adaptations

**Service Definition (Scope):**

Those physical adaptations to the private residence of the participant or the participant's family, required by the participant's service plan, that are necessary to ensure the health, welfare and safety of the participant or that enable the participant to function with greater independence in the home. Such adaptations include the installation of ramps and grab-bars, widening of doorways, modification of bathroom facilities, or the installation of specialized electric and plumbing systems that are necessary to accommodate the medical equipment and supplies that are necessary for the welfare of the participant. Excluded are those adaptations or improvements to the home that are of general utility, and are not of direct medical or remedial benefit to the participant. Adaptations that add to the total square footage of the home are excluded from this benefit except when necessary to complete an adaptation (e.g., in order to improve entrance/egress to a residence or to configure a bathroom to accommodate a wheelchair).

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

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

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

- Participant-directed as specified in Appendix E  
 Provider managed

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

- Legally Responsible Person  
 Relative  
 Legal Guardian

**Provider Specifications:**

Provider Category	Provider Type Title
Agency	Private contractor/business

## Appendix C: Participant Services

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

**Service Type: Other Service**

**Service Name: Home Accessibility Adaptations**

**Provider Category:**

Agency **Provider Type:**

Private contractor/business

**Provider Qualifications****License** (*specify*):**Certificate** (*specify*):**Other Standard** (*specify*):

Meet the State of CT Standard to provide Environmental Accessibility Adaptations through BRS and Home Improvement Registration by the Department of Consumer Protection; Adheres to State/Local Building Codes

**Verification of Provider Qualifications****Entity Responsible for Verification:**

Fiscal Intermediary under contract to DSS and DMHAS

**Frequency of Verification:**

At time of service

## Appendix C: Participant Services

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### C-1/C-3: Service Specification

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

**Service Type:**Other Service 

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

**Service Title:**

Non-medical transportation

**Service Definition** (*Scope*):

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

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

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

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

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

- Participant-directed as specified in Appendix E  
 Provider managed

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

- Legally Responsible Person  
 Relative  
 Legal Guardian

**Provider Specifications:**

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

**Appendix C: Participant Services****C-1/C-3: Provider Specifications for Service****Service Type: Other Service****Service Name: Non-medical transportation****Provider Category:**Individual **Provider Type:**

Individual Provider

**Provider Qualifications****License (specify):**

Valid driver's license

Safe driving record requirement

**Certificate (specify):****Other Standard (specify):**

Proof of current vehicle insurance and proof of a safe driving record

**Verification of Provider Qualifications****Entity Responsible for Verification:**

Fiscal Intermediary under contract to DSS and DMHAS

**Frequency of Verification:**

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

**Appendix C: Participant Services****C-1/C-3: Provider Specifications for Service****Service Type: Other Service****Service Name: Non-medical transportation****Provider Category:**Agency **Provider Type:**

Private transportation service

**Provider Qualifications****License (specify):**

DOT livery license

Safe driving record requirement

**Certificate (specify):****Other Standard (specify):**

Subcontractor for Medicaid Transportation Brokers

All licensed driver for non-medical transportation must have proof of a safe driving record

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

Fiscal Intermediary under contract to DSS and DMHAS

**Frequency of Verification:**

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

## Appendix C: Participant Services

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### C-1/C-3: Service Specification

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

**Service Type:**

Other Service

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

**Service Title:**

Peer Supports

**Service Definition (Scope):**

Peer Support is available as a step-down from more intensive waiver services such as Assertive Community Treatment (ACT) or Community Support Program (CSP), when an ACT or CSP level of care is no longer needed. Peer support includes face-to-face interactions that are designed to promote ongoing engagement of persons covered under the waiver in addressing residual problems resulting from psychiatric and substance use disorders, and promoting the individuals strengths and abilities to continue improving socialization, recovery, self-advocacy, development of natural supports, and maintenance of community living skills. Peer support also includes communication and coordination with behavioral health services providers and others in support of the participant.

Peer Support is least intensive of the three rehabilitative services. The Peer Support worker uses his/her first-hand knowledge about mental illness and how to overcome the disabling effects of these disorders to engage the participant and to continually reinforce and maintain the psychosocial rehabilitation skills acquired by the participant. Peer Support would be offered to individuals that have successfully completed their tenure in the Community Support Program.

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

Peer Support is subject to service volume (number of ¼ hours service units per day and/or week) and duration (number of months or specified service end date) limits established in the waiver Recovery Plan approved by DMHAS and DSS. The departments or their designee will enact these limits.

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

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

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

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

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

**Provider Specifications:**

Provider Category	Provider Type Title
Agency	Provider Agency

## Appendix C: Participant Services

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

**Service Type: Other Service**

**Service Name: Peer Supports**

**Provider Category:**

Agency

**Provider Type:**

Provider Agency

**Provider Qualifications**

**License** (*specify*):

**Certificate** (*specify*):

The agency must:

Meet general certification conditions established by DMHAS;

Demonstrate that its training of individuals providing Peer Support services (also know as "Recovery Support Specialists" services) meets minimum requirements established by DMHAS;

Maintain proper documentation that all staff who provide Peer Support services have completed required training;

Maintain accurate and complete personnel records for individuals providing Peer Support services;

Retain the aforementioned documentation and records for a period specified by DMHAS, and ensure that such materials are available for inspection by DMHAS or its designee at any time during normal business hours; and

Attest in writing that training and related documentation complies with guidelines established by DMHAS for individuals providing Peer Support services.

**Other Standard** (*specify*):

A Peer Support specialist shall:

Be at least 18 yrs old;

Possess at least a high school diploma or GED;

Possess a valid Connecticut driver's license;

Be certified as a Peer Support Specialist in accordance with requirements set by the Department of Mental Health and Addiction Services (DMHAS);

Meet requirements for ongoing continuing education set by DMHAS; and

Demonstrate ability to support the recovery of others from mental illness and/or substance abuse.

Training requirement: Training programs will address abilities to:

Follow instructions given by the participant or the participant's conservator;

Report changes in the participant's condition or needs;

Maintain confidentiality;

Meet the participant's needs as delineated in the waiver Recovery Plan;

Implement cognitive and behavioral strategies;

Function as a member of an interdisciplinary team;

Respond to fire and emergency situations;

Accept supervision in a manner prescribed by the department or its designated agent;

Maintain accurate, complete and timely records that meet Medicaid requirements;

Use crisis intervention and de-escalation techniques;

Provide services in a respectful, culturally competent manner; and

Use effective Peer Support practices.

**Verification of Provider Qualifications****Entity Responsible for Verification:**

Fiscal Intermediary under contract to DSS and DMHAS

**Frequency of Verification:**

At start of service and every two years thereafter

## Appendix C: Participant Services

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### C-1/C-3: Service Specification

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

**Service Type:**

Other Service

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

**Service Title:**

Recovery Assistant

**Service Definition (Scope):**

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

Recovery Assistant Services is subject to service volume (number of ¼ hours service units per day and/or week) and duration (number of months or specified service end date) limits established in the waiver Recovery Plan approved by DMHAS and DSS. The departments or their designee will enact these limits. Recovery Assistant services will not duplicate personal care services that are included in the state plan.

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

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

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

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

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

**Provider Specifications:**

Provider Category	Provider Type Title
Agency	Provider Agency
Individual	Certified Individual

## Appendix C: Participant Services

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

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**Service Type: Other Service**

**Service Name: Recovery Assistant**

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**Provider Category:**

Agency

**Provider Type:**

Provider Agency

**Provider Qualifications**

**License (specify):**

**Certificate** (*specify*):

The agency must:

Meet general certification conditions established by DMHAS;

Demonstrate that its training of individuals providing Recovery Assistant services meets minimum requirements established by DMHAS;

Maintain proper documentation that all staff who provide Recovery Assistant services have completed required training and meet any continuing education and/or training requirements set by DMHAS;

Maintain accurate and complete personnel records for individuals providing Recovery Assistant services;

Retain the aforementioned documentation and records for a period specified by DMHAS, and ensure that such materials are available for inspection by DMHAS or its designee at any time during normal business hours; and

Attest in writing that training and related documentation complies with guidelines established by DMHAS for individuals providing Recovery Assistant services.

**Other Standard** (*specify*):

A Recovery Assistant shall:

Be at least 18 yrs old;

Possess at least a high school diploma or GED;

Possess a valid Connecticut driver's license; and

Training requirement: Training programs will address abilities to:

Follow instructions given by the participant or the participant's conservator;

Report changes in the participant's condition or needs;

Maintain confidentiality;

Meet the participant's needs as delineated in the waiver Recovery Plan;

Implement cognitive and behavioral strategies;

Function as a member of an interdisciplinary team;

Respond to fire and emergency situations;

Accept supervision in a manner prescribed by the department or its designated agent;

Maintain accurate, complete and timely records that meet Medicaid requirements;

Use crisis intervention and de-escalation techniques; and

Provide services in a respectful, culturally competent manner.

**Verification of Provider Qualifications****Entity Responsible for Verification:**

Fiscal Intermediary under contract to DSS and DMHAS

**Frequency of Verification:**

At start of service and every two years thereafter

## Appendix C: Participant Services

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

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**Service Type: Other Service**  
**Service Name: Recovery Assistant**

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**Provider Category:**

**Provider Type:**

Certified Individual

**Provider Qualifications****License (specify):**

**Certificate (specify):**

**Other Standard (specify):**

A Recovery Assistant shall:

Be at least 18 yrs old;  
 Possess at least a high school diploma or GED;  
 Possess a valid Connecticut driver's license; and  
 Be registered with the Department of Mental Health and Addiction Services (DMHAS) as having completed an approved Recovery Assistant training program and meet any continuing education and/or training requirements set by DMHAS.

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

**Verification of Provider Qualifications****Entity Responsible for Verification:**

Fiscal Intermediary under contract to DSS and DMHAS

**Frequency of Verification:**

At start of services and annually thereafter

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## Appendix C: Participant Services

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### C-1/C-3: Service Specification

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

**Service Type:**

Other Service

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

**Service Title:**

Short Term Crisis Stabilization

**Service Definition** (*Scope*):

Short Term Crisis Stabilization consists of face-to-face mental health and substance abuse services provided to individuals within the home and community. The service involves brief, concentrated interventions to stabilize psychiatric conditions or behavioral and situational problems including substance abuse, prevent escalation of psychiatric symptoms, reduce the risk of harm to self or others, avert loss of housing, and wherever possible to avoid the need for hospitalization or other more restrictive placement. Services and interventions are highly individualized and tailored to the needs and preferences of the participant, with the goal of maximizing independence and supporting recovery.

STCS would take place in the participant's home or in other community (non-residential) settings. This intervention, sometimes called "specialing," typically takes place in 4 to 8 hour blocks of time, and might last up to 24 or 36 hours. If the individual cannot be stabilized within this time period, a more intensive intervention is usually needed (such as Mobile Crisis Team). Mobile Crisis Teams are located in DMHAS-operated and DMHAS-funded Local Mental Health Authorities (LMHAs) throughout Connecticut, and would act as a back-up to STCS for waiver participants needing such services.

Short Term Crisis Stabilization is subject to service volume (number of ¼ hours service units per day and/or week) and duration (number of months or specified service end date) limits established in the waiver Recovery Plan approved by DMHAS and DSS. The departments or their designee will enact these limits.

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

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

- Participant-directed as specified in Appendix E  
 Provider managed

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

- Legally Responsible Person  
 Relative  
 Legal Guardian

**Provider Specifications:**

Provider Category	Provider Type Title
Agency	Provider Agency

## Appendix C: Participant Services

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

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**Service Type: Other Service**  
**Service Name: Short Term Crisis Stabilization**

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**Provider Category:**Agency **Provider Type:**

Provider Agency

**Provider Qualifications****License (specify):****Certificate (specify):**

Commission on Accreditation of Rehabilitation Facilities (CARF), or The Joint Commission (TJC), or is a DMHAS designated Local Mental Health Authority (LMHA), or is a contracted affiliate of an LMHA.

**Other Standard (specify):**

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

Meet the State of Connecticut certification standards to provide Short-Term crisis stabilization services defined by the Department of Mental Health and Addiction Services

**Verification of Provider Qualifications****Entity Responsible for Verification:**

Fiscal Intermediary under contract to DSS and DMHAS

**Frequency of Verification:**

At start of services and at recertification

## Appendix C: Participant Services

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### C-1/C-3: Service Specification

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

**Service Type:**Other Service 

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

**Service Title:**

Specialized Medical Equipment

**Service Definition (Scope):**

Specialized medical equipment and supplies include: (a) devices, controls, or appliances, specified in the plan of care, that enable participants to increase their ability to perform activities of daily living; (b) devices, controls, or appliances that enable the participant to perceive, control, or communicate with the environment in which they live; (c) items necessary for life support or to address physical conditions along with ancillary supplies and equipment necessary to the proper functioning of such items; (d) such other durable and non-durable medical

equipment not available under the State plan that is necessary to address participant functional limitations; and, (e) necessary medical supplies not available under the State plan. Items reimbursed with waiver funds are in addition to any medical equipment and supplies furnished under the State plan and exclude those items that are not of direct medical or remedial benefit to the participant. All items shall meet applicable standards of manufacture, design and installation.

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

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

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

- Participant-directed as specified in Appendix E  
 Provider managed

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

- Legally Responsible Person  
 Relative  
 Legal Guardian

**Provider Specifications:**

Provider Category	Provider Type Title
Agency	DME
Agency	Medical Equipment Vendor

## Appendix C: Participant Services

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

**Service Type:** Other Service

**Service Name:** Specialized Medical Equipment

**Provider Category:**

Agency

**Provider Type:**

DME

**Provider Qualifications**

**License** (*specify*):

**Certificate** (*specify*):

**Other Standard** (*specify*):

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

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

Fiscal Intermediary under contract to DSS and DMHAS

**Frequency of Verification:**

At start of services

## Appendix C: Participant Services

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

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**Service Type: Other Service****Service Name: Specialized Medical Equipment**

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**Provider Category:**Agency **Provider Type:**

Medical Equipment Vendor

**Provider Qualifications****License (specify):****Certificate (specify):****Other Standard (specify):**

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

**Verification of Provider Qualifications****Entity Responsible for Verification:**

Fiscal Intermediary under contract to DSS and DMHAS

**Frequency of Verification:**

At start of services

## Appendix C: Participant Services

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### C-1/C-3: Service Specification

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

**Service Type:**Other Service 

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

**Service Title:**

Transitional Case Management

**Service Definition (Scope):**

Services provided to persons residing in institutional settings prior to their transition to the waiver to prepare them for discharge, or during the adjustment period immediately following discharge from an institution to stabilize them in a community setting, and to assist them with

other aspects of the transition to community life by helping them gain access to needed waiver and other state plan services, as well as medical, social, housing, educational and other services and supports, regardless of the funding source for the services or supports to which access is gained. The state shall claim the cost of case management services provided to institutionalized persons prior to their transition to the waiver for a period not to exceed 180 days. Transitional case management:

- a) Shall not be provided to a participant concurrently with state plan targeted case management services;
- b) Shall not duplicate the efforts of nursing facility discharge planning;
- c) Shall not be provided for a transition period exceeding 180 consecutive days prior to admission to the waiver; and
- d) Shall not be billable until the individual is enrolled in the waiver.

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

Transitional Case Management services are limited to a period of 180 days and two hundred (200) ¼ hour service units. However, additional limitations on the volume and duration of these services may be specified in the waiver Recovery Plan approved by DMHAS and DSS. The departments or their designee will enact these limits.

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

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

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

- Legally Responsible Person
- Relative
- Legal Guardian

**Provider Specifications:**

Provider Category	Provider Type Title
Agency	Agency Provider

## Appendix C: Participant Services

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

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**Service Type: Other Service**

**Service Name: Transitional Case Management**

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**Provider Category:**

Agency

**Provider Type:**

Agency Provider

**Provider Qualifications**

**License** (*specify*):

**Certificate** (*specify*):

Commission on Accreditation of Rehabilitation Facilities (CARF) or The Joint

Commission (TJC), and be designated by DMHAS as a "Local Mental Health Authority (LMHA).

**Other Standard** (*specify*):

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

Meet any other certification standards defined by the Department of Mental Health and Addiction Services.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

Fiscal Intermediary under contract to DSS and DMHAS

**Frequency of Verification:**

At start of services and at recertification

## Appendix C: Participant Services

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

- b. Alternate Provision of Case Management Services to Waiver Participants.** When case management is not a covered waiver service, indicate how case management is furnished to waiver participants (*select one*):
- Not applicable** - Case management is not furnished as a distinct activity to waiver participants.
  - Applicable** - Case management is furnished as a distinct activity to waiver participants.  
*Check each that applies*
    - As a Medicaid State plan service under §1915(g)(1) of the Act (Targeted Case Management).** *Complete item C-1-c.*
    - As an administrative activity.** *Complete item C-1-c.*
  - None of the above apply** (i.e., case management is furnished as a waiver service)
- c. Delivery of Case Management Services.** Specify the entity or entities that conduct case management functions on behalf of waiver participants:

The Department of Mental Health and Addiction Services Support Coordinators will provide case management functions to Waiver participants.

## Appendix C: Participant Services

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

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

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

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

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

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

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

- No. The State does not conduct abuse registry screening.**
- Yes. The State maintains an abuse registry and requires the screening of individuals through this registry.**

Specify: (a) the entity (entities) responsible for maintaining the abuse registry; (b) the types of positions for which abuse registry screenings must be conducted; and, (c) the process for ensuring that mandatory screenings have been conducted. State laws, regulations and policies referenced in this description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable):

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## Appendix C: Participant Services

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

- c. **Services in Facilities Subject to §1616(e) of the Social Security Act.** *Select one:*
- No. Home and community-based services under this waiver are not provided in facilities subject to §1616(e) of the Act.**
  - Yes. Home and community-based services are provided in facilities subject to §1616(e) of the Act. The standards that apply to each type of facility where waiver services are provided are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).**

## Appendix C: Participant Services

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

- d. **Provision of Personal Care or Similar Services by Legally Responsible Individuals.** A legally responsible individual is any person who has a duty under State law to care for another person and typically includes: (a) the parent (biological or adoptive) of a minor child or the guardian of a minor child who must provide care to the child or (b) a spouse of a waiver participant. Except at the option of the State and under extraordinary circumstances specified by the State, payment may not be made to a legally responsible individual for the provision of personal care or similar services that the legally responsible individual would ordinarily perform or be responsible to perform on behalf of a waiver participant. *Select one:*
- No. The State does not make payment to legally responsible individuals for furnishing personal care or similar services.**
  - Yes. The State makes payment to legally responsible individuals for furnishing personal care or similar services when they are qualified to provide the services.**

Specify: (a) the legally responsible individuals who may be paid to furnish such services and the services they may provide; (b) State policies that specify the circumstances when payment may be authorized for the provision of *extraordinary care* by a legally responsible individual and how the State ensures that the provision of services by a legally responsible individual is in the best interest of the participant; and, (c) the controls that are employed to ensure that payments are made only for services rendered. *Also, specify in Appendix C-1/C-3 the personal care or similar services for which payment may be made to legally responsible individuals under the State policies specified here.*

- e. **Other State Policies Concerning Payment for Waiver Services Furnished by Relatives/Legal Guardians.** Specify State policies concerning making payment to relatives/legal guardians for the provision of waiver services over and above the policies addressed in Item C-2-d. *Select one:*
- The State does not make payment to relatives/legal guardians for furnishing waiver**

**services.**

- The State makes payment to relatives/legal guardians under specific circumstances and only when the relative/guardian is qualified to furnish services.**

Specify the specific circumstances under which payment is made, the types of relatives/legal guardians to whom payment may be made, and the services for which payment may be made. Specify the controls that are employed to ensure that payments are made only for services rendered. *Also, specify in Appendix C-1/C-3 each waiver service for which payment may be made to relatives/legal guardians.*

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

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

- Other policy.**

Specify:

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

Open enrollment is applied to all providers of Waiver services. As the proposed operating agency for this waiver, DMHAS is developing a provider enrollment and certification process. This process includes a communications strategy: 1) to describe the purpose of the waiver, services to be covered, and expectations for the performance of those services, 2) to promote awareness among potential providers regarding the open enrollment opportunity, 3) to share details about how to apply, and, 4) to specify provider certification requirements. Any provider applicant who submits proper documentation of qualifications to perform a particular waiver service will be enrolled and certified to perform that service.

DMHAS, through the fiscal intermediary will accept applications from any provider who seeks to provide participant directed waiver service(s). DMHAS will develop a list of potential providers from its current network and from other state and local agencies that contract for similar services offered under this Waiver. DMHAS, through its fiscal intermediary will send notification to these providers regarding the types of services that are being sought and the qualifications for each service. The fiscal intermediary will complete the review of the provider qualification. The fiscal intermediary will make recommendations to DSS and DMHAS regarding network participation. The fiscal intermediary will be responsible for contracting with individuals that provide Recovery Assistant services. All other providers that meet the provider qualifications will be provided enrollment materials to submit for a Medicaid Provider Agreement. Once the Provider Agreement is on file, the fiscal intermediary will post the provider information in Provider Directories.

## Appendix C: Participant Services

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### C-3: Waiver Services Specifications

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

## Appendix C: Participant Services

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### C-4: Additional Limits on Amount of Waiver Services

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

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

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

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

There will be a \$10,000 per participant annual limit on the following services:  
Environmental Modifications and Specialized Medical Equipment.

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

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

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

## Appendix D: Participant-Centered Planning and Service Delivery

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

#### State Participant-Centered Service Plan Title:

Recovery Plan (RP)

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

- Registered nurse, licensed to practice in the State**  
 **Licensed practical or vocational nurse, acting within the scope of practice under State law**  
 **Licensed physician (M.D. or D.O)**  
 **Case Manager** (qualifications specified in Appendix C-1/C-3)  
 **Case Manager** (qualifications not specified in Appendix C-1/C-3).

*Specify qualifications:*

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- Social Worker.**  
*Specify qualifications:*
- 

- Other**  
*Specify the individuals and their qualifications:*

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

## Appendix D: Participant-Centered Planning and Service Delivery

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

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

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

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

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## Appendix D: Participant-Centered Planning and Service Delivery

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

- c. Supporting the Participant in Service Plan Development.** Specify: (a) the supports and information that are made available to the participant (and/or family or legal representative, as appropriate) to direct and be actively engaged in the service plan development process and (b) the participant's authority to determine who is included in the process.

The individual planning process will result in the development of a Recovery Plan, which will be the document to guide all supports and services provided to the individual. The Recovery Planning process will 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. The Recovery Planning process will be 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.

The Recovery Planning process will promote and encourage 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, managing, and evaluating supports and services. The Recovery Planning process will offer people the opportunities to lead self-determined lifestyles and exercise greater control in their lives. The person will be viewed holistically to develop a plan of supports and services that is meaningful to him or her. Services and supports will be identified to meet the person's unique desires and needs, regardless of funding source and may include state plan services, generic resources, and natural support networks.

Once a consumer is deemed eligible for waiver services, but prior to actual enrollment, he/she will choose a DMHAS Support Coordinator who will assist them in performing a bio-psychosocial assessment and developing an initial Recovery Plan. The consumer will have the authority to determine who is included in the development of the Recovery Plan. Family, friends, and anyone of the consumer's choosing may participate in developing the Recovery Plan.

## Appendix D: Participant-Centered Planning and Service Delivery

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

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

CMS upon request through the Medicaid agency or the operating agency (if applicable):

The DMHAS Support Coordinator (a RN or licensed mental health practitioner) will be responsible for assisting the consumer in developing the Recovery Plan. The Recovery Plan will outline in writing the services that will be provided to the consumer to meet his/her identified needs, taking into account the consumer's strengths, capacities, preferences, and desired outcomes.

Prior to the development of a Recovery Plan, the DMHAS Support Coordinator will complete an assessment of the consumer. A face to face assessment will be completed by the DMHAS Support Coordinator within 10 business days after receiving a referral from the DMHAS Lead Support Coordinator. The assessment, at a minimum will include the following components:

- Presenting problem including source of distress, precipitating events, associated problems or symptoms, and recent progressions
- Urgent needs, including suicide risk
- Personal strengths and natural support available to the consumer
- Abilities and/or interests
- Previous behavioral health services data (may be document review such as clinical record, discharge summary, etc) including treatment information (dates, locations, duration, frequency, modalities, efficacy—including factors that have contributed to or inhibited previous recovery efforts).
- Physical health history and current status including medication allergies and adverse reactions (within the last 1 year – must be evidence of review by a licensed physician as a part of Assessment)
- Medication use profile including efficacy of current and previously used medications
- Pertinent current and historical life situation information that establishes recovery/resilient environment including:
  - o Age
  - o Gender
  - o Employment history
  - o School/education history including current level of functioning
  - o Legal involvement
  - o Family history
  - o History of abuse (including trauma survivor issues, spousal/partner abuse, physical, psychological, sexual, emotional abuse, and whether the recipient was a victim or a perpetrator of said abuse)
  - o Relationships including natural supports
  - o Housing or living environment including where, with whom, how long, stability
- Use of alcohol, tobacco, and/or other drugs
- Mental status including at least:
  - o Appearance, attitude and behavior
  - o Orientation to person, place, time, and date
  - o Affect and mood
  - o Thought content/processes including
  - o Fund of knowledge
  - o Intelligence
  - o Cognitive processes
  - o Memory
  - o Insight
  - o Judgment; and

- o Homicidal/suicidal risk
- Current level of function in life skills
- Individualized needs
- Preferences (e.g., location, service type, provider, treatment orientation)
- Issues important to the recipient including:
  - o Cultural background
  - o Spiritual beliefs
  - o Sexual orientation
- Need for and availability of social supports
- Risk taking behaviors (e.g., unprotected sex, run away, etc)
- Advance directives if applicable
- Diagnostic impressions using DSM-IV, at least axes I-III

The Assessment will culminate in the development of a written Integrated Summary. The Integrated Summary will synthesize, evaluate, integrate, and interpret the data gathered in the Assessment. The Integrated Summary will identify and prioritize the recipient's needs and preferences, provide an evaluation of the efficacy of past interventions, and recommend the objectives, interventions, services and supports to be considered in the initial Recovery Plan.

Once the assessment is completed, the Recovery Planning process will commence. Consumers will develop their Recovery Plan with the DMHAS Support Coordinator. The consumer will have the authority to determine who is included in the development of the Recovery Plan. Family, friends, and anyone of the consumer's choosing may participate in developing the Recovery Plan. The DMHAS Support Coordinator will maximize the extent to which the consumer participates by:

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

The consumer, with the assistance of family, friends, the DMHAS Support Coordinator, and others of the individual's choosing will develop an initial Recovery Plan. The initial Recovery Plan will include the following:

- A summary of strengths, complaints, and complications indicating the need for services;
- Consumer's desired outcome;
- Specific short-term objectives and long-term goals, including discharge potential or plan;
- A description of the consumer's functional level;
- A description of risk factors and special procedures recommended for the health and safety of the consumer;
- Discharge plan;
- Any orders for the following:
  - o Medication(s);

- o Crisis triggers and interventions
- o Treatments; both medical and psychiatric;
- o Restorative and rehabilitative services;
- o Therapies;
- o Leisure activities;
- o Social services; and
- o Diet.

In addition, the Recovery Plan will include the specific services to be provided and the frequency of services. The plan will identify all services and supports needed by the individual including services included in the Medicaid state plan as well as services offered by other state agencies, general community resources, and natural supports. It will also identify (when applicable) the specific organization that will be requested to offer more formal treatment and support services. Each service proposed in the Recovery Plan will identify the reason for selecting the service, the expected goal and the timeframe for which the service is needed.

After the Recovery Plan has been developed, the DMHAS Support Coordinator will prepare the cost sheet. The cost sheet will also be completed when the Recovery Plan is significantly revised. The DMHAS Support Coordinator will explain the cost sheet to the consumer and/or representative at each review of the Recovery Plan, which occurs every 3 months.

The Recovery Plan will also have the signatures of all individuals who participated in the development of the plan, including the consumer and/or representative, and DMHAS Support Coordinator.

## **Appendix D: Participant-Centered Planning and Service Delivery**

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

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

Information and training will be provided every consumer to prepare them for playing a greater role in the support and Recovery Planning and delivery process. The information and training will cover health and safety factors, emergency back-up planning, and risk identification, assessment, and management. If the consumer's mental condition decompensates, family members and other supports will be provided with information and training and encouraged to participate with the consumer in the Recovery Planning process. Emergency back-up plans and risk identification and management will be included in the consumer's Recovery Plan. Emergency back-up plans will be defined and planned for on an individual basis, and may include an assessment of critical services and a back-up strategy for each identified critical service. Back-up may include:

- a) Consumer back-up incorporated into the Recovery Plan;
- b) Informal back-up (e.g., family, friends, neighbors);
- c) Enrolled Medicaid provider network and the local mental health provider offering clinical and rehabilitative services to the participant;

d) System level/local emergency response and crisis response including the statewide network of DMHAS crisis teams.

Back-up services (with the exception of DMHAS crisis teams) may be included and paid for by the waiver program. As part of quality assurance reviews, DMHAS and DSS will review every service and support plan to assure that it meets health care needs and that there is proper documentation for emergency back-up and risk management procedures. Additionally, participants will be trained and supported in developing Advanced Directives containing information about their preference for care during emergencies.

## Appendix D: Participant-Centered Planning and Service Delivery

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

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

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

## Appendix D: Participant-Centered Planning and Service Delivery

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

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

All Recovery Plans will be reviewed by the DMHAS Lead Support Coordinator and DSS. Review of the Recovery Plan will be based on the following:

- Completeness of plan which includes all necessary services (waiver and non-waiver services) being listed in terms of amount, frequency, duration and planned provider(s), including assurances of the consumers' freedom of choice of waiver and non-waiver providers;
- Consistency of the plan with assessment information regarding consumers' needs; and
- Presence of appropriate signatures.

DMHAS and DSS will review the Recovery Plan within 10 business days after the consumer approves and signs the Recovery Plan. Upon this review DMHAS and DSS will approve, pend or deny the Recovery Plan. DMHAS and DSS will determine if the cost of the Waiver services necessary to ensure the participant's health and safety does not exceed the cost limit established by the state.

If DMHAS and DSS approve the Recovery Plan the participant will be notified and offered

enrollment into the Waiver. If the Recovery Plan is pended, DMHAS and DSS will request additional information regarding the participant's need. DMHAS and DSS may also make recommendations to the Recovery Planning Team and the participant regarding changes to services and service budgets. DMHAS and DSS may also deny the Recovery Plan. Applicants or participants whose health and safety needs cannot be reasonably assured at their current level of assessed care and home and community based services within the Waiver will not be enrolled (or disenrolled if a current participant) in the Waiver.

In the event that the Applicant is denied enrollment or a current participant's services are being reduced or terminated, the applicant or participant will receive a Medicaid Notice of Action (NOA) regarding their right to a fair hearing in accordance with the rules of the Medicaid program.

## **Appendix D: Participant-Centered Planning and Service Delivery**

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

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

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

*Specify the other schedule:*

---

- i. Maintenance of Service Plan Forms.** Written copies or electronic facsimiles of service plans are maintained for a minimum period of 3 years as required by 45 CFR §74.53. Service plans are maintained by the following (*check each that applies*):

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

*Specify:*

## **Appendix D: Participant-Centered Planning and Service Delivery**

### **D-2: Service Plan Implementation and Monitoring**

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

### Service Plan Implementation

Once the participant is enrolled in the Waiver, the DMHAS Support Coordinator will arrange a Recovery Plan Implementation Meeting. The Support Coordinator will contact the participant, and any organizations that are identified in the Recovery Plan to discuss implementation. Prior to this meeting the DMHAS Support Coordinator will make the referrals and engage these organizations to participate in the Implementation Meeting. The purpose of this Implementation Meeting will be to have the participant meet the relevant organization's representative and to coordinate initial appointments to commence service delivery. Initially, the DMHAS Support Coordinator will assist the participant with scheduling, transportation, and initial case management tasks delineated in the initial Recovery Plan and Implementation Meeting. During the initial Recovery Plan and Implementation Meeting the participant may elect to receive transitional case management services. If elected, the agency providing transitional case management services will assist the participant with scheduling and transportation to the organizations identified in the Recovery Plan, arranging for community placement (e.g., locating and leasing an apartment) and providing other supports required by the participant during the transition to the community. The Transitional Case Manager will notify the DMHAS Support Coordinator when services are not being delivered in accordance with the Recovery Plan, or if the consumer requests a change in the Recovery Plan, or for any other reasons that would indicate a need to change the Recovery Plan.

During the initial Recovery Planning and Implementation Meeting, the participant will also be offered a choice of an agency providing Community Support Program (CSP) Team or Assertive Community Treatment (ACT). As soon as the consumer chooses an ACT or CSP team, the consumer, in discussions with the team will identify a principal clinician on the team to serve as the primary point of contact. Once the individual is discharged from the nursing facility this principal clinician will be responsible for monitoring the individual's level of functioning and their progress in accessing and participating in services identified in the Recovery Plan. The principal clinician will notify the DMHAS Support Coordinator when services are not being delivered in accordance with the Recovery Plan, or if the consumer requests a change in the Recovery Plan, or for any other reasons that would indicate a need to change the Recovery Plan.

Agencies that provide transitional case management to a participant prior to discharge from the nursing facility will work closely with the CSP or ACT provider identified by the consumer during the initial Recovery Planning and Implementation meeting. This will ensure a smooth transition and promote continuity of care during the transition for participants that are discharged from a nursing facility.

### Monitoring of the Recovery Plan

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

The DMHAS Support Coordinator will be responsible for monitoring the Recovery Plan quarterly or more frequently if needed. The frequency with which monitoring will be performed may vary based on risk factors that are identified during the assessment and Recovery Plan development process and during subsequent reviews. The DMHAS Support Coordinator will use interviews (e.g., with principal clinician), chart reviews and other data to determine whether:

- Services are furnished in accordance with the service plan;

- Participants have access to waiver services identified in the service plan
- Services continue to meet the needs of the participant;
- Back-up plans are effective;
- Participant health and welfare is assured;
- Participants continue to be offered and exercise free choice of providers; and,
- Participants have access to non-waiver services identified in the Recovery Plan, including access to health services.

These quarterly meetings will be face to face and include the participant, principal clinician, key providers and other individuals chosen by the participant. The meetings will also review the service implementation status, care efficacy, and participant progress. Participant safety, and health and welfare also will be reviewed. At these meetings, Recovery Plans will be adjusted congruent with consumer's needs. Proposed changes to a consumer's Recovery Plan will be submitted through the Support Coordinator to the DMHAS Lead Support Coordinator and DSS. Updates to the Recovery Plan will undergo the same review process as described above.

The participant, caregiver(s), or the principal clinician experiencing or identifying a problem with the implementation of a Recovery Plan will also immediately contact the participant's DMHAS Support Coordinator. The Support Coordinator will then contact the participant, principal clinician and/or caregiver(s) to assess the problem and strategize possible solutions. Solutions may include:

- o Conducting a meeting to revise the Recovery Plan, if the scope or amount of services are not appropriate for the participant
- o Contacting the necessary providers regarding any engagement and performance issues.
- o On-site reviews to assess and resolve any health and safety issues.

**b. Monitoring Safeguards. *Select one:***

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

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

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## **Appendix E: Participant Direction of Services**

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

- Yes. This waiver provides participant direction opportunities.** Complete the remainder of the Appendix.
- No. This waiver does not provide participant direction opportunities.** Do not complete the remainder of the Appendix.

*CMS urges states to afford all waiver participants the opportunity to direct their services. Participant*

*direction of services includes the participant exercising decision-making authority over workers who provide services, a participant-managed budget or both. CMS will confer the Independence Plus designation when the waiver evidences a strong commitment to participant direction.*

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

- Yes. The State requests that this waiver be considered for Independence Plus designation.**
- No. Independence Plus designation is not requested.**

## **Appendix E: Participant Direction of Services**

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### **E-1: Overview (1 of 13)**

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

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

The development of the Recovery Plan will be participant led. During the planning process services and supports will be identified to meet the person's unique desires and needs, regardless of funding source and may include state plan services, generic resources, and natural support networks. At the time of the planning process, the DMHAS Support Coordinator will ensure the person and caregiver (family member, spouse, partner, friend) have sufficient information available to make informed choices about the degree to which they wish to self-direct Recovery Assistant services. The Support Coordinator will also ensure the individual has the information to make informed selections of qualified waiver providers. Support Coordinator will also notify individuals about their ability to change providers when they are not satisfied with a provider's performance.

Self-direction will be included in the Recovery Plan to the extent the individual and/or caregiver wishes to directly manage services and supports. During this initial Waiver period, participants can self-direct individuals that provide Recovery Assistant Services. Individuals who choose to self-direct these services will be referred to a Fiscal Intermediary (FI) that will function as the common-law employer. The FI will be the employer of record for employees hired to provide Recovery Assistant Services for the individual, however the individual maintains the ability to select, schedule and supervise those workers. The individual may refer potential staff to the FI for employment. In both arrangements, the individual will have responsibility for managing the Recovery Assistant services.

The FI will function as the intermediary between each participant and individuals who perform self directed services. The FI will assist the individual and/or caregivers to facilitate the employment of Recovery Assistants by the individual or caregivers. Specific tasks performed by the FI will include:

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

The FI will work on behalf of Waiver participants for the purpose of managing the payroll task for the participant's employees who provide Recovery Assistant Services. In addition the FI will be responsible to individuals and agencies that provide these services for the following activities:

- Withholding federal, state and local tax payments including FICA and FUTA;
- File the necessary tax forms for the IRS and the State of Connecticut;
- Provide individuals with the necessary tax information on a timely basis;;
- File and withhold state unemployment insurance tax; and
- Making payment for invoices submitted by individuals or agencies providing these services.

The FI will enroll with DSS as a Medicaid provider. The FI will not provide any services directly. The FI service will be delivered as an administrative cost and is not included in individual budgets.

## Appendix E: Participant Direction of Services

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### E-1: Overview (2 of 13)

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

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

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

- Participant direction opportunities are available to participants who live in their own private residence or the home of a family member.**
- Participant direction opportunities are available to individuals who reside in other living arrangements where services (regardless of funding source) are furnished to fewer than four persons unrelated to the proprietor.**
- The participant direction opportunities are available to persons in the following other living arrangements**

Specify these living arrangements:

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## Appendix E: Participant Direction of Services

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### E-1: Overview (3 of 13)

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

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

*Specify the criteria*

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## Appendix E: Participant Direction of Services

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### E-1: Overview (4 of 13)

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

DMHAS Support Coordinators and the Fiscal Intermediary (FI) will provide information to Waiver participants regarding participant direction. Individuals will be informed of participant directed services during the assessment and Recovery Planning process. After completing the

assessment the DMHAS Support Coordinator will coordinate the Recovery Planning process and provide a continuing source of supports to participants after the Recovery Plan has been developed. The members of the Recovery Planning team will include the participant, DMHAS Support Coordinator and any other person chose by the participant. At this meeting, and in subsequent meetings to revise the Recovery Plan, the DMHAS Support Coordinator will provide information to the participant regarding the opportunity to direct their own care.

## Appendix E: Participant Direction of Services

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### E-1: Overview (5 of 13)

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

- The State does not provide for the direction of waiver services by a representative.**
- The State provides for the direction of waiver services by representatives.**

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

- Waiver services may be directed by a legal representative of the participant.**
- Waiver services may be directed by a non-legal representative freely chosen by an adult participant.**

Specify the policies that apply regarding the direction of waiver services by participant-appointed representatives, including safeguards to ensure that the representative functions in the best interest of the participant:

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

## Appendix E: Participant Direction of Services

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### E-1: Overview (6 of 13)

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

Participant-Directed Waiver Service	Employer Authority	Budget Authority
Recovery Assistant	<input checked="" type="checkbox"/>	<input type="checkbox"/>

## Appendix E: Participant Direction of Services

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### E-1: Overview (7 of 13)

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

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

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

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

## Appendix E: Participant Direction of Services

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### E-1: Overview (8 of 13)

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

- FMS are covered as the waiver service specified in Appendix C1/C3**

**The waiver service entitled:** \_\_\_\_\_

- FMS are provided as an administrative activity.**

Provide the following information

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

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

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

The fiscal intermediary will be paid on a monthly basis for activities set forth in the contract with DSS and DMHAS.

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

---

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

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- Assists participant in verifying support worker citizenship status**
- Collects and processes timesheets of support workers**
- Processes payroll, withholding, filing and payment of applicable federal, state and local employment-related taxes and insurance**
- Other**

*Specify:*

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

---

Supports furnished when the participant exercises budget authority:

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- Maintains a separate account for each participant's participant-directed budget**
- Tracks and reports participant funds, disbursements and the balance of participant funds**
- Processes and pays invoices for goods and services approved in the service plan**
- Provide participant with periodic reports of expenditures and the status of the participant-directed budget**
- Other services and supports**

*Specify:*

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Additional functions/activities:

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- Executes and holds Medicaid provider agreements as authorized under a written agreement with the Medicaid agency**
- Receives and disburses funds for the payment of participant-directed services under an agreement with the Medicaid agency or operating agency**

- Provides other entities specified by the State with periodic reports of expenditures and the status of the participant-directed budget**
- Other**

*Specify:*

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

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

- 1) The fiscal intermediary will provide DSS and DMHAS with quarterly and ad hoc reports
- 2) DSS and DMHAS will perform on-site administrative and operational reviews
- 3) DSS and DMHAS will attend trainings administered or approved by the fiscal intermediary to assess content and quality
- 4) DSS and DMHAS will collect information from participants and providers regarding the satisfaction with the fiscal intermediary's performance. This may include: focus groups, phone and face-to-face interviews.
- 5) DSS and DMHAS will monitor on a bi-weekly basis the fiscal intermediary during the first 90 days of operations. This will include a review of key implementation activities and deliverables.

## Appendix E: Participant Direction of Services

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### E-1: Overview (9 of 13)

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

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

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

---

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

<b>Participant-Directed Waiver Service</b>	<b>Information and Assistance Provided through this Waiver Service Coverage</b>
<b>Community Support</b>	<input type="checkbox"/>
<b>Non-medical transportation</b>	<input type="checkbox"/>
<b>Assertive Community Treatment</b>	<input type="checkbox"/>
<b>Transitional Case Management</b>	<input type="checkbox"/>
<b>Home Accessibility Adaptations</b>	<input type="checkbox"/>
<b>Specialized Medical Equipment</b>	<input type="checkbox"/>
<b>Supported Employment</b>	<input type="checkbox"/>
<b>Peer Supports</b>	<input type="checkbox"/>
<b>Recovery Assistant</b>	<input type="checkbox"/>
<b>Short Term Crisis Stabilization</b>	<input type="checkbox"/>

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

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

The DMHAS Support Coordinator will provide information to the waiver participant to support their efforts to direct their own services. This will occur during the initial Recovery Planning process and during reviews and updates to the plan. If the individual elects to direct their own services, they will be referred to the fiscal intermediary to provide employer related services. These include:

- Identifying and recruiting individuals or agencies that can provide Recovery Assistant Services;
- Developing a registry of individuals and agencies that provide Recovery Assistant Services;
- Developing an enrollment packet for individuals or agencies that will provide Recovery Assistant Services;
- Performing background checks on prospective individuals who will provide Recovery Assistant Services;
- Providing information and training materials to assist in employment and training of workers;
- Facilitating the meeting with the Participant and the individual or agency providing Recovery Assistant Services;
- Managing, on a monthly basis, all invoices for Recovery Assistant Services against the

amount of Recovery Assistant Services authorized in a Participants Recovery Plan and .

- Developing fiscal accounting and expenditure reports.

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

- The fiscal intermediary will provide DSS and DMHAS quarterly ad hoc reports
- DSS and DMHAS will perform on-site administrative and operational reviews
- DSS and DMHAS will attend trainings administered or approved by the fiscal intermediary to assess content and quality
- DSS and DMHAS will collect information from participants and providers regarding the satisfaction with the fiscal intermediary's performance. This may include: focus groups, phone and face-to-face interviews.
- DSS and DMHAS will monitor on a bi-weekly basis the fiscal intermediary during the first 90 days of operations. This will include a review of key implementation activities and deliverables.

## Appendix E: Participant Direction of Services

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### E-1: Overview (10 of 13)

#### k. Independent Advocacy (*select one*).

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

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

DMHAS will refer individuals to independent organizations that will provide consultation, advocacy, resource facilitation, support, information, and training to Waiver participants. These organizations will be intended to enable participants to advocate for themselves for access to services and supports. This will be provided through face to face and telephonic support as well as mailings and web-based information dissemination. The independent advocacy organization will be available by telephone and internet. The organizations providing the advocacy function will not provide direct services, perform assessments or have monitoring oversight or fiscal responsibilities.

## Appendix E: Participant Direction of Services

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### E-1: Overview (11 of 13)

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

Participant direction of self directed Waiver services may be voluntarily terminated. All Waiver services will be available through Waiver agency providers. If a participant chooses to terminate self direction, the DMHAS Support Coordinator will aid in the identification of the provider agency to support the consumer's need. The Recovery Plan will be revised and the DMHAS Support Coordinator will ensure linkage to the appropriate provider in a timely manner.

## Appendix E: Participant Direction of Services

### E-1: Overview (12 of 13)

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

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

## Appendix E: Participant Direction of Services

### E-1: Overview (13 of 13)

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

**Table E-1-n**

	<b>Employer Authority Only</b>	<b>Budget Authority Only or Budget Authority in Combination with Employer Authority</b>
<b>Waiver Year</b>	<b>Number of Participants</b>	<b>Number of Participants</b>
Year 1	15	
Year 2	30	
Year 3	45	

## Appendix E: Participant Direction of Services

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

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

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

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

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

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

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

- Recruit staff**  
 **Refer staff to agency for hiring (co-employer)**  
 **Select staff from worker registry**  
 **Hire staff common law employer**  
 **Verify staff qualifications**  
 **Obtain criminal history and/or background investigation of staff**

Specify how the costs of such investigations are compensated:

- Specify additional staff qualifications based on participant needs and preferences so long as such qualifications are consistent with the qualifications specified in Appendix C-1/C-3.**  
 **Determine staff duties consistent with the service specifications in Appendix C-1/C-3.**  
 **Determine staff wages and benefits subject to State limits**  
 **Schedule staff**  
 **Orient and instruct staff in duties**  
 **Supervise staff**  
 **Evaluate staff performance**  
 **Verify time worked by staff and approve time sheets**  
 **Discharge staff (common law employer)**

- Discharge staff from providing services (co-employer)
- Other

Specify:

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## Appendix E: Participant Direction of Services

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

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

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

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

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

Specify:

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## Appendix E: Participant Direction of Services

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

- b. Participant - Budget Authority**

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

- ii. Participant-Directed Budget** Describe in detail the method(s) that are used to establish the

amount of the participant-directed budget for waiver goods and services over which the participant has authority, including how the method makes use of reliable cost estimating information and is applied consistently to each participant. Information about these method (s) must be made publicly available.

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## Appendix E: Participant Direction of Services

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

#### b. Participant - Budget Authority

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

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

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## Appendix E: Participant Direction of Services

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

#### b. Participant - Budget Authority

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

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

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

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

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## Appendix E: Participant Direction of Services

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

**b. Participant - Budget Authority**

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

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

## Appendix F: Participant Rights

### Appendix F-1: Opportunity to Request a Fair Hearing

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

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

Applicants for and participants under this Waiver may request and receive a fair hearing in accordance with the DSS' Medical Assistance Program. Applicants will receive a copy of the DSS W-1035, Freedom of Choice/Hearing Notification Form, during the first visit with the DMHAS Support Coordinator. Participants are eligible for Fair Hearings in the following circumstances:

- Participant was not offered the choice of home and community services as an alternative to institutional care
- DSS does not reach a determination of financial eligibility within standards of promptness
- DSS denies the application for any reasons other than limitations on the number of individuals that can be served and/or funding limitations as established under this Waiver.
- DSS denies the application for the individual not meeting the level of care or other eligibility criteria

. DSS disapproves the individual's Recovery Plan.

- DSS denies or terminates a service of the individual's choice.
- DSS denies or terminates a payment to a provider of the individual's choice; or
- DSS discharges an individual from this Waiver.

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

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

## Appendix F: Participant-Rights

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### Appendix F-2: Additional Dispute Resolution Process

- a. Availability of Additional Dispute Resolution Process.** Indicate whether the State operates another dispute resolution process that offers participants the opportunity to appeal decisions that adversely affect their services while preserving their right to a Fair Hearing. *Select one:*
- No. This Appendix does not apply**
  - Yes. The State operates an additional dispute resolution process**
- b. Description of Additional Dispute Resolution Process.** Describe the additional dispute resolution process, including: (a) the State agency that operates the process; (b) the nature of the process (i.e., procedures and timeframes), including the types of disputes addressed through the process; and, (c) how the right to a Medicaid Fair Hearing is preserved when a participant elects to make use of the process: State laws, regulations, and policies referenced in the description are available to CMS upon request through the operating or Medicaid agency.
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## Appendix F: Participant-Rights

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### Appendix F-3: State Grievance/Complaint System

- a. Operation of Grievance/Complaint System.** *Select one:*
- No. This Appendix does not apply**
  - Yes. The State operates a grievance/complaint system that affords participants the opportunity to register grievances or complaints concerning the provision of services under this waiver**
- b. Operational Responsibility.** Specify the State agency that is responsible for the operation of the grievance/complaint system:
- Department of Mental Health and Addiction Services
- c. Description of System.** Describe the grievance/complaint system, including: (a) the types of grievances/complaints that participants may register; (b) the process and timelines for addressing grievances/complaints; and, (c) the mechanisms that are used to resolve grievances/complaints. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

DMHAS will require each agency participating in the Waiver to have a complaints and grievances process and to inform each person seeking or receiving services about how to use the process. The DMHAS Complaint, Grievance and Appeal system is available to anyone receiving DMHAS services (upon approval of the waiver, this would include waiver participants)

regardless of whether the service is State-funded or State-operated. Additionally, participants will be informed that the DSS Fair Hearing process is available to them at any time, and that the provider or DMHAS operated complaint and grievance process need not be completed for them to request a Fair Hearing.

As a general principle, DMHAS will encourage the handling of complaints and grievances at the level closest to the service recipient, in other words, in the program or facility where the service is located. In addition, DMHAS policy will focus on the mediation and settlement of grievances as soon as possible after they arise. However, when a grievance cannot be resolved to the satisfaction of the person raising the concern, a process will be in place for appealing a grievance finding to the Office of the Commissioner at DMHAS. A grievance-appeal will set into motion a time-critical sequence of events involving examination of the grievance conclusion to determine whether the agency-level decision on the grievance is supported or overturned. Waiver recipients will also have recourse to the DSS Fair Hearing process, as well as rights to judicial relief as specified in Chapter 54 of Connecticut General Statutes.

## Appendix G: Participant Safeguards

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### Appendix G-1: Response to Critical Events or Incidents

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

Under Connecticut Statute 17a-452b, authority for overseeing the quality of services for all Department of Mental Health and Addiction Services (DMHAS) clients, facilities and funded agencies is designated to the Medical Director. Reporting and review of critical incidents will be an important component of the ongoing evaluation and improvement of the quality of care and services offered under the Waiver.

Critical incidents will be defined as incidents that may have a serious or potential serious impact on, Waiver clients, staff, facilities, funded agencies, or the public or may bring about adverse publicity. The requirement to report a critical incident will apply under the following circumstances: the incident involves a Waiver client and/or occurred within a DMHAS operated facility or an agency or individual serving a Waiver recipient. The following events will be considered critical incidents:

- a. the death of a client, on-duty staff member, or visitor to the facility/agency, which is related to a critical incident, suicide, accident, unexplained circumstance or appearance of negligence, including such client deaths that occur up to 30 days after discharge (from any program level), if known;
- b. the escape of any client under the jurisdiction of the Psychiatric Security Review Board, patients confined pursuant to Section 54-56d C.G.S., or during a correctional transfer;
- c. any incident involving a client or the agency where it appears reasonable to expect that media coverage will or is likely to occur;

- d. threats by a client who has been assessed by the agency staff to represent a serious risk to the staff, other clients, or others;
- e. any serious suicide attempt including suicide attempts that occur up to 30 days after discharge (from any program level), if known;
- f. serious behaviors, that are committed or allegedly committed on or by clients, on-duty staff, or visitors to a facility or program, that have resulted or may result in a felony arrest, e.g., arson, assault, armed robbery, bomb threat, hostage taking, sexual assault, sale of illegal substances on program premises;
- g. emergency evacuation of program premises, other than for the purpose of conducting a drill;
- h. allegations of client abuse, neglect, exploitation, injury, or violation of confidentiality that have serious consequences or potentially serious consequences;
- i. significant loss or allegations of theft of property or property damage that have or could compromise staff or patient safety;
- j. emergency situations resulting in the notification of federal offices (e.g., FBI, U.S. Secret Service) in conformance with the incident reporting requirements of the respective agency; and
- k. any unexpected death of a DMHAS client beyond 30 days of being actively enrolled in a program.

All critical incidents will be reported, as outlined in this procedure, to the DMHAS Office of the Commissioner (OOC). Such reporting will be the responsibility of the Chief Executive Officer (CEO) or designee of the agency participating in the Waiver program.

#### Notification:

1. When a critical incident becomes known, verbal notification will be required to be provided by the agency CEO to the DMHAS OOC Health Care Systems (HCS) Division in not more than three (3) hours. This must be followed by the written/faxed notification within one (1) business day. Required information for the verbal and written/faxed notification is listed in "Required Information for Notification" section below.
2. During normal work hours (defined for this purpose as 8:00 a.m. to 3:30 p.m., Monday to Friday, excluding holidays) verbal notification should be made directly to HCS.
3. After hours notification (defined as after 3:30 p.m. on normal work days, and all weekends and holidays) also must be made within three (3) hours of learning of the incident, as follows:
  - a. The CEO of the agency will be required to provide verbal notification by calling the Connecticut Valley Hospital (CVH) switchboard. CVH then notifies the On-call Health Care Systems (HCS) Manager. The On-Call HCS Manager will contact the CEO for the verbal report of the incident. Depending upon the nature of the incident, the On-Call HCS Manager will contact the HCS Director, and, when appropriate, the DMHAS Chief Operations Officer.
  - b. The agency CEO will ensure that a written report, using the DMHAS Critical Incident Report

Form, is faxed to Health Care Systems (HCS) no later than the next business day.

c. The On-Call HCS Manager, as necessary, will assist with the management and coordination of activities related to the critical incident, until the next business day or longer if necessary, so as to protect the health and safety of Waiver participants, staff, members of the public, respond to any immediate problems, and safeguard facility property.

d. The HCS Regional Manager for the involved Region and the HCS Director will be required to be briefed by the On-Call HCS Manager no later than by 8:30 a.m. on the next business day about the incident, actions already taken, and any additional actions that need to be coordinated.

e. All members of the Medicaid Waiver participant's recovery planning team and service agency staff members will be required to report critical incidents.

#### Required Information for Notification:

##### 1. Verbal notification minimally includes:

a. A brief description of the incident, including the date, time and place of occurrence;

b. Person(s) involved, their relationships to the facility and each other;

c. Action already taken and/or immediate follow-up steps planned;

d. Any other information that may be of immediate significance or importance regarding the situation; and

e. If the incident involves a Medicaid Waiver participant, the DMHAS Waiver Program Support Coordinator must be notified. He/she in turn must notify the Waiver Program Nurse Clinician at the Department of Social Services (DSS). All members of the Waiver participant's recovery planning team and service staff members are required to report critical incidents.

##### 2. Written notification will be made using the DMHAS Critical Incident Report Form, and minimally includes the following information:

a. facility and program involved;

b. last time of facility/client contact;

c. services client was receiving at time of incident;

d. date of incident;

e. time of incident;

f. location of incident;

g. type of incident;

h. name of person(s) involved in incident;

i. if client, age, gender, race and current diagnoses;

j. relationship of involved person(s) to facility, i.e., client, staff, other;

k. role of involved person in terms of the incident, i.e., victim, alleged perpetrator, other;

l. any injuries relating to the critical incident;

m. immediate actions taken at incident and up to notification;

n. brief narrative description of incident, including if charges and arrests have occurred; and

o. name and title of person reporting incident.

3. In not more than one (1) business day of receiving the written notification of a Critical Incident, HCS will be required to notify the following DMHAS staff via e-mail:

- a. Medical Director
- b. Chief Operations Officer
- c. HCS Director
- d. HCS Regional Managers and HCS staff designated to investigate critical incidents
- e. Director of Young Adult Services, if client is a special populations, transitioning youth
- f. Director of Human Resources, if the incident involves an alleged work rule violation by a state employee.

4. HCS staff will then enter information from the telephoned and written report into the critical incident database and route the written report to the Administrative Assistant of the Director of Health Care System. At the same time, a copy of the written report will be placed in the designated central file.

5. The designated HCS Regional staff member will be required to contact the agency CEO or designee in not more than two (2) business days to discuss:

- a. current situation;
  - b. corrective or remedial actions already taken and/or needed; and
  - c. development of incident review plan including date, attendance and format.
- b. Participant Training and Education.** Describe how training and/or information is provided to participants (and/or families or legal representatives, as appropriate) concerning protections from abuse, neglect, and exploitation, including how participants (and/or families or legal representatives, as appropriate) can notify appropriate authorities or entities when the participant may have experienced abuse, neglect or exploitation.

DMHAS Support Coordinators will provide information to participants and their representatives at various times during their Waiver tenure regarding the reporting of potential abuse, neglect and exploitation. For instance, DMHAS Support Coordinators will provide written and verbal information regarding potential abuse and neglect during the recovery planning meetings. In addition, DMHAS will provide ongoing training and education to its providers regarding identifying and reporting abuse and neglect. Individuals who are under contract with the fiscal intermediary will be required to attend this training within the first 90 days of employment.

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

#### Critical Incident Review

1. Critical Incidents (CI) will be reviewed by the involved facility within 30 days of the incident. This review will focus on causative factors and will, when indicated, result in the development of a corrective action plan that would reduce the risk of reoccurrence of a similar event. Completed reviews will be sent to the DMHAS Office of the Commissioner within 30 days of the CI. If an autopsy or toxicology report is required to complete the review, the facility will notify OOC whether the final report is being delayed and the expected arrival date.

If the reporting facility is an affiliate of a state-operated Local Mental Health Authority (LMHA), the completed CI review will first be sent to the LMHA. After the LMHA review, the completed

review will be forwarded to HCS at OOC.

2. The HCS Regional Manager or designee will:

- a. maintain contact with the facility as necessary throughout the review process; and
- b. provide consultation, technical assistance and other support and recommendations as necessary during the review process.

3. The agency CEO or designee will ensure that the review:

- a. occurs in accordance with the provider facility policy;
- b. is completed within 30 days of incident unless delayed to wait for important findings such as the results of an autopsy report;
- c. includes a corrective action plan when appropriate, and that;
- d. follow-up information is provided to HCS as requested.

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

- a. factual description of the incident, including persons involved, date, time and location;
- b. context in which the incident occurred, including precipitating and contributing factors;
- c. a review of possible root causes of the incident, such as staffing, program, and environmental factors;
- d. actions taken at time of the incident;
- e. impact of incident upon persons, program, system, etc.;
- f. when a client is involved the review will include:
  - (1) the clinical background of the client;
  - (2) the treatment/service history of the client including current array of services and medications; and
  - (3) clinical intervention taken or planned for the client.
- g. a corrective action plan will be developed that includes:
  - (1) specific time frames for accomplishment;
  - (2) actions and recommendations that may include: changes in program design, education or training, supervision, employer, environmental changes, disciplinary action, staffing changes, development or modification of policies and procedures and supports offered to participants, family members, significant others and program staff.

5. If an incident involves more than one agency, then an inter-agency review will be conducted in not more than sixty (60) days of the incident date. This review will focus on continuum of care processes and system problems that may have occurred. Corrective actions will be developed and submitted to the HCS Team Leaders for incident completion.

6. The DMHAS Medical Director, at his discretion, may order that a special investigation or case review be held to elucidate circumstances and causative factors related to an incident. He may use findings of the review to initiate changes within a particular program or agency, or to establish policy changes with broad applicability designed to improve the health and safety of DMHAS clients, staff, or members of the public.

## Incident Review Closure

1. Within 15 days following the CI Review(s), or as determined in consultation with HCS staff, the agency CEO will be required to forward a written incident review completion report conveying the outcome of the review and the corrective action plan to the designated HCS team member. The report minimally will include the following information:

- a. Master Patient Index (MPI) Number;
- b. incident date
- c. date of critical incident review;
- d. brief summary of the findings of the review;
- e. correction action plan with date(s) to be completed; and
- f. the recommended date of incident closure.

2. The HCS Regional Manager will review the incident completion report and evaluate the critical incident review report, the correction action plan and recommended date of incident completion. When the HCS Manager determines that the information is complete and the correction action plan is adequate, the HCS Manager will document the closure of the CI. CI closures will be required to occur within 15 days of receipt of the incident review completion report. This information will be entered by HCS into the database. All written information related to the critical incident will be filed with the original report and kept on file for three years.

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

DMHAS will be responsible for overseeing the reporting and response to all critical incidents or events that affects Waiver participants. DMHAS will provide DSS with a monthly report on all critical incidents, the status of DMHAS review and a summary of DMHAS activities used to respond to these critical incidents.

## Appendix G: Participant Safeguards

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

- a. Use of Restraints or Seclusion.** *(Select one):*

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

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

All programs participating in the waiver, whether under contract or operated directly by the Department of Mental Health and Addiction Services, are prohibited from using restraints and seclusion.

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

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

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

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## Appendix G: Participant Safeguards

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

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

- The State does not permit or prohibits the use of restrictive interventions**

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

All programs participating in the waiver, whether under contract or operated directly by the Department of Mental Health and Addiction Services, are prohibited from using restraints and seclusion.

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

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

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

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## Appendix G: Participant Safeguards

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

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

**a. Applicability.** Select one:

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

**b. Medication Management and Follow-Up**

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

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- ii. Methods of State Oversight and Follow-Up.** Describe: (a) the method(s) that the State uses to ensure that participant medications are managed appropriately, including: (a) the identification of potentially harmful practices (e.g., the concurrent use of contraindicated medications); (b) the method(s) for following up on potentially harmful practices; and, (c) the State agency (or agencies) that is responsible for follow-up and oversight.

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## Appendix G: Participant Safeguards

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

**c. Medication Administration by Waiver Providers**

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

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

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

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

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

- Providers that are responsible for medication administration are required to both record and report medication errors to a State agency (or agencies).**

*Complete the following three items:*

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

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

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

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

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

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

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## **Appendix H: Quality Management Strategy (1 of 2)**

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

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

CMS recognizes that a state's waiver Quality Management Strategy may vary depending on the nature of the waiver target population, the services offered, and the waiver's relationship to other public programs, and will extend beyond regulatory requirements. However, for the purpose of this application,

the State is expected to have, at the minimum, systems in place to measure and improve its own performance in meeting six specific waiver assurances and requirements.

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

Quality management is dynamic and the Quality Management Strategy may, and probably will, change over time. Modifications or updates to the Quality Management Strategy shall be submitted to CMS in conjunction with the annual report required under the provisions of 42 CFR §441.302(h) and at the time of waiver renewal.

### **Quality Management Strategy: Minimum Components**

The Quality Management Strategy that will be in effect during the period of the waiver is included as Attachment #1 to Appendix H. The Quality Management Strategy should be no more than ten-pages in length. It may reference other documents that provide additional supporting information about specific elements of the Quality Management Strategy. Other documents that are cited must be available to CMS upon request through the Medicaid agency or the operating agency (if appropriate).

In the QMS, a state spells out:

- The evidence based *discovery* activities that will be conducted for each of the six major waiver assurances;
- The *remediation* processes followed when problems are identified in the implementation of each of the assurances;
- The *system improvement* processes followed in response to aggregated, analyzed information collected on each of the assurances;
- The correspondent *roles/responsibilities* of those conducting discovery activities, assessing, remediating and improving system functions around the assurances; and
- The process that the state will follow to continuously *assess the effectiveness of the QMS* and revise it as necessary and appropriate.

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

When the Quality Management Strategy spans more than one waiver and/or other types of long-term care services under the Medicaid State plan, specify the control numbers for the other waiver programs and identify the other long-term services that are addressed in the Quality Management Strategy.

## **Appendix H: Quality Management Strategy (2 of 2)**

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### **Attachment #1**

**The Quality Management Strategy for the waiver is:**  
Appendix H: Quality Improvement Strategy

The mission of the Department of Mental Health and Addiction Services is to improve the quality of life of the people of Connecticut by providing an integrated network of comprehensive, effective and efficient mental health and addiction services that foster self-sufficiency, dignity and respect.

By statute DMHAS is responsible for the care of persons with substance use and mental health disorders, providing a continuum of services from inpatient care in state hospitals to assisting with the integration of clients back into communities, helping realize the goal of “a life in the community for everyone.”

### System Improvements

DMHAS shall continuously improve quality through the process of discovery, remediation and system improvement. Data shall come from a variety of sources, including HCBS provider data, site reviews, follow-up compliance reviews, complaint investigations, evaluation reports, consumer satisfaction survey, consumer interviews and consumer records.

DMHAS or the designated fiscal intermediary (FI) will collect service level data for Waiver participants. These data will be processed monthly. In order to assist our teams with Waiver Program oversight activities, and in order to prepare service providers, DMHAS will make standardized monthly and quarterly reports available to DMHAS and DSS managers as well as DMHAS Support Coordinators. These reports will be used to accomplish monitoring and compliance assessments.

A DMHAS Annual Consumer Survey is conducted to solicit opinions from people receiving care in our system and to learn what they have to say about access, appropriateness, general satisfaction, outcomes, recovery, participation in treatment, and the degree of respect they experience as they interact with our network of care. Specific questions will be added to address specific issues with Waiver participants that are being discharged from Nursing Facilities.

DMHAS in collaboration with the FI will develop a data system needs that will examine a range of indicators including clinical, medical, legal, functional, living status, and others in order to develop recommendations regarding how the Waiver Services can better support program participants. Processes for data collection will be developed or enhanced as appropriate. Data will be submitted from providers on a monthly basis according to established contractual requirements. The data review will detect Waiver providers that are not meeting established performance measures while simultaneously recognizing programs that exceed performance measures

Staff from DMHAS EQMI {Evaluation Quality Management and Improvement} will conduct a quarterly review and trending of Critical Incidents in order to identify emerging or ongoing areas of concern. Critical incidents will also be evaluated and trended for the entire fiscal year in order to obtain a broad view of the type of critical incidents that are occurring in the system. The analysis will identify and recommend potential training needs and service enhancements. Training and education needs for both program staff and program participants will be examined.

The Wavier Project Team will develop an Annual Training and Education Plan. The plan will incorporate key findings from areas identified below. Training and Education will be focused on staff needs as well as educational needs of program participants that may be identified through mechanisms cited above. The Training and Education Plan will be reviewed by the Waiver Advisory Council who will make recommendations regarding the Plan. The Plan will be revised

and willand will be referred to DMHAS Department of Training and Education for implementation. This Plan may be one of the remediation processes DMHAS uses to correct system deficiencies.

The Waiver Project Team will develop an Annual Quality Improvement Plan that is informed by findings that emanate from mechanisms discussed below. The Quality Improvement Plan will be reviewed by the Waiver Advisory Council who will make recommendations regarding the Plan.

Discovery data and the progress and success of remediation strategies from various reports that will address the assurances set forth in the Waiver will be aggregated and shared quarterly, semi annually, annually or as needed with a variety department functional units as well as standing DMHAS committees and interest groups associated with the department.

Key DMHAS committees are responsible for trending, prioritizing, and recommending improvement strategies and system changes prompted as a result of analysis of discovery and remediation information. These committees meet periodically throughout the year to review data, make recommendations and follow up on status of improvement projects. Each committee is described below.

The Department of Mental Health and Addiction Services has structured its Quality Improvement Strategy to address all requirements of the six HCBS assurances both through its organizational structures and the establishment of standing committees described below.

#### DSS/DMHAS Joint Waiver Committee

Membership: DSS and DMHAS Operations and Waiver Policy and Project Managers  
Frequency of meeting: quarterly

The purpose of this joint committee is for DSS to assure that DMHAS meets federal quality requirements and expectations for the operation of its HCBS waiver. DSS monitors DMHAS activities and performance according to the Memorandum of Understanding between the two agencies and associated requirements found in the Administrative Authority assurance.

#### DMHAS Wavier Project Team

Membership: DMHAS Senior Analysts and Waiver Project Managers  
Invited Guests: DSS Waiver staff, DMHAS Fiscal representative, Fiscal Intermediary, DMHAS EQMI representative, DMHAS Regional Mangers.  
Frequency of Meeting: Core membership meets weekly, invited guest attended quarterly on a rotating basis.

The purpose of this committee is to monitor compliance with the six HCBS Waiver assurances and other federal, state, and agency requirements. The Waiver Project Team ensures that all changes in program and practice are appropriately reflected in the agency policy, procedure, and operations manuals and communicated to stakeholders.

Quarterly this team will include representatives from the DSS, the Fiscal Intermediary, DMHAS EQMI Division, Fiscal Division and DMHAS Regional Managers. The expanded team will review key performance indicators, develop recommendations regarding training and education needs, and will provide feedback regarding the Annual Quality Improvement Plan. The Committee will also review progress made toward actions that are specified in both the Training and Education Plan and the Annual Quality Improvement Plan.

## Waiver Advisory Council

Membership: DMHAS Waiver Project Managers , individuals and families receiving DMHAS services and supports, representatives from DMHAS Health Care Systems Division, representatives from the state operated and private not for profit mental health provider community, and a representatives from NAMI or other interested parties.

Frequency of meeting: Quarterly

The purpose of the Waiver Advisory Council is to provide opportunity for input from individuals and families receiving DMHAS waiver supports and services as well as other interested parties, to review key quality findings and data trends in order to make recommendations for system improvement. The Council will also review offer input for the annual Quality Improvement Plan. Feedback and recommendations will be communicated to the Waiver Project Team and DSS/DMHAS Joint Committee. This information will also be delivered to the Commissioners Executive Group for review and evaluation.

## Quality Improvement Strategy – Minimum Components

### Appendix A: Quality Improvement - Waiver Administration and Operation

Methods for Discovery: Administrative Authority

Performance Measures: DSS meets with DMHAS to evaluate DMHAS summary and performance reports related to service planning and delivery, provider qualifications, safeguards, fiscal integrity and consumer satisfaction and monitor compliance with Interagency Agreement as referenced in the waiver application, appendix A.

Data Source: Trends, remediation actions proposed/taken

Data Aggregation and Analysis: DMHAS will submit reports quarterly

Methods for Remediation/Fixing Individual Problems: Issues needing remediation will be identified and discussed at the quarterly meetings with DMHAS and DSS staff. A plan for remediation and person(s) responsible will be developed for each item identified. Remediation strategies and progress towards correction will be reviewed and documented at the next quarterly meeting.

### Appendix B: Quality Improvement - Participant Access and Eligibility

Methods for Discovery: Level of Care

Performance Measures: DMHAS Lead Support Coordinator verifies that any individual who is determined to be likely to require a level of care of the waiver will be informed of any feasible alternative under the waiver and given the choice of either institutional or home and community based care.

Data Source: Record Review

Data Aggregation and Analysis: DMHAS will monitor ongoing and continuous compliance.

Performance Measures: DMHAS staff conducts record audits to ensure LOC determinations are reevaluated annually

Data Source: Record reviews

Data Aggregation and Analysis: DMHAS staff assisted by the Fiscal Intermediary will review a random sample of 10-20 records quarterly.

Performance Measures: DSS representative reviews all new applications to verify that DMHAS follows policies and procedures regarding Level of Care determinations.

Data Source: Record review

Data Aggregation and Analysis: DSS will monitor ongoing and continuous compliance.

Methods for Remediation/Fixing Individual Problems: The DMHAS staff notifies staff notifies Support Coordinators of findings of record reviews and implement plan for remediation as needed.

#### Appendix C: Quality Improvement - Participant Services

Methods for Discovery: Qualified Providers

Performance Measures: DMHAS and /or Fiscal Intermediary under contract to DSS and DMHAS reviews all initial applications and renewals/renewals by providers to ensure that they meet all requirements to provide specific waiver services

Data Source: Application packets/Renewal packets

Data Aggregation and Analysis: Provider Performance Reviews and related data will be collected and contribute to an ongoing recertification process

Performance Measures: Fiscal Intermediary completes background check and verifies training qualifications of providers of self directed services.

Data Source: Records of background checks and training

Data Aggregation and Analysis: Continuous and ongoing review of application including background checks and training records

Methods for Remediation/Fixing Individual Problems: New providers who do not meet all requirements will be denied or have application pending for further action. For existing qualified providers when issues are identified providers are required to submit a plan of correction with timeframes for completion. If a provider continues to have less than acceptable performance they can be put on enhanced monitoring, or can be prohibited from serving any new participants until their performance has reached an acceptable level of quality, or can lose their status as a qualified provider for the service(s) with less than acceptable quality, and/or can be removed as a qualified provider altogether.

## Appendix D: Quality Improvement - Participant-Centered Planning and Service Delivery

### Methods for Discovery: Service Plans

Performance Measures: Record review conducted to ensure that all necessary assessments have been completed prior to the development of the Service Plan and that all identified needs have been incorporated.

Data Source: Record Review

Data Aggregation and Analysis: DMHAS will conduct a separate review of random sample of 10-20 records quarterly.

Performance Measures: Record review conducted to ensure that plans are reviewed/updated quarterly (or more frequently if needed) and to ensure individuals are receiving the scope, amount and duration of services set forth in the plan.

Data Source: Record review.

Data Aggregation and Analysis: DMHAS will conduct separate review of random sample of 10-20 records quarterly.

Performance Measures: Fiscal Intermediary compares service billing to service authorizations to ensure that services are delivered in accordance with the service plan, including type, scope, amount, and frequency specified in the Service Plan.

Data Source, Aggregation and Analysis: Financial records and reports by Fiscal Intermediary reviewed quarterly.

Methods for Remediation/Fixing Individual Problems: All participant specific findings are communicated to the service provider or DMHAS Support Coordinator as appropriate for corrective action. Provider systemic findings are presented and monitored for corrective action by the Fiscal Intermediary and DMHAS Waiver Project managers.

DSS meets with DMHAS Waiver Project managers on a quarterly basis to discuss findings and make recommendations for system improvement.

## Appendix E: Quality Improvement - Participant Direction of Services

### Methods for Discovery: Service Plan

Performance Measures: DMHAS will review a random sample of records to ensure that individuals have been provided with information and support to self-direct Recovery Assistant Services to the extent desired and that they were provided with information on qualified providers of services and supports outlined in the Recovery Plan, and were provided assistance as requested in the selection of qualified providers.

Data Source: Record Review

Data Aggregation and Analysis: DMHAS conduct separate review of random sample of 10-20 records quarterly.

Methods for Remediation/Fixing Individual Problems: DSS meets with DMHAS Waiver Project managers on a quarterly basis to discuss findings and make recommendations for system improvement and review progress made of recommendations from prior quarters.

#### Appendix F: Quality Improvement - Participant Rights

Methods for Discovery: Health and Welfare

Performance Measures: DMHAS Support Coordinators will provide information regarding the DSS Fair Hearing Process as well as DMHAS Grievance Procedure.

Data Source: Record Review

Data Aggregation and Analysis: DMHAS will conduct a review of a random sample of 10-20 records quarterly to assure provision of information regarding Fair Hearing and Grievance Procedure is made available to participants.

Methods for Remediation/Fixing Individual Problems:  
DSS meets with DMHAS Waiver Project managers on a quarterly basis to discuss findings and make recommendations for system improvement.

#### Appendix G: Quality Improvement - Participant Safeguards

Methods for Discovery: Health and Welfare

Performance Measures: DMHAS ensures that all critical incidents, including reported instances of abuse, neglect, or exploitation are reported to the DMHAS Office of the Commissioner. The complaints of issues are investigated and tracked for remediation.

Data Source: Critical Incident Data Base

Data Aggregation and Analysis: DMHAS monitoring and review will be continuous and ongoing

Methods for Remediation/Fixing Individual Problems: Critical incident follow-up reviews will be conducted by the reporting agency. The time of the review will depend on the urgency of the incident. Serious incidents will be reviewed and remediated immediately and other incidents within 30 days of the incident. This review will focus on causative factors and may result in the development of a corrective action plan designed to reduce risk of reoccurrence of similar events.

DSS meets with DMHAS Waiver Project managers on a quarterly basis to discuss findings and make recommendations for system improvement.

#### Appendix I: Quality Improvement - Financial Accountability

Methods for Discovery: Financial Accountability

Performance Measures: The DMHAS Fiscal Intermediary conducts sample audits of provider billing records.

Data Source: Financial Audits

Data Aggregation and Analysis: Random sample of specific provider's billings will be conducted as needed

Methods for Remediation/Fixing Individual Problems: Billing irregularities are analyzed and appropriate action is taken if necessary.

## Appendix I: Financial Accountability

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### I-1: Financial Integrity and Accountability

**Financial Integrity.** Describe the methods that are employed to ensure the integrity of payments that have been made for waiver services, including: (a) requirements concerning the independent audit of provider agencies; (b) the financial audit program that the state conducts to ensure the integrity of provider billings for Medicaid payment of waiver services, including the methods, scope and frequency of audits; and, (c) the agency (or agencies) responsible for conducting the financial audit program. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

The Department of Social Services has contracted with Electronic Data Systems (EDS) to serve as the claims payment subcontractor for waiver and state plan services. EDS reviews the claim for Medicaid eligibility and other elements (e.g. spend-down requirements) before reimbursing providers. Any claims paid by the fiscal intermediary for waiver services will be submitted to EDS for adjudication and are subject to the same financial audit requirements for other waiver services. The DSS Office of Quality Assurance (QA) conducts financial audits of Medicaid providers and issues exceptions when it identifies areas of non-compliance with the State's policy requirements. All Waiver providers are subject to audits performed by the QA Office. Overall audit demands and audit resources available to DSS QA impact the frequency of audit of Waiver providers.

## Appendix I: Financial Accountability

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### I-2: Rates, Billing and Claims (1 of 3)

- a. **Rate Determination Methods.** In two pages or less, describe the methods that are employed to establish provider payment rates for waiver services and the entity or entities that are responsible for rate determination. Indicate any opportunity for public comment in the process. If different methods are employed for various types of services, the description may group services for which the same method is employed. State laws, regulations, and policies referenced in the description are available upon request to CMS through the Medicaid agency or the operating agency (if applicable).

Pursuant to the Connecticut Department of Social Services Provider Manual. All schedules of payment for covered Medical Assistance Program goods and services shall be established by the Commissioner of Social Services and paid by the Department of Social Services in accordance with applicable federal and state statutes and regulations. Waiver service rates are based on direct and indirect costs of providing Waiver services. Consumers, provider organizations and DMHAS staff have had the opportunity to review the Waiver application and rates pursuant to the public notice. The Waiver application was also reviewed by the committees of cognizance of the Connecticut state legislature.

- b. Flow of Billings.** Describe the flow of billings for waiver services, specifying whether provider billings flow directly from providers to the State's claims payment system or whether billings are routed through other intermediary entities. If billings flow through other intermediary entities, specify the entities:

Payments are made by the Medicaid agency directly to the providers of State Plan services through the State's MMIS. There are provider agreements between DSS and each provider of State Plan services under the Waiver. Payment for Waiver services will be administered by the fiscal intermediary. DSS will have a provider agreement with the fiscal intermediary for Waiver services such that the fiscal intermediary will also submit its claims for adjudication through the MMIS. Consequently, payments for all Waiver and State Plan services will be made through an approved Connecticut Medicaid Management Information System (MMIS). DSS will pay the fiscal intermediary for Waiver services through the same fiscal agent as used in the rest of the Medicaid program.

## Appendix I: Financial Accountability

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### I-2: Rates, Billing and Claims (2 of 3)

- c. Certifying Public Expenditures** (*select one*):

- No. Public agencies do not certify expenditures for waiver services.**
- Yes. Public agencies directly expend funds for part or all of the cost of waiver services and certify their public expenditures (CPE) in lieu of billing that amount to Medicaid.**

*Select at least one:*

- Certified Public Expenditures (CPE) of State Public Agencies.**

Specify: (a) the public agency or agencies that certify public expenditures for waiver services; (b) how it is assured that the CPE is based on the total computable costs for waiver services; and, (c) how the State verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51(b).  
(*Indicate source of revenue for CPEs in Item I-4-a.*)

The Department of Mental Health and Addiction Services (DMHAS) certifies public expenditures for waiver services provided by DMHAS state operated Local Mental Health Authorities (LMHA). The public funds appropriated to DMHAS are not Federal funds. The State assures that the CPE is based on the total computable costs for waiver services by paying the same rates for all waiver services, whether provided

by private or DMHAS state-operated providers. Claims for services provided by DMHAS state-operated providers will be processed by the MMIS prior to inclusion in DSS's federal Medicaid claim.

**Certified Public Expenditures (CPE) of Non-State Public Agencies.**

Specify: (a) the non-State public agencies that incur certified public expenditures for waiver services; (b) how it is assured that the CPE is based on total computable costs for waiver services; and, (c) how the State verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51(b).

*(Indicate source of revenue for CPEs in Item I-4-b.)*

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## **Appendix I: Financial Accountability**

### **I-2: Rates, Billing and Claims (3 of 3)**

- d. Billing Validation Process.** Describe the process for validating provider billings to produce the claim for federal financial participation, including the mechanism(s) to assure that all claims for payment are made only: (a) when the individual was eligible for Medicaid waiver payment on the date of service; (b) when the service was included in the participant's approved service plan; and, (c) the services were provided:

Payments are made by the Medicaid agency directly to the providers of State Plan services through the State's MMIS. There are provider agreements between DSS and each provider of State Plan services under the waiver. The MMIS ensures that the individual was eligible for Medicaid waiver payment on the date of service. In addition, for those State plan services that are included in a participant's approved service plan and are subject to prior authorization under existing Medicaid policy, the authorized limits will be entered into the MMIS system and thus will prevent expenditures in excess of the service plan.

Payment for Waiver services will be administered by the fiscal intermediary. DSS will have a provider agreement with the fiscal intermediary for Waiver services such that the fiscal intermediary will also submit its claims for adjudication through the MMIS. The fiscal intermediary will enter the service plan limits into its claims system and thus prevent expenditures in excess of the service plan. The fiscal intermediary will in turn submit waiver service claims for adjudication through the DSS MMIS. The MMIS claims processing system will verify that the participant was Medicaid-eligible on the date of service delivery specified in the request for reimbursement and will allow payment only on claims for services provided within the eligibility period.

Claims and service records for all waiver and state plan services will be subject to audit through the DSS Office of Quality Assurance. This will ensure that service billed were in fact provided and documented.

- e. Billing and Claims Record Maintenance Requirement.** Records documenting the audit trail of adjudicated claims (including supporting documentation) are maintained by the Medicaid agency, the operating agency (if applicable), and providers of waiver services for a minimum period of 3 years as required in 45 CFR §74.53.

## Appendix I: Financial Accountability

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### I-3: Payment (1 of 7)

**a. Method of payments -- MMIS (*select one*):**

- Payments for all waiver services are made through an approved Medicaid Management Information System (MMIS).**
- Payments for some, but not all, waiver services are made through an approved MMIS.**

Specify: (a) the waiver services that are not paid through an approved MMIS; (b) the process for making such payments and the entity that processes payments; (c) and how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:

- 
- Payments for waiver services are not made through an approved MMIS.**

Specify: (a) the process by which payments are made and the entity that processes payments; (b) how and through which system(s) the payments are processed; (c) how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:

- 
- Payments for waiver services are made by a managed care entity or entities. The managed care entity is paid a monthly capitated payment per eligible enrollee through an approved MMIS.**

Describe how payments are made to the managed care entity or entities:

## Appendix I: Financial Accountability

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### I-3: Payment (2 of 7)

**b. Direct payment.** In addition to providing that the Medicaid agency makes payments directly to providers of waiver services, payments for waiver services are made utilizing one or more of the following arrangements (*select at least one*):

- The Medicaid agency pays providers through the same fiscal agent used for the rest of the Medicaid program.**
- The Medicaid agency pays providers of some or all waiver services through the use of a limited fiscal agent.**

Specify the limited fiscal agent, the waiver services for which the limited fiscal agent makes

payment, the functions that the limited fiscal agent performs in paying waiver claims, and the methods by which the Medicaid agency oversees the operations of the limited fiscal agent:

Payments will be made by the MMIS directly to providers of state plan services. Payments for waiver services will be made by the fiscal intermediary (FI). The fiscal intermediary will be enrolled as a Medicaid billing provider of waiver services and will submit claims on behalf of waiver service providers to the MMIS. The MMIS will adjudicate claims on a cash basis for services provided by private non-profit performing providers and will adjudicate claims on a non-cash basis for claims submitted on behalf of state-operated performing providers. DSS will advance funds to the FI to serve as a reserve for the payment of claims upon operation of the waiver.

The fiscal intermediary will ensure that claims for waiver services provided by individuals will be subject to the limitations established in the approved service plan. The fiscal intermediary will also request formal documentation (e.g. timesheets) from these individual providers regarding the amount of services provided. The fiscal intermediary will generate claims from this documentation and will also be responsible for reconciling any claim that was submitted but not paid by the MMIS. DSS and DMHAS will oversee the fiscal intermediary as set forth in this Waiver's Appendix A.

- Providers are paid by a managed care entity or entities for services that are included in the State's contract with the entity.**

Specify how providers are paid for the services (if any) not included in the State's contract with managed care entities.

## Appendix I: Financial Accountability

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### I-3: Payment (3 of 7)

- c. Supplemental or Enhanced Payments.** Section 1902(a)(30) requires that payments for services be consistent with efficiency, economy, and quality of care. Section 1903(a)(1) provides for Federal financial participation to States for expenditures for services under an approved State plan/waiver. Specify whether supplemental or enhanced payments are made. *Select one:*

- No. The State does not make supplemental or enhanced payments for waiver services.**
- Yes. The State makes supplemental or enhanced payments for waiver services.**

Describe:(a) the nature of the supplemental or enhanced payments that are made and the waiver services for which these payments are made and (b) the types of providers to which such payments are made. Upon request, the State will furnish CMS with detailed information about the total amount of supplemental or enhanced payments to each provider type in the waiver.

## Appendix I: Financial Accountability

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### I-3: Payment (4 of 7)

**d. Payments to Public Providers.** *Specify whether public providers receive payment for the provision of waiver services.*

- No. Public providers do not receive payment for waiver services.** Do not complete Item I-3-e.
- Yes. Public providers receive payment for waiver services.** Complete Item I-3-e.

Specify the types of public providers that receive payment for waiver services and the services that the public providers furnish: *Complete item I-3-e.*

DMHAS state operated Local Mental Health Authorities (LMHA) will provide certain waiver services including: Community Support Program, Assertive Community Treatment, Recovery Assistants, Supported Employment, Short Term Crisis Stabilization, Transitional Case Management and Peer Supports

## Appendix I: Financial Accountability

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### I-3: Payment (5 of 7)

**e. Amount of Payment to Public Providers.**

Specify whether any public provider receives payments (including regular and any supplemental payments) that in the aggregate exceed its reasonable costs of providing waiver services and, if so, how the State recoups the excess and returns the Federal share of the excess to CMS on the quarterly expenditure report. *Select one:*

- The amount paid to public providers is the same as the amount paid to private providers of the same service.**
- The amount paid to public providers differs from the amount paid to private providers of the same service. No public provider receives payments that in the aggregate exceed its reasonable costs of providing waiver services.**
- The amount paid to public providers differs from the amount paid to private providers of the same service. When a public provider receives payments (including regular and any supplemental payments) that in the aggregate exceed the cost of waiver services, the State recoups the excess and returns the federal share of the excess to CMS on the quarterly expenditure report.**

Describe the recoupment process:

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## Appendix I: Financial Accountability

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### I-3: Payment (6 of 7)

**f. Provider Retention of Payments.** Section 1903(a)(1) provides that Federal matching funds are only available for expenditures made by states for services under the approved waiver. *Select one:*

- Providers receive and retain 100 percent of the amount claimed to CMS for waiver services.**
- Providers do not receive and retain 100 percent of the amount claimed to CMS for waiver services.**

Provide a full description of the billing, claims, or payment processes that result in less than 100% reimbursement of providers. Include: (a) the methodology for reduced or returned payments; (b) a complete listing of types of providers, the amount or percentage of payments that are reduced or returned; and, (c) the disposition and use of the funds retained or returned to the State (i.e., general fund, medical services account, etc.):

- Providers are paid by a managed care entity (or entities) that is paid a monthly capitated payment.**

Specify whether the monthly capitated payment to managed care entities is reduced or returned in part to the State.

## Appendix I: Financial Accountability

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### I-3: Payment (7 of 7)

**g. Additional Payment Arrangements**

**i. Voluntary Reassignment of Payments to a Governmental Agency.** *Select one:*

- No. The State does not provide that providers may voluntarily reassign their right to direct payments to a governmental agency.**
- Yes. Providers may voluntarily reassign their right to direct payments to a governmental agency as provided in 42 CFR §447.10(e).**

Specify the governmental agency (or agencies) to which reassignment may be made.

**ii. Organized Health Care Delivery System.** *Select one:*

- No. The State does not employ Organized Health Care Delivery System (OHCDS) arrangements under the provisions of 42 CFR §447.10.**
- Yes. The waiver provides for the use of Organized Health Care Delivery System arrangements under the provisions of 42 CFR §447.10.**

Specify the following: (a) the entities that are designated as an OHCDS and how these entities qualify for designation as an OHCDS; (b) the procedures for direct provider enrollment when a provider does not voluntarily agree to contract with a designated OHCDS; (c) the method(s) for assuring that participants have free choice of qualified providers when an OHCDS arrangement is employed, including the selection of providers not affiliated with the OHCDS; (d) the method(s) for assuring that providers that furnish services under contract with an OHCDS meet applicable provider qualifications under the waiver; (e) how it is assured that OHCDS contracts with providers meet applicable requirements; and, (f) how financial accountability is assured when an OHCDS arrangement is used:

**iii. Contracts with MCOs, PIHPs or PAHPs. *Select one:***

- The State does not contract with MCOs, PIHPs or PAHPs for the provision of waiver services.**
- The State contracts with a Managed Care Organization(s) (MCO) and/or prepaid inpatient health plan(s) (PIHP) or prepaid ambulatory health plan(s) (PAHP) under the provisions of §1915(a)(1) of the Act for the delivery of waiver and other services. Participants may voluntarily elect to receive waiver and other services through such MCOs or prepaid health plans. Contracts with these health plans are on file at the State Medicaid agency.**

Describe: (a) the MCOs and/or health plans that furnish services under the provisions of §1915(a)(1); (b) the geographic areas served by these plans; (c) the waiver and other services furnished by these plans; and, (d) how payments are made to the health plans.

- This waiver is a part of a concurrent §1915(b)/§1915(c) waiver. Participants are required to obtain waiver and other services through a MCO and/or prepaid inpatient health plan (PIHP) or a prepaid ambulatory health plan (PAHP). The §1915(b) waiver specifies the types of health plans that are used and how payments to these plans are made.**

## **Appendix I: Financial Accountability**

### **I-4: Non-Federal Matching Funds (1 of 3)**

- a. State Level Source(s) of the Non-Federal Share of Computable Waiver Costs.** Specify the State source or sources of the non-federal share of computable waiver costs. *Select at least one:*

- Appropriation of State Tax Revenues to the State Medicaid agency**

**Appropriation of State Tax Revenues to a State Agency other than the Medicaid Agency.**

If the source of the non-federal share is appropriations to another state agency (or agencies), specify: (a) the entity or agency receiving appropriated funds and (b) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if the funds are directly expended by public agencies as CPEs, as indicated in Item I-2-c:

Funds are appropriated to DSS for waiver and state plan services provided by private non-profit providers. Funds are appropriated to DMHAS as a CPE for the provision of those waiver services that are provided by DMHAS state operated Local Mental Health Authorities (LMHAs). The State Department of Administrative Services (DAS) submits claims on behalf of the LMHAs to the fiscal intermediary, which will process the claims on a non-cash basis according to the limits established in the service plan. The fiscal intermediary will in turn submit the state-operated service claims to the MMIS, and the MMIS will adjudicate these claims on a non-cash basis.

**Other State Level Source(s) of Funds.**

Specify: (a) the source and nature of funds; (b) the entity or agency that receives the funds; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by public agencies as CPEs, as indicated in Item I-2-c:

## Appendix I: Financial Accountability

### I-4: Non-Federal Matching Funds (2 of 3)

**b. Local or Other Source(s) of the Non-Federal Share of Computable Waiver Costs.** Specify the source or sources of the non-federal share of computable waiver costs that are not from state sources. *Select One:*

**Not Applicable.** There are no non-State level sources of funds for the non-federal share.

**Applicable**

*Check each that applies:*

**Appropriation of Local Revenues.**

Specify: (a) the local entity or entities that have the authority to levy taxes or other revenues; (b) the source(s) of revenue; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement (indicate any intervening entities in the transfer process), and/or, indicate if funds are directly expended by public agencies as CPEs, as specified in Item I-2- c:

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**Other non-State Level Source(s) of Funds.**

Specify: (a) the source of funds; (b) the entity or agency receiving funds; and, (c) the mechanism that is used to transfer the funds to the State Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and /or, indicate if funds are directly expended by public agencies as CPEs, as specified in Item I-2- c:

## Appendix I: Financial Accountability

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### I-4: Non-Federal Matching Funds (3 of 3)

- c. Information Concerning Certain Sources of Funds.** Indicate whether any of the funds listed in Items I-4-a or I-4-b that make up the non-federal share of computable waiver costs come from the following sources: (a) provider taxes or fees; (b) provider donations; and/or, (c) federal funds (other than FFP). *Select one:*

- None of the specified sources of funds contribute to the non-federal share of computable waiver costs**
- The following source(s) are used**  
*Check each that applies:*
- Provider taxes or fees**
  - Provider donations**
  - Federal funds (other than FFP)**

For each source of funds indicated above, describe the source of the funds in detail:

## Appendix I: Financial Accountability

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### I-5: Exclusion of Medicaid Payment for Room and Board

- a. Services Furnished in Residential Settings.** *Select one:*
- No services under this waiver are furnished in residential settings other than the private residence of the individual.**
  - As specified in Appendix C, the State furnishes waiver services in residential settings other than the personal home of the individual.**
- b. Method for Excluding the Cost of Room and Board Furnished in Residential Settings.** The following describes the methodology that the State uses to exclude Medicaid payment for room and board in residential settings:  
**Do not complete this item.**

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## Appendix I: Financial Accountability

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### I-6: Payment for Rent and Food Expenses of an Unrelated Live-In Caregiver

#### Reimbursement for the Rent and Food Expenses of an Unrelated Live-In Personal Caregiver.

Select one:

- No. The State does not reimburse for the rent and food expenses of an unrelated live-in personal caregiver who resides in the same household as the participant.**
- Yes. Per 42 CFR §441.310(a)(2)(ii), the State will claim FFP for the additional costs of rent and food that can be reasonably attributed to an unrelated live-in personal caregiver who resides in the same household as the waiver participant. The State describes its coverage of live-in caregiver in Appendix C-3 and the costs attributable to rent and food for the live-in caregiver are reflected separately in the computation of factor D (cost of waiver services) in Appendix J. FFP for rent and food for a live-in caregiver will not be claimed when the participant lives in the caregiver's home or in a residence that is owned or leased by the provider of Medicaid services.**

The following is an explanation of: (a) the method used to apportion the additional costs of rent and food attributable to the unrelated live-in personal caregiver that are incurred by the individual served on the waiver and (b) the method used to reimburse these costs:

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## Appendix I: Financial Accountability

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### I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (1 of 5)

- a. **Co-Payment Requirements.** Specify whether the State imposes a co-payment or similar charge upon waiver participants for waiver services. These charges are calculated per service and have the effect of reducing the total computable claim for federal financial participation. *Select one:*
- No. The State does not impose a co-payment or similar charge upon participants for waiver services.**
  - Yes. The State imposes a co-payment or similar charge upon participants for one or more waiver services.**
    - i. **Co-Pay Arrangement.**

Specify the types of co-pay arrangements that are imposed on waiver participants (*check each that applies*):

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***Charges Associated with the Provision of Waiver Services (if any are checked, complete Items I-7-a-ii through I-7-a-iv):***

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- Nominal deductible**
- Coinsurance**
- Co-Payment**
- Other charge**

*Specify:*

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## **Appendix I: Financial Accountability**

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### **I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (2 of 5)**

**a. Co-Payment Requirements.**

**ii. Participants Subject to Co-pay Charges for Waiver Services.**

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**Answers provided in Appendix I-7-a indicate that you do not need to complete this section.**

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## **Appendix I: Financial Accountability**

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### **I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (3 of 5)**

**a. Co-Payment Requirements.**

**iii. Amount of Co-Pay Charges for Waiver Services.**

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**Answers provided in Appendix I-7-a indicate that you do not need to complete this section.**

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## **Appendix I: Financial Accountability**

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### **I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (4 of 5)**

**a. Co-Payment Requirements.**

**iv. Cumulative Maximum Charges.**

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**Answers provided in Appendix I-7-a indicate that you do not need to complete this section.**

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## Appendix I: Financial Accountability

### I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (5 of 5)

**b. Other State Requirement for Cost Sharing.** Specify whether the State imposes a premium, enrollment fee or similar cost sharing on waiver participants. *Select one:*

- No. The State does not impose a premium, enrollment fee, or similar cost-sharing arrangement on waiver participants.**
- Yes. The State imposes a premium, enrollment fee or similar cost-sharing arrangement.**

Describe in detail the cost sharing arrangement, including: (a) the type of cost sharing (e.g., premium, enrollment fee); (b) the amount of charge and how the amount of the charge is related to total gross family income; (c) the groups of participants subject to cost-sharing and the groups who are excluded; and, (d) the mechanisms for the collection of cost-sharing and reporting the amount collected on the CMS 64:

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## Appendix J: Cost Neutrality Demonstration

### J-1: Composite Overview and Demonstration of Cost-Neutrality Formula

**Composite Overview.** Complete the fields in Cols. 3, 5 and 6 in the following table for each waiver year. The fields in Cols. 4, 7 and 8 are auto-calculated based on entries in Cols 3, 5, and 6. The fields in Col. 2 are auto-calculated using the Factor D data from the J-2d Estimate of Factor D tables. Col. 2 fields will be populated ONLY when the Estimate of Factor D tables in J-2d have been completed.

**Level(s) of Care: Nursing Facility**

Col. 1	Col. 2	Col. 3	Col. 4	Col. 5	Col. 6	Col. 7	Col. 8
Year	Factor D	Factor D'	Total: D+D'	Factor G	Factor G'	Total: G+G'	Difference (Col 7 less Column4)
1	41482.42	30710.00	72192.42	77002.00	13184.00	90186.00	17993.58
2	34887.45	32307.00	67194.45	78927.00	13870.00	92797.00	25602.55
3	34339.63	33987.00	68326.63	80900.00	14591.00	95491.00	27164.37

## Appendix J: Cost Neutrality Demonstration

### J-2: Derivation of Estimates (1 of 7)

**a. Number Of Unduplicated Participants Served.** Enter the total number of unduplicated

participants from Item B-3-a who will be served each year that the waiver is in operation. When the waiver serves individuals under more than one level of care, specify the number of unduplicated participants for each level of care:

**Table: J-2-a: Unduplicated Participants**

Waiver Year	Total Number Unduplicated Number of Participants (from Item B-3-a)	Distribution of Unduplicated Participants by Level of Care (if applicable)
		Level of Care:
		Nursing Facility
Year 1	79	79
Year 2	169	169
Year 3	249	249

## Appendix J: Cost Neutrality Demonstration

### J-2: Derivation of Estimates (2 of 7)

- b. Average Length of Stay.** Describe the basis of the estimate of the average length of stay on the waiver by participants in item J-2-a.

The length of stay was calculated by dividing the annual summary of client days by the annual unduplicated caseload (factor c). The client days count was derived by multiplying the total beginning of the month client caseload by the number of month's days. The annual unduplicated caseload is the sum of the total number of the unduplicated caseload at the beginning of the month plus the total annual admissions.

## Appendix J: Cost Neutrality Demonstration

### J-2: Derivation of Estimates (3 of 7)

- c. Derivation of Estimates for Each Factor.** Provide a narrative description for the derivation of the estimates of the following factors.

- i. Factor D Derivation.** The estimates of Factor D for each waiver year are located in Item J-2-d. The basis for these estimates is as follows:

The estimates of Factor D are based on actual assessments of nursing home residents (or individuals discharged to community) with the appropriate combination of treatments and supports. A nine page Screening Tool was developed to review targeted clients. The screening tool contained: A) general demographic information, B) psychiatric diagnostic information, C) information about prior DMHAS service involvement, D) a history of nursing home involvement, E) a summary of findings from the MR/MI and PASRR Level II evaluations, F) re-evaluation information contained in the nursing home record, if any, G) medical diagnostic information and skilled services being provided by the nursing home to address medical conditions, H) a list of psychotropic and non-psychotropic medications,

I) any behavioral concerns noted in the NF record, and J) an estimate of the type and frequency of waiver services needed by the client. As a result of the survey, the client's need for community-based services, as reflected in each of the sources listed above, was used to develop an individualized service package based on services available in the proposed waiver. Service packages and utilization estimates were based on clinical judgment. The services are prorated for estimates of enrollment.

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

Factor D' was estimated based upon actual historical costs for the sample targeted population that resides in the community. The population was the set of persons identified by the State of Connecticut DSS as receiving hospital, nursing facility or ICF/MR services between February, 2006 and February, 2007 and as receiving expenditures 365 days prior to their first nursing home or Inpatient Hospital LOC with Psych Long Term confinement date.

This population was identified using the Medicaid Management Information System (MMIS) Provider Type data field, where NF or Inpatient Hospital LOC with Psych Long Term is identified as a distinct type of service provider. The average number of persons in this pool of Medicaid eligible was 37 between February, 2005 and February, 2006. The historic cost data were trended forward using actual CPI trends for medical care commodities for the package of non-institutional services.

This factor was originally calculated prior to the implementation of Medicare Part D. Therefore, this factor included pharmacy costs that would now be covered by that plan. In other words, the factor, as originally calculate, would be too high given the current program structure. An analysis was carried out to estimate the portion of the factor that is related to Part D and remove that from the cost neutrality calculation.

More specifically, a replica of the original study population was created for the 2006 time period, the first year in which Part D was operational. All service costs were gathered for the time period that each sample targeted populated was enrolled in Medicaid. The actual pharmacy costs for this population were studied, as they reflect the projected cost of pharmacy costs for a population with severe mental illness in the community in light of Part D. These lower cost levels replaced the original pharmacy component of the per capita costs for all other services provided to individuals in the waiver program.

A detailed breakout of the service costs that are reflected in the calculation of this factor is available upon request.

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

Factor G was estimated based upon actual historical cost data of the sample targeted population. The population was the set of persons identified by the State of Connecticut DSS as receiving hospital, nursing facility or ICF/MR services between February, 2006 and February, 2007. These represent persons residing in Connecticut nursing facilities who pass the PASARR Level II Screen, indicating that the resident has a serious mental illness.

This study population included roughly 70 individuals. Their Medicaid claims were examined to identify the specific time periods during which they resided in nursing facilities. Roughly 44 persons were studied for the time period. Once the time periods

associated with their nursing home stays were identified, all Medicaid expenditures were extracted from the States' MMIS. These expenditures were grouped into institutional claims and non-institutional claims. The former were used to estimate Factor G, while the latter were used to estimate Factor G'. The historic cost data were trended forward using actual observed trends for the State's nursing home components of the CHC and PCA waivers and the package of institutional services.

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

Factor G' was estimated based upon the same targeted population and analysis as that described under Factor G. The key difference is that only expenditures associated with the non-institutional services provided to institutional residents were included in the development of G'. The second difference is that the historic cost data were trended forward using actual CPI trends for medical care commodities for the package of non-institutional services.

Factor G' was adjusted to exclude pharmacy expenditures for Medicare/Medicaid dual eligibles as that described under Factor D'.

A detailed breakout of the service costs that are reflected in the calculation of this factor is available upon request.

## Appendix J: Cost Neutrality Demonstration

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### J-2: Derivation of Estimates (4 of 7)

**Component management for waiver services.** If the service(s) below includes two or more discrete services that are reimbursed separately, or is a bundled service, each component of the service must be listed. Select "*manage components*" to add these components.

Waiver Services
Community Support
Non-medical transportation
Assertive Community Treatment
Transitional Case Management
Home Accessibility Adaptations
Specialized Medical Equipment
Supported Employment
Peer Supports
Recovery Assistant
Short Term Crisis Stabilization

## Appendix J: Cost Neutrality Demonstration

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### J-2: Derivation of Estimates (5 of 7)

**d. Estimate of Factor D.**

**i. Non-Concurrent Waiver.** Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

**Waiver Year: Year 1**

<b>Waiver Service/Component</b>	<b>Unit</b>	<b># Users</b>	<b>Avg. Units Per User</b>	<b>Avg. Cost/Unit</b>	<b>Component Cost</b>	<b>Total Cost</b>
<b>Community Support Total:</b>						<b>583128.00</b>
Community Support Program - individual	Per 15 Min	30	780.00	24.92	<b>583128.00</b>	
Community Support Program - group	Per 15 Min	0	0.00	6.17	<b>0.00</b>	
<b>Non-medical transportation Total:</b>						<b>53009.12</b>
Non-medical transportation (Agency)	Per trip	44	23.00	24.66	<b>24955.92</b>	
Non-medical transportation (Private)	Per mile	35	1864.00	0.43	<b>28053.20</b>	
<b>Assertive Community Treatment Total:</b>						<b>1400455.98</b>
ACT - individual	Per 15 Min	42	927.00	35.97	<b>1400455.98</b>	
ACT - group	Per 15 Min	0	0.00	8.99	<b>0.00</b>	
<b>Transitional Case Management Total:</b>						<b>56632.62</b>

Transitional Case Management	Per 15 Min	53	66.00	16.19	<b>56632.62</b>	
<b>Home Accessibility Adaptations Total:</b>						<b>133000.00</b>
Home Accessibility Adaptations	Per Service	19	1.00	7000.00	<b>133000.00</b>	
<b>Specialized Medical Equipment Total:</b>						<b>46000.00</b>
Specialized Medical Equipment	Per Service	8	1.00	5750.00	<b>46000.00</b>	
<b>Supported Employment Total:</b>						<b>94225.80</b>
Supported Employment Individual	Per 15 Min	30	194.00	16.19	<b>94225.80</b>	
<b>Peer Supports Total:</b>						<b>4734.72</b>
Peer Supports	Per 15 Min	4	96.00	12.33	<b>4734.72</b>	
<b>Recovery Assistant Total:</b>						<b>823363.20</b>
Recovery Assistant Agency	Per 15 Min	72	2024.00	5.65	<b>823363.20</b>	
Recovery Assistant Individual	Per 15 Min	0	0.00	3.34	<b>0.00</b>	
<b>Short Term Crisis Stabilization Total:</b>						<b>82561.68</b>
Short Term Crisis Stabilization	Per 15 Min	72	93.00	12.33	<b>82561.68</b>	
<b>GRAND TOTAL:</b>						<b>3277111.12</b>

<b>Total Estimated Unduplicated Participants:</b>	<b>79</b>
<b>Factor D (Divide total by number of participants):</b>	<b>41482.42</b>
<b>Average Length of Stay on the Waiver:</b>	<b>180</b>

## Appendix J: Cost Neutrality Demonstration

### J-2: Derivation of Estimates (6 of 7)

#### d. Estimate of Factor D.

**i. Non-Concurrent Waiver.** Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

#### Waiver Year: Year 2

Waiver Service/Component	Unit	# Users	Avg. Units Per User	Avg. Cost/Unit	Component Cost	Total Cost
<b>Community Support Total:</b>						<b>1334208.75</b>
Community Support Program - individual	Per 15 Min	75	685.00	25.97	<b>1334208.75</b>	
Community Support Program - group	Per 15 Min	0	0.00	6.43	<b>0.00</b>	
<b>Non-medical transportation Total:</b>						<b>102158.64</b>
Non-medical transportation (Agency)	Per trip	78	23.00	25.40	<b>45567.60</b>	
Non-medical transportation (Private)	Per mile	69	1864.00	0.44	<b>56591.04</b>	
<b>Assertive</b>						

<b>Community Treatment Total:</b>						<b>2327208.16</b>
ACT - individual	Per 15 Min	76	817.00	37.48	<b>2327208.16</b>	
ACT - group	Per 15 Min	0	0.00	9.37	<b>0.00</b>	
<b>Transitional Case Management Total:</b>						<b>29505.63</b>
Transitional Case Management	Per 15 Min	53	33.00	16.87	<b>29505.63</b>	
<b>Home Accessibility Adaptations Total:</b>						<b>161000.00</b>
Home Accessibility Adaptations	Per Service	23	1.00	7000.00	<b>161000.00</b>	
<b>Specialized Medical Equipment Total:</b>						<b>46000.00</b>
Specialized Medical Equipment	Per Service	8	1.00	5750.00	<b>46000.00</b>	
<b>Supported Employment Total:</b>						<b>115289.58</b>
Supported Employment Individual	Per 15 Min	34	201.00	16.87	<b>115289.58</b>	
<b>Peer Supports Total:</b>						<b>26316.80</b>
Peer Supports	Per 15 Min	8	256.00	12.85	<b>26316.80</b>	
<b>Recovery Assistant Total:</b>						<b>1587755.52</b>
Recovery Assistant Agency	Per 15 Min	144	1872.00	5.89	<b>1587755.52</b>	

Recovery Assistant Individual	Per 15 Min	0	0.00	3.48	<b>0.00</b>	
<b>Short Term Crisis Stabilization Total:</b>						<b>166536.00</b>
Short Term Crisis Stabilization	Per 15 Min	144	90.00	12.85	<b>166536.00</b>	
<b>GRAND TOTAL:</b>						<b>5895979.08</b>
<b>Total Estimated Unduplicated Participants:</b>						<b>169</b>
<b>Factor D (Divide total by number of participants):</b>						<b>34887.45</b>
<b>Average Length of Stay on the Waiver:</b>						<b>239</b>

## Appendix J: Cost Neutrality Demonstration

### J-2: Derivation of Estimates (7 of 7)

#### d. Estimate of Factor D.

**i. Non-Concurrent Waiver.** Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

#### Waiver Year: Year 3

Waiver Service/Component	Unit	# Users	Avg. Units Per User	Avg. Cost/Unit	Component Cost	Total Cost
<b>Community Support Total:</b>						<b>2265246.72</b>
Community Support Program - individual	Per 15 Min	128	654.00	27.06	<b>2265246.72</b>	
Community Support Program - group	Per 15 Min	0	0.00	6.70	<b>0.00</b>	
<b>Non-medical</b>						

<b>transportation Total:</b>						<b>139889.52</b>
Non-medical transportation (Agency)	Per trip	114	23.00	26.16	<b>68591.52</b>	
Non-medical transportation (Private)	Per mile	85	1864.00	0.45	<b>71298.00</b>	
<b>Assertive Community Treatment Total:</b>						<b>3097641.25</b>
ACT - individual	Per 15 Min	95	835.00	39.05	<b>3097641.25</b>	
ACT - group	Per 15 Min	0	0.00	9.76	<b>0.00</b>	
<b>Transitional Case Management Total:</b>						<b>20498.28</b>
Transitional Case Management	Per 15 Min	53	22.00	17.58	<b>20498.28</b>	
<b>Home Accessibility Adaptations Total:</b>						<b>161000.00</b>
Home Accessibility Adaptations	Per Service	23	1.00	7000.00	<b>161000.00</b>	
<b>Specialized Medical Equipment Total:</b>						<b>46000.00</b>
Specialized Medical Equipment	Per Service	8	1.00	5750.00	<b>46000.00</b>	
<b>Supported Employment Total:</b>						<b>169682.16</b>
Supported Employment Individual	Per 15 Min	38	254.00	17.58	<b>169682.16</b>	

<b>Peer Supports Total:</b>						<b>49810.80</b>
Peer Supports	Per 15 Min	12	310.00	13.39	<b>49810.80</b>	
<b>Recovery Assistant Total:</b>						<b>2359510.56</b>
Recovery Assistant Agency	Per 15 Min	216	1782.00	6.13	<b>2359510.56</b>	
Recovery Assistant Individual	Per 15 Min	0	0.00	3.60	<b>0.00</b>	
<b>Short Term Crisis Stabilization Total:</b>						<b>241287.80</b>
Short Term Crisis Stabilization	Per 15 Min	212	85.00	13.39	<b>241287.80</b>	
<b>GRAND TOTAL:</b>						<b>8550567.09</b>
<b>Total Estimated Unduplicated Participants:</b>						<b>249</b>
<b>Factor D (Divide total by number of participants):</b>						<b>34339.63</b>
<b>Average Length of Stay on the Waiver:</b>						268