

3. A waiver of section 1902(a)(10)(B) of the Act is requested to target waiver services to one of the select group(s) of individuals who would be otherwise eligible for waiver services:

- a. aged (age 65 and older)
- b. disabled
- c. aged and/or disabled
- d. mentally retarded
- e. developmentally disabled
- f. mentally retarded and/or developmentally disabled
- g. chronically mentally ill

4. A waiver of section 1902(a)(10)(B) of the Act is also requested to impose the following additional targeting restrictions (specify):

- a. Waiver services are limited to the following age groups (specify):
- b. Waiver services are limited to individuals with the following disease(s) or condition(s) (specify):
- c. Waiver services are limited to individuals who are mentally retarded or developmentally disabled, who currently reside in general NFs, but who have been shown, as a result of the Pre-Admission Screening and Annual Resident Review process mandated by P.L. 100-203 to require active treatment at the level of an ICF/MR.

STATE: Connecticut

DATE: May 2005

9. A waiver of the "statewideness" requirements set forth in section 1902(a)(1) of the Act is requested.

a. Yes

b. No

If yes, waiver services will be furnished only to individuals in the following geographic areas or political subdivisions of the State (Specify):

Assisted living services shall be limited to service areas covered by Pilot Projects established under Public Act 97-2 of the June 18th Special Session and See PA 97-2 and PA 98-239 and PA 02-7.

10. A waiver of the amount, duration and scope of services requirements contained in section 1902(a)(10)(B) of the Act is requested, in order that services not otherwise available under the approved Medicaid State plan may be provided to individuals served on the waiver.

11. The State requests that the following home and community-based services, as described and defined in Appendix B.1 of this request, be included under this waiver:

a. Case management

b. Homemaker

c. Home health aide services

d. Personal care services

e. Respite care

f. Adult day health

g. Habilitation

Residential habilitation

STATE: Connecticut

DATE: May 2005

- Day habilitation
- Prevocational services
- Supported employment services
- Educational services

- h. Environmental accessibility adaptations
- i. Skilled nursing
- j. Transportation
- k. Specialized medical equipment and supplies
- l. Chore services
- m. Personal Emergency Response Systems
- n. Companion services
- o. Private duty nursing
- p. Family training
- q. Attendant care
- r. Adult Residential Care

- Adult Family Living
- Assisted living

STATE: Connecticut

DATE: May 2005

s. ___ Extended State plan services (Check all that apply):

- ___ Physician services
- ___ Home health care services
- ___ Physical therapy services
- ___ Occupational therapy services
- ___ Speech, hearing and language services
- ___ Prescribed drugs
- ___ Other (specify):

t. x Other services (specify): Mental Health Counseling
Home Delivered Meals

u. ___ The following services will be provided to individuals with chronic mental illness:

- ___ Day treatment/Partial hospitalization
- ___ Psychosocial rehabilitation
- ___ Clinic services (whether or not furnished in a facility)

12. The state assures that adequate standards exist for each provider of services under the waiver. The State further assures that all provider standards will be met.
13. An individual written plan of care will be developed by qualified individuals for each individual under this waiver. This plan of care will describe the medical and other services (regardless of funding source) to be furnished, their frequency, and the type of

STATE: Connecticut

DATE: May 2005

provider who will furnish each. All services will be furnished pursuant to a written plan of care. The plan of care will be subject to the approval of the Medicaid agency. FFP will not be claimed for waiver services furnished prior to the development of the plan of care. FFP will not be claimed for waiver services which are not included in the individual written plan of care.

14. waiver services will not be furnished to individuals who are inpatients of a hospital, NF, or ICF/MR.
15. FFP will not be claimed in expenditures for the cost of room and board, with the following exception(s) (Check all that apply):
- a. When provided as part of respite care in a facility approved by the State that is not a private residence (hospital, NF, foster home, or community residential facility).
 - b. Meals furnished as part of a program of adult day health services.
 - c. When a live-in personal caregiver (who is unrelated to the individual receiving care) provides approved waiver services, a portion of the rent and food that may be reasonably attributed to the caregiver who resides in the same household with the waiver recipient. FFP for rent and food for a live-in caregiver is not available if the recipient lives in the caregiver's home, or in a residence that is owned or leased by the provider of Medicaid services. An explanation of the method by which room and board costs are computed is included in Appendix G-3.

For purposes of this provision, "board" means 3 meals a day, or any other full nutritional regimen.

16. The Medicaid agency provides the following assurances to CMS:
- a. Necessary safeguards have been taken to protect the health and welfare of persons receiving services under this waiver. Those safeguards include:
 - 1. Adequate standards for all types of providers that furnish services under

STATE: Connecticut

DATE: May 2005

- the waiver (see Appendix B);
2. Assurance that the standards of any State licensure or certification requirements are met for services or for individuals furnishing services that are provided under the waiver (see Appendix B). The State assures that these requirements will be met on the date that the services are furnished; and
 3. Assurance that all facilities covered by section 1616(e) of the Social Security Act, in which home and community-based services will be provided, are in compliance with applicable State standards that meet the requirements of 45 CFR Part 1397 for board and care facilities.
- b. The agency will provide for an evaluation (and periodic reevaluations, at least annually) of the need for a level of care indicated in item 2 of this request, when there is a reasonable indication that individuals might need such services in the near future (one month or less), but for the availability of home and community-based services. The requirements for such evaluations and reevaluations are detailed in Appendix D.
 - c. When an individual is determined to be likely to require a level of care indicated in item 2 of this request, and is included in the targeting criteria included in items 3 and 4 of this request, the individual or his or her legal representative will be:
 1. Informed of any feasible alternatives under the waiver; and
 2. Given the choice of either institutional or home and community-based services.
 - d. The agency will provide an opportunity for a fair hearing, under 42 CFR Part 431, subpart E, to persons who are not given the choice of home or community-based services as an alternative to institutional care indicated in item 2 of this request, or who are denied the service(s) of their choice, or the provider(s) of their choice.
 - e. The average per capita expenditures under the waiver will not exceed 100 percent of the average per capita expenditures for the level(s) of care indicated in item 2 of this request under the State plan that would have been made in that fiscal year

STATE: Connecticut

DATE: May 2005

had the waiver not been granted.

- f. The agency's actual total expenditure for home and community-based and other Medicaid services under the waiver 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 by the State's Medicaid program for these individuals in the institutional setting(s) indicated in item 2 of this request in the absence of the waiver.
- g. Absent the waiver, persons served in the waiver would receive the appropriate type of Medicaid-funded institutional care that they require, as indicated in item 2 of this request.
- h. The agency will provide CMS annually with information on the impact of the waiver on the type, amount and cost of services provided under the State plan and on the health and welfare of the persons served on the waiver. The information will be consistent with a data collection plan designed by CMS.
- i. The agency will assure financial accountability for funds expended for home and community-based services, provide for an independent audit of its waiver program (except as CMS may otherwise specify for particular waivers), and it will maintain and make available to HHS, the Comptroller General, or other designees, appropriate financial records documenting the cost of services provided under the waiver, including reports of any independent audits conducted.

The State conducts a single audit in conformance with the Single Audit Act of 1984, P.L. 98-502.

a. Yes b. No

17. The State will provide for an independent assessment of its waiver that evaluates the quality of care provided, access to care, and cost-neutrality. The results of the assessment will be submitted to CMS at least 90 days prior to the expiration of the approved waiver period and cover the first 24 months (new waivers) or 48 months (renewal waivers) of the waiver.

STATE: Connecticut

DATE: May 2005

a. Yes b. No

18. The State assures that it will have in place a formal system by which it ensures the health and welfare of the individuals served on the waiver, through monitoring of the quality control procedures described in this waiver document (including Appendices). Monitoring will ensure that all provider standards and health and welfare assurances are continuously met, and that plans of care are periodically reviewed to ensure that the services furnished are consistent with the identified needs of the individuals. Through these procedures, the State will ensure the quality of services furnished under the waiver and the State plan to waiver persons served on the waiver. The State further assures that all problems identified by this monitoring will be addressed in an appropriate and timely manner, consistent with the severity and nature of the deficiencies.
19. An effective date of July 1, 2005 is requested.
20. The State contact person for this request is Michele Parsons, who can be reached by telephone at (860) 424-5177.
21. This document, together with Appendices A through G, and all attachments, constitutes the State's request for a home and community-based services waiver under section 1915(c) of the Social Security Act. The State affirms that it will abide by all terms and conditions set forth in the waiver (including Appendices and attachments), and certifies that any modifications to the waiver request will be submitted in writing by the State Medicaid agency. Upon approval by CMS, this waiver request will serve as the State's authority to provide home and community services to the target group under its Medicaid plan. Any proposed changes to the approved waiver will be formally requested by the State in the form of waiver amendments.

STATE: Connecticut

DATE: May 2005

The State assures that all material referenced in this waiver application (including standards, licensure and certification requirements) will be kept on file at the Medicaid agency.

Signature:

Print Name: Patricia A. Wilson-Coker

Title: Commissioner

Date: May 23, 2005

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0449. The time required to complete this information collection is estimated to average 160 hours for each new and renewed waiver request and an average of 30 hours for each amendment, including the time to review instructions, searching existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimates or suggestions for improving this form, please write to: CMS, P.O. Box 26684, Baltimore, Maryland 21207 and to the Office of Information and Regulatory Affairs, Office of Management and Budget, Washington, D.C. 20503.

STATE: Connecticut

DATE: May 2005

APPENDIX A - ADMINISTRATION

LINE OF AUTHORITY FOR WAIVER OPERATION

CHECK ONE:

- The waiver will be operated directly by the Medical Assistance Unit of the Medicaid agency.
- The waiver will be operated by _____, a separate agency of the State, under the supervision of the Medicaid agency. The Medicaid agency exercises administrative discretion in the administration and supervision of the waiver and issues policies, rules and regulations related to the waiver. A copy of the interagency agreement setting forth the authority and arrangements for this policy is on file at the Medicaid agency.
- The waiver will be operated by _____, a separate division within the Single State agency. The Medicaid agency exercises administrative discretion in the administration and supervision of the waiver and issues policies, rules and regulations related to the waiver. A copy of the interagency agreement setting forth the authority and arrangements for this policy is on file at the Medicaid agency.
- The waiver program will formally interact with the following programs funded under State or Federal authorities.

STATE: Connecticut

DATE: May 2005

APPENDIX B - SERVICES AND PROVIDER STANDARDS

APPENDIX B-1: DEFINITION OF SERVICES

The State requests that the following home and community-based services, as described and defined herein, be included under this waiver. Provider qualifications/standards for each service are set forth in Appendix B-2.

a. x Case Management

 Services which will assist individuals who receive waiver services in gaining access to needed waiver and other State plan services, as well as needed medical, social, educational and other services, regardless of the funding source for the services to which access is gained.

Case managers shall be responsible for ongoing monitoring of the provision of services included in the individual's plan of care.

1. x Yes 2. No

Case managers shall initiate and oversee the process of assessment and reassessment of the individual's level of care and the review of plans of care at such intervals as are specified in Appendices C & D of this request. Refer to page 13 a & 13b

1. x Yes 2. No

 x Other Service Definition (Specify):
The nurses and social workers at DSS initiate and oversee the process of assessment and reassessment and periodically monitor the plans of care for individuals who need only a minimal form of case management. See attached Process for Self Directed (page 59a)

STATE: Connecticut

DATE: May 2005

b. x Homemaker:

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

x Other Service Definition (Specify):
In addition, laundry services may be provided by professional cleaning companies.

c. ___ Home Health Aide services:

___ Services defined in 42 CFR 440.70, with the exception that limitations on the amount, duration and scope of such services imposed by the State's approved Medicaid plan shall not be applicable. The amount, duration and scope of these services shall instead be in accordance with the estimates given in Appendix G of this waiver request. Services provided under the waiver shall be in addition to any available under the approved State plan.

___ Other Service Definition (Specify):

d. ___ Personal care services:

___ Assistance with eating, bathing, dressing, personal hygiene, activities of daily living. This services may include assistance with preparation of meals, but does not include the cost of the meals themselves. when specified in the plan of care, this service may also include such housekeeping chores as bedmaking, dusting and vacuuming, which are incidental to the care furnished, or which are essential to the health and welfare of the individual, rather than the individual's family. Personal

STATE: Connecticut

DATE: May 2005

care providers must meet State standards for this service.

1. Services provided by family members (Check one):

Payment will not be made for personal care services furnished by a member of the individual's family.

Personal care providers may be members of the individual's family. Payment will not be made for services furnished to a minor by the child's parent (or step-parent), or to an individual by that person's spouse.

Justification attached. (Check one):

Family members who provide personal care services must meet the same standards as providers who are unrelated to the individual.

Standards for family members providing personal care services differ from those for other providers of this service. The different standards are indicated in Appendix B-2.

2. Supervision of personal care providers will be furnished by (Check all that apply):

A registered nurse, licensed to practice nursing in the State.

A licensed practical or vocational nurse, under the supervision of a registered nurse, as provided under State law.

Case managers

Other (Specify):

STATE: Connecticut

DATE: May 2005

3. Frequency or intensity of supervision (Check one):

As indicated in the plan of care

Other (Specify):

4. Relationship to State plan services (Check one):

Personal care services are not provided under the approved State plan.

Personal care services are included in the State plan, but with limitations. The waived service will serve as an extension of the State plan service, in accordance with documentation provided in Appendix G of this waiver request.

Personal care services under the State plan differ in service definition or provider type from the services to be offered under the waiver.

Other service definition (Specify):

e. Respite care:

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

STATE: Connecticut

DATE: May 2005

___ Other service definition (Specify):

FFP will not be claimed for the cost of room and board except when provided as part of respite care furnished in a facility approved by the State that is not a private residence.

Respite care will be provided in the following location(s) (Check all that apply):

- Individual's home or place of residence
- Foster home
- Medicaid certified Hospital
- Medicaid certified NF
- Medicaid certified ICF/MR
- Group home
- Licensed respite care facility
- Other community care residential facility approved by the State that its not a private residence (Specify type):
 - Licensed Home for the Aged
 - Adult Family Living Provider

___ Other service definition (Specify):

STATE: Connecticut

DATE: May 2005

f. x Adult day health:

 x Services furnished 4 or more hours per day on a regularly scheduled basis, for one or more days per week, in an outpatient setting, encompassing both health and social services needed to ensure the optimal functioning of the individual. Meals provided as part of these services shall not constitute a "full nutritional regimen" (3 meals per day). Physical, occupational and speech therapies indicated in the individual's plan of care will be furnished as component parts of this service.

Transportation between the individual's place of residence and the adult day health center will be provided as a component part of adult day health services. The cost of this transportation is included in the rate paid to providers of adult day health services. (Check one):

1. x Yes 2. No

 Other service definition (Specify):

Qualifications of the providers of adult day health services are contained in Appendix B-2.

g. Habilitation:

 Services designed to assist individuals in acquiring, retaining and improving the self-help, socialization and adaptive skills necessary to reside successfully in home and community-based settings. This service includes:

 Residential habilitation: assistance with acquisition, retention, or improvement in skills related to activities of daily living, such as personal grooming and cleanliness, bed making and household chores, eating and the preparation of food, and the social and adaptive skills

STATE: Connecticut

DATE: May 2005

necessary to enable the individual to reside in a non-institutional setting. Payments for residential habilitation are not made for room and board, the cost of facility maintenance, upkeep and improvement, other than such costs for modifications or adaptations to a facility required to assure the health and safety of residents, or to meet the requirements of the applicable life safety code. Payment for residential habilitation does not include payments made, directly or indirectly, to members of the individual's immediate family. Payments will not be made for the routine care and supervision which would be expected to be provided by a family or group home provider, or for activities or supervision for which a payment is made by a source other than Medicaid. Documentation which shows that Medicaid payment does not cover these components is attached to Appendix G.

— Day habilitation: assistance with acquisition, retention, or improvement in self-help, socialization and adaptive skills which takes place in a non-residential setting, separate from the home or facility in which the individual resides. Services shall normally be furnished 4 or more hours per day on a regularly scheduled basis, for 1 or more days per week unless provided as an adjunct to other day activities included in an individual's plan of care.

Day habilitation services shall focus on enabling the individual to attain or maintain his or her maximum functional level and shall be coordinated with any physical, occupational, or speech therapies listed in the plan of care. In addition, day habilitation services may serve to reinforce skills or lessons taught in school, therapy, or other settings.

— Prevocational services not available under a program funded under section 110 of the Rehabilitation Act of 1973 or section 602(16) and (17) of the Individuals with Disabilities Education Act (20 U.S.C. 1401(16 and 17)).

Services are aimed at preparing an individual for paid or unpaid employment, but are not job-task oriented. Services include teaching such concepts as compliance, attendance, task completion, problem solving and safety. Prevocational services are provided to persons not expected to be able to join the general work force or participate in a transitional sheltered workshop within one year (excluding supported employment programs). Prevocational services are available only to individuals who have previously been discharged from a SNF, ICF, NF or ICF/MR.

Check one:

- Individuals will not be compensated for prevocational services.
- When compensated, individuals are paid at less than 50 percent of the minimum wage.

Activities included in this service are not primarily directed at teaching specific job skills, but at underlying habilitative goals, such as attention span and motor skills. All prevocational services will be reflected in the individual's plan of care as directed to habilitative, rather than explicit employment objectives.

Documentation will be maintained in the file of each individual receiving this service that:

1. The service is not otherwise available under a program funded under the Rehabilitation Act of 1973, or P.L. 94-142; and

STATE: Connecticut

DATE: May 2005

2. The individual has been deinstitutionalized from a SNF, ICF, NF, or ICF/MR at some prior period.

— Educational services, which consist of special education and related services as defined in sections (15) and (17) of the Individuals with Disabilities Education Act, to the extent to which they are not available under a program funded by IDEA. Documentation will be maintained in the file of each individual receiving this service that:

1. The service is not otherwise available under a program funded under the Rehabilitation Act of 1973, or P.L. 94-142; and
2. The individual has been deinstitutionalized from a SNF, ICF, NF, or ICF/MR at some prior period.

— Supported employment services, which consist of paid employment for persons for whom competitive employment at or above the minimum wage is unlikely, and who, because of their disabilities, need intensive ongoing support to perform in a work setting. Supported employment is conducted in a variety of settings, particularly work sites in which persons without disabilities are employed. supported employment includes activities needed to sustain paid work by individuals receiving waiver services, including supervision and training. When supported employment services are provided at a work site in which persons without disabilities are employed, payment will be made only for the adaptations, supervision and training required by individuals receiving waiver services as a result of their disabilities, and will not include payment for the supervisory activities rendered as a normal part of the business setting.

Supported employment services furnished under the waiver are not available under a program funded by either the Rehabilitation Act of 1973 or P.L. 94-142. Documentation will be maintained in the file of each individual receiving this service that:

1. The service is not otherwise available under a program funded under the Rehabilitation Act of 1973, or P.L. 94-142; and
2. The individual has been deinstitutionalized from a SNF, ICF, NF, or ICF/MR at some prior period.

FFP will not be claimed for incentive payments, subsidies, or unrelated vocational training expenses such as the following:

1. Incentive payments made to an employer to encourage or subsidize the employer's participation in a supported employment program;
2. Payments that are passed through to users of supported employment programs; or
3. Payments for vocational training that is not directly related to an individual's supported employment program.

Transportation will be provided between the individual's place of residence and the site of the habilitation services, or between habilitation sites (in cases where the individual receives habilitation services in more than one place) as a component part of habilitation services. The cost of this transportation is included

in the rate paid to providers of the appropriate type of habilitation services.

1. Yes 2. No

Other service definition (Specify):

The State requests the authority to provide the following additional services, not specified in the statute. The State assures that each service is cost-effective and necessary to prevent institutionalization. The cost neutrality of each service is demonstrated in Appendix G. Qualifications of providers are found in Appendix B-2.

h. Environmental accessibility adaptations:

Those physical adaptations to the home, required by the individual's plan of care, which are necessary to ensure the health, welfare and safety of the individual, or which enable the individual to function with greater independence in the home, and without which, the individual would require institutionalization. Such adaptations may include the installation of ramps and grab-bars, widening of doorways, modification of bathroom facilities, or installation of specialized electric and plumbing systems which are necessary to accommodate the medical equipment and supplies which are necessary for the welfare of the individual. Excluded are those adaptations or improvements to the home which are of general utility, and are not of direct medical or remedial benefit to the individual, such as carpeting, roof repair, central air conditioning, etc. Adaptations which add to the total square footage of the home are excluded from this benefit. All services shall be provided in accordance with applicable State or local building codes.

Other service definition (Specify):
 Minor home modifications required by the individual's plan of care, which are necessary to ensure health welfare and safety of the individuals to

STATE: Connecticut

DATE: May 2005

function with greater independence in their home and without which the individual would require institutionalization. Such adaptation may include the installation of hand rails and grab bars in the tub area, widening of doorways and installation of ramps. Excluded are those adaptations or improvements to the home which are of general utility, and are not of direct medical or remedial benefit to the individuals, such as carpeting, roof repair, central air conditioning, etc. Adaptations which add to the total square footage of the home are excluded from this benefit. All services shall be provided in accordance with applicable State or local building codes:

i. Skilled nursing:

Services listed in the plan of care which are within the scope of the State's Nurse Practice Act and are provided by a registered professional nurse, or licensed practical or vocational nurse under the supervision of a registered nurse, licensed to practice in the State.

Other service definition (Specify):

j. Transportation:

Service offered in order to enable individuals served on the waiver to gain access to waiver and other community services, activities and resources, specified by the plan of care. This service is offered in addition to medical transportation required under 42 CFR 431.53 and transportation services under the State plan, defined at 42 CFR 440.170(a) (if applicable), and shall not replace them.

Other service definition (Specify):
Social and Community Service transportation to provide access to appropriate social or recreational facilities. Transportation services under the waiver shall be offered in accordance with the individual's plan of care. Whenever possible, family, neighbors, friends, or community agencies which can provide this service without charge will be utilized.

STATE: Connecticut

DATE: May 2005

k. ___ Specialized Medical Equipment and Supplies:

___ Specialized medical equipment and supplies to include devices, controls, or appliances, specified in the plan of care, which enable individuals to increase their abilities to perform activities of daily living, or to perceive, control, or communicate with the environment in which they live.

This service also includes items necessary for life support, ancillary supplies and equipment necessary to the proper functioning of such items, and durable and non-durable medical equipment not available under the Medicaid State plan. Items reimbursed with waiver funds shall be in addition to any medical equipment and supplies furnished under the State plan and shall exclude those items which are not of direct medical or remedial benefit to the individual. All items shall meet applicable standards of manufacture, design and installation.

___ Other service definition (Specify):

l. x Chore services:

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

STATE: Connecticut

DATE: May 2005

___ Other service definition (Specify):

m. x Personal Emergency Response Systems (PERS)

 x PERS is an electronic device which enables certain individuals at high risk of institutionalization to secure help in an emergency. The individual may also wear a portable "help" button to allow for mobility. The system is connected to the person's phone and programmed to signal a response center once a "help" button is activated. The response center is staffed by trained professionals, as specified in Appendix B-2. PERS services are limited to those individuals who live alone, or who are alone for significant parts of the day, and have no regular caregiver for extended periods of time, and who would otherwise require extensive routine supervision.

___ Other service definition (Specify):

n. x Adult companion services:

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

___ Other service definition (Specify):

STATE: Connecticut

DATE: May 2005

o. ___ Private duty nursing:

___ Individual and continuous care (in contrast to part time or intermittent care) provided by licensed nurses within the scope of State law. These services are provided to an individual at home.

___ Other service definition (Specify):

p. ___ Family training:

___ Training and counseling services for the families of individuals served on this waiver. For purposes of this service, "family" is defined as the persons who live with or provide care to a person served on the waiver, and may include a parent, spouse, children, relatives, foster family, or in-laws. "Family" does not include individuals who are employed to care for the consumer. Training includes instruction about treatment regimens and use of equipment specified in the plan of care, and shall include updates as necessary to safely maintain the individual at home. All family training must be included in the individual's written plan of care.

___ Other service definition (Specify):

q. ___ Attendant care services:

___ Hands-on care, of both a supportive and health-related nature, specific to the needs of a medically stable, physically handicapped individual. Supportive services are those which substitute for the absence, loss, diminution, or impairment of a physical or cognitive function. this service may include skilled or nursing care to the extent permitted by State law. Housekeeping activities which are incidental to the performance of care may also be furnished as part of this activity.

STATE: Connecticut

DATE: May 2005

Supervision (Check all that apply):

Supervision will be provided by a Registered Nurse, licensed to practice in the State. The frequency and intensity of supervision will be specified in the individual's written plan of care.

Supervision may be furnished directly by the individual, when the person has been trained to perform this function, and when the safety and efficacy of consumer-provided supervision has been certified in writing by a registered nurse or otherwise as provided in State law. This certification must be based on direct observation of the consumer and the specific attendant care provider, during the actual provision of care. Documentation of this certification will be maintained in the consumer's individual plan of care.

Other supervisory arrangements (Specify):

Other service definition (Specify):

r. Adult Residential Care (Check all that apply):

Adult foster care: (Adult Family Living) Personal care and services, homemaker, chore, attendant care and companion services medication oversight (to the extent permitted under State law) provided in a licensed (where applicable) private home by a principal care provider who lives in the home. Adult foster care is furnished to adults who receive these services in conjunction with residing in the home. the total number of individuals (including persons served in the waiver) living in the home, who are unrelated to the principal care provider, cannot exceed___. Separate payment will not be made for homemaker or chore services furnished to an individual receiving adult foster care services, since these services are integral to and inherent in the provision of adult foster care services.

STATE: Connecticut

DATE: May 2005

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

Personalized care is furnished to individuals who reside in their own living units (which may include dually occupied units when both occupants consent to the arrangement) which may or may not include kitchenette and/or living rooms and which contain bedrooms and toilet facilities. The consumer has a right to privacy. Living units may be locked at the discretion of the consumer, except when a physician or mental health professional has certified in writing that the consumer is sufficiently cognitively impaired as to be a danger to self or others if given the opportunity to lock the door. (This requirement does not apply where it conflicts with fire code.) Each living unit is separate and distinct from each other. The facility must have a central dining room, living room or parlor, and common activity center(s) (which may also serve as living rooms or dining rooms). The consumer retains the right to assume risk, tempered only by the individual's ability to assume responsibility for that risk. Care must be furnished in a way which fosters the independence of each consumer to facilitate aging in place. Routines of care provision and service delivery must be consumer-driven to the maximum extent possible, and treat each person with dignity and respect.

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

- Home health care
- Physical therapy

STATE: Connecticut

DATE: May 2005

- Occupational therapy
- Speech therapy
- Medication administration
- Intermittent skilled nursing services
- Transportation specified in the plan of care
- Periodic nursing evaluations
- Other (Specify)

However, nursing and skilled therapy services (except periodic nursing evaluations if specified above) are incidental, rather than integral to the provision of assisted living services. Payment will not be made for 24-hour skilled care or supervision. FFP is not available in the cost of room and board furnished in conjunction with residing in an assisted living facility.

- Other service definition (Specify):
Assisted Living Services shall be limited to service areas covered by Pilot projects established by Public Act 97-2 of the June 18th Special Session. Special Sessions Public Act 98-239, and Public Act 02-7.
All other services shall be available state-wide.
Separate payments will not be made for homemaker, attendant care, personal care, companion, or chore services. Since the activities included under these services are integral to and inherent in the provision of Assisted Living.

Payments for adult residential care services are not made for room and board, items of comfort or convenience, or the costs of facility maintenance, upkeep and improvement. Payment for adult residential care services does not include

STATE: Connecticut

DATE: May 2005

payments made, directly or indirectly, to members of the consumer's immediate family. The methodology by which payments are calculated and made is described in Appendix G.

s. x Other waiver services which are cost-effective and necessary to prevent institutionalization (Specify):

Home Delivered Meals are "Meals on Wheels" include the preparation and delivery of one(1) or (2) meals for persons who are unable to prepare or obtain nourishing meals on their own. Payment under the home care program is not available for more than 2 meals a day.

t. _____ Extended State plan services:

The following services, available through the approved State plan, will be provided, except that the limitations on amount, duration and scope specified in the plan will not apply. Services will be as defined and described in the approved State plan. The provider qualifications listed in the plan will apply, and are hereby incorporated into this waiver request by reference. These services will be provided under the State plan until the plan limitations have been reached. Documentation of the extent of services and cost-effectiveness are demonstrated in Appendix G. (Check all that apply):

_____ Physician services

_____ Home health care services

_____ Physical therapy services

_____ Occupational therapy services

_____ Speech, hearing and language services

STATE: Connecticut

DATE: May 2005

- Prescribed drugs
- Other State plan services (Specify):

Mental Health Counseling

Mental Health Counseling Services are professional counseling services provided to help resolve or enable the eligible individual to cope with individual, family, and/or environmentally related problems and conditions. Counseling focuses on issues such as problems in maintaining a home in the community, relocation within the community, dealing with long term disability, substance abuse, and family relationships.

Mental Health Counseling can be provided in the client's home or location best suited for the client.

- u. Services for individuals with chronic mental illness, consisting of (Check one):

- Day treatment or other partial hospitalization services (Check one):

- Services that are necessary for the diagnosis or treatment of the individual's mental illness. These services consist of the following elements:

- a. individual and group therapy with physicians or psychologists (or other mental health professionals to the extent authorized under State law),
- b. occupational therapy, requiring the skills of a qualified occupational therapist,
- c. services of social workers, trained psychiatric nurses, and other staff trained to work with individuals with psychiatric illness,

STATE: Connecticut

DATE: May 2005

- d. drugs and biologicals furnished for therapeutic purposes,
- e. individual activity therapies that are not primarily recreational or diversionary,
- f. family counseling (the primary purpose of which is treatment of the individual's condition),
- g. training and education of the individual (to the extent that training and educational activities are closely and clearly related to the individual's care and treatment), and
- h. diagnostic services.

Meals and transportation are excluded from reimbursement under this service. The purpose of this service is to maintain the individual's condition and functional level and to prevent relapse or hospitalization.

___ Other service definition (Specify):

___ Psychosocial rehabilitation services (Check one):

___ Medical or remedial services recommended by a physician or other licensed practitioner under State law, for the maximum reduction of physical or mental disability and the restoration of maximum functional level. Specific services include the following:

- a. restoration and maintenance of daily living skills (grooming, personal hygiene, cooking, nutrition, health and mental health education, medication management, money management and maintenance of the living environment);

STATE: Connecticut

DATE: May 2005

- b. social skills training in appropriate use of community services;
- c. development of appropriate personal support networks, therapeutic recreational services (which are focused on therapeutic intervention, rather than diversion); and
- d. telephone monitoring and counseling services.

The following are specifically excluded from Medicaid payment for psychosocial rehabilitation services:

- a. vocational services,
- b. prevocational services,
- c. supported employment services, and
- d. room and board.

Other service definition (Specify):

Clinic services (whether or not furnished in a facility) are services defined in 42 CFR 440.90.

Check one:

This service is furnished only on the premises of a clinic.

Clinic services provided under this waiver may be furnished outside the clinic facility. Services may be furnished in the following locations (Specify):

STATE: Connecticut

DATE: May 2005

APPENDIX B-2**PROVIDER QUALIFICATIONS****A. LICENSURE AND CERTIFICATION CHART**

The following chart indicates the requirements for the provision of each service under the waiver. Licensure, Regulation, State Administrative Code are referenced by citation. Standards not addressed under uniform State citation are attached.

Service	Provider	License	Certification	Other Standard
1b-1-a Care Management	Registered Nurse or Social Worker	CT Regulations 19-13-D66-D79		CT Regulations 17b-342-2(a)
2B-1b Homemaker	Non relative able to meet the individual's needs. In addition, laundry services may be provided by professional cleaning companies			CT Regulation 17b-342-2(h)
3B-1-e Respite	Nurse, Home Health Aide, Companion, etc. depending on the need and the reason authorized			CT Regulations 17b-342-2(l)
4B-1-f Adult Day Health	Adult Day Health Center			CT Regulations 17b-342-2(b)
5B-1-j Transportation	Private and Commercial Carriers			CT Regulations 17b-342-2(m)
6B-1-l Chore	Non relative able to meet the Individual's needs			CT Regulations 17b-342-2(c)
7B-1-m PERS	PERS Provider with 24 hours Response capability			CT Regulations 17b-342-2(k)
8B-1-n Companion	Non relative able to meet the Individual's needs			CT Regulations 17b-342-2(d)
9B-1-t Mental Health Counseling	Masters level or Certified Social Worker or Counselor			CT Regulations 17b-342-2(j)
10B-1-s Home Delivered Meals	Home Delivered Meals Providers			CT Regulations 17b-342-2(f)
11B-1-r Adult Family Living	Private, Non-relative's residence That meets standard			CT Regulations 17b-342-2(e)
12B-1-r Assisted Living	Licensed Assisted Living Service Agency			CT Regulations 17b-342-2(e) 17b-365 & PA 97-2
13b-1h Minor Home	Non relative able to meet the Individual's needs			PA 00-2

STATE: ConnecticutDATE: May 2005

Modifications				
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B. ASSURANCE THAT REQUIREMENTS ARE MET

The State assures that the standards of any State licensure or certification requirements are met for services or for individuals furnishing services provided under the waiver.

C. PROVIDER REQUIREMENTS APPLICABLE TO EACH SERVICE

For each service for which standards other than, or in addition to State licensure or certification must be met by providers, the applicable educational, professional, or other standards for service provision or for service providers are attached to this Appendix, tabbed and labeled with the name of the service(s) to which they apply.

When the qualifications of providers are set forth in State or Federal law or regulation, it is not necessary to provide copies of the applicable documents. However, the documents must be on file with the State Medicaid agency, and the licensure and certification chart at the head of this Appendix must contain the precise citation indicating where the standards may be found.

D. FREEDOM OF CHOICE

The State assures that each individual found eligible for the waiver will be given free choice of all qualified providers of each service included in his or her written plan of care.

APPENDIX B-3
KEYS AMENDMENT STANDARDS FOR BOARD AND CARE FACILITIES

KEYS AMENDMENT ASSURANCE:

The State assures that all facilities covered by section 1616(e) of the Social Security Act, in which home and community-based services will be provided are in compliance with applicable State standards that meet the requirements of 45 CFR Part 1397 for board and care facilities.

APPLICABILITY OF KEYS AMENDMENT STANDARDS:

Check one:

- Home and community-base services will not be provided in facilities covered by section 1616(e) of the Social Security Act. Therefore, no standards are provided.
- A copy of the standards applicable to each type of facility identified above is maintained by the Medicaid agency.

STATE: Connecticut

DATE: May 2005

APPENDIX C-Eligibility and Post-Eligibility

Appendix C-1--Eligibility

MEDICAID ELIGIBILITY GROUPS SERVED

Individuals receiving services under this waiver are eligible under the following eligibility group(s) in your State plan. The State will apply all applicable FFP limits under the plan. **(Check all that apply.)**

1. Low income families with children as described in section 1931 of the Social Security Act.
2. SSI recipients (SSI Criteria States and 1634 States).
3. Aged, blind or disabled in 209(b) States who are eligible under 435.121 (aged, blind or disabled who meet requirements that are more restrictive than those of the SSI program).
4. Optional State supplement recipients
5. Optional categorically needy aged and disabled who have income at (Check one):
 - a. 100% of the Federal poverty level (FPL)
 - b. % Percent of FPL which is lower than 100%.
6. The special home and community-based waiver group under 42 CFR 435.217 (Individuals who would be eligible for Medicaid if they were in an institution, who have been determined to need home and community-based services in order to remain in the community, and who are covered under the terms of this waiver).

STATE: Connecticut

DATE: May 2005

Spousal impoverishment rules are used in determining eligibility for the special home and community-based waiver group at 42 CFR 435.217.

A. Yes B. No

Check one:

a. The waiver covers all individuals who would be eligible for Medicaid if they were in a medical institution and who need home and community-based services in order to remain in the community; or

b. Only the following groups of individuals who would be eligible for Medicaid if they were in a medical institution and who need home and community-based services in order to remain in the community are included in this waiver: (check all that apply):

(1) A special income level equal to:

300% of the SSI Federal benefit (FBR)

% of FBR, which is lower than 300% (42 CFR 435.236)

\$ which is lower than 300%

(2) Aged, blind and disabled who meet requirements that are more restrictive than those of the SSI program. (42 CFR 435.121)

(3) Medically needy without spenddown in States which also provide Medicaid to recipients of SSI. (42 CFR 435.320, 435.322, and 435,324.)

(4) Medically needy without spenddown in 209(b) States.
(42 CFR 435.330)

(5) Aged and disabled who have income at:

a. 100% of the FPL

STATE: Connecticut

DATE: May 2005

b. ___% which is lower than 100%.

(6)___ Other (Include statutory reference only to reflect additional groups included under the State plan.)

7. ___ Medically needy (42 CFR 435.320, 435.322, 435.324 and 435.330)

8. ___ Other (Include only statutory reference to reflect additional groups under your plan that you wish to include under this waiver.)

Appendix C-2--Post-Eligibility

GENERAL INSTRUCTIONS

ALL Home and Community-Based waiver recipients found eligible under 435.217 are subject to post-eligibility calculations.

Eligibility and post-eligibility are two separate processes with two separate calculations. Eligibility determines whether a person may be served on the waiver. Post-eligibility determines the amount (if any) by which Medicaid reduces its payment for services furnished to a particular individual. By doing so, post-eligibility determines the amount (if any) for which an individual is liable to pay for the cost of waiver services.

An eligibility determination (and periodic redetermination) must be made for each person served on the waiver.

Post-eligibility calculations are made ONLY for persons found eligible under 435.217.

Post-eligibility determinations must be made for all groups of individuals who would be eligible for Medicaid if they were in a medical institution and need home and community-based services in order to remain in the community (435.217). For individuals whose eligibility is not determined under the spousal rules (1924 of the Social Security Act), the State must use the regular post-eligibility rules at 435.726 and 435.735. However, for persons found eligible for Medicaid using the spousal impoverishment rules, the State has two options concerning the application of post-eligibility rules:

OPTION 1: The State may use the post-eligibility (PE) rules under 42 CFR 435.726 and 435.735 just as it does for other individuals found eligible under 435.217 or;

OPTION 2: it may use the spousal post-eligibility rules under 1924.

REGULAR POST-ELIGIBILITY RULES--435.726 and 435.735

- o The State must provide an amount for the maintenance needs of the individual. This amount must be based upon a reasonable assessment of the individual's needs in the community.
- o If the individual is living with his or her spouse, or if the individual is living in the community and the spouse is living at home, the State must protect an additional amount for the spouse's maintenance. This amount is limited by the highest appropriate income standard for cash assistance, or the medically needy standard. The State may choose which standard to apply.

STATE: Connecticut

DATE: May 2005

- o If the individual's spouse is not living in the individual's home, no maintenance amount is protected for that spouse's needs.
- o If other family members are living with the individual, an additional amount is protected for their needs. This amount is limited by the AFDC need standard for a family of the same size or by the appropriate medically needy standard for a family of the same size. The State may choose which standard to apply.

SPOUSAL POST-ELIGIBILITY--1924

When a person who is eligible as a member of a 42 CFR 435.217 group has a community spouse, the State may treat the individual as if he or she is institutionalized and apply the post-eligibility rules of 1924 of the Act (protection against spousal impoverishment) instead of the post-eligibility rules under 42 CFR 435.726 and 435.735. The 1924 post-eligibility rules provide for a more generous community spouse and family allowance than the rules under 42 CFR 435.726 and 435.735. Spousal impoverishment post-eligibility rules can only be used if the State is using spousal impoverishment eligibility rules.

The spousal protection rules also provide for protecting a personal needs allowance (PNA) "described in 1902(q)(1)" for the needs of the institutionalized individual. This is an allowance which is reasonable in amount for clothing and other personal needs of the individual . . . while in an institution." For institutionalized individuals this amount could be as low as \$30 per month. Unlike institutionalized individuals whose room and board are covered by Medicaid, the personal needs of the home and community-based services recipient must include a reasonable amount for food and shelter as well as for clothing. The \$30 PNA is not a sufficient amount for these needs when the individual is living in the community.

Therefore, States which elect to treat home and community-based services waiver participants with community spouses under the 1924 spousal impoverishment post-eligibility rules must use as the personal needs allowance either the maintenance amount which the State has elected under 42 CFR 435.726 or 42 CFR 435.735, or an amount that the State can demonstrate is a reasonable amount to cover the individual's maintenance needs in the community.

POST ELIGIBILITY

REGULAR POST ELIGIBILITY

1. _____ **SSI State.** The State is using the post-eligibility rules at 42 CFR 435.726. Payment for home and community-based waiver services are reduced by the amount remaining after deduction the following amounts from the waiver recipients income.

A. . 435.726--States which **do not use more restrictive** eligibility requirements than SSI.

a. Allowances for the needs of the

1. individual: (Check one):

A. ___ The following standard included under the State plan (check one):

(1) ___ SSI

(2) ___ Medically needy

(3) ___ The special income level for the institutionalized

(4) ___ The following percent of the Federal poverty level): ___%

(5) ___ Other (specify):

B. ___ The following dollar amount:
\$ _____ *

* If this amount changes, this item will be revised.

C. ___ The following formula is used to determine the needs allowance:

Note: If the amount protected for waiver recipients in item 1. is **equal to, or greater than** the maximum amount of income a waiver recipient may have and be eligible under 42 CFR 435.217, **enter NA in items 2. and 3.** following.

2. spouse only (check one):

A. ___ SSI standard

B. ___ Optional State supplement standard

C. ___ Medically needy income standard

D. ___ The following dollar amount:
\$ _____*

* If this amount changes, this item will be revised.

E. ___ The following percentage of the following standard that is not greater than the standards above: _____% of standard.

F. ___ The amount is determined using the following formula:

G. ___ Not applicable (N/A)

3. Family (check one):

A. ___ AFDC need standard

B. ___ Medically needy income standard

The amount specified below 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 income standard established under 435.811 for a family of the same size.

C. ___ The following dollar amount:

\$ ____ *

*If this amount changes, this item will be revised.

D. ____ The following percentage of the following standard that is not greater than the standards above: % ____ of standard.

E. ____ The amount is determined using the following formula:

F. ____ Other

G. ____ Not applicable (N/A)

b. Medical and remedial care expenses specified in 42 CFR 435.726.

POST-ELIGIBILITY

REGULAR POST ELIGIBILITY

1.(b) x **209(b) State, a State that is using more restrictive eligibility requirements than SSI.** The State is using the post-eligibility rules at 42 435.735. Payment for home and community-based waiver services are reduced by the amount remaining after deduction the following amounts from the waiver recipients income.

B. 42 CFR 435.735--States **using more restrictive** requirements than SSI.

(a) Allowances for the needs of the

1. individual: (check one):

A. x The following standard included under the State plan (check one):

(1)___ SSI

(2)___ Medically needy

(3)___ The special income level for the institutionalized

(4) x The following percentage of the Federal poverty level: 200%

(5)___ Other (specify):

B. ___ The following dollar amount:
\$ ___*

* If this amount changes, this item will be revised.

C. ___ The following formula is used to determine the amount:

STATE: Connecticut

DATE: May 2005

Note: If the amount protected for waiver recipients in 1. is **equal to, or greater than** the maximum amount of income a waiver recipient may have and be eligible under 435.217, **enter NA in items 2. and 3.** following.

2. spouse only (check one):

A. The following standard under 42 CFR 435.121:

B. The medically needy income standard _____;

C. The following dollar amount:
\$ _____*

* If this amount changes, this item will be revised.

D. The following percentage of the following standard that is not greater than the standards above: _____% of

E. The following formula is used to determine the amount:

F. Not applicable (N/A)

3. family (check one):

A. AFDC need standard

B. Medically needy income standard

The amount specified below 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 income standard established under

STATE: Connecticut

DATE: May 2005

435.811 for a family of the same size.

C. ___ The following dollar amount:
\$ _____*

* If this amount changes, this item will be revised.

D. ___ The following percentage of the following standard that is not greater than the standards above: _____% of standard.

E. ___ The following formula is used to determine the amount:

F. ___ Other

G. ___ Not applicable (N/A)

b. Medical and remedial care expenses specified in 42 CFR 435.735.

POST ELIGIBILITY

SPOUSAL POST ELIGIBILITY

2. x The State uses the post-eligibility rules of 1924(d) of the Act (spousal impoverishment protection) to determine the individual's contribution toward the cost of home and community-based care if it determines the individual's eligibility under 1924 of the Act. There shall be deducted from the individual's monthly income a personal needs allowance (as specified below), and a community spouse's allowance, a family allowance, and an amount for incurred expenses for medical or remedial care, as specified in the State Medicaid plan.

(A) Allowance for personal needs of the individual:
(check one)

(a) SSI Standard

(b) Medically Needy Standard

(c) The special income level for the institutionalized

(d) x The following percent of the Federal poverty level:
 200%

(e) The following dollar amount
\$ **

**If this amount changes, this item will be revised.

(f) The following formula is used to determine the needs allowance:

(g) Other (specify):

If this amount is different from the amount used for the individual's maintenance allowance under 42 CFR 435.726 or 42 CFR 435.735, explain why you believe that this amount is reasonable to meet the individual's maintenance needs in the

STATE: Connecticut

DATE: May 2005

community.

APPENDIX D - ENTRANCE PROCEDURES AND REQUIREMENTS

APPENDIX D-1

a. EVALUATION OF LEVEL OF CARE

The agency will provide for an evaluation (and periodic reevaluations) of the need for the level(s) of care indicated in the Executive Summary of this request, when there is a reasonable indication that individuals might need such services in the near future, but for the availability of home and community-based services.

See attached Quality Management Systems functioning in evaluations/reevaluations of level of care (Appendix D-1 page 50a & 50b)

b. QUALIFICATIONS OF INDIVIDUALS PERFORMING INITIAL EVALUATION

The educational/professional qualifications of persons performing initial evaluations of level of care for waiver participants are (check all that apply):

- Discharge planning team
- Physician (MD or DO)
- Registered nurse, licensed in the state
- Licensed social worker
- Qualified mental retardation professional, as defined in 42 CFR 483.430(a)
- Other (specify):
State Social Worker (see attached pages 50c & 50d)
- _____
- _____

STATE: Connecticut

DATE: May 2005

APPENDIX D-2

a. REEVALUATIONS OF LEVEL OF CARE

Reevaluations of the level of care required by the individual will take place (at a minimum) according to the following schedule (specify):

- Every 3 months
- Every 6 months
- Every 12 months
- Other (specify):

b. QUALIFICATIONS OF PERSONS PERFORMING REEVALUATIONS

Check one:

The educational/professional qualifications of person(s) performing reevaluations of level of care are the same as those for persons performing initial evaluations.

The educational/professional qualifications of persons performing reevaluations of level of care differ from those of persons performing initial evaluations. The following qualifications are met for all individuals performing reevaluations of level of care (specify):

- Physician (MD or DO)
- Registered nurse, licensed in the state
- Licensed social worker
- Qualified mental retardation professional, as defined in 42 CFR 483.430(a)

STATE: Connecticut

DATE: May 2005

x

Other (specify):

Social Workers employed by the Access Agencies or the
Department (see attached page 52a & 52b)

c. PROCEDURES TO ENSURE TIMELY REEVALUATIONS

The state will employ the following procedures to ensure timely reevaluations of level of care (check below):

 x "Tickler" file

 x Edits in computer system

 x Component part of case management

 Other (specify):

APPENDIX D-3

a. MAINTENANCE OF RECORDS

1. Records of evaluations and reevaluations of level of care will be maintained in the following location(s) (check all that apply):

- By the Medicaid Agency in its central office
- By the Medicaid Agency in district/local offices
- By the agency designated in Appendix A as having primary authority for the daily operation of the waiver program
- By the case managers
- By the persons or agencies designated as responsible for the performance of evaluations and reevaluations
- By service providers
- Other (specify):

2. Written documentation of all evaluations and reevaluations will be maintained as described in this Appendix for a minimum period of 7 years.

b. COPIES OF FORMS AND CRITERIA FOR EVALUATION/ASSESSMENT

A copy of the written assessment instrument(s) to be used in the evaluation and reevaluation and screening procedures for individuals need for a level of care indicated in the Executive Summary of this request is attached to this Appendix.

For persons diverted rather than deinstitutionalized, the state's evaluation process must provide for a more detailed description of their evaluation and screening procedures for individuals to ensure that waiver services will be limited to persons who would otherwise receive the level of care specified in the Executive Summary of this request.

Check one:

The process for evaluating and screening diverted individuals is the same as that used for deinstitutionalized persons.

The process for evaluating and screening diverted individuals differs from that used for deinstitutionalized persons. Attached is a description of the process used for evaluating and screening diverted individuals.

APPENDIX D-4

a. FREEDOM OF CHOICE AND FAIR HEARING

1. When an individual is determined to be likely to require a level of care indicated in the Executive Summary of this request, the individual or his or her legal representative will be:
 - a. Informed of any feasible alternatives under the waiver; and
 - b. Given the choice of either institutional or home and community-based services.
2. The agency will provide an opportunity for a fair hearing under 42 CFR Part 431, subpart E, to individuals who are not given the choice of home or community-based services as an alternative to the institutional care indicated in the Executive Summary of this request or who are denied the service(s) of their choice, or the provider(s) of their choice.
3. The following are attached to this Appendix:
 - a. A copy of the form(s) used to document freedom of choice and to offer a fair hearing;
 - b. A description of the agency's procedure(s) for informing eligible individuals (or their legal representatives) of the feasible alternatives available under the waiver;
 - c. A description of the State's procedures for allowing individuals to choose either institutional or home and community-based services; and
 - d. A description of how the individual (or legal representatives) is offered the opportunity to request a fair hearing under 42 CFR Part 431, Subpart E.

b. FREEDOM OF CHOICE DOCUMENT

Specify where copies of this form are maintained:

In the client's record at the Access Agency

APPENDIX E - PLAN OF CARE

APPENDIX E-1

a. PLAN OF CARE DEVELOPMENT

1. The following individuals are responsible for the preparation of the plans of care:

- Registered nurse, licensed to practice in the State
- Licensed practical or vocational nurse, acting within the scope of practice under State law
- Physician (M.D. or D.O.) licensed to practice in the State
- Social Worker (qualifications attached to this Appendix)
- Case Manager
- Other (specify):
Social Worker employed by the Access Agency
Clients and care managers will sign off on all plans of care

2. Copies of written plans of care will be maintained for a minimum period of 3 years. Specify each location where copies of the plans of care will be maintained.

- At the Medicaid agency central office
- At the Medicaid agency county/regional offices
- By case managers
- By the agency specified in Appendix A
- By consumers

STATE: Connecticut

DATE: May 2005

- Other (specify):
The plans of care is maintained by the Access Agency for clients who are not self-directed.
For self directed clients, the plan of care is maintained by the Department or the provider agency (for example: Home Health Agency, Day Health Center)

See attached QM Process for Self Directed (Appendix E page 59a)

- 3. The plan of care is the fundamental tool by which the State will ensure the health and welfare of the individuals served under this waiver. As such, it will be subject to periodic review and update. These reviews will take place to determine the appropriateness and adequacy of the services, and to ensure that the services furnished are consistent with the nature and severity of the individual's disability. The minimum schedule under which these reviews will occur is:

Every 3 months

Every 6 months

Every 12 months

Other (specify):

State regulations mandate that plans of care which include home health services be reviewed at least every 6 months. For clients not monitored by an independent Access Agency, the Department re-certifies the care plan every 6 months. Plans of care are reviewed every 6 months and are maintained by the Access Agency.

APPENDIX E-2

a. MEDICAID AGENCY APPROVAL

The following is a description of the process by which the plan of care is made subject to the approval of the Medicaid agency:

The Access Agency submits the initial plan of care to the Alternate Care Unit at the Department of Social Services for approval. The approval of the care plan is performed by Utilization Review Nurses (licensed by the State of Connecticut) and Social Workers (who meet Department qualification as a social worker) employed by the Department of Social Services, Alternate Care Unit. The Access Agency is responsible to update the care plan as needed and must contact the client and or provider of services monthly and perform a home visit at least every 6 months. Every month the Alternate Care Unit reviews an 8% random sample of the total number of client care plans due for reassessment for that month.

See attached Plan of Care Approval Process (Appendix E-2 page 60a)

b. STATUTORY REQUIREMENTS AND COPY OF PLAN OF CARE

1. The plan of care will contain, at a minimum, the type of services to be furnished, the amount, the frequency and duration of each service, and the type of provider to furnish each service.
2. A copy of the plan of care form to be utilized in this waiver is attached to this Appendix.

Included as part of the Assessment Tool provided in Appendix D-3

APPENDIX F - AUDIT TRAIL

a. DESCRIPTION OF PROCESS

1. As required by sections 1905(a) and 1902(a)(32) of the Social Security Act, payments will be made by the Medicaid agency directly to the providers of waiver and State plan services.

2. As required by section 1902(a)(27) of the Social Security Act, there will be a provider agreement between the Medicaid agency and each provider of services under the waiver.

3. Method of payments (check one):

Payments for all waiver and other State plan services will be made through an approved Medicaid Management Information System (MMIS).

Payments for some, but not all, waiver and State plan services will be made through an approved MMIS. A description of the process by which the State will maintain an audit trail for all State and Federal funds expended, and under which payments will be made to providers is attached to this Appendix.

Payment for waiver services will not be made through an approved MMIS. A description of the process by which payments are made is attached to this Appendix, with a description of the process by which the State will maintain an audit trail for all State and Federal funds expended.

Other (Describe in detail):

b. BILLING AND PROCESS AND RECORDS RETENTION

1. Attached is a description of the billing process. This includes a description of the mechanism in place to assure that all claims for payment of waiver services 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 approved plan of care;
 - c. In the case of supported employment, prevocational or educational services included as part of habilitation services, when the individual was eligible to receive the services and the services were not available to the individual through a program funded under section 602(16) or (17) of the Individuals with Disabilities Education Act (P.L. 94-142) or section 110 of the Rehabilitation Act of 1973.

Yes

No. These services are not included in this waiver.

2. The following is a description of all records maintained in connection with an audit trail. Check one:

All claims are processed through an approved MMIS.

MMIS is not used to process all claims. Attached is a description of records maintained with an indication of where they are to be found.

3. Records documenting the audit trail will be maintained by the Medicaid agency, the agency specified in Appendix A (if applicable), and providers of waiver services for a minimum period of 7 years.

c. PAYMENT ARRANGEMENTS

1. Check all that apply:

- The Medicaid agency will make payments directly to providers of waiver services.
- The Medicaid agency will pay providers through the same fiscal agent used in the rest of the Medicaid program.
- The Medicaid agency will pay providers through the use of a limited fiscal agent who functions only to pay waiver claims.
- Providers may *voluntarily* reassign their right to direct payments to the following governmental agencies (specify):

Providers who choose not to voluntarily reassign their right to direct payments will not be required to do so. Direct payments will be made using the following method:

2. Interagency agreement(s) reflecting the above arrangements are on file at the Medicaid agency.

APPENDIX G - FINANCIAL DOCUMENTATIONAPPENDIX G-1
COMPOSITE OVERVIEW
COST NEUTRALITY FORMULA

INSTRUCTIONS: Complete one copy of this Appendix for each level of care in the waiver. If there is more than one level (e.g. hospital and nursing facility), complete a Appendix reflecting the weighted average of each formula value and the total number of unduplicated individuals served.

LEVEL OF CARE: NF

YEAR	FACTOR D	FACTOR D'	FACTOR G	FACTOR G'
1	<u>8,016</u>	<u>4,304</u>	<u>49,620</u>	<u>3,317</u>
2	<u>8,326</u>	<u>5,164</u>	<u>51,000</u>	<u>3,447</u>
3	<u>8,356</u>	<u>5,964</u>	<u>53,000</u>	<u>3,577</u>
4	<u>8,395</u>	<u>6,824</u>	<u>55,000</u>	<u>3,707</u>
5	<u>8,411</u>	<u>7,624</u>	<u>57,000</u>	<u>3,837</u>

STATE: ConnecticutDATE: May 2005

FACTOR C: NUMBER OF UNDUPLICATED INDIVIDUALS SERVED

YEAR	UNDUPLICATED INDIVIDUALS
1	<u>13,250</u>
2	<u>14,000</u>
3	<u>15,000</u>
4	<u>16,000</u>
5	<u>16,750</u>

EXPLANATION OF FACTOR C:

Check one:

The State will make waiver services available to individuals in the target group up to the number indicated as factor C for the waiver year.

The State will make waiver services available to individuals in the target group up to the lesser of the number of individuals indicated as factor C for the waiver year, or the number authorized by the State legislature for that time period.

The State will inform CMS in writing of any limit which is less than factor C for that waiver year.

STATE: Connecticut

DATE: May 2005

APPENDIX G-2
METHODOLOGY FOR DERIVATION OF FORMULA VALUES

FACTOR D

LOC: NF

The July 25, 1994 final regulation defines Factor D as:

"The estimated annual average per capita Medicaid cost for home and community-based services for individuals in the waiver program."

The demonstration of Factor D estimates is on the following page.

APPENDIX G-2 - **SEE ATTACHMENT APPENDIX G-2 PAGES 67 THRU 71**

FACTOR D

LOC:

Demonstration of Factor D estimates:

Waiver Year 1 x 2__ 3__ 4__ 5__

Waiver Service Column A	#Undup. Recip. (users) Column B	Avg. # Annual Units/User Column C	Avg. Unit Cost Column D	Total Column E
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				
GRAND TOTAL (sum of Column E):				
TOTAL ESTIMATED UNDUPLICATED RECIPIENTS:				
FACTOR D (Divide total by number of recipients):				\$
AVERAGE LENGTH OF STAY:				

STATE: Connecticut

DATE: May 2005

APPENDIX G-3
METHODS USED TO EXCLUDE PAYMENTS FOR ROOM AND BOARD

The purpose of this Appendix is to demonstrate that Medicaid does not pay the cost of room and board furnished to an individual under the waiver.

- A. The following service(s), other than respite care*, are furnished in residential settings other than the natural home of the individual (e.g., foster homes, group homes, supervised living arrangements, assisted living facilities, personal care homes, or other types of congregate living arrangements). (Specify):

Adult Family Living
Assisted Living

*NOTE: FFP may be claimed for the cost of room and board when provided as part of respite care in a Medicaid certified NF or ICF/MR, or when it is provided in a foster home or community residential facility that meets State standards specified in this waiver.)

- B. The following service(s) are furnished in the home of a paid caregiver. (Specify):

Attached is an explanation of the method used by the State to exclude Medicaid payment for room and board.

A separate payment is made by the client to the foster care provider for room and board. Currently the Medicaid payment of \$37.27 per day is only for services provided in the foster home

APPENDIX G-4
METHODS USED TO MAKE PAYMENT FOR RENT AND FOOD EXPENSES OF AN UNRELATED
LIVE-IN CAREGIVER

Check one:

The State will not reimburse for the rent and food expenses of an unrelated live-in personal caregiver who lives with the individual(s) served on the waiver.

The State will reimburse for the additional costs of rent and food attributable to an unrelated live-in personal caregiver who lives in the home or residence of the individual served on the waiver. The service cost of the live-in personal caregiver and the costs attributable to rent and food are reflected separately in the computation of factor D (cost of waiver services) in Appendix G-2 of this waiver request.

Attached is an explanation of the method used by the State 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.

APPENDIX G-5

FACTOR D'

LOC: NF

NOTICE: On July 25, 1994, CMS published regulations which changed the definition of factor D'. The new definition is:

"The estimated annual average per capita Medicaid cost for all other services provided to individuals in the waiver program."

Include in Factor D' the following:

The cost of all State plan services (including home health, personal care and adult day health care) furnished in addition to waiver services WHILE THE INDIVIDUAL WAS ON THE WAIVER.

The cost of short-term institutionalization (hospitalization, NF, or ICF/MR) which began AFTER the person's first day of waiver services and ended BEFORE the end of the waiver year IF the person returned to the waiver.

Do NOT include the following in the calculation of Factor D':

If the person did NOT return to the waiver following institutionalization, do NOT include the costs of institutional care.

Do NOT include institutional costs incurred BEFORE the person is first served under the waiver in this waiver year.

If institutional respite care is provided as a service under this waiver, calculate its costs under Factor D. Do not duplicate these costs in your calculation of Factor D'.

APPENDIX G-5

FACTOR D' (cont.)

LOC: NF

Factor D' is computed as follows (check one):

Based on CMS Form 2082 (relevant pages attached).

Based on CMS Form 372 for years 3 & 4 of waiver
0140.90.R2, which serves a similar target population.

Based on a statistically valid sample of plans of care for individuals with the disease or condition specified in item 3 of this request.

Other (specify):

APPENDIX G-6

FACTOR G

LOC: NF

The July 25, 1994 final regulation defines Factor G as:

"The estimated annual average per capita Medicaid cost for hospital, NF, or ICF/MR care that would be incurred for individuals served in the waiver, were the waiver not granted."

Provide data ONLY for the level(s) of care indicated in item 2 of this waiver request.

Factor G is computed as follows:

- Based on institutional cost trends shown by CMS Form 2082 (relevant pages attached). Attached is an explanation of any adjustments made to these numbers.
- Based on trends shown by CMS Form 372 for years 3 & 4 of waiver # 0149.90.R2, which reflect costs for an institutionalized population at this LOC. Attached is an explanation of any adjustments made to these numbers.
- Based on actual case histories of individuals institutionalized with this disease or condition at this LOC. Documentation attached.
- Based on State DRGs for the disease(s) or condition(s) indicated in item 3 of this request, plus outlier days. Descriptions, computations, and an explanation of any adjustments are attached to this Appendix.
- Other (specify):

If institutional respite care is provided as a service under this waiver, calculate its costs under Factor D. Do not duplicate these costs in your calculation of Factor G.

APPENDIX G-7

FACTOR G'

LOC: NF

The July 25, 1994 final regulation defines Factor G' as:

"The estimated annual average per capita Medicaid costs for all services other than those included in Factor G for individuals served in the waiver, were the waiver not granted.

Include in Factor G' the following:

The cost of all State plan services furnished WHILE THE INDIVIDUAL WAS INSTITUTIONALIZED.

The cost of short-term hospitalization (furnished with the expectation that the person would return to the institution) which began AFTER the person's first day of institutional services.

If institutional respite care is provided as a service under this waiver, calculate its costs under Factor D. Do not duplicate these costs in your calculation of Factor G'.

APPENDIX G-7

FACTOR G'

LOC: NF

Factor G' is computed as follows (check one):

Based on CMS Form 2082 (relevant pages attached).

Based on CMS Form 372 for years 3 & 4 of waiver
0140.90.R2, which serves a similar target population.

Based on a statistically valid sample of plans of care for individuals with the disease or condition
specified in item 3 of this request.

Other (specify):

APPENDIX G-8

DEMONSTRATION OF COST NEUTRALITY

LOC: NF

YEAR 1

FACTOR D: 8,016 FACTOR G: 49,620FACTOR D': 4,304 FACTOR G': 3,317TOTAL: 12,320 ≤ TOTAL: 52,937

YEAR 2

FACTOR D: 8,326 FACTOR G: 51,000FACTOR D': 5,164 FACTOR G': 3,447TOTAL: 13,490 ≤ TOTAL: 54,447

YEAR 3

FACTOR D: 8,356 FACTOR G: 53,000FACTOR D': 5,964 FACTOR G': 3,577TOTAL: 14,320 ≤ TOTAL: 56,577

APPENDIX G-8

DEMONSTRATION OF COST NEUTRALITY (cont.)

LOC: NF

YEAR 4

FACTOR D:	<u>8,395</u>		FACTOR G:	<u>55,000</u>
FACTOR D':	<u>6,824</u>		FACTOR G':	<u>3,707</u>
TOTAL:	<u>15,219</u>	\leq	TOTAL:	<u>58,707</u>

YEAR 5

FACTOR D:	<u>8,411</u>		FACTOR G:	<u>57,000</u>
FACTOR D':	<u>7,624</u>		FACTOR G':	<u>3,837</u>
TOTAL:	<u>16,035</u>	\leq	TOTAL:	<u>60,837</u>

APPENDIX H

B. Fairfield County Pilot Project

The Fairfield County Pilot Project began in June of 1983. In order to administer the program the Department contracted with Connecticut Community Care, Inc. (CCCI), then the state's only licensed Coordination, Assessment and Monitoring (CAM) agency, to provide assessment and case management services to program participants. In that capacity, CCCI screened elderly and disabled patients in Fairfield County hospital's who were awaiting nursing home placement, assessed their medical and social needs, evaluated their potential for return to the community, and determine whether the necessary home care services could be purchased for less than the cost of nursing home placement. If placement in the community was appropriate, and accepted by the client, CCCI arranged for and monitored the delivery of services to the elderly client. The CAM periodically reviewed the client's plan of care and re-assessed the individual's needs to assure the plan continued to be both appropriate and cost-effective.

The Fairfield county waiver was evaluated in December, 1985 by the LaJolla Management Corporation under with the Department. That evaluation analyzed cost and utilization data and reviewed cost effectiveness and program administration. LaJolla concluded that the waiver was indeed cost effective. It nevertheless made a number of recommendations to the Department, including improved data collection. Many of these recommendations were implemented for the duration of the Fairfield County Waiver, and all of them were incorporated into the subsequent statewide PAS/CBS Program and waiver development. (A copy of the LaJolla report is available from the Department as well as copies of the Department's reports required by the Federal Government.)

Statewide Program Planning and Development

The early promise of the pilot project led the Department in 1984 to begin planning for statewide implementation of a Preadmission Screening Program. In 1985, with growing evidence of the need and potential for preadmission screening in Connecticut, the Connecticut General Assembly, in close consultation with the Department, enacted Public Act 85-557, and Act Concerning a Statewide Community Based Services Program.

This act (and subsequent amendments in Public Acts 86-374 and 87-363) requires that the Commissioner of Income Maintenance establish a statewide Nursing Home Preadmission Screening and Community Based Services (PAS/CBS) Program for people sixty-five (65) years or older who are Medicaid eligible or would become Medicaid eligible upon or within one hundred eight (180) days of admission to a nursing home. The Act mandates that the program serve not only those individuals who are hospitalized and waiting for nursing home placement.

Section D: IMPACT OF THE WAIVER ON THE HEALTH AND WELFARE OF WAIVER RECEIPTS

The State of Connecticut has several systems in place to affirm that all provider standards and welfare assurances mandated by the federal home and community based services waiver is met.

PROVIDER STANDARDS—LICENSED AGENCIES

The Department of Social Services (DSS) monitors compliance in conjunction with the Department of Public Health (DPH). The Community Nursing and Home Health Division within the DPH monitors and annually inspects all licensed home health agencies including those providing services to CHCPE clients. Serious issues of non-compliance with the regulations are brought to the attention of staff at DSS; in addition, DSS shares with DPH referrals that relate to non-compliance or other matters by licensed home health agencies.

Referrals to DSS concerning client health and safety are expedited using a protocol developed by the Department's Quality Assurance Unit.

During this reporting period the Quality Assurance Unit received from SFY 2001 - Present One Hundred & Twenty-Two referrals that were potentially client related health and safety issues. All were monitored collaboratively between the Quality Assurance team and the Access

Agency until satisfactory resolution was obtained. Access Agencies continue to be effective in identifying those situations, which have the potential for being problematic.

NON—LICENSED SERVICES

The Department of Social Services has established standards for all services and the primary responsibilities for monitoring provider compliance rests with the Access Agencies. The specific standards are outlined in the CHCP Regulations. Each Access Agency must document that all subcontractors meet the Department's standards. The Access Agencies must maintain written confirmation that the provider has:

Received and reviewed the Department's provider participation standards.

Provide assurance to the Access Agency that it has the capacity to meet them Signed and submitted to the Access Agency a statement verifying this understanding and capacity.

In addition, the Quality Assurance team has a protocol that is used when visits are made to these providers on a quarterly basis. (See attached provider visit worksheet)

ACCESS AGENCY RESPONSIBILITIES

Contract language states that Access Agencies shall provide a copy of the Department's Bill of Rights and responsibilities to all clients at the time of enrollment and shall develop a grievance procedure for all clients.

The contract further states that arrangements shall be in place for individuals who are non-English speaking, hearing impaired, or who have other special needs.

In addition, the contractor shall meet the following outcome measures: that 80% of clients for whom a plan of care is established shall remain in the community for 18 months after they have been enrolled in the program.

Regulations also require that the Access Agencies have in place a Quality Assurance Plan, subject to Department approval, which will include quarterly reviews on client records by health professionals and an annual client satisfaction survey.

ADDITIONAL QUALITY ASSURANCE ACTIVITIES

(See attached the Connecticut Home Care Program for Elders Quality Assurance and Enhancement Plan.)

Quality Enhancement System

The goals of the Connecticut Home Care Program for Elders are to offer those persons who are functionally and financially eligible and at risk of institutionalization, safe and cost effective home care services to enable them to remain in their homes. The Department administers this program through contracts with Access Agencies. Access Agencies conduct comprehensive assessments of applicants, develop plans of care, arrange provision of services by home care agencies to clients, monitor and coordinate these services, and provide care management services.

Our Quality Enhancement system has 4 teams to provide ongoing monitoring of program functions:

- The Quality Review Team conducts quarterly on-site audits of access agency records and visits provider agencies and clients;
- The Peer Review team reviews the process, efficiency, and quality of operations by a quarterly client record review process;
- The Report Team reviews Access Agency Reports to identify any trends, issues and questions on the reported information. This team monitors the timeliness of information received and provides any necessary follow-up with the Access Agencies; and
- The Training Team visits home health agencies, community service providers, nursing facilities and hospitals and provides information on OBRA requirements and the CT Home Care Program.

The Quality Assurance Team in Central Office has developed and implemented a process to provide additional program monitoring. Office staff review annual reassessments on existing clients and identify any "outliers", care plans that are outside of established norms in terms of cost and utilization of services. Quality assurance staff review these individual plans of care, follow up with clinical staff and access agency staff if additional information is needed and a determination is made as follows:

- Appropriate - the care manager's activities in developing, implementing, and monitoring the client plan of care are judged to be meeting the client's needs;
- Over use - the care manager is judged to have over utilized services or placed a more skilled service than is indicated by the client's actual needs;
- Under use - the care manager is judged to have under utilized services or placed a less skilled service than is indicated by the client's actual needs; and
- Information inadequate - the quality assurance reviewer is unable to judge the adequacy of services based on the documentation reviewed; additional follow up is needed.

Structure Indicators

Our quality enhancement system provides monitoring to ensure excellence and efficiency of program operations. The system is designed to identify the unique needs of the population we serve, and to evolve with the program as we continue to meet these needs.

Process Indicators

Our system is designed to promote an individual's privacy and dignity by having mechanisms in place to promote the confidentiality of individuals. We ensure that client - centered goals are developed and that processes are in place to promote quality and efficiency in the delivery of program services. Our monitoring ensures that the home care program allows for a negotiated client driven system.

Outcome Indicators

Our system ensures that issues which affect the client's "quality of life" are acknowledged by the home care program. Our focus is on the impact that services have on individual outcomes:

- Are clients safe in their homes?
- Are clients free from exploitation and abuse?
- Have they achieved or maintained normalcy in their lives?
- Are clients' tasks getting done?
- Has clients' quality of life improved?
- Are clients satisfied with their services?
- Has physical functioning improved, been maintained, or was a decline expected?

Implementation of Structure Indicators

Onsite quarterly reviews of contracted access agencies includes:

- An administrative review of the Access Agency's policies and procedures to ensure contract and regulation compliance;
- A review of the Access Agency's subcontracted provider procedures; and
- Monitoring of Access Agency compliance with reporting requirements.

Implementation of Process Indicators

These are conducted in order to oversee the process of implementation:

- An ongoing peer review process, conducted quarterly, on client records in the field offices;
- A chart review focusing on the total plan of care and service utilization;
- A quarterly review of Access Agency required reports to DSS;
- Ongoing review of the Alternate Care Unit processes in order to increase efficiency and streamline paperwork;
- Monitoring of data input into EMS for accuracy, to decrease billing errors;
- Bank matches are conducted by the Fraud and Recovery Unit on State-funded clients;
- The report team monitors and reviews access agency data submitted to the Central Office. These reports are monitored for timeliness and accuracy of information as required by the Department. Reminders of outstanding reports are sent promptly to access agencies;
- The peer review process is ongoing. This process is governed by the peer review team. The purpose of this process is to ensure the uniformity of procedures/processes across the state. This process also functions as an educational tool for staff by identifying omissions and errors in record keeping; and
- State funded clients discontinued from the program because of permanent placement in a nursing facility or death are tracked by Liaisons and names forwarded to the Recovery Unit.

Continuing Education/Improvement

- Ongoing regional meetings with Protective Services regional staff, Access Agency staff and ACU staff;
- Conduct in - services, provide community presentations on the Home Care Program, and maintain the units' information and resource line;
- Program staff is encouraged to take advantage of state offered training programs in both technical skills and quality of life issues; and
- The training team takes advantage of all requests to provide in-service training and presentations to community agencies, organizations, nursing facilities and hospitals statewide. In addition, when training needs are identified or program changes are made, the Department offers training as appropriate. During SFY 2004, twenty-two (22) in-service sessions were

presented throughout the state.

Implementation of Outcome Indicators

Home visits are conducted to assess "quality of life" outcomes for clients. On site visits to contracted social service providers are conducted to ensure compliance with regulations and program guidelines.

To provide ongoing monitoring of the quality and appropriateness of services provided to clients through the home care program, existing procedures have been expanded and new procedures implemented. As part of the client centered process, a complaint log for non-health/safety issues is maintained. Twenty-Five (25) complaints were logged during this fiscal year and each has been resolved.

A Health and Safety Log is maintained and monitored by the quality assurance staff. Any issues concerning client safety or well being are reported in writing to QA staff. Specific client cases which raise questions on client health and safety are reported immediately to Protective Services; QA staff investigate the basis of the complaint/referral submitted by any source, research the client's status at the time of the referral (medical, social, environmental) and monitor the situation until satisfactory resolution is obtained. QA staff makes a home visit to the client if it is determined that it is warranted.

The Department of Social Services monitors provider compliance in conjunction with the Department of Public Health. The Community Nursing and Home Health Division within DPH conducts annual licensure inspections of all licensed home health agencies. Serious issues of regulatory non-compliance by a licensed agency, which could jeopardize a client's health or safety, are brought to an expeditious hearing; any recommended action is immediately instituted. The Department is informed and kept apprised of such actions.

Client satisfaction is considered by the Department of Social Services to be a critical measure of the effectiveness of the Connecticut Home Care Program for Elders. Accordingly, eight client satisfaction surveys were done between SFY 2001 - Present to assess the program's impact on the participant's life and their degree of satisfaction with the services they receive (Please see attached client satisfaction surveys.)

Goals for New Fiscal Year

- To continue to conduct client satisfaction surveys annually, as our Home Care Program evolves to include choices such as Assisted Living services, and to continue to obtain a measure of how our services affect the individual.
- To continue to expand the self directed care component of the Home Care Program by identifying appropriate clients.
- To improve the quality and accuracy of ad hoc program reporting with the implementation of our Micro Systems Unit.

QUALITY ENHANCEMENT PLAN

A) Quarterly review of Access agencies:

- 1) a review of client records by the Quality Review Team, to ensure Access Agency documentation of compliance with program regulations and procedures.
- 2) a review of the Access Agency's policies and procedures to ensure contract and regulation compliance.

B) Quarterly onsite reviews of subcontractors

During the review of Access Agency files, providers are randomly selected by the review team. (The Department of Health licenses and monitors home care agencies, therefore it was decided to focus subcontractor reviews on social service providers) ACU staff set up an appointment with agency owner/supervisor for a scheduled visit. Information is collected through dialog and direct observation, on the services being provided to an individual client. Any concerns are addressed with the client, the provider, and the Access Agency. (note: draft form currently used will be modified as needed to identify and formulate plan of correction as subcontractor reviews evolve)

C) Home visits to clients:

To collect information directly from individuals served by the home care program. During Access Agency review of client records, clients are selected at random for an in-home visit. Clients are contacted and consent obtained from individual/family prior to visit. This visit is to ensure that the plan of care is meeting the health care needs of the client and that the client and/or family has input into the plan of care. The reviewer focuses on client-centered outcomes, gathers information regarding specific goals, and the client's perception of the quality of services provided.

The outcome indicators, which the reviewer focuses on, are client overall functioning - noting any changes in ADL/IADL status, client safety, client's health, and client's satisfaction with the program. Note: the draft form currently in use will be modified as our quality enhancement plan evolves.

D) Peer Review

A review of client records is conducted quarterly. Quality Assurance staff participates in a chart review of clients whose names have been randomly selected. The purpose of this process is to identify Access Agency and Alternate Care staff processing errors. Our plan of correction is to provide education to Alternate Care staff and in-service to Access Agencies to prevent future errors; our goal is to enhance provision of services to CHCP clients..

E) Complaint Log

Documentation of client-generated problems (other than those of client health/safety) regarding all client services. For SFY 2001 - Present, 108 complaints have been received: all have been resolved. QA staff are responsible for gathering information from client, Access Agency, and provider, and monitoring complaint for resolution.

F) Report Team

This team was established to review and monitor Access Agency compliance for reporting data specified by the RFP. Meetings are held bi-monthly to review Access Agency reports for compliance, identification of trends, and noting outliers. Our goal is to achieve an effective flow of information from the Access Agencies which will result in improvement of services delivered to the population served.

G) Client Satisfaction Surveys

To implement client satisfaction surveys, via mass mailings, to allow individuals and families a means to provide feedback regarding the quality of the services. The gathering of this information will allow assessment of the impact that services has had on the quality of life of the individual served. The data obtained will facilitate program evaluation and enable identification of trends to promote continuous quality improvement.

H) Health and Safety Log

QA staff maintain a log of reported concerns regarding the health and safety of clients. QA staff investigate the basis of the complaint/referral and consult with the Unit Manager. A determination is made if the access agency is pursuing corrective action. QA staff request progress reports and monitor the case until satisfactory resolution of the complaint is achieved. QA staff consult with the Unit Manager before making any final recommendations.

I) Outliers audit

Field office clinical staff receives checklists from the Access Agencies on each client annually. This checklist states the need for continuing care management or indicate that the client may be served on the self-directed portion of our program. Field office clinical staff request a current care plan on 8 to 10% of these clients. Care plans are checked for utilization of services.

From this 10%, those with care plan costs that are below 20% or above 80% of care plan cost caps are reviewed and assessed by clinical staff for appropriateness of care and under or over utilization of services.

J) MO3 Discontinuances

Liaisons forward to the Fraud & Recovery Division information on state-funded clients that die or become permanently placed in a nursing facility. A 1547 is completed on each case and along with a copy of the client's most recent WIF is sent to the Fraud & Recovery Division. Each liaison where tracking is maintained sends a list of names of these identified clients to the ACU quality assurance staff.

K) State Funded Bank Match

Central Office Fraud & Recovery completes bank matches on state funded clients. Any CHCP clients with a balance exceeding \$1600 are sent to us on a printout and asset page of their most current WIF is reviewed and compared to identify bank accounts for exceeding program asset limitation. If it is determined that client assets exceed program limits, a letter is sent to the client requesting a response and documentation within 10 days if the client disagrees. Discontinuance procedures from CHCP will begin if client does not make contact within this time.

Rev 2/2002

Provider Visits/Quality Assurance

Contact the agency's owner or supervisor to set up an appointment. Let them know that this will be an informal visit, which is part of the Ct.Home Care for Elders quality assurance activities.

1. What services does this agency provide?

2. Does this agency send service reports to the access agency? How often are they sent? _____

_____ Ask
for a sample copy of the provider report sent to the access agency.

3. Does this agency keep a record or file on individual clients?

4. Does the agency have a method for reporting client changes or problems/issues to the access agency and client's care manager?

5. Is there staff training for new employees? Does it include confidentiality, client right to privacy, to identify and report client changes in health risk factors, or general problems? _____

6. Is there any type of background check/verification of references done on applicants for employment?

7. How do your employees report the time spent in client's home?

Is the client required to sign a time sheet or work order? _____

8. How are call-ins and schedule changes handled? _____

Ask for any written information about the agency, pamphlets, etc.

General comments about the agency _____

Reviewer _____ Date __/__/__

Client Visits/Quality Assurance

Client name: _____

Address: _____

Client visits follow the quarterly record reviews of access agency records. If possible, a visit to the social service provider agency servicing this client should also be done. The home visit should be conducted as informally as possible, in the context of normal conversation.

Client specific goals:

1. Do you feel that the quality of your life has improved since receiving services through CHCPE? yes no
2. Did you have choices and input into your plan of care? yes no
3. Do the services you receive help your life to run smoother? yes no
4. Do you feel safe and secure in your home? yes no
5. What do you do if your caregivers don't show? yes no

To reviewer: Does client's environment appear safe? Are adequate safety measures in place – locks on doors, telephone accessibility, etc?

Comments: _____

Service specific goals:

1. Are you satisfied with the help you are receiving? yes no
2. Is your helper reliable? Are you notified if your worker is late or out sick? yes no
3. Have staff been respectful and caring? yes no

4. Do you know which duties your helpers are supposed to do? yes no

To reviewer: Review the plan of care with the client to determine if the services are being provided as ordered. Is the client's health and safety at risk if staff doesn't show?

Program quality:

1. Do you know who your care manager is and how to contact him/her? yes no

2. Has anyone explained the what actions you can take if you have a problem or complaint? (is client aware of grievance? procedure?) yes no

3. Would you recommend the home care program to others? yes no

4. If you could change or improve any aspect of the program what would it be? _____

5. How did you learn about the CT Home Care program? _____

Reviewer _____

Date __/__/__

Client visits.doc 1/2002