

1915(i) State plan Home and Community-Based Services Administration and Operation

The State implements the optional 1915(i) State plan Home and Community-Based Services (HCBS) benefit for elderly and disabled individuals as set forth below.

1. Services. *(Specify service title(s) for the HCBS listed in Attachment 4.19-B that the State plans to cover):*

Adult Day Health, Care Management, Homemaker, Personal Care Assistant, Respite, Assisted Living, Assistive Technology, Chore Services, Companion, Environmental Accessibility Adaptations, Home Delivered Meals, Mental Health Counseling, Personal Emergency Response Systems, Transportation

2. Statewideness. *(Select one):*

<input checked="" type="radio"/>	The State implements the 1915(i) State plan HCBS benefit statewide, per §1902(a)(1) of the Act.
<input type="radio"/>	The State implements this benefit without regard to the statewideness requirements in §1902(a)(1) of the Act. State plan HCBS will only be available to individuals who reside in the following geographic areas or political subdivisions of the State. <i>(Specify the areas to which this option applies):</i>

3 State Medicaid Agency (SMA) Line of Authority for Operating the State plan HCBS Benefit. *(Select one):*

<input checked="" type="radio"/>	The State plan HCBS benefit is operated by the SMA. Specify the SMA division/unit that has line authority for the operation of the program <i>(select one):</i>	
<input checked="" type="radio"/>	The Medical Assistance Unit(<i>Alternate Care Unit</i>):	
<input type="radio"/>	Another division/unit within the SMA that is separate from the Medical Assistance Unit <i>(name of division/unit)</i> <i>This includes administrations/divisions under the umbrella agency that have been identified as the Single State Medicaid Agency.</i>	
<input type="radio"/>	The State plan HCBS benefit is operated by <i>(name of agency)</i>	
separate agency of the State that is not a division/unit of the Medicaid agency. In accordance with 42 CFR §431.10, the Medicaid agency exercises administrative discretion in the administration and supervision of the State plan HCBS benefit and issues policies, rules and regulations related to the State plan HCBS benefit. The interagency agreement or memorandum of understanding that sets forth the authority and arrangements for this delegation of authority is available through the Medicaid agency to CMS upon request.		

4. Distribution of State plan HCBS Operational and Administrative Functions.

(By checking this box the State assures that): When the Medicaid agency does not directly conduct an administrative function, it supervises the performance of the function and establishes and/or approves policies that affect the function. All functions not performed directly by the Medicaid agency must be delegated in writing and monitored by the Medicaid Agency. When a function is performed by an agency/entity other than the Medicaid agency, the agency/entity performing that function does not substitute its own judgment for that of the Medicaid agency with respect to the application of policies, rules and regulations. Furthermore, the Medicaid Agency assures that it maintains accountability for the performance of any operational, contractual, or local regional entities. In the following table, specify the entity or entities that have responsibility for conducting each of the operational and administrative functions listed (check each that applies):

(Check all agencies and/or entities that perform each function):

Function	Medicaid Agency	Other State Operating Agency	Contracted Entity	Local Non-State Entity
1 Individual State plan HCBS enrollment	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2 State plan HCBS enrollment managed against approved limits, if any	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3 Eligibility evaluation	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
4 Review of participant service plans	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
5 Prior authorization of State plan HCBS	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6 Utilization management	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7 Qualified provider enrollment	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
8 Execution of Medicaid provider agreement	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9 Establishment of a consistent rate methodology for each State plan HCBS	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10 Rules, policies, procedures, and information development governing the State plan HCBS benefit	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11 Quality assurance and quality improvement activities	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>

(Specify, as numbered above, the agencies/entities (other than the SMA) that perform each function):

Access Agencies provide case management and Fiscal Intermediary functions

Target Population: Persons age 65 and older who require assistance with one or two critical needs. Critical needs are bathing, dressing, toileting, transferring, eating/feeding, meal preparation and medication administration.

(By checking the following boxes the State assures that):

5. **Conflict of Interest Standards.** The State assures the independence of persons performing evaluations, assessments, and plans of care. Written conflict of interest standards ensure, at a minimum, that persons performing these functions are not:
- related by blood or marriage to the individual, or any paid caregiver of the individual
 - financially responsible for the individual
 - empowered to make financial or health-related decisions on behalf of the individual
 - providers of State plan HCBS for the individual, or those who have interest in or are employed by a provider of State plan HCBS; except, at the option of the State, when providers are given responsibility to perform assessments and plans of care because such individuals are the only willing and qualified provider in a geographic area, and the State devises conflict of interest protections. *(If the State chooses this option, specify the conflict of interest protections the State will implement):*

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6. **Fair Hearings and Appeals.** The State assures that individuals have opportunities for fair hearings and appeals in accordance with 42 CFR 431 Subpart E.
7. **No FFP for Room and Board.** The State has methodology to prevent claims for Federal financial participation for room and board in State plan HCBS.
8. **Non-duplication of services.** State plan HCBS will not be provided to an individual at the same time as another service that is the same in nature and scope regardless of source, including Federal, State, local, and private entities. For habilitation services, the State includes within the record of each individual an explanation that these services do not include special education and related services defined in the Individuals with Disabilities Improvement Act of 2004 that otherwise are available to the individual through a local education agency, or vocational rehabilitation services that otherwise are available to the individual through a program funded under §110 of the Rehabilitation Act of 1973.

Number Served

1. Projected Number of Unduplicated Individuals To Be Served Annually.

(Specify for year one. Years 2-5 optional):

Annual Period	From	To	Projected Number of Participants
Year 1	7/1/2011	06/30/2012	350
Year 2	7/1/2012	06/30/2013	400
Year 3	7/1/2013	06/30/2014	425
Year 4	07/01/14	06/30/2015	450
Year 5	07/01/15	06/30/2016	500

2. Annual Reporting. *(By checking this box the State agrees to):* annually report the actual number of unduplicated individuals served and the estimated number of individuals for the following year.

3. Optional Annual Limit on Number Served. *(Select one):*

<input checked="" type="radio"/>	The State does not limit the number of individuals served during the year or at any one time. Skip to next section.																																										
<input type="radio"/>	The State chooses to limit the number of <i>(check each that applies):</i>																																										
<input type="checkbox"/>	Unduplicated individuals served during the year. <i>(Specify in column A below):</i>																																										
<input type="checkbox"/>	Individuals served at any one time (“slots”). <i>(Specify in column B below):</i>																																										
	<table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 15%;"></th> <th style="width: 15%;">Annual Period</th> <th style="width: 15%;">From</th> <th style="width: 15%;">To</th> <th style="width: 20%;">A</th> <th style="width: 20%;">B</th> </tr> <tr> <td></td> <td></td> <td></td> <td></td> <td style="text-align: center;">Maximum Number served annually <i>(Specify):</i></td> <td style="text-align: center;">Maximum Number served at any one time <i>(Specify):</i></td> </tr> </thead> <tbody> <tr> <td></td> <td>Year 1</td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td></td> <td>Year 2</td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td></td> <td>Year 3</td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td></td> <td>Year 4</td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td></td> <td>Year 5</td> <td></td> <td></td> <td></td> <td></td> </tr> </tbody> </table>		Annual Period	From	To	A	B					Maximum Number served annually <i>(Specify):</i>	Maximum Number served at any one time <i>(Specify):</i>		Year 1						Year 2						Year 3						Year 4						Year 5				
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	Year 1																																										
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<input type="checkbox"/>	The State chooses to further schedule limits within the above annual period(s). <i>(Specify):</i>																																										

4. Waiting List. *(Select one only if the State has chosen to implement an optional annual limit on the number served):*

<input checked="" type="radio"/>	The State will not maintain a waiting list.
<input type="radio"/>	The State will maintain a single list for entrance to the State plan HCBS benefit. State-established selection policies: are based on objective criteria; meet requirements of the Americans with Disabilities Act and all Medicaid regulations; and ensure that only individuals enrolled in the State plan HCBS benefit receive State plan HCBS once they leave/are taken off of the waiting list.

Financial Eligibility

1. **Income Limits.** *(By checking this box the State assures that):* Individuals receiving State plan HCBS are in eligibility group covered under the State's Medicaid State plan, and who have income that does not exceed 150% of the Federal Poverty Level (FPL). Individuals with incomes up to 150% of the FPL who are only eligible for Medicaid because they are receiving 1915(c) waiver services may be eligible to receive services under 1915(i) provided they meet all other requirements of the 1915(i) State plan option. The State has a process in place that identifies individuals who have income that does not exceed 150% of the FPL.

2. **Medically Needy.** *(Select one):*

<input checked="" type="radio"/>	The State does not provide State plan HCBS to the medically needy.
<input type="radio"/>	The State provides State plan HCBS to the medically needy <i>(select one):</i>
<input type="radio"/>	The State elects to disregard the requirements at section 1902(a)(10)(C)(i)(III) of the Social Security Act relating to community income and resource rules for the medically needy.
<input type="radio"/>	The State does not elect to disregard the requirements at section 1902(a)(10)(C)(i)(III).

Needs-Based Evaluation/Reevaluation

1. **Responsibility for Performing Evaluations / Reevaluations.** Eligibility for the State plan HCBS benefit must be determined through an independent evaluation of each individual). Independent evaluations/reevaluations to determine whether applicants are eligible for the State plan HCBS benefit are performed *(select one):*

<input type="radio"/>	Directly by the Medicaid agency
<input checked="" type="radio"/>	By Other <i>(specify State agency or entity with contract with the State Medicaid agency):</i>
	Contracted entity-access Agency Case managers

2. **Qualifications of Individuals Performing Evaluation/Reevaluation.** The independent evaluation is performed by an agent that is independent and qualified. There are qualifications (that are reasonably related to performing evaluations) for the individual responsible for evaluation/reevaluation of needs-based eligibility for State plan HCBS. *(Specify qualifications):*

The care manager who conducts the assessments, develops care plans and provides ongoing monitoring shall be either a registered nurse licensed in the state where care management services are provided or a social services worker who is a graduate of an accredited four-year college or university. The nurse or social services worker shall have a minimum of two years of experience in health care or human services. A bachelor's degree in nursing, health, social work, gerontology or a related field may be substituted for one year of experience.

Care managers shall have the following additional qualifications:

demonstrated interviewing skills which include the professional judgment to probe as necessary to uncover underlying concerns of the applicants; demonstrated ability to establish and maintain empathic relationships; experience in conducting social and health assessments; Knowledge of human behavior, family/caregiver dynamics, human development and disabilities; awareness of community resources and services; the ability to understand and apply complex service reimbursement issues; and the ability to evaluate, negotiate and plan for the costs of care options.

3. **Process for Performing Evaluation/Reevaluation.** Describe the process for evaluating whether individuals meet the needs-based State plan HCBS eligibility criteria and any instrument(s) used to make this determination. If the reevaluation process differs from the evaluation process, describe the differences:

Once the referral and initial level of care review is done by Alternate Care Unit staff and the client appears to meet functional and financial eligibility criteria for the 1915i, the referral is sent to an Access Agency for the initial evaluation. The Care Manager meets with the client and his or her representative and explains the program prior to initiating the assessment. If the client consents, the care manager initiates the assessment. The uniform assessment instrument (W-1507A) evaluates 7 domains: health, function, psychosocial, environment, cognition, support system and finances. Risk indicators are discussed with the client and/or their representative.

Based on the assessment, unmet needs are identified and service options are discussed with the participant and their representative. Options regarding service providers are presented for the client to choose their services and providers.

The assessment is utilized to develop client centered goals and plans are developed that assist the client in achieving those goals. The Department as part of its audit process, reviews records to ensure that client goals are identified and reviewed at least annually.

Once the plan is developed, the costs of the plan are calculated. The client and/or their representative are asked to sign off on the plan indicating their approval and/or agreement with it. The final plan of care is submitted to the department for utilization review and to ensure that needs and goals are addressed by the plan.

The Total Plan of Care is coordinated by the care manager and includes not only waiver and state plan services but also in-kind, Medicare covered, other insurance covered services and other federal funded such as Older American's Act programs.

The reevaluation utilizes the same level of care tool annually.

State: Connecticut
TN: 12-001
Effective: 02/01/12

§1915(i) HCBS State plan Services

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Approved:

Supersedes: NEW

11-13-2008

4. **Needs-based HCBS Eligibility Criteria.** *(By checking this box the State assures that):* Needs-based criteria are used to evaluate and reevaluate whether an individual is eligible for State plan HCBS.

The criteria take into account the individual's support needs, and may include other risk factors: *(Specify the needs-based criteria):*

In order to qualify for Home and community based services under the 1915i, the applicant must be a minimum of 65 years of age and require assistance with 1 or 2 critical needs. Critical needs are as follows: bathing, dressing, toileting, eating/feeding, transferring, meal preparation, medication administration. Persons with needs beyond 2 critical needs will be served under a 1915c waiver

5. **Needs-based Institutional and Waiver Criteria.** *(By checking this box the State assures that):* There are needs-based criteria for receipt of institutional services and participation in certain waivers that are more stringent than the criteria above for receipt of State plan HCBS. If the State has revised institutional level of care to reflect more stringent needs-based criteria, individuals receiving institutional services and participating in certain waivers on the date that more stringent criteria become effective are exempt from the new criteria until such time as they no longer require that level of care. *(Complete chart below to summarize the needs-based criteria for State Plan HCBS and corresponding more-stringent criteria for each of the following institutions):*

Needs-Based/Level of Care (LOC) Criteria

State plan HCBS needs-based eligibility criteria	NF (& NF LOC waivers)	ICF/MR (& ICF/MR LOC waivers)	Applicable Hospital* LOC (& Hospital LOC waivers)
Requiring assistance with 1-2 critical needs	Requiring assistance with 3 or more critical needs or hands on assistance with 2 Activities of Daily Living	Having a diagnosis of an intellectual disability as evidenced by testing and requiring substantial assistance with ADLs on a daily basis	Each chronic disease client shall require services that can be provided safely and effectively at a chronic disease hospital level, shall be ordered by a physician and documented in the client's medical record, and shall include at least a daily physician visit and

			assessment or the 24-hour availability of medical services and equipment available only in a hospital setting; and The client's medical condition and treatment needs are such that no effective, safe, less costly alternative placement is available to the client.
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*Long Term Care/Chronic Care Hospital

(By checking the following boxes the State assures that):

6. **Reevaluation Schedule.** Needs-based eligibility reevaluations are conducted at least every twelve months.
7. **Adjustment Authority.** The State will notify CMS and the public at least 60 days before exercising the option to modify needs-based eligibility criteria in accord with 1915(i)(1)(D)(ii).
8. **Residence in home or community.** The State plan HCBS benefit will be furnished to individuals who reside in their home or in the community, not in an institution. The State attests that each individual receiving State plan HCBS:
 - (i) Resides in a home or apartment not owned, leased or controlled by a provider of any health-related treatment or support services; or
 - (ii) Resides in a home or apartment that is owned, leased or controlled by a provider of one or more health-related treatment or support services, if such residence meets standards for community living as defined by the State. *(If applicable, specify any residential settings, other than an individual's home or apartment, in which residents will be furnished State plan HCBS. Describe the standards for community living that optimize participant independence and community integration, promote initiative and choice in daily living, and facilitate full access to community services):*

Person-Centered Planning & Service Delivery

(By checking the following boxes the State assures that):

1. There is an independent assessment of individuals determined to be eligible for the State plan HCBS benefit. The assessment is based on:
 - An objective face-to-face assessment with a person-centered process by an agent that is independent and qualified;
 - Consultation with the individual and if applicable, the individual's authorized representative, and includes the opportunity for the individual to identify other persons to be consulted, such as, but not limited to, the individual's spouse, family, guardian, and treating and consulting health and support professionals caring for the individual;
 - An examination of the individual's relevant history, including findings from the independent evaluation of eligibility, medical records, an objective evaluation of functional ability, and any other records or information needed to develop the plan of care;
 - An examination of the individual's physical and mental health care and support needs, strengths and preferences, available service and housing options, and when unpaid caregivers will be relied upon to implement the plan of care, a caregiver assessment;
 - If the State offers individuals the option to self-direct State plan HCBS, an evaluation of the ability of the individual (with and without supports), or the individual's representative, to exercise budget and/or employer authority; and
 - A determination of need for (and, if applicable, determination that service-specific additional needs-based criteria are met for), at least one State plan home and community-based service before an individual is enrolled into the State plan HCBS benefit.
2. Based on the independent assessment, the individualized plan of care:
 - Is developed with a person-centered process in consultation with the individual, and others at the option of the individual such as the individual's spouse, family, guardian, and treating and consulting health care and support professionals. The person-centered planning process must identify the individual's physical and mental health support needs, strengths and preferences, and desired outcomes;
 - Takes into account the extent of, and need for, any family or other supports for the individual, and neither duplicates, nor compels, natural supports;
 - Prevents the provision of unnecessary or inappropriate care;
 - Identifies the State plan HCBS that the individual is assessed to need;
 - Includes any State plan HCBS in which the individual has the option to self-direct the purchase or control ;
 - Is guided by best practices and research on effective strategies for improved health and quality of life outcomes; and
 - Is reviewed at least every 12 months and as needed when there is significant change in the individual's circumstances.
3. **Responsibility for Face-to-Face Assessment of an Individual's Support Needs and Capabilities.**

There are educational/professional qualifications (that are reasonably related to performing assessments) of the individuals who will be responsible for conducting the independent assessment, including specific training in assessment of individuals with physical and mental needs for HCBS. *(Specify qualifications):*

The care manager who conducts the assessments, develops care plans and provides ongoing monitoring shall be either a registered nurse licensed in the state where care management services are provided or a social services worker who is a graduate of an

accredited four-year college or university. The nurse or social services worker shall have a minimum of two years of experience in health care or human services. A bachelor's degree in nursing, health, social work, gerontology or a related field may be substituted for one year of experience.

Care managers shall have the following additional qualifications:

demonstrated interviewing skills which include the professional judgment to probe as necessary to uncover underlying concerns of the applicants; demonstrated ability to establish and maintain empathic relationships; experience in conducting social and health assessments;

knowledge of human behavior, family/caregiver dynamics, human development and disabilities; awareness of community resources and services; the ability to understand and apply complex service reimbursement issues; and the ability to evaluate, negotiate and plan for the costs of care options.

The registered nurse shall hold a license to practice nursing in the State of CT. Care Managers are encouraged but not required to be certified as a long term care manager.

4. **Responsibility for Plan of Care Development.** There are qualifications (that are reasonably related to developing plans of care) for persons responsible for the development of the individualized, person-centered plan of care. *(Specify qualifications):*

Same as number 3.

5. **Supporting the Participant in Plan of Care Development.** Supports and information are made available to the participant (and/or the additional parties specified, as appropriate) to direct and be actively engaged in the plan of care development process. *(Specify: (a) the supports and information made available, and (b) the participant's authority to determine who is included in the process):*

Once the referral is processed by Alternate Care Unit staff and the client appears to meet functional and financial eligibility criteria for state plan Home and Community Based Services, the referral is sent to an Access Agency for the initial evaluation. The Care Manager makes an appointment to meet with the client and his or her representative if the client chooses to have someone else present. Most often, that is identified at the time of referral. The care manager explains the program prior to initiating the assessment. If the client consents, the care manager initiates the assessment. The uniform assessment instrument (W-1507A) evaluates 7 domains: health, function, psychosocial, environment, cognition, support system and finances.

Based on the assessment, unmet needs are identified and service options are discussed with the participant and their representative. Options regarding service providers are presented for the client to choose their services and providers.

The assessment is utilized to develop client centered goals and plans are developed that assist the client in achieving those goals.

6. **Informed Choice of Providers.** *(Describe how participants are assisted in obtaining information about and selecting from among qualified providers of the 1915(i) services in the plan of care):*

During the development of the Total Plan of Care, participants will select providers from a list prepared by the Access Agency. The Access Agencies maintain the list of service providers according to geographic areas within the state, and the availability may vary by geographic area. For example, in the western part of the state, a provider that serves the greater Danbury area may well not agree to provide services to a client living in Torrington. The client might choose a provider that will not extend their coverage outside of their service area. The care managers make a concerted effort to provide the clients with as many choices as possible and the expectation is that there is documentation in the clinical record of the choices given. The client may request a copy of the list at any time. If the client does not have a specific choice, providers are assigned on a rotating basis as long as the provider can meet all of the specifications requested by the client such as language spoken and the days and times that services are available. The Care Manager will describe the services available from providers on the list. Participants choose providers from the list and their signature on the total Plan of Care acknowledges freedom of choice. Additionally, in every follow up monitoring contact the client is asked if they are satisfied with the services provided and if there are any problems with the delivery of the formal services. If the client indicates there are problems, then changing to another service provider is discussed as an option and the Care Manager again reviews with the participant, the service providers available to choose from. Again, that documentation is found in the clinical record.

New providers are added to the list as they meet the qualifications and are enrolled. Once added to the list, the care managers provide the info to the participant as part of the monitoring contact if the client wishes to change providers and is also provided as a choice to all new clients.

7. Process for Making Plan of Care Subject to the Approval of the Medicaid Agency. *(Describe the process by which the plan of care is made subject to the approval of the Medicaid agency):*

ACU staff review 100% of all new service plans and must authorize the plan before it can be implemented. Utilization Review Nurses match needs with services to ensure all health and safety needs are being met.

ACU staff conducts annual client record reviews for each of the three Access Agencies. Approximately one hundred (100) client records are randomly selected for review. In addition to the record reviews done by ACU staff, the Access Agencies are contractually required to perform record audits and produce quarterly reports to the Department summarizing those audits. A representative sample is achieved by combining the audits of both the Access Agency supervisors and Department staff. The reviews include an examination of the client's most recent reassessment and confirm that the identified critical needs are consistent with the POC. The POC is reviewed to ensure that all identified needs are being met. ACU staff conducts client satisfaction surveys in each of the five areas of the state that define the Access Agencies service areas.

ACU client record reviews are conducted to monitor contractual agreements. The Access Agencies are contractually obligated to conduct client record reviews including assessing appropriateness of POC and report annually to the Department of Social Services.

Access Agencies must update the POC at the time of reassessment or when a significant change occurs in the client's status, and utilize care plans consistent with the program's Uniform Client Care Plan. The Uniform Client Care Plan identifies provider, type of service, number of hours provided, date service began, and date service was discontinued, noting the need for a back up plan. These services are monitored by the Department of Social Services through Quality Assurance and Client Satisfaction Annual Reports generated by the Access Agencies.

On annual reassessment, ACU staff select for review, every 10th care plan submitted monthly. The review consists of an evaluation of whether the plan is meeting health and safety needs of the participant and monitors outlier care plans, (utilization below 20% or above 80% of the cost limits).

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

<input checked="" type="checkbox"/>	Medicaid agency	<input type="checkbox"/>	Operating agency	<input checked="" type="checkbox"/>	Case manager
<input type="checkbox"/>	Other (<i>specify</i>):				

Services

1. **State plan HCBS.** (Complete the following table for each service. Copy table as needed):

Service Specifications (Specify a service title for the HCBS listed in Attachment 4.19-B that the State plans to cover):	
Service Title:	Adult Day health
Service Definition (Scope):	
<p>The service is provided 4 or more hours per day on a regularly scheduled basis for one or more days per week, or as specified in the service plan, in a non-institutional, community-based setting and shall encompass both health and social services needed to ensure the optimal functioning of the participant. Transportation to and from the center is included in the service definition and in the rate structure. Meals provided as part of these services shall not constitute a full nutritional regimen. Claims will be denied by any Adult Day Health provider attempting to bill for transportation procedure codes. These procedure codes are not included on the Adult Day Health fee schedule and will deny as edits are built into the claim processing system to prevent duplicative transportation services for Adult Day Health from occurring.</p> <p>Services Covered and Limitations</p> <p>Payment for adult day services under the rate for a medical model is limited to providers which demonstrate to the department their ability to meet the following additional requirements:</p> <p>a program nurse shall be available on site for not less than fifty percent of each operating day;</p> <p>the program nurse shall be a registered nurse, except that a program nurse may be a licensed practical nurse if the program is located in a hospital or long term care facility licensed by the Department of Public Health, with ready access to a registered nurse from such hospital or long term care facility or the program nurse is supervised by a registered nurse who can be reached by telephone at any time during the operating day and who can be called to the center if needed within one half hour of the request. The program nurse is responsible for administering medications as needed and assuring that the participant's nursing services are coordinated with other services provided in the adult day health center, health and social services currently received at home or provided by existing community health agencies and personal physicians;</p> <p>additional personal care services shall be provided as specified in the individual plan of care, including but not limited to, bathing and transferring;</p> <p>ongoing training shall be available to the staff on a regular basis including, but not be limited to, orientation to key specialty areas such as physical therapy, occupational therapy, speech therapy and training in techniques for recognizing when to arrange or refer clients for such services; and</p>	

individual therapeutic and rehabilitation services shall be coordinated by the center as specified in the individual plan of care including but not limited to, physical therapy, occupational therapy and speech therapy. The center shall have the capacity to provide such services on site; this requirement shall not preclude the provider of adult day health services from also arranging to provide therapeutic and rehabilitation services at other locations in order to meet needs of individual clients.

Payment for adult day services shall include the costs of transportation, meals and all other required services except for individual therapeutic and rehabilitation services.

For participants receiving assisted living services, adult day services are included as part of the monthly rate. A separate reimbursement for this service is not authorized. The assisted living service agency may arrange for adult day health services and reimburse the adult day service provider from their all-inclusive rate.

Additional needs-based criteria for receiving the service, if applicable (*specify*):

Specify limits (if any) on the amount, duration, or scope of this service for (*choose each that applies*):

Categorically needy (*specify limits*):
 May be provided up to 7 times per week

Medically needy (*specify limits*):

Provider Qualifications (*For each type of provider. Copy rows as needed*):

Provider Type (<i>Specify</i>):	License (<i>Specify</i>):	Certification (<i>Specify</i>):	Other Standard (<i>Specify</i>):
Adult Day Center-provider Agency	None	Certified by Adult Day Care Association	Providers of Adult Day Health services shall meet all applicable federal, state and local requirements including zoning, licensing, sanitation, fire and safety requirements provide, at a minimum, nursing consultation services, social work services, nutritionally balanced meals to meet specialized dietary needs as prescribed by health care personnel, personal care services, recreational therapy and transportation services for individuals to and from their homes; provide adequate personnel to operate the program including: <ul style="list-style-type: none"> • a full-time program administrator; • nursing consultation during the full operating day by a

			<p>Registered Nurse (RN) licensed in the state of Connecticut; and</p> <ul style="list-style-type: none"> the direct care staff-to-participant ratio shall be a minimum of one to seven. Staffing shall be adequate to meet the needs of the client base. Volunteers shall be included in the ratio only when they conform to the same standards and requirements as paid staff. <p>In order to be a provider of services to department clients, any facility located and operating within the state of Connecticut or located and operating outside the state of Connecticut, in a bordering state, shall be certified by the Connecticut Association of Adult Day Centers Incorporated, its successor agency or a department designee.</p> <p>A facility (center) located and operating outside the state of Connecticut in a bordering state shall be licensed or certified by its respective state and comply at all times with all pertinent licensure or certification requirements in addition to the approved standards for certification by the department.</p> <p>Certified facilities (centers) shall be in compliance with all applicable requirements in order to continue providing services to department clients. The failure to comply with any applicable requirements shall be grounds for the termination of its certification and participation as a department service provider.</p>
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Verification of Provider Qualifications (For each provider type listed above. Copy rows as needed):

Provider Type	Entity Responsible for Verification	Frequency of Verification
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<i>(Specify):</i>	<i>(Specify):</i>	<i>(Specify):</i>
Provider Agency	Access Agency- verifies certification by ADC Association prior to initiating enrollment	Every 2 years. In addition, Department Staff maintain and distribute a list of all the certified programs and their renewal dates for certification
Service Delivery Method. (Check each that applies):		
<input type="checkbox"/> Participant-directed	<input checked="" type="checkbox"/> Provider managed	

Service Specifications <i>(Specify a service title for the HCBS listed in Attachment 4.19-B that the State plans to cover):</i>	
Service Title:	Case (Care) Management
Service Definition (Scope):	
<p>Services that assist participants in gaining access to needed services, as well as medical, social, educational and other services, regardless of the funding source for the services to which access is gained. Care managers additionally are responsible to monitor the ongoing provision of services in the participants' plan of care and continually monitor that the client's health and safety needs are being addressed. They complete the initial and annual assessment and reassessment of an individual's needs in order to develop a comprehensive plan of care. They confirm the initial needs based criteria determination done by Department staff and reassess the eligibility annually and maintain documentation for department review. Care Managers also explain opportunities for participant directed services options to participants.</p> <p>The Departments allows for a status review visit by the case manager when a HCBS participant is in a hospital or nursing facility setting when the purpose of that visit is to reevaluate the total plan of care needs upon discharge back to the community based setting. This transitional care management service is provided one time in the first 45 days of a nursing home stay and/or one time only during a hospital stay. The reimbursement is based on a percentage of the rate for an initial assessment</p>	
Additional needs-based criteria for receiving the service, if applicable <i>(specify):</i>	
Specify limits (if any) on the amount, duration, or scope of this service for <i>(chose each that applies):</i>	
<input checked="" type="checkbox"/>	Categorically needy <i>(specify limits):</i> Service may be billed on a per diem basis as long as the client remains in a community based setting. Prior authorization is required for a status review visit after the first 45 days of a nursing home stay.
<input type="checkbox"/>	Medically needy <i>(specify limits):</i>

Provider Qualifications (For each type of provider. Copy rows as needed):			
Provider Type (Specify):	License (Specify):	Certification (Specify):	Other Standard (Specify):
Provider Agency	If an RN, must possess nursing license in the State of CT	Care Management certification is encouraged but not required	<p>The care manager who conducts the assessments, develops care plans and provides ongoing monitoring shall be either a registered nurse licensed in the state where care management services are provided or a social services worker who is a graduate of an accredited four-year college or university. The nurse or social services worker shall have a minimum of two years of experience in health care or human services. A bachelor's degree in nursing, health, social work, gerontology or a related field may be substituted for one year of experience.</p> <p>Care managers shall have the following additional qualifications: demonstrated interviewing skills which include the professional judgment to probe as necessary to uncover underlying concerns of the applicants; demonstrated ability to establish and maintain empathic relationships; experience in conducting social and health assessments;</p> <p>Knowledge of human behavior, family/caregiver dynamics, human development and disabilities; awareness of community resources and services; the ability to understand and apply complex service reimbursement issues; and the ability to evaluate, negotiate and plan for the costs of care options.</p>
Verification of Provider Qualifications (For each provider type listed above. Copy rows as needed):			
Provider Type (Specify):	Entity Responsible for Verification (Specify):		Frequency of Verification (Specify):

Provider Agency	Access Agency	Upon employment and as part of the Case Manager's annual performance appraisal
Service Delivery Method. (Check each that applies):		
<input type="checkbox"/> Participant-directed	<input checked="" type="checkbox"/> Provider managed	

Service Specifications (Specify a service title for the HCBS listed in Attachment 4.19-B that the State plans to cover):

Service Title:	Homemaker
Service Definition (Scope):	
Services consisting of general household activities (meal preparation, laundry 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.	
Additional needs-based criteria for receiving the service, if applicable (specify):	

Specify limits (if any) on the amount, duration, or scope of this service for (choose each that applies):

<input checked="" type="checkbox"/>	Categorically needy (specify limits):
	Up to six hours per week
<input type="checkbox"/>	Medically needy (specify limits):

Provider Qualifications (For each type of provider. Copy rows as needed):

Provider Type (Specify):	License (Specify):	Certification (Specify):	Other Standard (Specify):
Provider Agency	N/A	Certification required from the Department of Consumer Protection	N/A

Verification of Provider Qualifications (For each provider type listed above. Copy rows as needed):

Provider Type (Specify):	Entity Responsible for Verification (Specify):	Frequency of Verification (Specify):
Provider Agency	Access Agency (contracted provider)	Every 2 years

Service Delivery Method. (Check each that applies):

<input type="checkbox"/> Participant-directed	<input checked="" type="checkbox"/> Provider managed
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Service Specifications <i>(Specify a service title for the HCBS listed in Attachment 4.19-B that the State plans to cover):</i>	
Service Title:	Personal Care Assistant
Service Definition (Scope):	
<p>One or more persons assisting an elder with tasks that the individual would typically do for him/herself in the absence of a disability. Such tasks may be performed at home or in the community. The participant has employer authority and is responsible to direct the activities of the PCA. A fiscal intermediary assists participants who exercise this self directed option. The fiscal intermediary processes time sheets and issues payments on behalf of the participant. The fiscal intermediary claims are processed through the state's MMIS. Such services may include physical or verbal assistance to the consumer in accomplishing any Activity of Daily Living (ADL), or Instrumental Activities of Daily Living (IADL). ADL's include bathing, dressing, toileting, transferring, and feeding. IADLs include meal preparation, shopping, housekeeping, laundry and cueing/reminders for self medication administration. Transportation costs associated with the provision of personal care outside of the participant's home is billed separately and is not included in the scope of personal care. An agency based PCA option is also available to participants who prefer not to self direct their services.</p> <p>PCAs may be members of the individual's family who meet the training requirements specified by the Department, except that the personal care provider may not be the participant's spouse, the participant's conservator/legal guardian, or a relative of the participant's conservator/legal guardian.</p> <p>The plan of care that is developed focuses on unmet needs. When family members who reside with waiver participants are paid as PCAs, the plan of care will be developed to address needs that are not currently being met by the family member. Examples of needs that would be assessed as met by the family member residing with the waiver participant might be usual household activities including but not limited to services such as meal preparation, laundry, shopping and housekeeping.</p>	
Additional needs-based criteria for receiving the service, if applicable <i>(specify)</i> :	
Must require hands on assistance with personal care to qualify to receive this service	
Specify limits (if any) on the amount, duration, or scope of this service for <i>(chose each that applies)</i> :	
<input checked="" type="checkbox"/>	Categorically needy <i>(specify limits)</i> : Up to 14 hours per week. PCA services shall be cost effective on an individual basis when compared with Home Health Aide, Homemaker and Companion services. Recipients of PCA services will not be eligible to receive Homemaker or Companion services. Edits have been created in the MMIS to deny any Homemaker or Companion claims for PCA service recipients. Personal Care may not be provided to participants receiving Assisted Living Services as all of the functions of personal care are provided by the Assisted Living Service provider. The benefit plan for Assisted Living service recipients excludes personal care so that there could be no duplicative billing.
<input type="checkbox"/>	Medically needy <i>(specify limits)</i> :

Provider Qualifications (For each type of provider. Copy rows as needed):			
Provider Type (Specify):	License (Specify):	Certification (Specify):	Other Standard (Specify):
Provider Agency	If the provider agency is a Home Health Agency, it is required to be licensed in the state of Connecticut as specified in Subsection (k) section 19a-490 of the general statutes	If the agency is a Homemaker/Companion agency, it must be registered with the Department of Consumer Protection in the State of CT.	The PCA hired by the agency shall meet all of the same qualifications as an individual PCA as follows: <ul style="list-style-type: none"> • Be at least 18 years of age • Have experience doing personal care • Be able to follow written or verbal instructions given by the consumer or the consumer's conservator • Be physically able to perform the services required • Follow instructions given by the consumer or the consumer's conservator • Receive instruction/training from consumer or their designee concerning all personal care services delineated in the service plan • Be able to handle emergencies
Verification of Provider Qualifications (For each provider type listed above. Copy rows as needed):			
Provider Type (Specify):	Entity Responsible for Verification (Specify):		Frequency of Verification (Specify):
Provider Agency	Provider Agency and Access Agency		At the time of employment
Service Delivery Method. (Check each that applies):			
<input checked="" type="checkbox"/>	Participant-directed		<input checked="" type="checkbox"/> Provider managed

Provider Qualifications (For each type of provider. Copy rows as needed):			
Provider Type (Specify):	License (Specify):	Certification (Specify):	Other Standard (Specify):
Individual Provider			Personal care provider shall: <ul style="list-style-type: none"> • Be at least 18 years of age

			<ul style="list-style-type: none"> • Have experience doing personal care • Be able to follow written or verbal instructions given by the consumer or the consumer's conservator • Be physically able to perform the services required • Follow instructions given by the consumer or the consumer's conservator • Receive instruction/training from consumer or their designee concerning all personal care services delineated in the service plan • Be able to handle emergencies <p>A pre-employment criminal background check will be conducted on individual personal care assistants. The fiscal intermediary is responsible for ensuring the background check is completed and that the results are shared with the waiver participant.</p>
Verification of Provider Qualifications (For each provider type listed above. Copy rows as needed):			
Provider Type (Specify):	Entity Responsible for Verification (Specify):		Frequency of Verification (Specify):
Individual provider	Fiscal Intermediary		At the time of employment
Service Delivery Method. (Check each that applies):			
<input checked="" type="checkbox"/>	Participant-directed	<input type="checkbox"/>	Provider managed
Service Title: Respite			
Service Definition (Scope):			
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. In home respite providers shall include but are not limited to homemakers, companions or Home Health aides. Services may be provided in the home or outside of the home including			

but not limited to a licensed or certified facility such as a Rest Home with Nursing supervision or Chronic and Convalescent Nursing Home. Federal financial participation is not 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.			
Additional needs-based criteria for receiving the service, if applicable (<i>specify</i>):			
Specify limits (if any) on the amount, duration, or scope of this service for (<i>chose each that applies</i>):			
<input checked="" type="checkbox"/>	Categorically needy (<i>specify limits</i>):		
	Respite services provided in a licensed facility are limited to 30 days per calendar year per recipient. In home respite services are limited to 720 hours per year per recipient.		
<input type="checkbox"/>	Medically needy (<i>specify limits</i>):		
Provider Qualifications (<i>For each type of provider. Copy rows as needed</i>):			
Provider Type (<i>Specify</i>):	License (<i>Specify</i>):	Certification (<i>Specify</i>):	Other Standard (<i>Specify</i>):
Agency	Home Health Agencies must be licensed by the CT Department of Public Health	Homemaker/companion Agencies must be certified by the Dept of Consumer Protection	
Verification of Provider Qualifications (<i>For each provider type listed above. Copy rows as needed</i>):			
Provider Type (<i>Specify</i>):	Entity Responsible for Verification (<i>Specify</i>):	Frequency of Verification (<i>Specify</i>):	
Agency	Access Agency for Homemaker/Companion Agencies and Dept of Public Health for Home Health Agencies	Every 2 years	
Service Delivery Method. (<i>Check each that applies</i>):			
<input type="checkbox"/>	Participant-directed	<input checked="" type="checkbox"/>	Provider managed
Provider Qualifications (<i>For each type of provider. Copy rows as needed</i>):			
Provider Type (<i>Specify</i>):	License (<i>Specify</i>):	Certification (<i>Specify</i>):	Other Standard (<i>Specify</i>):
Facility	For respite in a facility, either Rest Home with Nursing supervision or Chronic and	N/A	N/A

	Convalescent Nursing Home, facilities must be licensed by the CT Department of Public Health.		
Verification of Provider Qualifications (For each provider type listed above. Copy rows as needed):			
Provider Type (Specify):	Entity Responsible for Verification (Specify):	Frequency of Verification (Specify):	
Agency	CT Department of Public Health	Every 2 years	
Service Delivery Method. (Check each that applies):			
<input type="checkbox"/>	Participant-directed	<input checked="" type="checkbox"/>	Provider managed

Service Specifications (Specify a service title for the HCBS listed in Attachment 4.19-B that the State plans to cover):	
Service Title:	Assisted Living
Service Definition (Scope):	
<p>Personal care and services, homemaker, chore, attendant care, companion services, medication oversight, therapeutic social and recreational programming, provided in a home-like environment in a Managed Residential Community, in conjunction with residing in the community. A managed residential community is a living arrangement consisting of private residential units that provides a managed group living environment including housing and services. A private residential unit means a living arrangement rented by the participant that includes a private full bath within the unit and facilities and equipment for the preparation and storage of food. Each unit has lockable access, is free to receive visitors and leave the setting at times and durations of the individual's choosing, access to the grater community is easily facilitated and individuals can choose whether to share a living space. 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 Managed Residential Community, but the care provided by these other entities supplements that provided by the community care facility and does not supplant it. Mental health counseling and the Personal Emergency Response System are services available to assisted living clients above and beyond the assisted living service.. Nursing and skilled therapy services are incidental rather than integral to the provision of assisted living services. Payment is not made for 24 hour skilled care. Federal financial participation is not available for room and board, items of comfort or convenience, or the costs of facility maintenance, upkeep and improvement. The methodology by which the costs of room and board are</p>	

excluded from payments for assisted living services is described in Appendix I-5.

Personalized care is furnished to individuals who reside in their own living units (which may include dually occupied units when both occupants consent to the arrangement) which includes kitchenette and living rooms and which contain bedrooms and toilet facilities. The 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. Each living unit is separate and distinct from each other. The communities 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. Routines of care provision and service delivery must be consumer-driven to the maximum extent possible, and treat each person with dignity and respect.

Care plans will be developed based on the individual's service needs. There are four levels of service provided in assisted living facilities based on the consumer's combined needs for personal care and nursing services. The four levels are occasional which is 1-3.75 hours per week of service, limited which is 4-8.75 hours per week of service, moderate which is 9-14.75 hours per week of service and extensive which is 15-25 hours per week of service. Level of service assigned depends upon the volume and extent of services needed by each individual and is not a limitation of service.

Assisted Living services are provided statewide in Private Assisted Living Facilities under CGS 17b-365 and in 17 state funded congregate and 5 HUD facilities under CGS 8-206e(e). Additionally, Assisted Living Services are provided in 4 demonstration sites under 19-13-D105 of the regulations of CT state agencies.

Additional needs-based criteria for receiving the service, if applicable (*specify*):

Specify limits (if any) on the amount, duration, or scope of this service for (*choose each that applies*):

Categorically needy (*specify limits*):
 Persons receiving Assisted Living services may not receive PCA services and PCA is not included on the fee schedule for clients receiving Assisted Living services preventing duplicative billing. The claims would reject as "not being covered under the participant's benefit plan."

Medically needy (*specify limits*):

Provider Qualifications (*For each type of provider. Copy rows as needed*):

Provider Type (<i>Specify</i>):	License (<i>Specify</i>):	Certification (<i>Specify</i>):	Other Standard (<i>Specify</i>):
Assisted Living Service Agency	The Assisted Living Service Provider (ALSA) is		

	licensed by the CT Department of Public Health in accordance with chapter 368v. Regulations regarding a Managed Residential Community and the ALSA are found in Regulations of the State of CT agencies in 19-13-D104 and 19-13-D105.		
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Verification of Provider Qualifications (For each provider type listed above. Copy rows as needed):

Provider Type (Specify):	Entity Responsible for Verification (Specify):	Frequency of Verification (Specify):
Agency	MMIS contractor and Department Quality Assurance staff	At the time of enrollment and biannually thereafter

Service Delivery Method. (Check each that applies):

<input type="checkbox"/> Participant-directed	<input checked="" type="checkbox"/> Provider managed
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Service Specifications (Specify a service title for the HCBS listed in Attachment 4.19-B that the State plans to cover):

Service Title:	Assistive Technology
Service Definition (Scope):	
<p>An item, piece of equipment, or product system, whether acquired commercially, modified, or customized, that is used to increase, maintain, monitor or improve functional capabilities of participants to perform Activity of Daily Living (ADL), or Instrumental Activities of Daily Living. (IADL). Assistive technology service means a service that directly assists a participant in the selection, acquisition, or use of an assistive technology device.</p> <p>A. Services consisting of purchasing, leasing, or otherwise providing for the acquisition of assistive technology devices.</p> <p>B. Services consisting of selecting, designing, fitting, customizing, adapting, applying, maintaining, repairing, or replacing assistive technology devices.</p>	

C. Training or technical assistance for the participant or for the direct benefit of the participant receiving the service, and where appropriate, the family members, guardians, advocates or authorized representatives of the participants.

Additional needs-based criteria for receiving the service, if applicable (*specify*):

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

Specify limits (if any) on the amount, duration, or scope of this service for (*chose each that applies*):

Categorically needy (*specify limits*):
 The service shall be capped at an annual cost of \$1000

Medically needy (*specify limits*):

Provider Qualifications (*For each type of provider. Copy rows as needed*):

Provider Type (<i>Specify</i>):	License (<i>Specify</i>):	Certification (<i>Specify</i>):	Other Standard (<i>Specify</i>):
Agency	N/A	N/A	Medicaid provider status for assistive technology and supplies or agency that obtains Medicaid performing provider status

Verification of Provider Qualifications (*For each provider type listed above. Copy rows as needed*):

Provider Type (<i>Specify</i>):	Entity Responsible for Verification (<i>Specify</i>):	Frequency of Verification (<i>Specify</i>):
Agency	Access Agency	At the start of service

Service Delivery Method. (*Check each that applies*):

Participant-directed Provider managed

Provider Qualifications (*For each type of provider. Copy rows as needed*):

Provider Type (<i>Specify</i>):	License (<i>Specify</i>):	Certification (<i>Specify</i>):	Other Standard (<i>Specify</i>):
Agency	Pharmacy	N/A	Medicaid provider status for assistive technology and supplies or agency that obtains Medicaid performing provider status

Verification of Provider Qualifications (*For each provider type listed above. Copy rows as needed*):

<i>needed):</i>		
Provider Type <i>(Specify):</i>	Entity Responsible for Verification <i>(Specify):</i>	Frequency of Verification <i>(Specify):</i>
Agency	Access Agency	At the start of service
Service Delivery Method. <i>(Check each that applies):</i>		
<input type="checkbox"/> Participant-directed	<input checked="" type="checkbox"/> Provider managed	

Service Specifications <i>(Specify a service title for the HCBS listed in Attachment 4.19-B that the State plans to cover):</i>			
Service Title:	Chore Services		
Service Definition (Scope):			
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 payer 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.			
Additional needs-based criteria for receiving the service, if applicable <i>(specify):</i>			
When an individual requires one-time only unique or specialized services in order to maintain a healthy and safe environment, they may receive highly skilled chore services which include but are not limited to moving, extensive cleaning or extermination services. Highly skilled chore services are subject to prior authorization by the department.			
Specify limits (if any) on the amount, duration, or scope of this service for <i>(chose each that applies):</i>			
<input checked="" type="checkbox"/>	Categorically needy <i>(specify limits):</i>		
	Highly skilled Chore service is subject to prior authorization by the department.		
<input type="checkbox"/>	Medically needy <i>(specify limits):</i>		
Provider Qualifications <i>(For each type of provider. Copy rows as needed):</i>			
Provider Type <i>(Specify):</i>	License <i>(Specify):</i>	Certification <i>(Specify):</i>	Other Standard <i>(Specify):</i>
Agency	N/A	If provider is a homemaker/companion/chore agency, they must be registered with	N/a

		the Department of Consumer Protection. Chore services providers shall demonstrate the ability to meet the needs of the individual seeking services.	
Verification of Provider Qualifications (For each provider type listed above. Copy rows as needed):			
Provider Type (Specify):	Entity Responsible for Verification (Specify):		Frequency of Verification (Specify):
Agency	Access Agency		At the time of enrollment and every two years
Service Delivery Method. (Check each that applies):			
<input type="checkbox"/> Participant-directed		<input checked="" type="checkbox"/> Provider managed	
Provider Qualifications (For each type of provider. Copy rows as needed):			
Provider Type (Specify):	License (Specify):	Certification (Specify):	Other Standard (Specify):
Individual	Electrician, plumbers and other contractors must hold the appropriate license to perform highly skilled chore services.	N/a	N/a
Verification of Provider Qualifications (For each provider type listed above. Copy rows as needed):			
Provider Type (Specify):	Entity Responsible for Verification (Specify):		Frequency of Verification (Specify):
Agency	Access Agency		At the time of the service
Service Delivery Method. (Check each that applies):			

<input type="checkbox"/> Participant-directed	<input checked="" type="checkbox"/> Provider managed
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Service Specifications <i>(Specify a service title for the HCBS listed in Attachment 4.19-B that the State plans to cover):</i>	
Service Title:	Companion
Service Definition (Scope):	
<p>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.</p> <p>Companion services may include, but are not limited to, the following activities:</p> <ul style="list-style-type: none"> (A) escorting an individual to recreational activities or to necessary medical, dental or business appointments; (B) reading to or for an individual; (C) supervising or monitoring an individual during the self-performance of activities of daily living such as meal preparation and consumption, dressing, personal hygiene, laundry and simple household chores; (D) reminding an individual to take self-administered medications; (E) providing monitoring to ensure the safety of an individual; (F) assisting with telephone calls and written communications; and (G) reporting changes in an individual's needs or condition to the supervisor or care manager. 	
Additional needs-based criteria for receiving the service, if applicable <i>(specify)</i> :	
Specify limits (if any) on the amount, duration, or scope of this service for <i>(chose each that applies)</i> :	
<input checked="" type="checkbox"/>	Categorically needy <i>(specify limits)</i> : Companion Services may not be provided to a participant receiving PCA services. An edit was built into the MMIS to reject any billing for the Companion procedure code if the PCA procedure code is billed. The total plan of care specifies if both homemaker and companion services are authorized for the participant. The duties of each are defined as part of the overall plan and are not duplicative. This service may not be provided by a relative of the participant.

<input type="checkbox"/> Medically needy (<i>specify limits</i>):			
Provider Qualifications (<i>For each type of provider. Copy rows as needed</i>):			
Provider Type (<i>Specify</i>):	License (<i>Specify</i>):	Certification (<i>Specify</i>):	Other Standard (<i>Specify</i>):
Agency	N/A		<p>In order to provide companion services and receive reimbursement from the Connecticut Home Care Agency must be registered as a provider of Companion Services with the Department of Consumer Protection in the state of CT.</p> <p>The companion employed by the agency shall be at least eighteen (18) years of age, be of good health, have the ability to read, write and follow instructions, be able to report changes in a person's condition or needs to the department, the access agency, or the agency or organization that contracted the persons to perform such functions and shall maintain confidentiality and complete required record-keeping of the employer or contractor of services.</p> <p>Companion services are not licensed or regulated and shall be provided by a person hired by an agency or organization. Certain relatives of the client cannot be provider of services as defined in section 17b-342-1(b)(29) of the Regulations of Connecticut State Agencies. Providers shall demonstrate the ability to meet the needs of the service recipient. The access agency or a department designee shall also ensure that the services provided are appropriate for companion services and are not services which should be provided by a licensed provider of home health services.</p> <p>Companion service agencies or</p>

			<p>organizations shall abide by the standards and requirements as described in the performing provider agreement and sub-contract with the department or any authorized entity. Any homemaker-companion agency must register with the Department of Consumer Protection pursuant to sections 20-671 to 20-680, inclusive, of the Connecticut General Statutes.</p>
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Verification of Provider Qualifications (For each provider type listed above. Copy rows as needed):

Provider Type (Specify):	Entity Responsible for Verification (Specify):	Frequency of Verification (Specify):
Agency	Access Agency	At the time of enrollment and bi-annually thereafter

Service Delivery Method. (Check each that applies):

<input type="checkbox"/> Participant-directed	<input checked="" type="checkbox"/> Provider managed
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Service Specifications (Specify a service title for the HCBS listed in Attachment 4.19-B that the State plans to cover):

Service Title:	Environmental Accessibility Modifications
Service Definition (Scope):	<p>Minor Home Modifications required by the individual's plan of care which are necessary to ensure health, welfare and safety of the individuals to function with greater independence in their home and without which the individual would require institutionalization. Such adaptations may include the installation of hand rails and grab bars in the tub area, widening of doors and installation of ramps. Excluded are those adaptations or improvements to the home which are of general utility and are not of direct medical or remedial benefit to the individuals such as carpeting, roof repair or air conditioning. Adaptations which add to the total square footage of the home are excluded from this benefit. All services shall be provided in accordance with applicable state or local building codes. Adaptations are excluded if the residence is owned by someone other than the participant and the adaptations would be the responsibility of the owner/landlord.</p>
Additional needs-based criteria for receiving the service, if applicable (specify):	
Specify limits (if any) on the amount, duration, or scope of this service for (chose each that applies):	
<input checked="" type="checkbox"/> Categorically needy (specify limits):	

This service is subject to prior authorization by Department staff			
<input type="checkbox"/> Medically needy (<i>specify limits</i>):			
Provider Qualifications (<i>For each type of provider. Copy rows as needed</i>):			
Provider Type (<i>Specify</i>):	License (<i>Specify</i>):	Certification (<i>Specify</i>):	Other Standard (<i>Specify</i>):
Individual (non relative)		<p>1. The vendor or contractor shall provide all services, materials, and labor that are necessary to complete the project/minor home modification(s) as indicated.</p> <p>2. The vendor or contractor must be registered with the Department of Consumer Protection to do business in the State of Connecticut.</p> <p>3. The vendor or contractor must show evidence of a valid home improvement registration and evidence of worker's compensation (if applicable) and liability insurance, at the time they provide an estimate for the project.</p> <p>4. If applicable, the vendor or contractor must apply for, obtain, and pay for all permits. All work done shall be done per applicable codes, regulations and standards of construction, including American National Standards Institute (ANSI) standards for</p>	

		barrier-free access and safety requirement. 5. The vendor or contractor shall warranty all work, including labor and materials, for one year from the date of acceptance and thereafter, one year from the date of completion of the project. 6. When equipment is required to make the home accessible, a separate vendor may provide and install the equipment.	
Verification of Provider Qualifications (For each provider type listed above. Copy rows as needed):			
Provider Type (Specify):	Entity Responsible for Verification (Specify):	Frequency of Verification (Specify):	
Agency	Access Agency	Prior to the initiation of service	
Service Delivery Method. (Check each that applies):			
<input type="checkbox"/>	Participant-directed	<input checked="" type="checkbox"/>	Provider managed
Service Specifications (Specify a service title for the HCBS listed in Attachment 4.19-B that the State plans to cover):			
Service Title:	Mental Health Counseling		
Service Definition (Scope):			
<p>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.</p> <p>The department shall pay for mental health services conforming to accepted methods of diagnosis and treatment, including:</p> <p>(A) mental health evaluation and assessment;</p> <p>(B) individual counseling;</p>			

(C) group counseling; and (D) family counseling. Mental Health Counseling can be provided in the client's home or location best suited for the client.			
Additional needs-based criteria for receiving the service, if applicable (<i>specify</i>):			
Specify limits (if any) on the amount, duration, or scope of this service for (<i>chose each that applies</i>):			
<input checked="" type="checkbox"/>	Categorically needy (<i>specify limits</i>):		
<input type="checkbox"/>	Medically needy (<i>specify limits</i>):		
Provider Qualifications (<i>For each type of provider. Copy rows as needed</i>):			
Provider Type (<i>Specify</i>):	License (<i>Specify</i>):	Certification (<i>Specify</i>):	Other Standard (<i>Specify</i>):
Individual			A social worker who holds a masters degree from an accredited school of social work, or an individual who has a master's degree in counseling, psychology or psychiatric nursing and has experience in providing mental health services to the elderly may also provide mental health counseling.
Verification of Provider Qualifications (<i>For each provider type listed above. Copy rows as needed</i>):			
Provider Type (<i>Specify</i>):	Entity Responsible for Verification (<i>Specify</i>):	Frequency of Verification (<i>Specify</i>):	
Individual	Access Agency	At the time of enrollment as a provider and bi-annually thereafter	
Service Delivery Method. (<i>Check each that applies</i>):			
<input type="checkbox"/>	Participant-directed	<input checked="" type="checkbox"/>	Provider managed

Service Specifications (<i>Specify a service title for the HCBS listed in Attachment 4.19-B that the State plans to cover</i>):	
Service Title:	Home Delivered Meals
Service Definition (Scope): Home delivered meals, or "meals on wheels," include the preparation and delivery of one or two meals for persons who are unable to prepare or obtain nourishing meals on their own. Meals on Wheels providers include delicatessens, Family Services Agencies, Community Action Agencies, Catholic Charities, Town Social Services, visiting nurse agencies, assisted living	

agencies, senior centers, soup kitchens. Meals must meet a minimum of one-third for single meals and two-thirds for double meals of the daily recommended allowance and requirements as established by the Food and Nutrition Academy of Sciences National Research Council. Special diet meals are available such as diabetic, cardiac, low sodium and renal as are ethnic meals such as Hispanic and Kosher meals.

Liquid supplements, such as Ensure, are generally unavailable as the home delivered meals. There is one Community Action Agency in Northwest CT that provides liquid supplement meal replacement.

Additional needs-based criteria for receiving the service, if applicable (*specify*):

Specify limits (if any) on the amount, duration, or scope of this service for (*chose each that applies*):

Categorically needy (*specify limits*):
 No more than two meals per day up to seven times per week as specified in the individual service plan. Liquid supplements are covered by the CT Medicaid program with prior authorization for clients who are tube fed.

Medically needy (*specify limits*):

Provider Qualifications (*For each type of provider. Copy rows as needed*):

Provider Type (<i>Specify</i>):	License (<i>Specify</i>):	Certification (<i>Specify</i>):	Other Standard (<i>Specify</i>):
Home Delivered meals Provider			Reimbursement for home delivered meals shall be available only to providers which provide meals that meet a minimum of one-third of the current daily recommended dietary allowance and requirements as established by the Food and Nutrition Board of the National Academy of Sciences National Research Council. All "meals on wheels" providers shall provide their menus to the department, contracted agencies or department designee for review and approval. Quality assurance and quality control shall be performed by the department's contracted providers to ensure that the "meals on wheels" service providers are in compliance with the dietary requirements and the requirements for the preparation and storage and delivery of food based on the department policies for the elderly nutrition program and Title (III) of the Older American's Act.

Verification of Provider Qualifications (For each provider type listed above. Copy rows as needed):		
Provider Type (Specify):	Entity Responsible for Verification (Specify):	Frequency of Verification (Specify):
Agency	Access Agency	At the time of enrollment and biannually thereafter
Service Delivery Method. (Check each that applies):		
<input type="checkbox"/> Participant-directed	<input checked="" type="checkbox"/> Provider managed	

Service Specifications (Specify a service title for the HCBS listed in Attachment 4.19-B that the State plans to cover):			
Service Title:	Personal Emergency Response System		
Service Definition (Scope): PERS is an electronic device which enables certain individuals at high risk of institutionalization to secure help in an emergency. The individual may also wear a portable "help" button to allow for mobility. The system is connected to the person's phone and programmed to signal a response center once a "help" button is activated. The response center is staffed by trained professionals 24/7. PERS services are limited to those individuals who live alone, or who are alone for significant parts of the day, and have no regular caregiver for extended periods of time, and who would otherwise require extensive routine supervision. Installation, upkeep and maintenance of the device are provided.			
Additional needs-based criteria for receiving the service, if applicable (specify):			
Specify limits (if any) on the amount, duration, or scope of this service for (chose each that applies):			
<input checked="" type="checkbox"/>	Categorically needy (specify limits):		
	Provider may bill for one time only installation and monthly rate thereafter		
<input type="checkbox"/>	Medically needy (specify limits):		
Provider Qualifications (For each type of provider. Copy rows as needed):			
Provider Type (Specify):	License (Specify):	Certification (Specify):	Other Standard (Specify):
Agency-vendors who sell and install PERS equipment			Vendor that has an approved contract through DSS as a performing provider
Verification of Provider Qualifications (For each provider type listed above. Copy rows as needed):			

Provider Type <i>(Specify):</i>	Entity Responsible for Verification <i>(Specify):</i>	Frequency of Verification <i>(Specify):</i>
Agency	Access Agency	At the time of enrollment and biannually thereafter
Service Delivery Method. <i>(Check each that applies):</i>		
<input type="checkbox"/> Participant-directed	<input checked="" type="checkbox"/> Provider managed	

Service Specifications <i>(Specify a service title for the HCBS listed in Attachment 4.19-B that the State plans to cover):</i>			
Service Title:	Transportation		
Service Definition (Scope):			
<p>Transportation services provide access to social services, community services and appropriate social or recreational facilities that are essential to help some individuals avoid institutionalization by enabling these individuals to retain their role as community members. This service is offered in addition to medical transportation offered under the state plan and shall not replace it.</p> <p>(A) These services are provided when transportation is required to promote and enhance independent living and self-support; and</p> <p>(B) Transportation services may be provided by taxi, livery, bus, invalid coach, volunteer organization or individuals. They shall be reimbursed when they are necessary to provide access to needed community based services or community activities as specified in the approved plan of care.</p>			
Additional needs-based criteria for receiving the service, if applicable <i>(specify):</i>			
Specify limits (if any) on the amount, duration, or scope of this service for <i>(choose each that applies):</i>			
<input checked="" type="checkbox"/>	Categorically needy <i>(specify limits):</i>		
	Adult Day Health providers cannot bill the transportation procedure code. Transportation is a separate and distinct procedure code and that service is not contracted to be provided by Adult Day Care providers thus preventing duplicate billing.		
<input type="checkbox"/>	Medically needy <i>(specify limits):</i>		
Provider Qualifications <i>(For each type of provider. Copy rows as needed):</i>			
Provider Type <i>(Specify):</i>	License <i>(Specify):</i>	Certification <i>(Specify):</i>	Other Standard <i>(Specify):</i>
Agency-Commercial Transportation Providers	In order to receive payment, all commercial		

	transportation providers shall be regulated carriers and meet all applicable state and federal permit and licensure requirements, and vehicle registration requirements. Commercial transportation providers shall also meet all applicable Medicaid program enrollment requirements		
Verification of Provider Qualifications <i>(For each provider type listed above. Copy rows as needed):</i>			
Provider Type <i>(Specify):</i>	Entity Responsible for Verification <i>(Specify):</i>	Frequency of Verification <i>(Specify):</i>	
Agency	Access Agency	At the time of enrollment and bi annually thereafter	
Service Delivery Method. <i>(Check each that applies):</i>			
<input type="checkbox"/>	Participant-directed	<input checked="" type="checkbox"/>	Provider managed

2. **Policies Concerning Payment for State plan HCBS Furnished by Relatives, Legally Responsible Individuals, and Legal Guardians.** *(By checking this box the State assures that):* There are policies pertaining to payment the State makes to qualified persons furnishing State plan HCBS, who are relatives of the individual. There are additional policies and controls if the State makes payment to qualified legally responsible individuals or legal guardians who provide State Plan HCBS. *(Specify (a) who may be paid to provide State plan HCBS ; (b) how the State ensures that the provision of services by such persons is in the best interest of the individual; (c) the State's strategies for ongoing monitoring of services provided by such persons; (d) the controls to ensure that payments are made only for services rendered; and (e) if legally responsible individuals may provide personal care or similar services, the policies to determine and ensure that the services are extraordinary (over and above that which would ordinarily be provided by a legally responsible individual):*

<p>The Department allows for a Personal Care Assistant to be a family member. The care manager as part of the comprehensive assessment evaluates whether provision of services by a family member is in the best interest of the client. An example might be a situation where the participant has dementia and is resistant to care provided by someone they are unfamiliar with. The care manager monitors the appropriateness and effectiveness of the services provided as part of their required monthly monitoring contact. The Department does not pay legally liable relatives or relatives of Conservators of Person (COP) or Conservators of Estate (COE) to provide care. A COP is appointed by the Probate court to supervise the personal affairs of an individual including the arrangement for medical needs and ensuring the individual has nutritious meals, clothing, safe and adequate housing, and personal hygiene and is protected from physical abuse or harm. A COE is also appointed by the Probate Court to supervise the financial affairs of an individual found to be incapable of managing his/her own affairs to the extent that property is jeopardized unless management is provided. PCA participants are able to select qualified providers for Personal Care Assistants. In some circumstances, this may be a non-legally liable relative, who is not related to the consumer's Conservator of Person or Conservator of Estate. The participant or their conservator must sign timesheets to confirm the dates and times services were performed. The fiscal intermediary reviews timesheets for accuracy and whether they match the allocation in the service plan. Any discrepancy results in the notification to DSS prior to the issuance of payment. Family members must meet the same qualifications as</p>			
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<p>unrelated providers. Any reported concerns regarding fraudulent billing are addressed as it would be with other service vendors. (e.g., investigation, provider termination, etc.) When a participant resides with a family member who is being paid to provide PCA services, reimbursement will be available for hands on care only and not for usual household functions including but not limited to laundry, cleaning, shopping and meal preparation that are routinely performed in the household for both the benefit of the participant and the caregiver. PCA is the only waiver service that can be provided by a relative.</p>			

Participant-Direction of Services

Definition: Participant-direction means self-direction of services per §1915(i)(1)(G)(iii).

1. Election of Participant-Direction. *(Select one):*

<input type="radio"/>	The State does not offer opportunity for participant-direction of State plan HCBS.
<input type="radio"/>	Every participant in State plan HCBS (or the participant's representative) is afforded the opportunity to elect to direct services. Alternate service delivery methods are available for participants who decide not to direct their services.
<input checked="" type="checkbox"/>	Participants in State plan HCBS (or the participant's representative) are afforded the opportunity to direct some or all of their services, subject to criteria specified by the State. <i>(Specify criteria):</i> Every applicant is offered the opportunity to self direct PCA services if their unmet needs justify the utilization of the PCA service. Both self directed employer authority and agency based co-employer options are available to participants.

2. Description of Participant-Direction. *(Provide an overview of the opportunities for participant-direction under the State plan HCBS, including: (a) the nature of the opportunities afforded; (b) how participants may take advantage of these opportunities; (c) the entities that support individuals who direct their services and the supports that they provide; and, (d) other relevant information about the approach to participant-direction):*

Participants will have several options for directing their own services to the extent they are able. If they are unable, they may designate a representative to act on their behalf. Clients may self direct PCA services and may choose to be the common law employer with the assistance of a Fiscal Intermediary or they may choose a co-employer option by utilizing agencies to secure services. Yet other clients may opt to manage their own services without the assistance of a care manager.

Care managers have had several trainings on principals of person centered planning. When the Care Manager completes the initial assessment, self directed options are explained as a potential service that the participant may choose. The participant is encouraged to have anyone that they choose, present for the assessment. During the assessment process, the participant is supported and encouraged to lead and fully participate in the planning process. Total Plans of Care are signed by the participant, confirming agreement on the plan and a copy is maintained in both the Care Manager and the Alternate Care Unit's file.

For participants who choose the common law employer option, the fiduciary agent assists with the enrollment process and provides training and support to the participant. The fiduciary describes in detail the participant's responsibility as a household employer and reviews the roles of hiring, recruiting, supervising and managing the PCA. As part of this process they advise the participant of the potential liabilities associated with employer authority. Participants are told they have the ability to determine the wage for the PCA as long as it falls within the maximum allowable rate approved by the Department For participants who choose the co-employer option, the agency that will provide the worker assists the participant. In situations, common law and co-employer, the Care Manager may also assist the applicant in understanding the processes and procedures associated with

employer authority.

3. Limited Implementation of Participant-Direction. *(Participant direction is a mode of service delivery, not a Medicaid service, and so is not subject to statewideness requirements. Select one):*

<input checked="" type="checkbox"/>	Participant direction is available in all geographic areas in which State plan HCBS are available.
<input type="checkbox"/>	Participant-direction is available only to individuals who reside in the following geographic areas or political subdivisions of the State. Individuals who reside in these areas may elect self-directed service delivery options offered by the State, or may choose instead to receive comparable services through the benefit's standard service delivery methods that are in effect in all geographic areas in which State plan HCBS are available. <i>(Specify the areas of the State affected by this option):</i>

4. Participant-Directed Services. *(Indicate the State plan HCBS that may be participant-directed and the authority offered for each. Add lines as required):*

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

5. Financial Management. *(Select one):*

<input type="checkbox"/>	Financial Management is not furnished. Standard Medicaid payment mechanisms are used.
<input checked="" type="checkbox"/>	Financial Management is furnished as a Medicaid administrative activity necessary for administration of the Medicaid State plan.

6. Participant-Directed Plan of Care. *(By checking this box the State assures that):* Based on the independent assessment, a person-centered process produces an individualized plan of care for participant-directed services that:

- Be developed through a person-centered process that is directed by the individual participant, builds upon the individual's ability (with and without support) to engage in activities that promote community life, respects individual preferences, choices, strengths, and involves families, friends, and professionals as desired or required by the individual;
- Specifies the services to be participant-directed, and the role of family members or others whose participation is sought by the individual participant;
- For employer authority, specifies the methods to be used to select, manage, and dismiss providers;
- For budget authority, specifies the method for determining and adjusting the budget amount, and a procedure to evaluate expenditures; and
- Includes appropriate risk management techniques, including contingency plans, which recognize the roles and sharing of responsibilities in obtaining services in a self-directed manner and assure the appropriateness of this plan based upon the resources and support needs of the individual.

6. Voluntary and Involuntary Termination of Participant-Direction. *(Describe how the State facilitates an individual's transition from participant-direction, and specify any circumstances when transition is involuntary):*

The Care Manager assists the client with the selection of services as an alternative to participant directed services if the participant chooses to terminate the self directed services. The Care Manager discusses with the individual/family all the available options and resources available, updates the total plan of care and begins the process of referral to those options. Once the new options have been identified and secured, the care manager is responsible for ensuring a seamless transition for the participant. There is a wide range of services available under the 1915i that do not require the participant to self direct if they choose not to.

The participant could be terminated involuntarily from self direction if it is substantiated that they were aware of or a party to fraudulent claims.

7. Opportunities for Participant-Direction

a. Participant–Employer Authority (individual can hire and supervise staff). *(Select one):*

<input checked="" type="checkbox"/>	The State does not offer opportunity for participant-employer authority.
<input type="radio"/>	Participants may elect participant-employer Authority <i>(Check each that applies):</i>
<input checked="" type="checkbox"/>	Participant/Co-Employer. The participant (or the participant’s representative) functions as the co-employer (managing employer) of workers who provide waiver services. An agency is the common law employer of participant-selected/recruited staff and performs necessary payroll and human resources functions. Supports are available to assist the participant in conducting employer-related functions.
<input checked="" type="checkbox"/>	Participant/Common Law Employer. The participant (or the participant’s representative) is the common law employer of workers who provide waiver services. An IRS-approved Fiscal/Employer Agent functions as the participant’s agent in performing payroll and other employer responsibilities that are required by federal and state law. Supports are available to assist the participant in conducting employer-related functions.

b. Participant–Budget Authority (individual directs a budget). *(Select one):*

<input type="radio"/>	The State does not offer opportunity for participants to direct a budget.
<input type="radio"/>	Participants may elect Participant–Budget Authority.
	Participant-Directed Budget. <i>(Describe in detail the method(s) that are used to establish the amount of the budget over which the participant has authority, including how the method makes use of reliable cost estimating information, is applied consistently to each participant, and is adjusted to reflect changes in individual assessments and service plans. Information about these method(s) must be made publicly available and included in the plan of care):</i>
	Expenditure Safeguards. <i>(Describe the safeguards that have been established for the timely prevention of the premature depletion of the participant-directed budget or to address potential service delivery problems that may be associated with budget underutilization and the entity (or entities) responsible for implementing these safeguards):</i>

Quality Improvement Strategy

(Describe the State's quality improvement strategy in the tables below):

Discovery Activities				Remediation		
Requirement	Discovery Evidence (Performance Measures)	Discovery Activity (Source of Data & sample size)	Monitoring Responsibilities (agency or entity that conducts discovery activities)	Frequency	Remediation Responsibilities (Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)	Frequency of Analysis and Aggregation
Service plans address assessed needs of 1915(I) participants, are updated annually, and document choice of services and providers.	<p>1. Number and percent of service plans that are updated and revised annually.</p> <p>2. Number and percent of clients educated about the full range of services and choices of providers available as evidenced by their signature on the W-990 form, "Your</p>	Representative sample of record audits conducted by both the contracted entity and the SMA	Contracted Agency and SMA	Contracted entity- quarterly SMA- annually	SMA	Annually

Providers meet required qualifications.	Rights and Responsibilities Number and percent of providers that meet waiver qualifications for enrollment both initially and on an ongoing basis	State Medicaid Agency Audits Summary reports from Access Agencies	SMA MMIS Contractor Contracted Agencies doing FI functions	Annual audits Continuously and ongoing	SMA and contracted Access Agencies	Continuously and ongoing
The SMA retains authority and responsibility for program operations and oversight.	Number and percent of required reports received in accordance with contract requirements Number and percent of Access Agencies that are audited annually by SMA	Monthly, quarterly, semiannual and annual reports generated by contracted entity and reviewed by SMA	SMA and Contracted Agency	Monthly, quarterly, semiannually and annually	SMA	Continuously and ongoing
The SMA maintains financial accountability through payment of claims for services that	Access Agency is the billing provider for waiver services. Bills from	Access Agency-100% of all claims	Contracted entity		SMA and contracted entity	Continuously and ongoing

are authorized and furnished to 1915(I) participants by qualified providers.	provider entities are compared to authorized service plan.	100% of all claims	SMA, contracted entity	Continuously and ongoing	SMA, contracted entity	Continuously and ongoing
The State identifies, addresses and seeks to prevent incidents of abuse, neglect, and exploitation, including the use of restraints.	Edits and audits within MMIS Number and percent of serious incident reports that are reported to the ACU Nurse consultant within 48 hours as required by the waiver	Critical Incident Reports	Contracted Access Agency and SMA	Continuously and Ongoing	SMA	Continuously and ongoing
	The number and percent of critical incidents regarding waiver participants requiring investigation by Protective Services for Elders	Critical Incident Reports, Protective Services for elders reports	Contracted Access Agency and SMA	Continuously and ongoing	SMA	Continuously and ongoing

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System Improvement: <i>(Describe process for systems improvement as a result of aggregated discovery and remediation activities.)</i>	
Methods for Analyzing Data and Prioritizing Need for System Improvement	<p>The State of Connecticut has been utilizing a comprehensive system of checks and balances in order to establish consistent quality assurance within services provided to clients through its Medicaid Waiver and state funded Home Care Program for Elders. The state has been guided by state and federal regulations to assist in establishing procedures and the many varied data collection, aggregation and analysis processes that are currently utilized. Through the productive process of analysis, discovery, remediation and improvement, the state recognizes the benefit to client services that can be obtained through some system design changes.</p> <p>Statewide chart audits of access agency clients are conducted quarterly. Sampling size of client chart reviews requires a representative sample. Therefore, we have developed a system in which the Access Agencies</p>

provide data on supervisory record audits utilizing a tool developed by a Quality Improvement Committee consisting of both Access Agency and Alternate Care Unit (SMA) staff. A system was designed to accomplish a representative sample review by utilizing the data from that supervisory review supplemented by annual reviews done by SMA staff. We have added a quarterly reporting requirement for the Access Agencies to provide a summary report of supervisory record reviews done on a regular basis.

Service Plan

The SMA contracts with Access Agencies who provide independent care managers. The care managers complete a comprehensive, multi-dimensional assessment that is consumer centered and is the basis for the development of the service plan. The assessment instrument is designed to identify unmet needs and health and safety risk factors as well as personal goals. Service plans are updated and revised as client's needs change but no less frequently than annually. Department Utilization Review Nurses review and approve every initial plan of care before the services are implemented. The Care Manager monitors the clients' needs and the delivery of the authorized service plan on a monthly basis. Alternate Care Utilization Review staff also review a representative sample of reassessment plans of care. In addition SMA staff conducts annual record audits of the care managers' records. This combined with the Access Agency supervisory record review, constitutes a representative sample. Access agency care managers have been trained in person centered planning and further training is planned.

A tool was developed for access agency supervisors to complete when conducting supervisory record reviews. The data is summarized and reported to the SMA quarterly.

Consumer satisfaction surveys are conducted by both the Access Agency and SMA staff. The surveys are useful in identifying trends that may require system remediation.

Qualified Providers

Access Agencies are currently monitoring provider licensure, certification and qualifications at time of enrollment and every two years thereafter. The certifications and qualifications are incorporated into the regulations that govern the CT Home Care Program for Elders (17b-342). The Department has incorporated an expanded administrative review of audits to include verification that licensure, certification and qualifications are monitored and documented as required through contracts, policies and procedures.

The Department cross matches providers with the HHS-OIG Fraud Protection and Detection Exclusion list to block participation of providers found on this list.

Access Agencies perform checks of staff licensure (RN and SW if applicable) routinely at time hire and annual performance review.

The Access Agencies are required to have procedures in place to verify that subcontractors meet all of the criteria to be a waiver provider. They must provide documentation that the subcontractor meets Department standards and requirements to assure provider eligibility, adherence to program requirements and standards, quality of service delivery and that services are delivered in accordance with participants' plans of care.

Access Agencies are contractually obligated to assist providers in meeting the provider qualifications needed to be a participating provider. They offer training programs both for existing providers as well as for providers who wish to enroll. Documentation of the grievances and all of the accompanying correspondence is maintained in a central file in the Alternate Care Unit.

Access Agencies are also contractually required to audit a sample of the waiver providers to ensure that they have appropriate documentation to substantiate the claims that are billed.

Department audit staff also perform regular audit of the contracted providers

to ensure that services are documented and being billed accurately

Health and Welfare

The Department holds Access Agency meetings bi-monthly for the purpose of disseminating information and discussing issues of concern. Elder Protective Services (PSE), Alternate Care Unit and Access Agencies collaborate to identify and resolve health and safety concerns. The Alternate Care Unit Manager and/or Health and Safety Nurse Consultant have ongoing consultation and dialogue with the Protective Services for Elders manager as needed on case by case basis.

A workgroup was developed to facilitate discussions between access agencies, PSE and ACU staff with respect to informed risk versus self determination, i.e. what is an acceptable level of risk to both the client and the program.

All findings related to participant safeguards are entered into a data base within the Alternate Care Unit. Communications occur with the care manager and other Access Agency staff as appropriate for any corrective action or interventions. Access Agency staff monitors the waiver participants on a monthly basis and will continue to follow up on the identified problem as needed.

Self neglect was identified as a trend in Health and Safety Reporting. Improved collaboration between ACU, PSE and AA's was established for the purpose of updating "best practices" guidelines for care managers when addressing self-neglect issues.

Health standard monitoring is already in place at the Access Agency level, but data aggregation and reporting, including analysis for trending of this information, will be initiated in ACU in SFY 2012. Health promotion and prevention questions will be added to the Uniform Assessment Instrument and reported annually allowing for further analysis.

We intend to transition to a web based critical incident reporting system that was developed for the MFP Demonstration. This change is targeted for SFY 2012. In the interim, we track critical incident reports in an access data base.

Financial Accountability

The State of Connecticut contracts with HP (formerly EDS) to employ a data system to ensure reimbursement is consistent with waiver requirements. The Department introduced the MMIS system Interchange for the purpose of upgrading the old claims processing system. It is now a Windows environment. The MMIS has now been certified by CMS. The provider relations unit oversees the contract with HP, as part of the medical operations process. They can make changes to procedure codes, edits and audits. Clients are identified by Medical Eligibility or Benefit Plan code. Providers are based on type and specialty. The system is designed to make sure it can be billed only for what is allowed through the edits and audits system. We have requested this report from MAR on a semi-annual basis. Problematic providers will be identified for potential additional training. MAR reports 382 and 383 are already in place and can be separated by Medicaid eligibility code to identify the number, percent of denied claims, the error code reason, provider number, top 5 most frequently occurring error reasons, error status code. After the first six month report, Alternate Care Unit staff will decide if additional search codes should be requested to be added to the reports.

Methods and Standards for Establishing Payment Rates

1. **Services Provided Under Section 1915(i) of the Social Security Act.** For each optional service, describe the methods and standards used to set the associated payment rate. *(Check each that applies, and describe methods and standards to set rates):*

<input checked="" type="checkbox"/>	<p>HCBS Case Management</p> <p>Rates are determined by the Department's Rate Setting Unit.</p> <p>Pursuant to the Connecticut Department of Social Services Provider Manual, all schedules of payment for covered Medical Assistance Program goods and services shall be established by the Commissioner of Social Services and paid by the Department of Social Services in accordance with applicable federal and State states and regulations. Service rates are the same as the waiver service rates and are based on direct and indirect costs of providing HCBS services. Consumers, provider organizations and DSS staff have had the opportunity to review the application and rates pursuant to the public notice. The rate structure for the program consists of 1) fee-for-service billing from an established fee schedule that pays uniform rates across providers; 2) usual and customary rates established individually with providers based on special provider needs such as serving hazardous urban areas which require accompaniment by security personnel; 3) "up to max" rates that are used for assistive technology equipment or other services such as home modifications that require manual pricing. The only variance for the self directed care program is that the Access Agencies bill a claim processing fee for submitting claims on behalf of the self directed clients to Enterprises. Other than the self hire PCA rates do not vary for different providers of waiver services. Rates are usually prospective. If retroactive rate setting should occur, this will result in mass adjustments during a claim cycle to either compensate providers for a rate increase or recoupments if rates are decreased. During the life of this waiver service rates may be adjusted based on legislatively approved increases or decreases to the Department's appropriation. Case management services are priced at max fee.</p>
<input checked="" type="checkbox"/>	<p>HCBS Homemaker</p> <p>Same methodology as HCBS case management and Homemaker service is priced at max fee.</p>
<input checked="" type="checkbox"/>	<p>HCBS Assisted Living</p> <p>Same methodology as HCBS case management and Assisted Living is priced at max fee.</p>
<input checked="" type="checkbox"/>	<p>HCBS Personal Care Assistant</p> <p>Same methodology as HCBS Case Management and is priced at max fee. The client who self hires their PCA can decide the pay rate up to the maximum allowable rate. When the PCA is provided by an agency, the agency determines the rate of pay but the maximum allowable rate for the service is established by the department in its fee schedule. Other than the self hire PCA rates do not vary for different providers of waiver services</p>
<input checked="" type="checkbox"/>	<p>HCBS Adult Day Health</p> <p>Same methodology as HCBS Case Management and Adult Day Health is paid at max fee.</p>
<input checked="" type="checkbox"/>	<p>HCBS Assistive Technology</p> <p>Same methodology as HCBS Case Management but Assistive Technology is priced up to max and is capped at \$1,000 per year</p>

<input checked="" type="checkbox"/>	HCBS Respite Care
	Same methodology as HCBS Case Management and respite care services are priced at max fee
<input checked="" type="checkbox"/>	HCBS Chore Service
	Same methodology as HCBS Case Management and HCBS Chore service is priced at max fee
<input checked="" type="checkbox"/>	HCBS Companion
	Same methodology as HCBS Case Management and HCBS Companion service is priced at max fee
<input checked="" type="checkbox"/>	HCBS Environmental Accessibility Adaptations
	Same methodology as HCBS Case Management and HCBS Environmental Accessibility Adaptations are manually Priced.
<input checked="" type="checkbox"/>	HCBS Home Delivered meals
	Same methodology as HCBS Case Management and HCBS Home Delivered Meal service is priced at max fee
<input checked="" type="checkbox"/>	HCBS Mental Health Counseling
	Same methodology as HCBS Case Management and HCBS Mental Health Counseling service is priced at max fee
<input checked="" type="checkbox"/>	HCBS Personal Emergency Response Systems
	Same methodology as HCBS Case Management and HCBS Personal Emergency Response System service is priced at max fee
<input checked="" type="checkbox"/>	HCBS Transportation
	Same methodology as HCBS Case Management and HCBS Transportation service is priced at max fee

**NOTICE OF PROPOSED CHANGES TO THE STATE MEDICAID PLAN
CONCERNING CERTAIN HOME AND COMMUNITY BASED SERVICES**

Pursuant to Section 1915(i) of the Social Security Act, the Connecticut Department of Social Services intends to submit a state plan amendment to CMS for approval with an effective date on or after February 1, 2012.

Under State Plan Amendment # 12-001, DSS proposes to provide home and community based services including Case Management, Homemaker, Companion, Chore, Assisted Living, Adult Day Care, Emergency Response System, Personal Care Assistant, Respite, Assistive Technology, Home Delivered Meals, Mental Health Counseling and Transportation.

This service package will be available to Medicaid recipients 65 years of age and older in the categorically needy Medicaid coverage group who need assistance with one or two of the following daily activities: bathing, dressing, toileting, eating/feeding, transferring, medication administration and meal preparation. All persons wishing to access services will receive a comprehensive, in-home, multidimensional assessment to determine their unmet needs and develop a total plan of care.

The amendment will not result in additional state costs in SFY 2012 and 2013. However, expenditures for the program will qualify for federal financial participation of 50 per cent.

Copies of the proposed changes may be obtained at each of the DSS's regional offices and on the DSS web site: www.dss.state.ct.us Go to "Publications" and then to "News and Updates". For information please contact Kathy Bruni at 860-424-5177 or Kathy.a.bruni@ct.gov.

Written comments may be sent by November 30, 2011 to:

Director of Medical Care Administration
Re: TN 12-001 Home and Community Based Services – 1915(i) SPA
Department of Social Services
25 Sigourney Street, 11th floor
Hartford, CT 06106