

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

PURPOSE OF THE HCBS WAIVER PROGRAM

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

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

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

1. Request Information

- A. The **State of Connecticut** requests approval for an amendment to the following Medicaid home and community-based services waiver approved under authority of §1915(c) of the Social Security Act.
- B. **Program Title:**
CT ABI Waiver II
- C. **Waiver Number:** CT.1085
- D. **Amendment Number:**
- E. **Proposed Effective Date:** (mm/dd/yy)

05/01/16

Approved Effective Date of Waiver being Amended: 12/01/14

2. Purpose(s) of Amendment

Purpose(s) of the Amendment. Describe the purpose(s) of the amendment:

The purpose of this amendment is to request authority to change the care management service to an administrative service as well as change who is providing the case management service. The waiver case management service functions are added to the scope of the case management claimed as administrative match instead. Since the current waiver structure allows providers of other ABI waiver services to also provide case management, we are requesting this amendment to fully comply with CMS requirements for conflict free case management.

3. Nature of the Amendment

- A. **Component(s) of the Approved Waiver Affected by the Amendment.** This amendment affects the following component(s) of the approved waiver. Revisions to the affected subsection(s) of these component(s) are being submitted concurrently (*check each that applies*):

Component of the Approved Waiver	Subsection(s)
<input checked="" type="checkbox"/> Waiver Application	
<input checked="" type="checkbox"/> Appendix A Waiver Administration and Operation	A-1,3, 5, 7
<input checked="" type="checkbox"/> Appendix B Participant Access and Eligibility	B-2, B-6, B-QI, B-7e
<input checked="" type="checkbox"/> Appendix C Participant Services	C-1
<input checked="" type="checkbox"/> Appendix D Participant Centered Service Planning and Delivery	D-1
<input type="checkbox"/> Appendix E Participant Direction of Services	
<input type="checkbox"/> Appendix F Participant Rights	

Component of the Approved Waiver	Subsection(s)
<input type="checkbox"/> Appendix G Participant Safeguards	
<input type="checkbox"/> Appendix H	
<input checked="" type="checkbox"/> Appendix I Financial Accountability	I-2
<input checked="" type="checkbox"/> Appendix J Cost-Neutrality Demonstration	

B. Nature of the Amendment. Indicate the nature of the changes to the waiver that are proposed in the amendment (*check each that applies*):

- Modify target group(s)
- Modify Medicaid eligibility
- Add/delete services
- Revise service specifications
- Revise provider qualifications
- Increase/decrease number of participants
- Revise cost neutrality demonstration
- Add participant-direction of services
- Other

Specify:

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

1. Request Information (1 of 3)

A. The **State of Connecticut** requests approval for a Medicaid home and community-based services (HCBS) waiver under the authority of §1915(c) of the Social Security Act (the Act).

B. Program Title (*optional - this title will be used to locate this waiver in the finder*):

CT ABI Waiver II

C. Type of Request: amendment

Requested Approval Period: (*For new waivers requesting five year approval periods, the waiver must serve individuals who are dually eligible for Medicaid and Medicare.*)

- 3 years 5 years

Draft ID: **CT.035.00.05**

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

Regular Waiver ▼

E. Proposed Effective Date of Waiver being Amended: 12/01/14

Approved Effective Date of Waiver being Amended: 12/01/14

1. Request Information (2 of 3)

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

Hospital

Select applicable level of care

Hospital as defined in 42 CFR §440.10

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

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

Nursing Facility

Select applicable level of care

Nursing Facility as defined in 42 CFR §440.40 and 42 CFR §440.155

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

The Waiver Uses NF and ABI/NF

1.-Nursing Facility - As defined in 42 CFR §440.40 and 42 CFR §440.155

2.-Acquired Brain Injury Nursing Facility (ABI/NF) - A type of nursing facility that provides specialized programs for persons with acquired brain injury.

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

Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) (as defined in 42 CFR §440.150)

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

1. Request Information (3 of 3)

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

Not applicable

Applicable

Check the applicable authority or authorities:

Services furnished under the provisions of §1915(a)(1)(a) of the Act and described in Appendix I

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

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

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

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

§1915(b)(2) (central broker)

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

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

A program operated under §1932(a) of the Act.

Specify the nature of the State Plan benefit and indicate whether the State Plan Amendment has been submitted or previously approved:

A program authorized under §1915(i) of the Act.

A program authorized under §1915(j) of the Act.

A program authorized under §1115 of the Act.

Specify the program:

H. Dual Eligibility for Medicaid and Medicare.

Check if applicable:

This waiver provides services for individuals who are eligible for both Medicare and Medicaid.

2. Brief Waiver Description

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

Goals and Objectives

Connecticut's Acquired Brain Injury Waiver (ABI) serves persons who are at least 18 years of age with acquired brain injury who, without such services, would otherwise require placement in one of four types of institutional settings. It is designed to assist

participants to relearn, improve or retain the skills needed to support community living. The waiver employs the principles of person-centered planning to develop an adequate, appropriate and cost-effective plan of care from a menu of nineteen home and community-based services to achieve personal outcomes that support the individual's ability to live in his/her community of choice.

Organizational Structure:

The Department of Social Services (DSS), as the state Medicaid Agency pursuant to Connecticut General Statutes (CGS) 17b-1, directly administers the ABI Waiver according to CGS 17b-260a. DSS assures that all individuals receiving waiver services meet the categorically and medically needy eligibility and income/asset requirements. DSS is responsible for calculating the consumer's share of liability that can be applied to the cost of waiver services. DSS also informs individuals determined eligible to receive waiver services of their due process rights and gives them the choice of institutional or home and community-based services.

Case managers, contracted with the department as a result of competitive procurement, in consultation with the consumer, their family and care providers (e.g., skilled nursing/ABI facility staff, primary care physicians, and neuropsychologists) develop plans of care to meet an individual's cognitive, physical, and behavioral support needs. DSS clinical staff in the HCBS unit review completed Plans of Care (POC) for eligibility, service adequacy and responsiveness to the waiver participant's needs.

DSS contracts with a fiscal agent to conduct provider recruitment; training; engage in fiscal monitoring; claims processing and reporting; and provider credentialing. Quarterly reports, at a minimum, are submitted to the Department to facilitate State oversight of the waiver program. In addition, routine quality assurance activities through staff meetings, training; case conferences, consumer record maintenance, and staff supervision are components of the Department's oversight of the ABI waiver program.

Service Delivery

ABI Waiver credentialed providers deliver services in the client's home and community. These services are based on the plan developed in consultation with the provider team. The providers collaborate with the consumer and other members of the team to implement strategies to support community living. These include the following:

- Provide instruction and training in one or more areas of need to enhance the participant's ability to live independently in their own home
- Implement strategies to address behavioral, medical or other needs identified in the ABI Service Plan
- Provide assistance with personal care or activities of daily living
- Support the attainment of vocational skills
- Provide training or practice in consumer skills (e.g., banking, budgeting, shopping)

3. Components of the Waiver Request

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

- A. Waiver Administration and Operation.** Appendix A specifies the administrative and operational structure of this waiver.
- B. Participant Access and Eligibility.** Appendix B specifies the target group(s) of individuals who are served in this waiver, the number of participants that the State expects to serve during each year that the waiver is in effect, applicable Medicaid eligibility and post-eligibility (if applicable) requirements, and procedures for the evaluation and reevaluation of level of care.
- C. Participant Services.** Appendix C specifies the home and community-based waiver services that are furnished through the waiver, including applicable limitations on such services.
- D. Participant-Centered Service Planning and Delivery.** Appendix D specifies the procedures and methods that the State uses to develop, implement and monitor the participant-centered service plan (of care).
- E. Participant-Direction of Services.** When the State provides for participant direction of services, Appendix E specifies the participant direction opportunities that are offered in the waiver and the supports that are available to participants who direct their services. (*Select one*):
 - Yes. This waiver provides participant direction opportunities.** Appendix E is required.
 - No. This waiver does not provide participant direction opportunities.** Appendix E is not required.
- F. Participant Rights.** Appendix F specifies how the State informs participants of their Medicaid Fair Hearing rights and other procedures to address participant grievances and complaints.
- G. Participant Safeguards.** Appendix G describes the safeguards that the State has established to assure the health and welfare of waiver participants in specified areas.
- H. Quality Improvement Strategy.** Appendix H contains the Quality Improvement Strategy for this waiver.

I. Financial Accountability. Appendix I describes the methods by which the State makes payments for waiver services, ensures the integrity of these payments, and complies with applicable federal requirements concerning payments and federal financial participation.

J. Cost-Neutrality Demonstration. Appendix J contains the State's demonstration that the waiver is cost-neutral.

4. Waiver(s) Requested

A. Comparability. The State requests a waiver of the requirements contained in §1902(a)(10)(B) of the Act in order to provide the services specified in Appendix C that are not otherwise available under the approved Medicaid State plan to individuals who: (a) require the level(s) of care specified in Item 1.F and (b) meet the target group criteria specified in Appendix B.

B. Income and Resources for the Medically Needy. Indicate whether the State requests a waiver of §1902(a)(10)(C)(i)(III) of the Act in order to use institutional income and resource rules for the medically needy (*select one*):

Not Applicable

No

Yes

C. Statewideness. Indicate whether the State requests a waiver of the statewideness requirements in §1902(a)(1) of the Act (*select one*):

No

Yes

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

Geographic Limitation. A waiver of statewideness is requested in order to furnish services under this waiver only to individuals who reside in the following geographic areas or political subdivisions of the State.

Specify the areas to which this waiver applies and, as applicable, the phase-in schedule of the waiver by geographic area:

Limited Implementation of Participant-Direction. A waiver of statewideness is requested in order to make *participant-direction of services* as specified in Appendix E available only to individuals who reside in the following geographic areas or political subdivisions of the State. Participants who reside in these areas may elect to direct their services as provided by the State or receive comparable services through the service delivery methods that are in effect elsewhere in the State.

Specify the areas of the State affected by this waiver and, as applicable, the phase-in schedule of the waiver by geographic area:

5. Assurances

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

A. Health & Welfare: The State assures that necessary safeguards have been taken to protect the health and welfare of persons receiving services under this waiver. These safeguards include:

1. As specified in Appendix C, adequate standards for all types of providers that provide services under this waiver;
2. Assurance that the standards of any State licensure or certification requirements specified in Appendix C are met for services or for individuals furnishing services that are provided under the waiver. The State assures that these requirements are met on the date that the services are furnished; and,
3. Assurance that all facilities subject to §1616(e) of the Act where home and community-based waiver services are provided comply with the applicable State standards for board and care facilities as specified in Appendix C.

B. Financial Accountability. The State assures financial accountability for funds expended for home and community-based services and maintains and makes available to the Department of Health and Human Services (including the Office of the Inspector General), the Comptroller General, or other designees, appropriate financial records documenting the cost of services provided under the waiver. Methods of financial accountability are specified in Appendix I.

- C. Evaluation of Need:** The State assures that it provides for an initial evaluation (and periodic reevaluations, at least annually) of the need for a level of care specified for this waiver, when there is a reasonable indication that an individual might need such services in the near future (one month or less) but for the receipt of home and community-based services under this waiver. The procedures for evaluation and reevaluation of level of care are specified in **Appendix B**.
- D. Choice of Alternatives:** The State assures that when an individual is determined to be likely to require the level of care specified for this waiver and is in a target group specified in **Appendix B**, the individual (or, legal representative, if applicable) is:
1. Informed of any feasible alternatives under the waiver; and,
 2. Given the choice of either institutional or home and community-based waiver services. **Appendix B** specifies the procedures that the State employs to ensure that individuals are informed of feasible alternatives under the waiver and given the choice of institutional or home and community-based waiver services.
- E. Average Per Capita Expenditures:** The State assures that, for any year that the waiver is in effect, the average per capita expenditures under the waiver will not exceed 100 percent of the average per capita expenditures that would have been made under the Medicaid State plan for the level(s) of care specified for this waiver had the waiver not been granted. Cost-neutrality is demonstrated in **Appendix J**.
- F. Actual Total Expenditures:** The State assures that the actual total expenditures for home and community-based waiver and other Medicaid services and its claim for FFP in expenditures for the services provided to individuals under the waiver will not, in any year of the waiver period, exceed 100 percent of the amount that would be incurred in the absence of the waiver by the State's Medicaid program for these individuals in the institutional setting(s) specified for this waiver.
- G. Institutionalization Absent Waiver:** The State assures that, absent the waiver, individuals served in the waiver would receive the appropriate type of Medicaid-funded institutional care for the level of care specified for this waiver.
- H. Reporting:** The State assures that annually it will provide CMS with information concerning the impact of the waiver on the type, amount and cost of services provided under the Medicaid State plan and on the health and welfare of waiver participants. This information will be consistent with a data collection plan designed by CMS.
- I. Habilitation Services.** The State assures that prevocational, educational, or supported employment services, or a combination of these services, if provided as habilitation services under the waiver are: (1) not otherwise available to the individual through a local educational agency under the Individuals with Disabilities Education Act (IDEA) or the Rehabilitation Act of 1973; and, (2) furnished as part of expanded habilitation services.
- J. Services for Individuals with Chronic Mental Illness.** The State assures that federal financial participation (FFP) will not be claimed in expenditures for waiver services including, but not limited to, day treatment or partial hospitalization, psychosocial rehabilitation services, and clinic services provided as home and community-based services to individuals with chronic mental illnesses if these individuals, in the absence of a waiver, would be placed in an IMD and are: (1) age 22 to 64; (2) age 65 and older and the State has not included the optional Medicaid benefit cited in 42 CFR §440.140; or (3) age 21 and under and the State has not included the optional Medicaid benefit cited in 42 CFR § 440.160.

6. Additional Requirements

Note: Item 6-I must be completed.

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

- D. Access to Services.** The State does not limit or restrict participant access to waiver services except as provided in **Appendix C**.
- E. Free Choice of Provider.** In accordance with 42 CFR §431.151, a participant may select any willing and qualified provider to furnish waiver services included in the service plan unless the State has received approval to limit the number of providers under the provisions of §1915(b) or another provision of the Act.
- F. FFP Limitation.** In accordance with 42 CFR §433 Subpart D, FFP is not claimed for services when another third-party (e.g., another third party health insurer or other federal or state program) is legally liable and responsible for the provision and payment of the service. FFP also may not be claimed for services that are available without charge, or as free care to the community. Services will not be considered to be without charge, or free care, when (1) the provider establishes a fee schedule for each service available and (2) collects insurance information from all those served (Medicaid, and non-Medicaid), and bills other legally liable third party insurers. Alternatively, if a provider certifies that a particular legally liable third party insurer does not pay for the service(s), the provider may not generate further bills for that insurer for that annual period.
- G. Fair Hearing:** The State provides the opportunity to request a Fair Hearing under 42 CFR §431 Subpart E, to individuals: (a) who are not given the choice of home and community-based waiver services as an alternative to institutional level of care specified for this waiver; (b) who are denied the service(s) of their choice or the provider(s) of their choice; or (c) whose services are denied, suspended, reduced or terminated. **Appendix F** specifies the State's procedures to provide individuals the opportunity to request a Fair Hearing, including providing notice of action as required in 42 CFR §431.210.
- H. Quality Improvement.** The State operates a formal, comprehensive system to ensure that the waiver meets the assurances and other requirements contained in this application. Through an ongoing process of discovery, remediation and improvement, the State assures the health and welfare of participants by monitoring: (a) level of care determinations; (b) individual plans and services delivery; (c) provider qualifications; (d) participant health and welfare; (e) financial oversight and (f) administrative oversight of the waiver. The State further assures that all problems identified through its discovery processes are addressed in an appropriate and timely manner, consistent with the severity and nature of the problem. During the period that the waiver is in effect, the State will implement the Quality Improvement Strategy specified in **Appendix H**.
- I. Public Input.** Describe how the State secures public input into the development of the waiver:
Prior to drafting the new waiver, a forum sponsored by the Brain Injury Alliance of CT was held on September 17, 2013. On October 7, 2013, comments were received from the Traumatic Brain Injury Advisory Board. Pursuant to Connecticut General Statutes Section 17b-8, the Commissioner of Social Services shall publish a notice that the commissioner intends to seek such a waiver or submit a proposed amendment to the federal government in the Connecticut Law Journal, along with a summary of the provisions of the waiver application or the proposed amendment and the manner in which individuals may submit comments. The commissioner shall allow fifteen days for written comments on the waiver application or proposed amendment prior to submission of the application for a waiver or proposed amendment to the General Assembly under subsection (a) of this section and shall include all written comments with the waiver application or proposed amendment in the submission to the General Assembly.
The Department published notice in the CT Law Journal on January 7, 2014, and received multiple comments from entities such as the Brain Injury Alliance of CT and the CT Brain Injury Support Network as well as a large number of consumers during the 15 day comment period. Those comments resulted in some modifications and additions to the waiver. The primary concerns expressed were regarding the 150% cost cap and the impact of the new waiver on the existing ABI waiver.

In August 2014, CMS advised that the waiver with the changes as a result of the RAI should be posted and offer another comment period. The department posted the waiver document itself as well as a summary document that outlined all of the changes made as a result of the RAI. A 15 day comment period was provided and closed on September 10th. Two advocacy groups and two advocates submitted comments. There were comments regarding the clarification to the service definition of cognitive behaviorist needing to be based on an in person, face to face visit. There was both support and opposition expressed to this clarification. The department opted to leave this clarification in the waiver as it is consistent with best practice. Several persons expressed concern about the new two year limit on the pre-vocational service and said that it violates federal regulations. We consulted with CMS for clarification on the rationale behind the two year limit. The department received confirmation from CMS that the service definition for prevocational services is consistent with CMS guidance to states on employment related service requirements. There were also comments regarding whether CARF or JCAHO certification was required for some services. This was clarified in the application to identify that the certification could be CARF or JCAHO but also the requirement could be met if all requirements listed under other standards were met.

For this amendment, notice was posted in print in the CT Law Journal as well as on the DSS web site and the notice requested comments for a 30 day period. No comments were received.

For this amendment(5-1-16) regarding changing care management, the department held an informational forum for participants and their family members on October 1st. A presentation was also done for the ABI Waiver Advisory Committee on September 10, 2015. In addition a printed notice was published in the CT Law Journal on October 20, 2015

and published on the department's web site on October 27, 2015. The two Connecticut tribes were notified on October 8, 2015. No comments were received regarding this amendment.

A public hearing was held on December 17, 2015. The Committees of cognizance did not approve submission of the amendment. Public comment focused on the qualifications and experience of the proposed care managers.

The department made modifications to the waiver amendment and reposted notice in the CT Law Journal on February 9, 2016 and on the DSS website on February 3, 2016. A 30 day comment period was provided.

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

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

7. Contact Person(s)

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

Last Name:

Bruni

First Name:

Kathy

Title:

Director, Home and community Based Services

Agency:

CT Department of Social Services

Address:

55 Farmington Ave

Address 2:

City:

Hartford

State:

Connecticut

Zip:

06105

Phone:

(860) 424-5177 **Ext:** TTY

Fax:

(860) 424-4963

E-mail:

kathy.a.bruni@ct.gov

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

Last Name:

First Name:

Title:

Agency:

Address:

Address 2:

City:

State:

Connecticut

Zip:

Phone:

 Ext: **TTY**

Fax:

E-mail:

8. Authorizing Signature

This document, together with the attached revisions to the affected components of the waiver, constitutes the State's request to amend its approved waiver under §1915(c) of the Social Security Act. The State affirms that it will abide by all provisions of the waiver, including the provisions of this amendment when approved by CMS. The State further attests that it will continuously operate the waiver in accordance with the assurances specified in Section V and the additional requirements specified in Section VI of the approved waiver. The State certifies that additional proposed revisions to the waiver request will be submitted by the Medicaid agency in the form of additional waiver amendments.

Signature:

State Medicaid Director or Designee

Submission Date:

Note: The Signature and Submission Date fields will be automatically completed when the State Medicaid Director submits the application.

Last Name:

McEvoy

First Name:

Kate

Title:

Director of the Division of Health Services

Agency:

Ct Department of Social Services

Address:

55 Farmington Ave.

Address 2:

City:

Hartford

State:

Connecticut

Zip:

06105

Phone:

(860) 424-5383

Ext:

TTY

Fax:

(860) 424-4963

E-mail:

kate.mcevoy@ct.gov

Attachments

Attachment #1: Transition Plan

Check the box next to any of the following changes from the current approved waiver. Check all boxes that apply.

- Replacing an approved waiver with this waiver.
- Combining waivers.
- Splitting one waiver into two waivers.
- Eliminating a service.
- Adding or decreasing an individual cost limit pertaining to eligibility.
- Adding or decreasing limits to a service or a set of services, as specified in Appendix C.
- Reducing the unduplicated count of participants (Factor C).
- Adding new, or decreasing, a limitation on the number of participants served at any point in time.
- Making any changes that could result in some participants losing eligibility or being transferred to another waiver under 1915(c) or another Medicaid authority.
- Making any changes that could result in reduced services to participants.

Specify the transition plan for the waiver:

Eliminating a service that will be available under the Medicaid state plan. Participants will not be impacted.

The state intends to operate a concurrent 1915k that will offer self directed PCA, PERS, Home Delivered Meals, transitional services, environmental accessibility adaptations, assistive technology, and health coaching. It is the state's intention to assure that the effective dates for changes in the program authority will coincide so participants will continue to receive seamless services. Neither participants nor providers will be impacted by this seamless transition.

Participants will be notified by staff supporting the CFC initiative that their services will be provided as a state plan service. Although we do not anticipate any reductions in services, if that should be indicated, the participant would have rights to a Fair hearing.

For the amendment requested for 5/1/16: The case management service currently in the waiver is bifurcated consisting of the DSS social workers doing the assessment and care plan development as an administrative service with case management also provided as a waiver service. The state is striving to comply with CMS' conflict free case management requirements and will be eliminating case management as a waiver service but providing it instead as a comprehensive administrative service. The new providers will be selected as the result of a competitive procurement and the selected providers will not be providers of other ABI services.

Attachment #2: Home and Community-Based Settings Waiver Transition Plan

Specify the state's process to bring this waiver into compliance with federal home and community-based (HCB) settings requirements at 42 CFR 441.301(c)(4)-(5), and associated CMS guidance.

Consult with CMS for instructions before completing this item. This field describes the status of a transition process at the point in time of submission. Relevant information in the planning phase will differ from information required to describe attainment of milestones.

To the extent that the state has submitted a statewide HCB settings transition plan to CMS, the description in this field may reference that statewide plan. The narrative in this field must include enough information to demonstrate that this waiver complies with federal HCB settings requirements, including the compliance and transition requirements at 42 CFR 441.301(c)(6), and that this submission is consistent with the portions of the statewide HCB settings transition plan that are germane to this waiver. Quote or summarize germane portions of the statewide HCB settings transition plan as required.

Note that Appendix C-5 HCB Settings describes settings that do not require transition; the settings listed there meet federal HCB setting requirements as of the date of submission. Do not duplicate that information here.

Update this field and Appendix C-5 when submitting a renewal or amendment to this waiver for other purposes. It is not necessary for the state to amend the waiver solely for the purpose of updating this field and Appendix C-5. At the end of the state's HCB settings transition process for this waiver, when all waiver settings meet federal HCB setting requirements, enter "Completed" in this field, and include in Section C-5 the information on all HCB settings in the waiver.

The state assures that the settings transition plan included with this waiver amendment will be subject to any provisions or requirements included in the State's approved Statewide Transition Plan. The State will implement any required changes upon approval of the Statewide Transition Plan and will make conforming changes to its waiver when it submits the next amendment or renewal.

Additional Needed Information (Optional)

Provide additional needed information for the waiver (optional):

The state will assess the settings in which waiver applicants reside for compliance with the new rules as they apply for and are assessed for participation in the waiver. Waiver participants reside in their own homes, apartments or with family members. Under this waiver, participants may also choose to reside in provider owned homes. Prior to an individual accessing any of the services listed below the state will verify that the provider owned or controlled setting comports with CMS home and community based settings requirements through its person centered assessment process. The person centered assessment is completed to determine functional eligibility for the waiver and must be completed prior to waiver services being authorized to begin. If the social worker assesses that the setting is not compliant with the new rules, the social worker will discuss and offer the participant alternative settings that would be compliant. The applicant could choose another setting or remain in their current setting. If they stay in the setting that has been assessed not to be compliant, they would not be approved to receive services under this waiver.

When a waiver participant chooses to live in a provider owned setting the department's social worker will, prior to initiating services, utilize a checklist that will ensure within the setting that:

- the person has a lease
- the individual has privacy including lockable doors
- have a choice of roommates
- freedom to control their own schedules
- free to have visitors
- is integrated into the community and facilitates access to community activities such as movies, shopping, recreational activities

To meet this requirement on an ongoing basis, case managers will continue to review the participant's choice of settings at reassessments and team meetings. This will ensure that all settings where individuals receive services will continue to meet the HCB settings requirements on an ongoing basis. In addition to the individual review of the setting done by the case manager, the state will also verify compliance with the settings requirements during the provider credentialing and re-credentialing process. Currently providers are credentialed every two years. We have reviewed existing regulations for other waivers that provide this service. The current regulations contain no language that is out of compliance with the settings requirements. The regulations specify the following:

"Adult day health services are provided through a community-based program designed to meet the needs of cognitively and physically impaired adults through a structured, comprehensive program that provides a variety of health, social and related support services including, but not limited to, socialization, supervision and monitoring, personal care and nutrition in a protective setting during any part of a day. There are two different models of adult day health services: The social model and the medical model." We intend to amend the regulations to be more clear about what is required.

In addition, as regulations are modified for this waiver, we will include CMS settings language into the regulations.

Adult Day Health is a service that is provided in a group setting outside of the waiver participants home. By definition, the service is to reduce isolation and facilitate integration, socialization and access to activities. Additionally, the service:

- is chosen by the participant from a selection of services from qualified providers
- is selected by the participant as part of the person centered planning process
- facilitates integration to community activities and employment
- facilitates interaction with non-Medicaid recipients

The state has assessed the Adult Day Health Service with regard to the new settings requirements. Initially, the state met with the Adult Day Care Association certification team to discuss the certification process. Our assessment of the certification process concluded that there is no conflict between the certification process and the settings requirements. The process ensures compliance with the CMS settings requirements. However to reinforce and strengthen the certifications process, the state working with the association, will include language from the final rule in their certification standards by 12/31/14.

In addition, in collaboration with the ADC Association, the Department specifically reviewed weekly and monthly calendars for programs that were adjacent to or on the grounds of a non public facility. There are no ADC programs on the grounds of or adjacent to a public facility. There are several programs located adjacent to a private facility and others that are on the grounds of communities that have a range of levels of care ranging from complete independent living to nursing home. In all cases, the activities calendars indicated that the program serves to facilitate integration into the community and interaction with non-HCBS program participants. For example, one center had activities such as a trip to the Hartford Symphony, games, outdoor gardening, movies, religious services, bocchi, an outing to a restaurant for lunch, shopping, reiki, manicures, picnic at a local park as well as other club type activities. Department staff have also visited a number of the day programs and overall were quite impressed by the quality and range of programming and services offered. Visits to the programs will be integrated into the department's quality assurance activities on an ongoing basis. The department will add language to existing regulations to emphasize the intent of the final rules. This will be accomplished by December 31, 2015. We also surveyed care managers who regularly visit waiver participants at the day programs and the survey results concluded that the centers comply with the settings requirements. Based on our assessment of the service definitions, certification standards, direct observation, review of weekly and monthly schedules of activities and survey data supplied by care managers, the department has concluded that this service fully comports with the CMS final rules. There were two centers who scored lower than the others. Although we have concluded that those two centers meet the minimum requirements for compliance with the settings regulation, our intention is to work with those two centers on a quality improvement plan.

The five other services that DSS identified for further review are:

- Prevocational Services;
- Supported Employment;
- ABI Group Day;
- Community Living Support Services; and
- Substance Abuse Programs.

DSS has operating regulations for the existing ABI Waiver (CT.0302) and all of the services below are included in both the existing waiver and this new waiver. In the absence of fully promulgated regulations, these operating regulations published 4/1/13 serve as the standard that determines operation of the waiver.

DSS reviewed the operating program regulations and service definitions for Prevocational Services DSS and determined that:

- The service is selected by the participant as part of the person centered planning process from a range of available services and

qualified providers.

- The service facilitates access to the community and supports access to employment in competitive integrated settings.
- The certification process for providers of this service emphasizes participants' rights to privacy, dignity and respect.
- This service is provided either in the participant's home or in a fully integrated work setting.

The service definition specifies that services are not delivered in facility based, congregate or sheltered work settings where individuals are supervised for the primary purpose of producing goods or performing services.

Based on this assessment, we have concluded that this service is compliant with the CMS final rules.

Based on review of the operating program regulations and service definitions, DSS has concluded that Supported Employment complies with the new HCB settings requirements because:

- The service is selected by the participant as part of the person centered planning process from a range of available services and qualified providers.
- The service facilitates access to the community.
- The service facilitates interaction with non-Medicaid individuals.
- The certification process for providers of this service emphasizes participants' rights to privacy, dignity and respect.
- The service is provided in a competitive work setting that employs persons both with and without disabilities.

Based on a review of the operating program regulations and the service definitions included in this waiver application DSS has concluded that ABI Group Day complies with the new HCB settings requirements because:

- The service is selected by the participant as part of the person centered planning process from a range of available services and qualified providers.
- The service facilitates access to the community.
- The service facilitates interaction with non-Medicaid individuals.
- The certification process for providers of this service emphasizes participants' rights to privacy, dignity and respect.
- The service is not provided in a facility setting. It is provided in the home or an agency based setting that might teach such skills as meal planning and preparation, mobility training, or relaxation techniques.

Another example might be taking several waiver participants out to a community activity such as shopping, the library, a movie or lunch.

Based on a review of the draft program regulations and the service definitions DSS has concluded that Community Living Support Services complies with the new HCB settings requirements because:

- The service is selected by the participant as part of the person centered planning process from a range of available services and qualified providers.
- The service facilitates access to the community.
- The service facilitates interaction with non-Medicaid individuals.
- The certification process for providers of this service emphasizes participants' rights to privacy, dignity and respect.
- The service is provided in the participant's own home including a private or family home or in a setting owned or controlled by a provider. The service is not provided in a facility/congregate setting

Upon review of the draft program regulations and the service definitions DSS has concluded that Substance Abuse Programs complies with the new HCB settings requirements because this service is provided in the community or clinic settings, not institutional settings.

As providers enroll to be providers under this waiver, the department will review the service definitions with them to ensure that only those providers who meet HCBS settings requirements can enroll and provide services under this waiver.

Appendix A: Waiver Administration and Operation

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

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

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

- The Medical Assistance Unit.**

Specify the unit name:

HCBS Unit

(Do not complete item A-2)

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

Specify the division/unit name. This includes administrations/divisions under the umbrella agency that has been identified as the Single State Medicaid Agency.

(Complete item A-2-a).

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

Specify the division/unit name:

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

Appendix A: Waiver Administration and Operation

2. Oversight of Performance.

- a. Medicaid Director Oversight of Performance When the Waiver is Operated by another Division/Unit within the State Medicaid Agency.** When the waiver is operated by another division/administration within the umbrella agency designated as the Single State Medicaid Agency. Specify (a) the functions performed by that division/administration (i.e., the Developmental Disabilities Administration within the Single State Medicaid Agency), (b) the document utilized to outline the roles and responsibilities related to waiver operation, and (c) the methods that are employed by the designated State Medicaid Director (in some instances, the head of umbrella agency) in the oversight of these activities:

As indicated in section 1 of this appendix, the waiver is not operated by another division/unit within the State Medicaid agency. Thus this section does not need to be completed.

- b. Medicaid Agency Oversight of Operating Agency Performance.** When the waiver is not operated by the Medicaid agency, specify the functions that are expressly delegated through a memorandum of understanding (MOU) or other written document, and indicate the frequency of review and update for that document. Specify the methods that the Medicaid agency uses to ensure that the operating agency performs its assigned waiver operational and administrative functions in accordance with waiver requirements. Also specify the frequency of Medicaid agency assessment of operating agency performance:

As indicated in section 1 of this appendix, the waiver is not operated by a separate agency of the State. Thus this section does not need to be completed.

Appendix A: Waiver Administration and Operation

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

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

Specify the types of contracted entities and briefly describe the functions that they perform. *Complete Items A-5 and A-6.:* DSS contracts with a non-profit fiscal intermediary that does not provide ABI Waiver Services. DSS recently issued a request for proposal for this service and this entity was again determined the successful bidder. Provides fiduciary, training, and credentialing services. (See Items A-5 and A-6).

BIACs contract is an infrastructure grant to support organization general advocacy activities. It is not client-based contract, but BIAC has the capacity and does support participants. they provide advocacy, support groups and client support at team meetings on a self referred basis.

DSS is also contracting with new providers of care management effective 5/1/16. The providers will be selected as the result of a competitive procurement.

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

Appendix A: Waiver Administration and Operation

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

Not applicable

Applicable - Local/regional non-state agencies perform waiver operational and administrative functions.

Check each that applies:

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

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

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

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

Appendix A: Waiver Administration and Operation

5. **Responsibility for Assessment of Performance of Contracted and/or Local/Regional Non-State Entities.** Specify the state agency or agencies responsible for assessing the performance of contracted and/or local/regional non-state entities in conducting waiver operational and administrative functions:

The Department of Social Services (i.e., Home and Community Based Services and Quality Assurance) is responsible for assessing the performance of the fiscal intermediary which performs operational and administrative duties for the ABI Waiver. The FI is responsible for provider credentialing and enrollment. This entity also does payroll processing for self-directed staff and claims processing to the MMIS on behalf of performing service providers and reimburses providers for services provided. They coordinate training for all provider types and conduct trainings employers/participants who choose to self-direct their staff.

The DSS HCBS unit is responsible to monitor the performance of the contracted case management providers.

Appendix A: Waiver Administration and Operation

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

DSS directly ensures that all waiver services must be included in a plan of care that is signed by the consumer, case manager and department prior to implementation of services. DSS has a contract with a fiscal intermediary to perform operational/administrative duties. The department assesses the performance of waiver functions, for which the contractor responsible, on an ongoing and regular basis, using diverse methods. These methods and frequency of their use are specified below:

1. Quarterly and ad hoc reports from the fiscal intermediary (All Functions)
2. Annual on-site visits to review operational and administrative functions (All Functions)
3. DSS staff attends trainings administered/approved by the fiscal intermediary to assess quality and consistency (2 times annually) (Training Function)
4. Annual on site record reviews of client records by case management agency.
5. Review of required case management agency client satisfaction surveys data

6. DSS staff attends a number of forums to gather information in each area of the state about how the Waiver is functioning. These include but are not limited to the following:
- a. Brain Injury Alliance of Connecticut support group meetings (1 in each of Connecticut's 3 geographic regions). Participants: persons with brain injuries (Waiver and non-waiver) and their family members. (All Functions with an emphasis on claims payment for self-directed services, general responsiveness)
 - b. The Traumatic Brain Injury Advisory Committee (All Functions with an emphasis on provider recruitment, training, and credentialing)
 - c. Provider Council Meetings facilitated by the Brain Injury Alliance of Connecticut (BIAC) (bi-monthly). Participants: ABI Waiver Providers(All Functions with an emphasis on provider credentialing and vendor claims payment)

Attendance at each of these forums provides department staff with feedback on the performance of the FI functions. It is an open forum where consumers are encouraged to share experiences with the FI both positive and negative. We seek feedback on payroll processing, frequency and quality of training and claims payment.

7. Ongoing correspondence between the fiscal intermediary and DSS staff regarding progress on deliverables (e.g., claims processing, training schedules, numbers of credentialed providers, etc.) (All Functions)

8. A bi-annual survey of waiver participants is issued to consumers, advocates and providers to gauge the functioning of the Waiver, including its fiscal intermediary. (All Functions with an emphasis on claims payment for self-directed services, general responsiveness)

9. DSS shall facilitate an interagency advisory board established pursuant to statutory requirements consisting of consumers, waiver providers and others to study the impact of the cost cap and other matters the Board deems appropriate by February 1, 2015. (All Functions)

The aforementioned approaches aid the department in measuring, observing and seeking feedback of the contracted provider in regard to performance of assigned duties.

Appendix A: Waiver Administration and Operation

- 7. Distribution of Waiver Operational and Administrative Functions.** In the following table, specify the entity or entities that have responsibility for conducting each of the waiver operational and administrative functions listed (*check each that applies*): In accordance with 42 CFR §431.10, when the Medicaid agency does not directly conduct a function, it supervises the performance of the function and establishes and/or approves policies that affect the function. All functions not performed directly by the Medicaid agency must be delegated in writing and monitored by the Medicaid Agency. *Note: More than one box may be checked per item. Ensure that Medicaid is checked when the Single State Medicaid Agency (1) conducts the function directly; (2) supervises the delegated function; and/or (3) establishes and/or approves policies related to the function.*

Function	Medicaid Agency	Contracted Entity
Participant waiver enrollment	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Waiver enrollment managed against approved limits	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Waiver expenditures managed against approved levels	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Level of care evaluation	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Review of Participant service plans	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Prior authorization of waiver services	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Utilization management	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Qualified provider enrollment	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Execution of Medicaid provider agreements	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Establishment of a statewide rate methodology	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Rules, policies, procedures and information development governing the waiver program	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Quality assurance and quality improvement activities	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>

Appendix A: Waiver Administration and Operation

Quality Improvement: Administrative Authority of the Single State Medicaid Agency

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

a. Methods for Discovery: Administrative Authority

The Medicaid Agency retains ultimate administrative authority and responsibility for the operation of the waiver program by exercising oversight of the performance of waiver functions by other state and local/regional non-state agencies (if appropriate) and contracted entities.

i. Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance, complete the following. Performance measures for administrative authority should not duplicate measures found in other appendices of the waiver application. As necessary and applicable, performance measures should focus on:

- Uniformity of development/execution of provider agreements throughout all geographic areas covered by the waiver
- Equitable distribution of waiver openings in all geographic areas covered by the waiver
- Compliance with HCB settings requirements and other new regulatory components (for waiver actions submitted on or after March 17, 2014)

Where possible, include numerator/denominator.

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

Performance Measure:

Number and percent of data reports specified in the agreement with the Medicaid Agency that were submitted on time and in the correct format by the Fiscal Intermediary. Numerator = number of on time reports Denominator=total number of reports received.

Data Source (Select one):

Other

If 'Other' is selected, specify:

Reports from the fiscal intermediary

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input checked="" type="checkbox"/> Other Specify: Fiscal Intermediary- Allied Community Resources	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input checked="" type="checkbox"/> Other Specify: Fiscal Intermediary	<input type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

Performance Measure:

Number and percent of claims paid in accordance with the participant's authorized services.
Numerator= authorized claims payments, Denominator= number of payments.

Data Source (Select one):

Record reviews, on-site

If 'Other' is selected, specify:

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

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input checked="" type="checkbox"/> Other Specify: Fiscal Intermediary	<input type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

Performance Measure:

Number and Percent of new waiver providers who complete required training prior to delivery of services. Numerator = number of new waiver providers who received training prior to service delivery and denominator = total number of new providers trained.

Data Source (Select one):

Record reviews, on-site

If 'Other' is selected, specify:

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

Data Aggregation and Analysis:

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

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input checked="" type="checkbox"/> Other Specify: Fiscal Intermediary	<input type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

Performance Measure:

Number of background checks conducted by the fiscal intermediary in accordance with contract requirements. Numerator = number of background checks completed according to contract requirements and denominator = number of background checks completed

Data Source (Select one):

Reports to State Medicaid Agency on delegated Administrative functions

If 'Other' is selected, specify:

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

Data Aggregation and Analysis:

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

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

Performance Measure:

Number and percent of case management providers that receive both a clinical and administrative review by department staff on an annual basis.

Data Source (Select one):

Record reviews, on-site

If 'Other' is selected, specify:

Responsible Party for data collection/generation(check each that applies):	Frequency of data collection/generation(check each that applies):	Sampling Approach(check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input checked="" type="checkbox"/> Other Specify: contracted case management provider	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

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

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

- ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible. The HCBS unit manager and director have ongoing correspondence with the fiscal intermediary, including a monthly conference call to proactively address any issues or potential issues. Public Assistance Consultant, a member of the HCBS staff has ongoing correspondence with the fiscal intermediary, including a bi-weekly conference call to proactively address eligibility/claims issues.

b. Methods for Remediation/Fixing Individual Problems

- i. Describe the States method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.

A Central Office staff, who will be assigned oversight of the contract and the fiscal intermediary and serve the point person for all problems that may occur. The staff member will hear and assess the problem, contact any person or department that needs to address the problem and then follow up to assure there has been resolution. The Department maintains a corrective action log regarding identified problems and related resolution.

ii. Remediation Data Aggregation

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

Responsible Party(check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input checked="" type="checkbox"/> Other Specify: Fiscal Intermediary	<input type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Administrative Authority that are currently non-operational.

- No
 Yes

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

Appendix B: Participant Access and Eligibility

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

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

Target Group	Included	Target SubGroup	Minimum Age	Maximum Age	
				Maximum Age Limit	No Maximum Age Limit
<input type="checkbox"/> Aged or Disabled, or Both - General					
	<input type="checkbox"/>	Aged			<input type="checkbox"/>
	<input type="checkbox"/>	Disabled (Physical)			
	<input type="checkbox"/>	Disabled (Other)			
<input checked="" type="checkbox"/> Aged or Disabled, or Both - Specific Recognized Subgroups					
	<input checked="" type="checkbox"/>	Brain Injury	18		<input checked="" type="checkbox"/>
	<input type="checkbox"/>	HIV/AIDS			<input type="checkbox"/>
	<input type="checkbox"/>	Medically Fragile			<input type="checkbox"/>
	<input type="checkbox"/>	Technology Dependent			<input type="checkbox"/>
<input type="checkbox"/> Intellectual Disability or Developmental Disability, or Both					
	<input type="checkbox"/>	Autism			<input type="checkbox"/>
	<input type="checkbox"/>	Developmental Disability			<input type="checkbox"/>
	<input type="checkbox"/>	Intellectual Disability			<input type="checkbox"/>
<input type="checkbox"/> Mental Illness					
	<input type="checkbox"/>	Mental Illness			
	<input type="checkbox"/>	Serious Emotional Disturbance			

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

ABI Waiver II applicants must be age 18 through 64. ABI Waiver II applicants must have sustained a brain injury and complete the eligibility assessment process prior to age 65. Participants who turn age 65 would be offered a choice to remain on the ABI Waiver, access institutional placement, or transition to the Home and Community-Based Services Elder Waiver, which serves clients age 65 and over.

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

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

Specify:

Appendix B: Participant Access and Eligibility

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

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

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

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

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

Specify the percentage:

- Other**

Specify:

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

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

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

- The following dollar amount:**

Specify dollar amount:

The dollar amount (*select one*)

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

Specify the formula:

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

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

Specify percent:

Other:

Specify:

Appendix B: Participant Access and Eligibility

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

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

DSS must determine that the cost of waiver services necessary to ensure the individual's health and safety does not exceed identified level of care annual cost limits. The ABI Waiver II utilizes four levels of care, each with different spending caps and an assessment tool is used to identify those individual needs and determine level of care. This same tool is used to assess whose needs cannot be met within the cost cap. Applicants or participants whose health and safety needs cannot be reasonably assured by the formal supports, informal supports and home and community-based services within the waiver, will first be assessed to determine if a higher level of care within the waiver is applicable. If this is not possible, the applicant or participant will not be enrolled or shall be dis-enrolled from the ABI Waiver II. In the event that an applicant is denied enrollment or a participant has services that are proposed to be reduced, suspended or terminated, the applicant/participant is notified via a Medicaid Notice of Action (NOA) regarding their right to a fair hearing in accordance with the rules of the Department's Medicaid Program.

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

- The participant is referred to another waiver that can accommodate the individual's needs.**
- Additional services in excess of the individual cost limit may be authorized.**

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

When a consumer's Level of Care (LOC) is thought to be inappropriate, the case manager reassesses that individual, with oversight by the Department's HCBS staff and a neuropsychologist if appropriate to ensure that all necessary factors have been considered in assigning the care level. If the services cannot be accommodated within an appropriate LOC, it is determined that a client does not qualify for services under the ABI Waiver II. If a subsequent service reduction or termination is indicated, the client receives, as noted above, a Notice of Action that sets forth the proposed denial/change. Clients are afforded the opportunity for a Fair Hearing in accordance with Departmental Medicaid Policy. Service cannot be reduced until the hearing decision is issued if a client requests a hearing within 10 days of the date of the NOA.

If a client's needs cannot be accommodated at the level of care within the 150% cost cap a team meeting is held that includes the participant and/or their representative, options are offered and if unsuccessful, verbal notice is given followed the formal written notice of action with appeal rights process is implemented.

- Other safeguard(s)**

Specify:

Appendix B: Participant Access and Eligibility

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

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

Table: B-3-a

Waiver Year	Unduplicated Number of Participants
Year 1	105
Year 2	180
Year 3	255
Year 4	330
Year 5	405

b. Limitation on the Number of Participants Served at Any Point in Time. Consistent with the unduplicated number of participants specified in Item B-3-a, the State may limit to a lesser number of participants who will be served at any point in time during a waiver year. Indicate whether the State limits the number of participants in this way: *(select one)*:

- The State does not limit the number of participants that it serves at any point in time during a waiver year.**
- The State limits the number of participants that it serves at any point in time during a waiver year.**

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

Table: B-3-b

Waiver Year	Maximum Number of Participants Served At Any Point During the Year
Year 1	[]
Year 2	[]
Year 3	[]
Year 4	[]
Year 5	[]

Appendix B: Participant Access and Eligibility

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

c. Reserved Waiver Capacity. The State may reserve a portion of the participant capacity of the waiver for specified purposes (e.g., provide for the community transition of institutionalized persons or furnish waiver services to individuals experiencing a crisis) subject to CMS review and approval. The State *(select one)*:

- Not applicable. The state does not reserve capacity.**
- The State reserves capacity for the following purpose(s).**

Purpose(s) the State reserves capacity for:

Purposes	
Reserved Capacity for Money Follows the Person Demonstration (MFP) Participants	
Reserved Capacity for DMHAS Acquired Brain Injury Services Program Participants	

Appendix B: Participant Access and Eligibility

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

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

Reserved Capacity for Money Follows the Person Demonstration (MFP) Participants

Purpose (describe):

The State reserves capacity to cover consumers transitioning off of the Money Follows the Person Demonstration (MFP) and onto the ABI Waiver II from November 2014 through November 30, 2019. The reservation of these ABI Waiver II slots is required to maintain continuity of care post the MFP demonstration for consumers targeted for this waiver.

Describe how the amount of reserved capacity was determined:

Reserved capacity was determined by transition trend experiences in January 2012 through September 2013.

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

Waiver Year	Capacity Reserved
Year 1	27
Year 2	54
Year 3	54
Year 4	54
Year 5	54

Appendix B: Participant Access and Eligibility

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

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

Reserved Capacity for DMHAS Acquired Brain Injury Services Program Participants

Purpose (describe):

The State reserves capacity to cover consumers transitioning from DMHAS Acquired Brain Injury Services onto the ABI Waiver II from November 1, 2014 through November 30, 2019.

Describe how the amount of reserved capacity was determined:

Rate was identified by completed ABI Waiver and approved assessments in 2013 for DMHAS Acquired Brain Injury Services participants who are ready for discharge.

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

Waiver Year	Capacity Reserved
Year 1	50
Year 2	8
Year 3	8
Year 4	8
Year 5	8

Appendix B: Participant Access and Eligibility

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

d. **Scheduled Phase-In or Phase-Out.** Within a waiver year, the State may make the number of participants who are served subject to a phase-in or phase-out schedule (*select one*):

- The waiver is not subject to a phase-in or a phase-out schedule.**
- The waiver is subject to a phase-in or phase-out schedule that is included in Attachment #1 to Appendix B-3. This schedule constitutes an intra-year limitation on the number of participants who are served in the waiver.**

e. Allocation of Waiver Capacity.

Select one:

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

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

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

A recipient of medical assistance benefits who applies for coverage of acquired brain injury services and applicants for acquired brain injury services shall meet all requirements for eligibility in the Department's medical assistance program that are applicable to disabled adults as stated in the regulations promulgated by the Department and contained in its Uniform Policy Manual pursuant to Section 17b-10 of the Connecticut General Statutes, including, without limitation, all regulations establishing medical assistance eligibility requirements related to the filing of applications for assistance, verifications, redeterminations, existence of a disabling condition, citizenship status, residency, institutional status, assistance unit composition and income and asset limits.

-Applicants served on a first come first served basis, other than reserved capacity as noted above.

Applicants for acquired brain injury services are treated as if they were institutionalized and all medical assistance eligibility rules that apply to institutionalized applicants or recipients of medical assistance benefits are also applied in the same way to applicants or recipients of acquired brain injury services. Applicants and recipients for acquired brain injury services are subject to the same rules that govern eligibility related to the transfer of assets and to the treatment of the resources and income of spouses of institutionalized applicants for assistance.

-Applicants to the ABI Waiver must also meet the following program criteria:

1. The individual must have an Acquired Brain Injury, which is defined as any combination of focal and diffuse central nervous system dysfunctions, both immediate and/or delayed, at the brain stem level or above. These dysfunctions may be acquired through the interaction of any external forces and the body, as well as through oxygen deprivation, infection, toxicity, surgery and vascular disorders not associated with aging. These disorders are not developmental or degenerative.
2. The individual must meet the level of care criteria;
3. The individual must be able to participate in the development of a service plan that offers an alternative to institutionalization. Note: This provision allows for this role to be fulfilled by a conservator for applicants who have been deemed incapable of managing their own affairs; and
4. The total cost of the individual's service plan, does not exceed 150% of the state's projected expenditure if the individual had been placed in or remained in institutional care.

The following supports the selection of individuals to the ABI Waiver:

- The Connecticut General Statutes 17b-260a-1 and proposed amended regulations
- ABI Waiver Desk Guide
- ABI Waiver Procedural Bulletins
- W-953 DSS Assessment for Adult Community Based Services or ABI Waiver Services

Appendix B: Participant Access and Eligibility

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

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

Appendix B: Participant Access and Eligibility

B-4: Eligibility Groups Served in the Waiver

a.

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

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

2. Miller Trust State.

Indicate whether the State is a Miller Trust State (*select one*):

- No
 Yes

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

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

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

Select one:

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

Specify percentage:

- Working individuals with disabilities who buy into Medicaid (BBA working disabled group as provided in §1902(a)(10)(A)(ii)(XIII) of the Act)
 Working individuals with disabilities who buy into Medicaid (TWWIIA Basic Coverage Group as provided in §1902(a)(10)(A)(ii)(XV) of the Act)
 Working individuals with disabilities who buy into Medicaid (TWWIIA Medical Improvement Coverage Group as provided in §1902(a)(10)(A)(ii)(XVI) of the Act)
 Disabled individuals age 18 or younger who would require an institutional level of care (TEFRA 134 eligibility group as provided in §1902(e)(3) of the Act)
 Medically needy in 209(b) States (42 CFR §435.330)
 Medically needy in 1634 States and SSI Criteria States (42 CFR §435.320, §435.322 and §435.324)
 Other specified groups (include only statutory/regulatory reference to reflect the additional groups in the State plan that may receive services under this waiver)

Specify:

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

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

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

Select one and complete Appendix B-5.

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

Check each that applies:

- A special income level equal to:

Select one:

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

Specify percentage:

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

Specify dollar amount:

- Aged, blind and disabled individuals who meet requirements that are more restrictive than the SSI program (42 CFR §435.121)**
- Medically needy without spenddown in States which also provide Medicaid to recipients of SSI (42 CFR §435.320, §435.322 and §435.324)**
- Medically needy without spend down in 209(b) States (42 CFR §435.330)**
- Aged and disabled individuals who have income at:**

Select one:

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

Specify percentage amount:

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

Specify:

Appendix B: Participant Access and Eligibility

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

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

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

Note: For the five-year period beginning January 1, 2014, the following instructions are mandatory. The following box should be checked for all waivers that furnish waiver services to the 42 CFR §435.217 group effective at any point during this time period.

- Spousal impoverishment rules under §1924 of the Act are used to determine the eligibility of individuals with a community spouse for the special home and community-based waiver group. In the case of a participant with a community spouse, the State uses *spousal* post-eligibility rules under §1924 of the Act.**
Complete Items B-5-e (if the selection for B-4-a-i is SSI State or §1634) or B-5-f (if the selection for B-4-a-i is 209b State) and Item B-5-g unless the state indicates that it also uses spousal post-eligibility rules for the time periods before January 1, 2014 or after December 31, 2018.

Note: The following selections apply for the time periods before January 1, 2014 or after December 31, 2018 (select one).

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

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

- Use spousal post-eligibility rules under §1924 of the Act.**
(Complete Item B-5-c (209b State) and Item B-5-d)
- Use regular post-eligibility rules under 42 CFR §435.726 (SSI State) or under §435.735 (209b State)**
(Complete Item B-5-c (209b State). Do not complete Item B-5-d)

- Spousal impoverishment rules under §1924 of the Act are not used to determine eligibility of individuals with a community spouse for the special home and community-based waiver group. The State uses regular post-eligibility rules for individuals with a community spouse.**
(Complete Item B-5-c (209b State). Do not complete Item B-5-d)

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (2 of 7)

Note: The following selections apply for the time periods before January 1, 2014 or after December 31, 2018.

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

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

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (3 of 7)

Note: The following selections apply for the time periods before January 1, 2014 or after December 31, 2018.

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

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

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

- The following standard included under the State plan**

(select one):

- The following standard under 42 CFR §435.121**

Specify:

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

(select one):

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

Specify percentage:

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

Specify dollar amount:

- A percentage of the Federal poverty level**

Specify percentage:

- Other standard included under the State Plan**

Specify:

- The following dollar amount**

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

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

Specify:

- Other**

Specify:

200% of Federal Poverty Level.

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

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

Specify:

Specify the amount of the allowance (select one):

- The following standard under 42 CFR §435.121**

Specify:

- Optional State supplement standard**
- Medically needy income standard**
- The following dollar amount:**

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

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

Specify:

iii. Allowance for the family (select one):

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

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

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

Specify:

Other

Specify:

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

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

Select one:

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

Specify:

Appendix B: Participant Access and Eligibility

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

Note: The following selections apply for the time periods before January 1, 2014 or after December 31, 2018.

d. Post-Eligibility Treatment of Income Using Spousal Impoverishment Rules

The State uses the post-eligibility rules of §1924(d) of the Act (spousal impoverishment protection) to determine the contribution of a participant with a community spouse toward the cost of home and community-based care if it determines the individual's eligibility under §1924 of the Act. There is deducted from the participant's monthly income a personal needs allowance (as specified below), a community spouse's allowance and a family allowance as specified in the State Medicaid Plan. The State must also protect amounts for incurred expenses for medical or remedial care (as specified below).

i. Allowance for the personal needs of the waiver participant

(select one):

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

Specify percentage:

The following dollar amount:

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

The following formula is used to determine the needs allowance:

Specify formula:

Other

Specify:

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

Select one:

- Allowance is the same
- Allowance is different.

Explanation of difference:

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

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

Select one:

- Not Applicable (see instructions) *Note: If the State protects the maximum amount for the waiver participant, not applicable must be selected.*
- The State does not establish reasonable limits.
- The State uses the same reasonable limits as are used for regular (non-spousal) post-eligibility.

Appendix B: Participant Access and Eligibility

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

Note: The following selections apply for the five-year period beginning January 1, 2014.

e. Regular Post-Eligibility Treatment of Income: SSI State or §1634 State - 2014 through 2018.

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

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (6 of 7)

Note: The following selections apply for the five-year period beginning January 1, 2014.

f. Regular Post-Eligibility Treatment of Income: 209(B) State - 2014 through 2018.

Answers provided in Appendix B-5-a indicate the selections in B-5-c also apply to B-5-f.

Appendix B: Participant Access and Eligibility

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

Note: The following selections apply for the five-year period beginning January 1, 2014.

g. Post-Eligibility Treatment of Income Using Spousal Impoverishment Rules - 2014 through 2018.

The State uses the post-eligibility rules of §1924(d) of the Act (spousal impoverishment protection) to determine the contribution of a participant with a community spouse toward the cost of home and community-based care. There is deducted from the participant's monthly income a personal needs allowance (as specified below), a community spouse's allowance and a family allowance as specified in the State Medicaid Plan. The State must also protect amounts for incurred expenses for medical or remedial care (as specified below).

Answers provided in Appendix B-5-a indicate the selections in B-5-d also apply to B-5-g.

Appendix B: Participant Access and Eligibility

B-6: Evaluation/Reevaluation of Level of Care

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

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

i. Minimum number of services.

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

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

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

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

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

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

Specify the entity:

- Other**
Specify:

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

The department will utilize contracted case managers to complete an evaluation of the need or level(s) of care in collaboration with a neuropsychologist who is familiar with the participant. Other qualified individuals will join the interdisciplinary team as appropriate. This is done after the department's clinical staff perform a health screen, review of the neuropsychological exam and level of care determination. The case managers who conduct the initial evaluations are required to have no less than a masters degree in Social Work and be a licensed practitioner or have a Masters degree in Human Services, Counseling or Rehabilitative Counseling or be a registered nurse with no less than a bachelor's degree. The Staff must have the ability to serve multicultural, multilingual populations; and the skill set to lead and facilitate the Care Team that includes the participant's team of providers and supporters, and reach consensus on the Service Plan. The provider agency is also required to have 5 years experience in the provision of case management service and the individual case manager is required to have at least two years experience in case management in health care or human services settings.

Neuropsychologist Qualifications: Licensure by the Connecticut Department of Public Health pursuant to Connecticut General Statutes Sections. 20-186 to 20-195 are required to serve in this role.

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

The Department conducts level of care assessments to evaluate and reevaluate whether an individual needs services through the waiver and the type of institutional care that the individual would otherwise require. The level of care assessment is based upon information obtained from the individual, medical reports from his or her physician(s), including a neuropsychologist, and any other clinical personnel who are familiar with the individual's case and history.

The ABI Waiver allows participants to be served at 150% of LOC. If a participant meets the criteria for more than one institutional LOC, their care plan costs can be effectively met within the flexibility of the lower level.

As a means to guide this level of care assessment, Connecticut Department of Social Services utilizes form W-1034 Level of Care Determination: ABI Waiver Programs in accordance with, Connecticut General Statutes 17b-260a-1, Connecticut Department of Social Services pending regulations and the Connecticut Department of Social Services Acquired Brain Injury Desk Guide.

Level of Care Criteria:

1. Category I (NF) - The individual is considered to require care in a nursing facility (NF) if he or she resides in such a facility, or has impaired cognition and, due to physical or cognitive deficits, requires physical assistance, supervision or cueing with two or more activities of daily living. Activities of daily living (ADLs) include eating, bathing, dressing, toileting and transfers.
2. Category II (ABI/NF) - The individual is considered to require care in an acquired brain injury nursing facility (ABI/NF) if he or she resides in such a facility, or has impaired cognition, impaired behavior requiring daily supervision or cueing, and a mental illness which manifested itself before the brain injury occurred. Persons who did not have a premorbid mental illness would not qualify for this level of care and would be evaluated for other levels of care.
3. Category III (ICF/IID) - The individual is considered to require care in an intermediate care facility for individuals with intellectual disabilities (ICF/IID) if he or she resides in such a facility, or has impaired cognition, an acquired brain injury that occurred before the age of 22 and, due to physical deficits, requires physical assistance, with two or more ADLs.
4. Category IV (CDH) - The individual is considered to require care in a chronic disease hospital (CDH) if he or she resides in such a facility, or has impaired cognition, impaired behavior and, due to physical or cognitive deficits, requires physical assistance, supervision or cueing with two or more ADLs.

In the event that an individual who meets the level of care requirements for more than one institutional level, such individual shall be served at the lower level of care.

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

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

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

Institutional Long Term Care placement is facilitated through a referral from a physician, using Form W-10. Elements of the form are as follows:

- Identifying information,
- Patient care information (pertinent history diagnoses and problems) and plan of care (includes treatment diet, and activity permitted).
- Orders (medications, allergies, therapeutic goals, level of care (e.g., Acute Hospital, Chronic Hospital, Nursing Facility)

The Assessment for ABI Waiver utilizes a more structured assessment tool. The instrument utilized for the Acquired Brain Injury Waiver differs from the standard form used for institutional care but yields reliable results as it is based on the assessment for ABI Waiver Services (Form W-953). This document provides the framework to assess the following:

- Environment,
- Health
- Life Planning
- Behavioral Issues
- Communication
- Risk Factors and a functional assessment

Workers then use the Level of Care Determination Form (Form W-1034) to assign a level of care. This form addresses Activities of Daily Living (ADLs) and the data gathered for the assessment, and the results of a neuropsychological to select a level of care that are defined on the assessment form for easy reference. The departments clinical HCBS staff review and approve the final level of care determination.

The Institutional and Waiver LOC forms assess the same domain needs: Chronic Condition (acquired brain injury), Activity of Daily Living support needs (hands on or supervision), and need factors (impaired cognition/impaired behavior).

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

For the purposes of determining level of care, a Department of Social Services clinical staff make an initial determination of the level of care of each applicant. Information gathered for the evaluation/reevaluation of care is derived from interviews and includes a thorough evaluation of the clients individual circumstances and a neuropsychological evaluation/review. The level of care determination form (W-1034) is used to summarize this information and confirm level of care. The case manager's face to face assessment confirms or recommends modification of the department's level of care assignment. The reassessment process requires a case manager to do an annual review of each applicant and the completion of the W-1034.

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

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

Specify the other schedule:

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

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

Specify the qualifications:

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

Reevaluations (reassessments) are conducted by the contracted care manager. DSS utilizes an electronic data base that tracks reassessment due dates and completion of those reviews. The system generates reports of overdue reassessments. Compliance with the reassessment process is verified during the on site reviews that will be conducted of each case management providers

j. Maintenance of Evaluation/Reevaluation Records. Per 42 CFR §441.303(c)(3), the State assures that written and/or electronically retrievable documentation of all evaluations and reevaluations are maintained for a minimum period of 3 years

as required in 45 CFR §92.42. Specify the location(s) where records of evaluations and reevaluations of level of care are maintained:

Written copies of the care plan evaluations and reevaluation documents are maintained by the Department of Social Services in its electronic data base. This is done to conform with 42 CFR 441.303(c)(3) and 45 CFR 74.53. The DSS case management database also retains an electronic record of the performance of evaluations and reevaluations. As a back-up the fiscal intermediary maintains copies of approved care plans.

Appendix B: Evaluation/Reevaluation of Level of Care

Quality Improvement: Level of Care

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

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

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

i. Sub-Assurances:

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

Performance Measures

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

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

Performance Measure:

Number and percentage of participants who received an initial level of care determination indicating need for institutional level of care prior to receipt of waiver services. Numerator= participants who received an initial level of care determination indicating need for institutional level of care prior to receipt of waiver services
Denominator=all new participants.

Data Source (Select one):

Record reviews, on-site

If 'Other' is selected, specify:

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach(check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>

<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

Performance Measure:

**Number and percentage of participants' initial LOC determinations forms/instruments that were completed as required by the state. Numerator=number of initial assessments
Denominator=number of new participants.**

Data Source (Select one):

Other

If 'Other' is selected, specify:

Compiled report completed by Fiscal Intermediary that provides a timeliness assessment of submitted claim LOC determination forms forwarded by the Medicaid agency.

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample

		Confidence Interval = <input type="text"/>
<input checked="" type="checkbox"/> Other Specify: Fiscal Intermediary	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis(check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input checked="" type="checkbox"/> Other Specify: Fiscal Intermediary	<input type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

- b. *Sub-assurance: The levels of care of enrolled participants are reevaluated at least annually or as specified in the approved waiver.*

Performance Measures

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

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

- c. *Sub-assurance: The processes and instruments described in the approved waiver are applied appropriately and according to the approved description to determine participant level of care.*

Performance Measures

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

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

Performance Measure:

Number and percent of participants initial LOC determinations were made on the state's approved forms/instruments. Numerator= initial LOC determinations made on the state's approved forms/instruments Denominator= total initial LOC determinations.

Data Source (Select one):

Record reviews, on-site

If 'Other' is selected, specify:

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify:	<input type="checkbox"/> Annually

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis(check each that applies):
<input type="text"/>	
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

Performance Measure:

Number and percentage of participants whose LOC determinations were made by a case manager and approved by the department's clinical HCBS staff. Numerator=approved LOC determination Denominator=total number of LOC determinations made.

Data Source (Select one):

Record reviews, on-site

If 'Other' is selected, specify:

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach(check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis(check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

- ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

b. Methods for Remediation/Fixing Individual Problems

- i. Describe the States method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.

The case manager will re-assess a client if it appears that they require a different level of care. If it is determined that a level of care is either too high or too low, the service plan is adjusted and a Notice of Action is sent to the client. The consumer is afforded full access to the Medicaid appeals process, which is administered by the DSS office of Legal Counsel, Regulations, and Fair Hearings.

Individual concerns regarding the health and safety of clients is reported to DSS HCBS staff. The Waiver manager determines whether DSS' Quality Assurance division or clinical staff investigates the basis of the complaint/referral. Once an investigation is completed HCBS or QA staff consults with the Waiver Manager who makes determination if corrective action is pursued. For health and welfare matters the case managers monitor in collaboration with department clinical staff monitor until a satisfactory resolution is achieved. Any final recommendations are made in consultation with the manager. QA staff monitors non-health and safety complaints until satisfactory resolution is obtained.

- ii. **Remediation Data Aggregation**

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

Responsible Party (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input checked="" type="checkbox"/> Other Specify: As needed.

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Level of Care that are currently non-operational.

- No
- Yes

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

Appendix B: Participant Access and Eligibility

B-7: Freedom of Choice

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

- i. informed of any feasible alternatives under the waiver; and
- ii. given the choice of either institutional or home and community-based services.

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

At the time of screening for eligibility to participate in this waiver, the case manager informs the potential participant of his or her option of receiving services in a long-term care institution or through this waiver. In addition a copy of the program brochure is shared with the participant that outlines all of the available services. The form W-1035 (Freedom of Choice/Fair Hearing Notification) provides applicants and participants the opportunity to choose between institutional care or home and community-based services. The form also provides the individual with written notification of his/her right to a Fair Hearing. This form is maintained by the case manager in the participants case file.

b. Maintenance of Forms. Per 45 CFR §92.42, written copies or electronically retrievable facsimiles of Freedom of Choice forms are maintained for a minimum of three years. Specify the locations where copies of these forms are maintained.

All materials pertaining to a specific waiver participant is maintained in their individual file. The signed Freedom of Choice/Hearing Notification form and other documents are maintained by the social worker in the participants case file.

Appendix B: Participant Access and Eligibility

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

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

Potential and active waiver participants with limited fluency in English must have access to services without undue hardship. The DSS Request for Waiver Services (W-1130) is available in Spanish. Case managers are required to make arrangements to provide interpretation or translation services for potential and active waiver participants who need them. This is accomplished through the use of bilingual staff and/or purchasing/contracting for interpreters. Non-English speaking waiver applicants/participants may bring an interpreter of their choice with them to DSS, provider and planning meetings. They cannot, however, be required to bring their own interpreter. No person can be denied access on the basis of English proficiency.

Appendix C: Participant Services

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

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

Service Type	Service		
Statutory Service	ABI Group Day		
Statutory Service	Adult Day Health		
Statutory Service	Case Management		

Service Type	Service		
Statutory Service	Homemaker		
Statutory Service	Personal Care		
Statutory Service	Prevocational Services		
Statutory Service	Respite		
Statutory Service	Supported Employment		
Other Service	ABI Recovery Assistant II		
Other Service	ABI Recovery Assistant		
Other Service	Chore		
Other Service	Cognitive Behavioral Programs		
Other Service	Community Living Support Services (CLSS)		
Other Service	Companion		
Other Service	Consultation Services		
Other Service	Environmental Accessibility Modifications		
Other Service	Home Delivered Meals		
Other Service	Independent Living Skills Training		
Other Service	Personal Emergency Response Systems (PERS)		
Other Service	Specialized Medical Equipment and Supplies		
Other Service	Substance Abuse Programs		
Other Service	Transportation		
Other Service	Vehicle Modification Services		

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Statutory Service

Service:

Day Treatment

Alternate Service Title (if any):

ABI Group Day

HCBS Taxonomy:

Category 1:

Sub-Category 1:

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Category 4:

Sub-Category 4:

Service Definition (Scope):

Services and supports that lead to the acquisition, improvement and/or retention of skills and abilities to prepare an individual for health and wellness, self-care or for work and/or community participation, or support meaningful socialization, leisure activities. This service is provided by a qualified provider in community locations. Transportation to and from home is not included as part of this waiver service.

Meals may be provided as part of the group day service but shall not constitute a full nutritional regimen (3 meals per day)

The service is not provided in a facility setting.

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

This service is limited to no more than 8 hours per day.

Service Delivery Method (check each that applies):

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

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

- Legally Responsible Person
- Relative
- Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Community Integration/Agency Provider
Agency	Employment Services/Supports Agency Provider
Individual	Rehabilitation Hospital Outpatient Department

Appendix C: Participant Services

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

Service Type: Statutory Service

Service Name: ABI Group Day

Provider Category:

Provider Type:

Community Integration/Agency Provider

Provider Qualifications

License (specify):

CARF certification in brain injury and/or Community Support, or JCAHO accreditation for Behavioral Health Care

Certificate (specify):

Other Standard (specify):

Employee staff who:

- are at least 18 years old
- have a minimum of a Bachelor's Degree and one year's experience providing services to individuals with brain injuries in the community, and completed training program(s) concerning acquired brain injury and person-centered planning, given by a state agency, the fiduciary, community providers, Brain Injury Association of CT, or Independent Living Center, or have a high school diploma and two years experience providing services to individuals with brain injuries in the community and completed training program(s) concerning acquired brain injury and person-centered planning, given by a state agency, broker agency, community providers, Brain Injury Association of CT, or Independent Living Center
- demonstrate ability to function as a member of an interdisciplinary team
- have documented experience implementing cognitive/Behavioral interventions developed by a clinician and utilized in community settings
- or, meet qualifications for Cognitive/Behavioral Programs

Verification of Provider Qualifications

Entity Responsible for Verification:

Fiscal intermediary

Frequency of Verification:

At start of services and at recertification/re-accreditation (Every two years)

Appendix C: Participant Services

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

Service Type: Statutory Service

Service Name: ABI Group Day

Provider Category:

Agency 

Provider Type:

Employment Services/Supports Agency Provider

Provider Qualifications

License (specify):

Certificate (specify):

Commission on Accreditation of Rehabilitation Facilities (CARF) -Employment Services

Other Standard (specify):

Meet the State of CT Standard to provide vocational rehabilitation services for the Department of Rehabilitation Services, Department of Developmental Services or the Department of Mental Health and Addiction Services

Verification of Provider Qualifications

Entity Responsible for Verification:

Fiscal Intermediary

Frequency of Verification:

At start of services or at recertification (Every two years)

Appendix C: Participant Services

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

Service Type: Statutory Service

Service Name: ABI Group Day

Provider Category:

Individual 

Provider Type:

Rehabilitation Hospital Outpatient Department

Provider Qualifications

License (specify):

Certificate (specify):

CARF certification in brain injury and/or Community Support, or JCAHO accreditation for Behavioral Health Care

Other Standard (specify):

Employee staff who:

- are at least 18 years old
- have a minimum of a Bachelor's Degree and one year's experience providing services to individuals with brain injuries in the community, and completed training program(s) concerning acquired brain injury and person-centered planning, given by a state agency, the fiduciary, community providers, Brain Injury Alliance of CT, or Independent Living Center, or have a high school diploma and two years experience providing services to individuals with brain injuries in the community and completed training program(s) concerning acquired brain injury and person-centered planning, given by a state agency, broker agency, community providers, Brain Injury Association of CT, or Independent Living Center
- demonstrate ability to function as a member of an interdisciplinary team
- have documented experience implementing cognitive/Behavioral interventions developed by a clinician and utilized in community settings
- or, meet qualifications for Cognitive/Behavioral Programs

Verification of Provider Qualifications

Entity Responsible for Verification:

Fiscal Intermediary

Frequency of Verification:

At start of services and at recertification/re-accreditation (Every two years)

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Statutory Service ▼

Service:

Adult Day Health ▼

Alternate Service Title (if any):

HCBS Taxonomy:

Category 1:

Sub-Category 1:

▼

Category 2:

Sub-Category 2:

▼

Category 3:

Sub-Category 3:

Category 4:

Sub-Category 4:

Service Definition (Scope):

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. Both a noon meal and snacks are provided daily. 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 be denied as edits are built into the claim processing system to prevent duplicative transportation services for Adult Day Health from occurring.

Services Covered and Limitations:

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:

a program nurse shall be available on site for not less than fifty percent of each operating day;

the program nurse shall be a registered nurse, except that a program nurse may be a licensed practical nurse if the program is adjacent to a long term care facility and 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;

additional personal care services shall be provided as specified in the individual plan of care, including but not limited to, bathing and transferring;

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

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. , the ADC is required to have a separate entrance and bathroom and bathing facilities.

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

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

Service Delivery Method (check each that applies):

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

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

- Legally Responsible Person
- Relative

Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Agency Provider

Appendix C: Participant Services

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

Service Type: Statutory Service

Service Name: Adult Day Health

Provider Category:

Agency ▼

Provider Type:

Agency Provider

Provider Qualifications

License (specify):

Certificate (specify):

Certification required by the Adult Day Care Association of CT. Certification is for 3 years.

Other Standard (specify):

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

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

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

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

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

the provider must also have one or more staff who have completed an approved training program concerning acquired brain injury and person centered planning as directed by the Department.

Verification of Provider Qualifications

Entity Responsible for Verification:

Fiscal Intermediary

Frequency of Verification:

At time of provider enrollment and with recertification every two years.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Statutory Service

Service:

Case Management

Alternate Service Title (if any):

HCBS Taxonomy:

Category 1:

Sub-Category 1:

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Category 4:

Sub-Category 4:

Service Definition (Scope):

This service is to assist the waiver participant in developing and implementing their service plan, and on-going assurance of effective coordination, communication and cooperation among all sources of support and services to the waiver participant. The consumer and the case-management provider regularly review the effectiveness of the plan, focusing on the consumer's satisfaction as the primary measure of quality. Case-management services will be purchased only if the waiver participant is unable to coordinate and/or oversee their own plan, does not have a conservator, family or other natural supports to act in this role. The service is limited to 12 hours per day. This service is provided when there is an assessed need for service coordination beyond the core case management provided by the DSS social worker.

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

12 hrs/day

This service will be provided as a waiver service through 4/30/16 and thereafter will be provided as an administrative service.

Service Delivery Method (check each that applies):

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

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

- Legally Responsible Person
- Relative
- Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Accredited Rehabilitative Facilities
Individual	Certified Rehabilitation Counselor
Agency	Case Management Agency
Agency	Accredited Health Organizations
Agency	Accredited Behavioral Health Care
Individual	Certified Case-Manager
Individual	Case Manager

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Case Management

Provider Category:

Agency ▼

Provider Type:

Accredited Rehabilitative Facilities

Provider Qualifications

License (specify):

Commission on Accreditation of Rehabilitative Facilities (CARF), or JCAHO Accreditation for Behavioral Health Care

Certificate (specify):

Other Standard (specify):

Employed licensed Social Workers, Certified Rehabilitation Counselors and/or Certified Case Managers, or The agency employee providing ABI case management services must have a Masters Degree in Psychology, Rehabilitation or Social Work and one years experience providing service coordination to persons with disabilities and knowledge of community resources, or a Bachelors Degree and two years of the above experience.

Must have completed an approved training program on acquired brain injury and person centered planning as determined by the Department.

Verification of Provider Qualifications

Entity Responsible for Verification:

Fiscal Intermediary

Frequency of Verification:

At time of provider enrollment and with recertification every two years.

Appendix C: Participant Services

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

Service Type: Statutory Service

Service Name: Case Management

Provider Category:

Individual ▼

Provider Type:

Certified Rehabilitation Counselor

Provider Qualifications

License (specify):

Certificate (specify):

Commission on Rehabilitation Counselor Certificate

Other Standard (specify):

One year's experience in providing service coordination to persons with disabilities and knowledge of community resources.

Complete DSS approved training program(s) given by a state agency, the fiduciary, community providers, Brain Injury Alliance of CT, or Independent Living Center.

Must have completed an approved training program concerning acquired brain injury and person centered planning as determined by the Department

Verification of Provider Qualifications

Entity Responsible for Verification:

Fiscal Intermediary

Frequency of Verification:

At time of provider enrollment and with recertification every two years.

Appendix C: Participant Services

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

Service Type: Statutory Service

Service Name: Case Management

Provider Category:

Agency ▼

Provider Type:

Case Management Agency

Provider Qualifications

License (specify):

Certificate (specify):

Other Standard (specify):

Person with a Master's Degree in Psychology, Rehabilitation or Social Work and one years experience in providing service coordination to persons with disabilities and knowledge of community resources, or a person with s Bachelors Degree and two years of the above experience.

Complete DSS approved training program(s) given by a state agency, the fiduciary, community providers, Brain Injury Alliance of CT, or Independent Living Center.

Verification of Provider Qualifications

Entity Responsible for Verification:

Fiscal Intermediary

Frequency of Verification:

At time of provider enrollment and with recertification every two years..

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Case Management

Provider Category:

Agency ▼

Provider Type:

Accredited Health Organizations

Provider Qualifications

License (specify):

Commission on Accreditation of Rehabilitative Facilities (CARF), or JCAHO Accreditation for Behavioral Health Care

Certificate (specify):

Other Standard (specify):

Employed licensed Social Workers, Certified Rehabilitation Counselors and/or Certified Case Managers, or The agency employee providing ABI case-management services must have a Masters Degree in Psychology, Rehabilitation or Social Work and one year's experience providing service coordination to persons with disabilities and knowledge of community resources, or a Bachelors Degree and two years of the above experience. Complete DSS approved training program(s) given by a state agency, the fiduciary, community providers, Brain Injury Alliance of CT, or Independent Living Center.

Verification of Provider Qualifications

Entity Responsible for Verification:

Fiscal Intermediary

Frequency of Verification:

At time of provider enrollment and with recertification every two years.

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Case Management

Provider Category:

Agency ▼

Provider Type:

Accredited Behavioral Health Care

Provider Qualifications

License (specify):

Commission on Accreditation of Rehabilitative Facilities (CARF), or JCAHO Accreditation for Behavioral Health Care

Certificate (specify):

Other Standard (specify):

Employed licensed Social Workers, Certified Rehabilitation Counselors and/or Certified Case Managers, or The agency employee providing ABI case-management services must have a Masters Degree in Psychology, Rehabilitation or Social Work and one year's experience providing service coordination to persons with disabilities and knowledge of community resources, or a Bachelor's Degree and two years of the above experience.

--Complete DSS approved training program(s) given by a state agency, the fiduciary, community providers, Brain Injury Alliance of CT, or Independent Living Center.

Verification of Provider Qualifications

Entity Responsible for Verification:

Fiscal Intermediary

Frequency of Verification:

At time of provider enrollment and with recertification every two years.

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Case Management

Provider Category:

Individual ▼

Provider Type:

Certified Case-Manager

Provider Qualifications

License (specify):

Certificate (specify):

Other Standard (specify):

One year's experience in providing service coordination to persons with disabilities and knowledge of community resources and meet CT Social Work Licensure Requirements as noted below:

- Hold a master's or doctorate degree from a social work program accredited by the Council on Social Work Education (CSWE);
- Successfully completed three thousand (3000) hours of post-master's social work experience including not less than one hundred (100) hours of work experience under professional supervision by a licensed clinical or certified independent social worker;
- Successfully completed the Clinical Level Examination of the Association of Social Work Boards;
- Complete DSS approved training program(s) given by a state agency, the fiduciary, community providers, Brain Injury Alliance of CT, or Independent Living Center.

Verification of Provider Qualifications

Entity Responsible for Verification:

Fiscal Intermediary

Frequency of Verification:

At time of provider enrollment and with recertification every two years.

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Case Management

Provider Category:

Individual ▼

Provider Type:

Case Manager

Provider Qualifications

License (specify):

State of CT Department of Public Health(CGS Chap. 383b, 20-195m)

Certificate (specify):

Other Standard (specify):

One year's experience in providing service coordination to persons with disabilities and knowledge of community resources. Complete DSS approved training program(s) given by a state agency, the fiduciary, community providers, Brain Injury Alliance of CT, or Independent Living Center.

- Effective 4/1/16 the case management provider shall possess:
- 2. The Staff designated to provide Care Management Services must have no less than a Master’s Degree in Social Work and be a Licensed Master Social Worker (LMSW) or a Licensed Clinical Social Worker (LCSW), or have a Bachelor’s Degree in Nursing;
 - 3. The Staff must have the ability to serve multicultural, multilingual populations; and
 - 4. The skill set to lead and facilitate the Care Team that includes the participant’s team of providers and supporters, and reach consensus on the Service Plan.

Verification of Provider Qualifications

Entity Responsible for Verification:

Fiscal Intermediary

Frequency of Verification:

At time of provider enrollment and with recertification every two years.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Service:

Alternate Service Title (if any):

HCBS Taxonomy:

Category 1:

Sub-Category 1:

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Category 4:

Sub-Category 4:



Service Definition (Scope):

Homemaker services consist of general household activities, including meal preparation and routine household chores. Homemaker services are provided by the Department only when the individual regularly responsible for these activities is temporarily absent from the home or unable to manage the home and care for him/herself or others in the home; or, when the waiver participant is unable to (re)learn such skills.

Homemaker services may not be provided by a member of the participant's family.

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

A member of the consumer's family or the conservator or their family may not provide these services.

Service Delivery Method (check each that applies):

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

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

- Legally Responsible Person
- Relative
- Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Agency provider
Individual	Private household employee

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Homemaker

Provider Category:

Agency

Provider Type:

Agency provider

Provider Qualifications

License (specify):

Certificate (specify):

Other Standard (specify):

Homemaker service providers are not licensed or regulated.

A homemaker provider shall:

- be at least 18 years of age
- follow instructions given by the consumer or the consumer's conservator
- be able to report changes in the consumer's condition or needs
- maintain confidentiality
- have the ability or skills necessary to meet the consumer's needs as delineated in the service plan
- demonstrate ability to implement cognitive and behavioral strategies

Verification of Provider Qualifications

Entity Responsible for Verification:

Fiscal Intermediary

Frequency of Verification:

At time of provider enrollment and with recertification every two years.

Appendix C: Participant Services

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

Service Type: Statutory Service

Service Name: Homemaker

Provider Category:

Individual ▾

Provider Type:

Private household employee

Provider Qualifications

License (specify):

Certificate (specify):

Other Standard (specify):

Homemaker service providers are not licensed or regulated.

A homemaker provider shall:

- be at least 18 years of age
- follow instructions given by the consumer or the consumer's conservator
- be able to report changes in the consumer's condition or needs
- maintain confidentiality
- have the ability or skills necessary to meet the consumers needs as delineated in the service plan
- demonstrate understanding of challenges that persons with brain injury face.

Verification of Provider Qualifications

Entity Responsible for Verification:

Fiscal Intermediary

Frequency of Verification:

At time of provider enrollment and with recertification every two years.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Statutory Service ▾

Service:

Personal Care ▾

Alternate Service Title (if any):

HCBS Taxonomy:

Category 1:

Sub-Category 1:



Category 2:

Sub-Category 2:



Category 3:

Sub-Category 3:



Category 4:

Sub-Category 4:



Service Definition (Scope):

Personal care consists of assistance with eating, bathing, dressing, personal hygiene and other activities of daily living performed by a qualified person in the consumer's home or community. Cueing and/or supervision are also included in this service description. Personal care assistance is provided if the individual's physical ability to perform these activities of daily living is impaired, or if the individual's cognitive/behavioral impairments interfere with his or her ability to perform these tasks.

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

Service Delivery Method (check each that applies):

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

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

- Legally Responsible Person
- Relative
- Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Agency Provider

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Personal Care

Provider Category:

Provider Type:

Agency Provider

Provider Qualifications

License (specify):

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

Certificate (specify):

If the agency is a Homemaker/Companion agency, it must be registered with the Department of Consumer Protection in the State of Connecticut.

Other Standard (specify):

A personal care provider shall:

- 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
- demonstrate the ability to implement cognitive behavioral interventions/take direction to carry out plan
- be able to function as a member of an interdisciplinary team

Training requirement:

Has completed an approved training program(s) concerning acquired brain injury and person-centered planning given by a state agency, the fiduciary, community providers, Brain Injury Alliance of CT, or an Independent Living Center.

Verification of Provider Qualifications

Entity Responsible for Verification:

Fiscal Intermediary

Frequency of Verification:

At time of provider enrollment and with recertification every two years.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Statutory Service

Service:

Prevocational Services

Alternate Service Title (if any):

HCBS Taxonomy:

Category 1:

Sub-Category 1:

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Category 4:

Sub-Category 4:

Service Definition (Scope):

Services that provide learning and work experiences, including volunteer work, where the individual can develop general, non-job-task-specific strengths and skills that contribute to employability in paid employment in integrated community settings. Services are expected to occur over a defined period of time and with specific outcomes to be achieved, as determined by the individual and his/her service and supports planning team through an ongoing person-centered planning process. Services are delivered in a participant's home or in a fully integrated work setting based on the participant's needs and preferences. Services are not delivered in facility based, congregate or sheltered work settings where individuals are supervised for the primary purpose of producing goods or performing services.

Individuals receiving prevocational services must have employment-related goals in their person-centered services and supports plan; the general habilitation activities must be designed to support such employment goals. Competitive, integrated employment in the community for which an individual is compensated at or above the minimum wage, but not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by individuals without disabilities is considered to be the optimal outcome of prevocational services.

Prevocational services should enable each individual to attain the highest level of work in the most integrated setting and with the job matched to the individual's interests, strengths, priorities, abilities, and capabilities, while following applicable federal wage guidelines. Services are intended to develop and teach general skills. Examples include, but are not limited to: ability to communicate effectively with supervisors, co-workers and customers; generally accepted community workplace conduct and dress; ability to follow directions; ability to attend to tasks; workplace problem solving skills and strategies; general workplace safety and mobility training.

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

40 hours per week. This service will be limited to two years. A maximum allowable time exceeding two years would not be considered appropriate without strong justification.

Service Delivery Method (check each that applies):

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

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

- Legally Responsible Person
- Relative
- Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Vocational Agency Provider

Appendix C: Participant Services

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

Service Type: Statutory Service

Service Name: Prevocational Services

Provider Category:

Agency ▼

Provider Type:

Vocational Agency Provider

Provider Qualifications

License (specify):

Commission on Accreditation of Rehabilitation Facilities (CARF)- Employment Services or meet the qualifications below listed under other standard

Certificate (specify):

Other Standard (specify):

Meet the State of CT Standard to provide vocational rehabilitation services for the Department of Rehabilitation Services, Department of Developmental Services or the Department of Mental Health and Addiction Services. This shall include: A Director of Vocational Services has Commission on Rehabilitation Counselor certification and a minimum of two years experience (experience is defined as a minimum of 1000 documented service hours per year) in providing community-based vocational services to persons with disabilities. OR The Director of Vocational Services has a Bachelors degree in a relevant area and a minimum of five years experience (experience is defined as a minimum of 1000 documented service hours per year) in providing community based vocational services to persons with disabilities.

Verification of Provider Qualifications

Entity Responsible for Verification:

Fiscal Intermediary

Frequency of Verification:

At time of provider enrollment and with recertification every two years.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Statutory Service ▼

Service:

Respite ▼

Alternate Service Title (if any):

HCBS Taxonomy:

Category 1:

Sub-Category 1:

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Category 4:

Sub-Category 4:

Service Definition (Scope):

Services provided to persons unable to care for themselves, and furnished on a short-term basis only in the individual's home or place of residence, when person normally performing such services is absent or in need of relief.

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

Service Delivery Method (check each that applies):

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

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

- Legally Responsible Person
- Relative
- Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Agency Provider
Individual	Private Household Employee

Appendix C: Participant Services

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

Service Type: Statutory Service

Service Name: Respite

Provider Category:

Provider Type:

Agency Provider

Provider Qualifications

License (specify):

Certificate (specify):

Commission on Accreditation of Rehabilitation Facilities (CARF)-Community Support Services.

Other Standard (specify):

Employ staff who:

- are at least 18 years of age
- demonstrate the ability to maintain a safe and healthy living environment
- demonstrate knowledge of basic first aid
- demonstrate knowledge of response to fire and emergency situations
- demonstrate ability to implement cognitive and behavioral strategies
- demonstrate ability to function as a member of an interdisciplinary team.
- Must be capable of performing all functions of the primary caregiver in their absence.

Training requirement

Must have completed an approved training program(s) concerning acquired brain injury and person-centered planning, given by a state agency, the state's fiduciary, community providers, Brain Injury Alliance of CT, or an Independent Living Center.

Verification of Provider Qualifications

Entity Responsible for Verification:

Fiscal Intermediary

Frequency of Verification:

Every 3 years.

Appendix C: Participant Services

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

Service Type: Statutory Service

Service Name: Respite

Provider Category:

Individual ▾

Provider Type:

Private Household Employee

Provider Qualifications

License (specify):

Certificate (specify):

Other Standard (specify):

Household Employee Staff who:

- are at least 18 years of age
- demonstrate the ability to maintain a safe and healthy living environment
- demonstrate knowledge of basic first aid
- demonstrate knowledge of response to fire and emergency situations
- demonstrate ability to implement cognitive and behavioral strategies
- demonstrate ability to function as a member of an interdisciplinary team.
- Must be capable of performing all functions of the primary caregiver in their absence.

Training requirement

Must have completed an approved training program(s) concerning acquired brain injury and person-centered planning, given by a state agency, the state's fiduciary, community providers, Brain Injury Alliance of CT, or an Independent Living Center.

OR meet the qualifications for Independent Living Skills Training or ABI Recovery Assistant.

Verification of Provider Qualifications

Entity Responsible for Verification:

Fiscal Intermediary

Frequency of Verification:

At start of service and at recertification every 2 years.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Statutory Service ▼

Service:

Supported Employment ▼

Alternate Service Title (if any):

HCBS Taxonomy:

Category 1:

Sub-Category 1:

▼

Category 2:

Sub-Category 2:

▼

Category 3:

Sub-Category 3:

▼

Category 4:

Sub-Category 4:

▼

Service Definition (Scope):

Supported Employment -Individual Employment Support services are the ongoing supports to participants who, because of their disabilities, need intensive on-going support to obtain and maintain an individual job in competitive or customized employment, or self-employment, in an integrated work setting in the general workforce for which an individual is compensated at or above the minimum wage, but not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by individuals without disabilities. The outcome of this service is sustained paid employment at or above the minimum wage in an integrated setting in the general workforce, in a job that meets personal and career goals.

Supported employment services can be provided through many different service models. Some of these models can include evidence-based supported employment for individuals with mental illness, or customized employment for