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)
☑ **Waiver Application**	
☑ **Appendix A Waiver Administration and Operation**	A-1,3, 5, 7
☑ **Appendix B Participant Access and Eligibility**	B-2, B-6, B-QI, B-7a
☑ **Appendix C Participant Services**	C-1
☑ **Appendix D Participant Centered Service Planning and Delivery**	D-1
☐ **Appendix E Participant Direction of Services**	
☐ **Appendix F Participant Rights**	

Component of the Approved Waiver	Subsection(s)
☐ Appendix G Participant Safeguards	
☐ Appendix H	
☑ Appendix I Financial Accountability	I-2
☑ 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 in42 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 Eligiblity 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 JCHAO 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 activates. 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	☑	☑
Waiver enrollment managed against approved limits	☑	☐
Waiver expenditures managed against approved levels	☑	☑
Level of care evaluation	☑	☑
Review of Participant service plans	☑	☐
Prior authorization of waiver services	☑	☐
Utilization management	☑	☑
Qualified provider enrollment	☑	☑
Execution of Medicaid provider agreements	☑	☐
Establishment of a statewide rate methodology	☑	☐
Rules, policies, procedures and information development governing the waiver program	☑	☐
Quality assurance and quality improvement activities	☑	☑

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):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☑ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☑ **Other** Specify: Fiscal Intermediary-Allied Community Resources	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

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):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☑ **Other** Specify: Fiscal Intermediary	☐ **Annually**
	☑ **Continuously and Ongoing**
	☐ **Other** Specify:

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):*
☐ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☑ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☑ **Other** Specify: Fiscal Intermediary	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

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):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☑ **Other** Specify: Fiscal Intermediary	☐ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

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):*
☐ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☑ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☑ **Other** Specify: Fiscal Intermediary	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

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):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☑ **Other** Specify: Fiscal Intermediary	☐ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

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):*
☐ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☑ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☑ **Other** Specify: Fiscal Intermediary	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

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):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

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):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☑ **Other** Specify: contracted case management provider	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

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):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

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 eligbility/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):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☑ **Other** Specify: Fiscal Intermediary	☐ **Annually**
	☑ **Continuously and Ongoing**
	☐ **Other** Specify:

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
☐ Aged or Disabled, or Both - General					
	☐	Aged			☐
	☐	Disabled (Physical)			
	☐	Disabled (Other)			
☑ Aged or Disabled, or Both - Specific Recognized Subgroups					
	☑	Brain Injury	18		☑
	☐	HIV/AIDS			☐
	☐	Medically Fragile			☐
	☐	Technology Dependent			☐
☐ Intellectual Disability or Developmental Disability, or Both					
	☐	Autism			☐
	☐	Developmental Disability			☐
	☐	Intellectual Disability			☐
☐ Mental Illness					
	☐	Mental Illness			
	☐	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:

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: 150

  - ○ **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 the number of participants who will be served at any point in time during a waiver year. Indicate whether the State limits the number of participants in this way: *(select one)*:

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

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

Table: B-3-b

Waiver Year	Maximum Number of Participants Served At Any Point During the Year
Year 1	
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 Novembr 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 particpants 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**
- [x] **Aged, blind or disabled in 209(b) states who are eligible under 42 CFR §435.121**
- [x] **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: [ ]

- [x] **Working individuals with disabilities who buy into Medicaid (BBA working disabled group as provided in §1902 (a)(10)(A)(ii)(XIII)) of the Act)**
- [x] **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)**
- [x] **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:

    - [x] **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: 200

○ **The following dollar amount:**

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

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

Specify formula:

○ **Other**

Specify:

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

Select one:

◉ **Allowance is the same**
○ **Allowance is different.**

Explanation of difference:

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

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

Select one:

○ **Not Applicable (see instructions)***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: 2

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 Statutes17b-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):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☑ **Quarterly**	☐ **Representative Sample** Confidence Interval =

☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

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):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☑ **Continuously and Ongoing**
	☐ **Other** Specify:

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):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☑ **Quarterly**	☐ **Representative Sample**

		Confidence Interval =
☑ **Other** Specify: Fiscal Intermediary	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

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):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☑ **Other** Specify: Fiscal Intermediary	☐ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

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 *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

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):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☐ **Annually**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
	☑ **Continuously and Ongoing**
	☐ **Other** Specify:

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):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☑ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

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):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

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):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☑ **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**
- [x] **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:
Agency
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 Accredidation 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 denied by any Adult Day Health provider attempting to bill for transportation procedure codes. These procedure codes are not included on the Adult Day Health fee schedule and will deny as edits are built into the claim processing system to prevent duplicative transportation services for Adult Day Health from occurring.
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**
- [x] **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.

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 serive 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..

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:
A minimum of five (5) years of demonstrated experience providing Care Management services, 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:
Statutory Service

Service:
Homemaker

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)*:

- [x] **Participant-directed as specified in Appendix E**
- [x] **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**
- [x] **Provider managed**

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

- [ ] **Legally Responsible Person**
- [x] **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:
Agency

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**
- [x] **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)*:

- [x] **Participant-directed as specified in Appendix E**
- [x] **Provider managed**

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

- [ ] **Legally Responsible Person**
- [x] **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:
Agency
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 individuals with significant disabilities. States may define other models of individualized supported employment that

promote community inclusion and integrated employment.
Supported employment individual employment supports may also include support to establish or maintain self-employment, including home-based self-employment. Supported employment services are individualized and may include any combination of the following services: vocational/job-related discovery or assessment, person-centered employment planning, job placement, job development, negotiation with prospective employers, job analysis, job carving, training and systematic instruction, job coaching, benefits support, training and planning, transportation (Transportation to and from the individual's residence and a day habilitation site is included in the rate paid to the provider), asset development and career advancement services, and other workplace support services including services not specifically related to job skill training that enable the waiver participant to be successful in integrating into the job setting.
Documentation is maintained that the service is not available under a program funded under section 110 of the Rehabilitation Act of 1973 or the IDEA (20 U.S.C. 1401 et seq.).
Federal financial participation is not claimed for incentive payments, subsidies, or unrelated vocational training expenses such as the following:

1. Incentive payments made to an employer to encourage or subsidize the employer's participation in supported employment; or
2. Payments that are passed through to users of supported employment 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**
- [x] **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 Vocational Providers

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Supported Employment

Provider Category:
Agency
Provider Type:
Agency Vocational Providers
Provider Qualifications
License *(specify)*:

Certificate *(specify)*:
Commission on Accreditation of Rehabilitation Facilities (CARF) Employment Services or meet standards below in other standard
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 Bachelor's 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 start of services or 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:

Other Service

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

Service Title:

ABI Recovery Assistant II

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):*

Assists the individual with the support of non-medical assistance, and includes safety monitoring assistance with activities of daily living (hands-on and cueing) and integration into the community. These services can be provided in

the individual's residence or in the community. Safety monitoring ensures supervision and health and safety for participants with cognitive deficits that interfere with awareness, cause nocturnal disturbance, and health needs necessitating overnight support with things such as toileting/transfer.Recovery Assistant and Recovery Assistant II have distinct procedure codes thus preventing duplicate billing.

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

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

- [x] **Participant-directed as specified in Appendix E**
- [x] **Provider managed**

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

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

Provider Specifications:

Provider Category	Provider Type Title
Individual	Certified Individual provider
Agency	Community Integration Services Agency
Agency	Rehabilitation Hospital Outpatient Department

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: ABI Recovery Assistant II

Provider Category:
Individual

Provider Type:
Certified Individual provider

Provider Qualifications

License *(specify)*:

Certificate *(specify)*:

Other Standard *(specify)*:
A Recovery Assistant shall:
Be at least 18 yrs old;
Possess at least a high school diploma or GED;
Possess a valid Connecticut driver's license; and
Be registered with the Department of Mental Health and Addiction Services (DMHAS) as having completed an approved Recovery Assistant training program that includes training on acquired brain injury and person-centered planning and meet any continuing education and/or training requirements set by DMHAS.
Training requirement: Training programs will address abilities to:
Follow instructions given by the participant or the participant's conservator;
Report changes in the participant's condition or needs;
Maintain confidentiality;
Meet the participant's needs as delineated in the waiver Recovery Plan;
Implement cognitive and behavioral strategies;
Function as a member of an interdisciplinary team;
Respond to fire and emergency situations;
Accept supervision in a manner prescribed by the department or its designated agent;

Maintain accurate, complete and timely records that meet Medicaid requirements;
Use crisis intervention and de-escalation techniques; and
Provide services in a respectful, culturally competent manner.

Verification of Provider Qualifications

Entity Responsible for Verification:

Fiscal intermediary

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: Other Service
Service Name: ABI Recovery Assistant II

Provider Category:

Agency

Provider Type:

Community Integration Services Agency

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):*

Employ staff who:
Are at least 18 yrs old;
Possess at least a high school diploma or GED;
Possess a valid Connecticut driver's license; and
Complete DSS approved training program(s) given by a state agency, the fiduciary, community providers, Brain Injury Alliance of CT, or Independent Living Center.
Topics include, but not limited to, the following topics: person-centered planning, cognitive and behavioral strategies, confidentiality, boundaries, use of crisis intervention and de-escalation techniques, and cultural competence.

- 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

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

Verification of Provider Qualifications

Entity Responsible for Verification:

Fiscal Intermediary

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: Other Service
Service Name: ABI Recovery Assistant II

Provider Category:
Agency
Provider Type:
Rehabilitation Hospital Outpatient Department
Provider Qualifications
License *(specify):*

Certificate *(specify):*
JCAHO
Other Standard *(specify):*
Employ staff who:
Are at least 18 yrs old;
Possess at least a high school diploma or GED;
Possess a valid Connecticut driver's license; and
Complete DSS approved training program(s) given by a state agency, the fiduciary, community providers, Brain Injury Alliance of CT, or Independent Living Center.
Topics include, but are not limited to, the following topics: person-centered planning, cognitive and behavioral strategies, confidentiality, boundaries, use of crisis intervention and de-escalation techniques, and cultural competence.
- 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

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

Verification of Provider Qualifications
Entity Responsible for Verification:
Fiscal Intermediary.
Frequency of Verification:
At start of services and at recertification/re-accreditation 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:
Other Service
As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.
Service Title:

ABI Recovery Assistant

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)*:
Promote participant's strengths and abilities to maintain and foster community living skills, in accordance with therapeutic goals outlined in the participant's plan of care. These include activities to improve socialization, self-advocacy, and the development of natural supports. Service also includes communication and coordination with service providers and others in support of the participant. Although not a primary function, ABI Recovery Assistants can provide help with ADL's and have a role cueing with support of a med box for medications. Recovery Assistant and Recovery Assistant II have distinct procedure codes thus preventing duplicate billing.

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

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

- [x] **Participant-directed as specified in Appendix E**
- [x] **Provider managed**

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

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

Provider Specifications:

Provider Category	Provider Type Title
Individual	Certified Individual provider
Agency	Community Agency Provider

Provider Category	Provider Type Title
Agency	Rehabilitation Hospital Outpatient Department

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: ABI Recovery Assistant

Provider Category:
Individual
Provider Type:
Certified Individual provider
Provider Qualifications
License *(specify):*

Certificate *(specify):*
Must have completed and received certification as a Recovery Assitant and the training would include a program on acquired brain injury and person-centered planning and would be given by a state agency, the state's fiduciary or the Brain Injury Alliance of CT.
Other Standard *(specify):*
An ABI Recovery Assistant shall:
Be at least 18 yrs old;
Possess at least a high school diploma or GED;
Possess a valid Connecticut driver's license; and
Be registered with the Department of Mental Health and Addiction Services (DMHAS) as having completed an approved Recovery Assistant training program including trainging on acquired brain injury and person-centered planning and meet any continuing education and/or training requirements set by DMHAS.
Training requirement: Training programs will address abilities to:
Follow instructions given by the participant or the participant's conservator;
Report changes in the participant's condition or needs;
Maintain confidentiality;
Meet the participant's needs as delineated in the waiver service Plan;
Implement cognitive and behavioral strategies;
Function as a member of an interdisciplinary team;
Respond to fire and emergency situations;
Accept supervision in a manner prescribed by the department or its designated agent;
Maintain accurate, complete and timely records that meet Medicaid requirements;
Use crisis intervention and de-escalation techniques; and
Provide services in a respectful, culturally competent manner.
Verification of Provider Qualifications
Entity Responsible for Verification:
Fiscal intermediary
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: Other Service
Service Name: ABI Recovery Assistant

Provider Category:
Agency
Provider Type:
Community Agency Provider

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Employ staff who:
Are at least 18 yrs old;
Possess at least a high school diploma or GED;
Possess a valid Connecticut driver's license; and
Complete DSS approved training program(s) given by a state agency, the fiduciary, community providers, Brain Injury Alliance of CT, or Independent Living Center.
Topics include, but are not limited to, the following topics: person-centered planning, cognitive and behavioral strategies, confidentiality, boundaries, use of crisis intervention and de-escalation techniques, and cultural competence.

- 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

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

Verification of Provider Qualifications

Entity Responsible for Verification:

Fiscal Intermediary

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: Other Service
Service Name: ABI Recovery Assistant

Provider Category:

Agency

Provider Type:

Rehabilitation Hospital Outpatient Department

Provider Qualifications

License *(specify):*

Certificate *(specify):*

JCAHO

Other Standard *(specify):*

Employ staff who:
Are at least 18 yrs old;
Possess at least a high school diploma or GED;
Possess a valid Connecticut driver's license; and

Complete DSS approved training program(s) given by a state agency, the fiduciary, community providers, Brain Injury Alliance of CT, or Independent Living Center.
Topics include, but are not limited to, the following topics: person-centered planning, cognitive and behavioral strategies, confidentiality, boundaries, use of crisis intervention and de-escalation techniques, and cultural competence.

- 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

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

Verification of Provider Qualifications

Entity Responsible for Verification:
Fiscal Intermediary

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:
Other Service

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

Service Title:
Chore

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 needed to maintain the consumer's home in a clean, sanitary and safe condition. This service includes heavy household chores, such as washing floors, windows, walls, and moving heavy items of furniture in order to provide safe access and egress. Services shall not be provided by any person who is a relative of the participant, is the participant's conservator, or is a member of the conservator's family.Chore services are provided only when neither the individual, nor anyone else in the household, is capable of performing or financially providing for them, or where no other third party is capable for their provision. ABI Waiver funds shall not be used if the service may be provided free of charge through friends, relatives, caregiver or community agencies. In the case of rental property, any service that is the responsibility of the landlord or his or her designee shall not be paid from ABI waiver funds; a copy of the lease agreement shall be reviewed before this service is authorized.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:

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

- [x] **Participant-directed as specified in Appendix E**
- [x] **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	Self employed private provider

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Chore

Provider Category:
Agency
Provider Type:
Agency Provider
Provider Qualifications
License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*
Chore service providers are not licensed or regulated. A chore service provider shall:
Be at least 18 years of age and be able to physically perform the service required.
Be able to 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.

Verification of Provider Qualifications

Entity Responsible for Verification:
Fiscal Intermediary
Frequency of Verification:
At start of service and recertification every 2 years.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Chore

Provider Category:
Individual

Provider Type:
Self employed private provider

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*
Chore service providers are not licensed or regulated. A chore service provider shall:
Be at least 18 years of age and be able to physically perform the service required.
Be able to follow instructions given by the consumer or the consumerŁs 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.

Verification of Provider Qualifications

Entity Responsible for Verification:
Fiscal Intermediary
Frequency of Verification:
At start of services and 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:
Other Service

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

Service Title:
Cognitive Behavioral Programs

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):*
Individual interventions designed to increase an individual's cognitive and behavioral capabilities and to further the individual's adjustment to successful community engagement including:
- Comprehensive assessment of cognitive strengths and liabilities, quality of adjustment and behavioral functioning
- Development and implementation of cognitive and behavioral strategies
- Development of a structured cognitive/behavioral intervention plan
- Ongoing or periodic consultation with the waiver participant, support system and providers concerning cognitive and behavioral strategies and interventions specified in the cognitive/ behavioral intervention plan
- Ongoing or periodic assistance with training of the waiver participant, support system and providers concerning cognitive behavior strategies and interventions
- Periodic reassessment and revision as needed, of the cognitive/behavioral intervention plan.

This service is performed within the context of the individual's person-centered team, in concert with the case manager. Cognitive/behavioral programs may be provided in the individual's home or in the community in order to reinforce the training in a real-life situation.

The service will be delivered utilizing two procedure codes, one for in person face to face visits that include the participant, providers and/or supporters. A quarterly, in person meeting with the waiver participant is required for this service.
The second procedure code is for non face-to-face service that includes development of the cognitive behavioral plan and phone or other types of interactions with participants, providers or supporters.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:

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

- [x] **Participant-directed as specified in Appendix E**
- [x] **Provider managed**

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

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

Provider Specifications:

Provider Category	Provider Type Title
Individual	Educational Psychologists
Individual	Neuropsychologist
Individual	Physical Therapist
Individual	Speech Therapist
Individual	Psychologists
Agency	Agency Provider
Agency	Rehabilitation Hospital (Outpatient Department)
Individual	Occupational Therapist

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Cognitive Behavioral Programs

Provider Category:
Individual
Provider Type:
Educational Psychologists
Provider Qualifications
License *(specify)*:

Certificate *(specify)*:
Certification in Special Education CT General Statutes Sec. 10-145d-538 and Sec. 10-145d-539.
Other Standard *(specify)*:
Ph.D. in Education with concentration in cognitive strategy development and remediation and/or post-doctoral experience in providing such services.
If not otherwise proven as part of an educational record, providers must complete a Department approved brain injury training program given by the state agency, the fiduciary or the Brain Injury Alliance of CT. Content areas should include, but not be limited to, the following: person-centered planning, brain injury 101, cognitive and behavioral strategies, confidentiality, boundaries, crisis intervention and de-escalation techniques, cultural competence and community resources.
Verification of Provider Qualifications
Entity Responsible for Verification:
Fiscal Intermediary
Frequency of Verification:
At beginning of services and recertification (every two years).

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Cognitive Behavioral Programs

Provider Category:

Individual

Provider Type:

Neuropsychologist

Provider Qualifications

License *(specify):*

State of CT Dept. of Public Health(DPH) Section 20-188-1

Certificate *(specify):*

Other Standard *(specify):*

Post-doctoral study or clinical supervision in neuropsychology

If not otherwise proven as part of an educational record, providers must complete a Department approved brain injury training program given by the state agency, the fiduciary or the Brain Injury Alliance of CT. Content areas should include, but not be limited to, the following: person-centered planning, brain injury 101, cognitive and behavioral strategies, confidentiality, boundaries, crisis intervention and de-escalation techniques, cultural competence and community resources.

Verification of Provider Qualifications

Entity Responsible for Verification:

Fiscal Intermediary

Frequency of Verification:

At beginning of services and recertification (Every two years)

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Cognitive Behavioral Programs

Provider Category:

Individual

Provider Type:

Physical Therapist

Provider Qualifications

License *(specify):*

State of CT General Statutes Section 20-66.

Certificate *(specify):*

Other Standard *(specify):*

At least three year's experience in cognitive/behavioral programming for people with a brain injury, delivered in community settings.

If not otherwise proven as part of an educational record, providers must complete a Department approved brain injury training program given by the state agency, the fiduciary or the Brain Injury Alliance of CT. Content areas should include, but not be limited, to the following: person-centered planning, brain injury 101, cognitive and behavioral strategies, confidentiality, boundaries, crisis intervention and de-escalation techniques, cultural competence and community resources.

Verification of Provider Qualifications

Entity Responsible for Verification:

Fiscal Intermediary

Frequency of Verification:

At beginning of services and recertification (every two years).

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Cognitive Behavioral Programs

Provider Category:
Individual
Provider Type:
Speech Therapist
Provider Qualifications
License *(specify):*
State of CT General Statutes Section 20-408.
Certificate *(specify):*

Other Standard *(specify):*
At least three year's experience in cognitive/behavioral programming for people with a brain injury, delivered in community settings.
If not otherwise proven as part of an educational record, providers must complete a Department approved brain injury training program given by the state agency, the fiduciary or the Brain Injury Alliance of CT. Content areas should include, but not be limited to, the following: person-centered planning, brain injury 101, cognitive and behavioral strategies, confidentiality, boundaries, crisis intervention and de-escalation techniques, cultural competence and community resources.
Verification of Provider Qualifications
Entity Responsible for Verification:
Fiscal Intermediary
Frequency of Verification:
At beginning of services and recertification (every two years).

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Cognitive Behavioral Programs

Provider Category:
Individual
Provider Type:
Psychologists
Provider Qualifications
License *(specify):*
State of CT DHS Chap.383B, Section 20-188-1 Sec. 20-188-2 and Sec. 20-188-3.
Certificate *(specify):*

Other Standard *(specify):*
At least three year's experience in cognitive/behavioral programming for people with a brain injury, delivered in community settings.
If not otherwise proven as part of an educational record, providers must complete a Department approved brain injury training program given by the state agency, the fiduciary or the Brain Injury Alliance of CT. Content areas should include, but not be limited to, the following: person-centered planning, brain injury 101, cognitive and behavioral strategies, confidentiality, boundaries, crisis intervention and de-escalation techniques, cultural competence and community resources.
Verification of Provider Qualifications
Entity Responsible for Verification:
Fiscal Intermediary
Frequency of Verification:
At beginning of services and recertification (every two years).

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Cognitive Behavioral Programs

Provider Category:
Agency

Provider Type:
Agency Provider

Provider Qualifications

License *(specify):*

Certificate *(specify):*
CARF certification in Brain Injury, or JCAHO, or Accreditation for Behavioral Health Care

Other Standard *(specify):*
Employ neuro-psychologists, educational psychologists, psychologists, occupational therapists, speech therapists or physical therapists that meet the standards of individual providers.
If not otherwise proven as part of an educational record, providers must complete a Department approved brain injury training program given by the state agency, the fiduciary or the Brain Injury Alliance of CT. Content areas should include, but not be limited to, the following: person-centered planning, brain injury 101, cognitive and behavioral strategies, confidentiality, boundaries, crisis intervention and de-escalation techniques, cultural competence and community resources.

Verification of Provider Qualifications

Entity Responsible for Verification:
Fiscal Intermediary

Frequency of Verification:
At beginning of services and recertification (every two years).

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Cognitive Behavioral Programs

Provider Category:
Agency

Provider Type:
Rehabilitation Hospital (Outpatient Department)

Provider Qualifications

License *(specify):*

Certificate *(specify):*
JCAHO

Other Standard *(specify):*
Employ neuro-psychologists, educational psychologists, psychologists, occupational therapists, speech therapists or physical therapists that meet the standards of individual providers.
If not otherwise proven as part of an educational record, providers must complete a Department approved brain injury training program given by the state agency, the fiduciary or the Brain Injury Alliance of CT. Content areas should include, but not be limited to, the following: person-centered planning, brain injury 101, cognitive and behavioral strategies, confidentiality, boundaries, crisis intervention and de-escalation techniques, cultural competence and community resources.

Verification of Provider Qualifications

Entity Responsible for Verification:
Fiscal intermediary

Frequency of Verification:
At beginning of services and recertification (every two years).

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Cognitive Behavioral Programs

Provider Category:
Individual
Provider Type:
Occupational Therapist
Provider Qualifications
License *(specify):*
State of CT General Statutes Section 20-74a
Certificate *(specify):*

Other Standard *(specify):*
At least three year's experience in cognitive/behavioral programming for people with a brain injury, delivered in community settings.
If not otherwise proven as part of an educational record, providers must complete a Department approved brain injury training program given by the state agency, the fiduciary or the Brain Injury Alliance of CT. Content areas should include, but not be limited to, the following: person-centered planning, brain injury 101, cognitive and behavioral strategies, confidentiality, boundaries, crisis intervention and de-escalation techniques, cultural competence and community resources.
Verification of Provider Qualifications
Entity Responsible for Verification:
Fiscal Intermediary
Frequency of Verification:
At beginning of services and 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:
Other Service
As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.
Service Title:
Community Living Support Services (CLSS)

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 provides supervised living in the consumer's residence that provides up to 24-hour support services, including overnight supervision, for up to three individuals with acquired brain injury. Services are provided in the residence or in the community and include supervision of and assistance with: self-care; medication management; communication and interpersonal skills; socialization; sensory/motor skills; mobility; community transportation skills; problem-solving skills; money management and ability to maintain a household. Assessment and training services are not provided under this component. Edits in the MMIS prevent duplicate billing

The CLSS provider must develop a plan that demonstrates its ability to work with the individual and to provide services that are consistent with the therapeutic goals of his or her overall service plan. When the individual chooses, or improves his or her ability to live more independently, the CLSS provider will work with the individual and the DSS Social Worker to develop and implement a plan to transition the individual to greater independence in the community.

CLSS participants are not precluded from attending or participating in other community-based services if these are determined by the individual and the DSS Social Worker to be of potential benefit in providing the individual with skills and training needed to achieve independence.

No ABI funds will be spent on the room and board component of CLSS services.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
This service is purchased by the day or half (12-hour) day. If the individual is involved in other service plan activities that consistently involve being away from the CLSS for a significant period of time, more than six hours per day, this service shall be paid on a half-day basis.

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

- [ ] **Participant-directed as specified in Appendix E**
- [x] **Provider managed**

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

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

Provider Specifications:

Provider Category	Provider Type Title
Individual	Rehabilitation Hospital
Agency	Agency Provider

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Community Living Support Services (CLSS)

Provider Category:
Individual
Provider Type:
Rehabilitation Hospital
Provider Qualifications
License *(specify):*

Certificate *(specify):*
JCAHO/CARF certification in community support service and/or brain injury community integrated services
Other Standard *(specify):*

Verification of Provider Qualifications
Entity Responsible for Verification:
Fiscal Intermediary
Frequency of Verification:
At start of services and at recertification (every two years).

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Community Living Support Services (CLSS)

Provider Category:
Agency
Provider Type:
Agency Provider
Provider Qualifications
License *(specify):*

Certificate *(specify):*
Commission on Accreditation of Rehabilitative Facilities (CARF), Community Support Services, or JCAHO Accreditation for Behavioral Health Care
Other Standard *(specify):*
Shall have an existing service contract with the Department of Rehabilitation Services, the Department of Developmental Services or the Department of Mental Health and Addiction Services to provide rehabilitation services.
Residence must meet all provisions of CT State Building Code, fire prevention, safety and construction standards.
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.

Training requirement
Must have completed an approved training program(s) concerning acquired brain injury and person-centered

planning, given by the a state agency, 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:

At start of services 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:

Other Service

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

Service Title:

Companion

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):*

Non-medical care, supervision and socialization that are provided in accordance with a therapeutic goal included in the service plan. May assist in or supervise such tasks as meal preparation, laundry, or light housekeeping tasks that are incidental to the care and supervision of the individual.

This service is not duplicative of Personal Care Assistance because it does not provide hands-on care. This service is not duplicative of Chore because it does not provide household management tasks.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Service is limited to 18 service hours per day.

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

- [x] **Participant-directed as specified in Appendix E**
- [x] **Provider managed**

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

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

Provider Specifications:

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

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Companion

Provider Category:
Individual
Provider Type:
Private Household Employee
Provider Qualifications
License *(specify)*:

Certificate *(specify)*:

Other Standard *(specify)*:
A provider shall:
- be at least 18 years of age
- be physically able to perform the services required
- 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
- 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 start of services and every two years.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Companion

Provider Category:
Agency

Provider Type:
Agency Provider

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*
A provider shall:
- be at least 18 years of age
- be physically able to perform the services required
- 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
- 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 start of services and 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:
Other Service

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

Service Title:
Consultation Services

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):*
Is a service to provide assistance to team and/or participants to address issues related to service implementation that have presented as a barrier for resolution. This service aids in the development of individual interventions designed to decrease the individual's severe maladaptive behaviors, which jeopardize his or her ability to remain integrated in the community. Services may be provided in a team meeting at the participant's home or other community locations. Qualified providers shall include licensed: neuropsychologists, substance abuse specialists and occupational therapists and other professional clinical providers.

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**
- [x] **Provider managed**

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

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

Provider Specifications:

Provider Category	Provider Type Title
Individual	Private Providers
Agency	Agency/Hospital/Rehabilitation Hospital

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Consultation Services

Provider Category:
Individual
Provider Type:
Private Providers
Provider Qualifications
License *(specify):*
Professionals Licensed by the CT Department of Public Health:
- Physicians
- Psychologists
- Social workers (Licensed Clinical Social Worker)
- Speech pathologists
- Speech therapists
- Occupational Therapists
- Physical therapists
- Registered nurses
- Dieticians/Nutritionist
- Rehabilitation counselors

Certificate *(specify):*
- CT Department of Public Health Certified Substance Abuse Specialists

Other Standard *(specify):*

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: Provider Specifications for Service

Service Type: Other Service
Service Name: Consultation Services

Provider Category:
Agency
Provider Type:
Agency/Hospital/Rehabilitation Hospital
Provider Qualifications
License *(specify):*
Professionals Licensed by the CT Department of Public Health:
- Physicians
- Psychologists
- Social workers (Licensed Clinical Social Worker)
- Speech pathologists
- Speech therapists
- Occupational Therapists
- Physical therapists
- Registered nurses
- Dieticians/Nutritionist
- Rehabilitation counselors

Certificate *(specify):*
- CT Department of Public Health Certified Substance Abuse Specialists

Other Standard *(specify):*

Verification of Provider Qualifications
Entity Responsible for Verification:
Fiscal Intermediary

Frequency of Verification:
At beginning of services and 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:
Other Service
As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.
Service Title:
Environmental Accessibility Modifications

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):*
Environmental Accessibility Adaptations are physical adaptations to the consumer's home that ensure the health, welfare and safety of the consumer, that enhance and promote greater independence, and without which the individual would require institutionalization. Adaptations may include but are not limited to the installation of ramps, widening of doorways, modification of bathroom facilities and specialized electrical and plumbing installations.

All services must be provided in accordance with applicable state or local building codes. Adaptations not covered under the ABI program are improvements which are not of direct medical or remedial benefit to the individual, such as carpeting, central air conditioning, and roof repair. In addition, adaptations that add to the square footage of the home

are not covered.

Environmental accessibility adaptations may not be furnished to adapt living arrangements that are owned or leased by providers of waiver 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	Private contractor/business

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Environmental Accessibility Modifications

Provider Category:
Agency

Provider Type:
Private contractor/business

Provider Qualifications

License *(specify)*:

Certificate *(specify)*:

Other Standard *(specify)*:
A Department of Rehabilitation Services approved contractor
Home Improvement Registration by the Dept. of Consumer Protection
Adheres to State/Local Building Codes.

Verification of Provider Qualifications

Entity Responsible for Verification:
Fiscal Intermediary

Frequency of Verification:
At time of services and 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:

Other Service

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

Service Title:

Home Delivered Meals

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 preparation and home delivery of meals for consumers who are unable to prepare or obtain nourishing meals independently, or when the individual responsible for this activity is temporarily absent or unable to prepare meals.Home delivered meals, or "meals on wheels," include the preparation and delivery of one or two meals for persons who are unable to prepare or obtain nourishing meals on their own. Meals on Wheels providers include delicatessans, Family Services Agencies, Community Action Agencies, Catholic Charities, Town Social Services, visiting nurse agencies, assisted living agencies, senior centers, soup kitchens. Meals must meet a minimum of one-third for single meals and two-thirds for double meals of the daily recommended allowance and requirements as established by the Food and Nutrition Academy of Sciences National Reasearch Council. Special diet meals are available such as diabetic, cardiac,low sodium and renal as are ethnic meals such as Hispanic and Kosher meals.

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

Meals provided shall not include a full nutrition regime (three meals per day). Meals may be either a single or double meal provided up to seven times per week

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

- [ ] **Participant-directed as specified in Appendix E**
- [x] **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: Other Service
Service Name: Home Delivered Meals

Provider Category:
Agency

Provider Type:
Agency Provider

Provider Qualifications

License *(specify)*:

Certificate *(specify)*:

Other Standard *(specify)*:
Must have an approval/contract through DSS, or a contractor of the Department of Aging, to provide home-delivered meals for other existing programs. Reimbursement for home delivered meals shall be available under the ABI Waiver to providers which provide meals that meet a minimum of one-third of the current daily recommended dietary allowance and requirements as established by the Food and Nutrition Board of the National Academy of Sciences National Research Council.

All meals on wheels providers shall provide their menus to the department, contracted agencies or department designee for review and approval. Service providers must be in compliance with the dietary requirements and the requirements for the preparation and storage and delivery of food based on the department policies for the elderly nutrition program and Title (III) of the Older Americans Act.
Meals on Wheels providers include delicatessans, Family Services Agencies, Community Action Agencies, Catholic Charities, Town Social Services, visiting nurse agencies, assisted living agencies, senior centers, soup kitchens.

Verification of Provider Qualifications

Entity Responsible for Verification:
Fiscal Intermediary

Frequency of Verification:
At start of services and at 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:
Other Service

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

Service Title:
Independent Living Skills Training

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 designed and delivered on an individual basis to improve the consumer's ability to live independently in the community, as well as to carry out strategies developed in Cognitive /Behavioral Programs. Independent Living Skills Training is a teaching service. Specific activities may include assessment and training in: self-care; medication management; task completion; communication and interpersonal skills; socialization; sensory/motor skills; mobility and community transportation skills; problem solving skills; and money management and ability to maintain a household. Assistance and supervision are not provided under this component.

Services are purchased on an hourly basis and provided in the real world, i.e., in the individual's home, community, environment or specific life situation that calls for intensive assessment and training. Services are provided under this component when the individual has particular difficulty with transferring and generalizing knowledge and skills from one situation to another, as well as to carry-out strategies developed in Cognitive/Behavioral programs by the clinician.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Assistance and supervision are not provided under this component.
Service maximimum is 12 hours per day.

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

- [x] **Participant-directed as specified in Appendix E**
- [x] **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	ILST Agency Provider
Agency	Rehabilitation Hospital Outpatient Department
Individual	Private individual provider

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Independent Living Skills Training

Provider Category:
Agency
Provider Type:
ILST Agency Provider
Provider Qualifications
License *(specify):*

Certificate *(specify):*
CARF certification in brain injury and/or Community Support, or JCAHO accreditation for Behavioral Health Care or meets requirements below under other standard
Other Standard *(specify):*
Employee staff who:
are at least 18 years old
have a minimum of a Bachelors Degree and one 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, 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 Alliance 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

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Independent Living Skills Training

Provider Category:
Agency
Provider Type:
Rehabilitation Hospital Outpatient Department
Provider Qualifications
License *(specify):*

Certificate *(specify):*
JCAHO
Other Standard *(specify):*
Employ staff who:
are at least 18 years old
have a minimum of a Bachelors Degree and one 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, 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 Alliance 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 every 2 years.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Independent Living Skills Training

Provider Category:
Individual
Provider Type:
Private individual provider
Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*
Meet the following:
are at least 18 years old
have a minimum of a Bachelors Degree and one 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, 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 Alliance 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 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:

Other Service

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

Service Title:

Personal Emergency Response Systems (PERS)

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):*

An electronic device that enables certain consumers at high risk of institutionalization to secure help in an emergency; the system may include a portable "help" button to allow for mobility. The system is connected to the person's telephone and programmed to signal a response center once "help" button is activated. Trained professionals shall staff the response center. Device installation, upkeep and maintenance are provided. Response center staff are available 24/7. The availability of this service under the ABI waiver is limited to individuals who live alone, or are alone for significant parts of the day, and who have no regular caregiver and who would otherwise require extensive routine supervision. Need is determined based on the assessment and as part of the person centered planning process. Installation, upkeep and maintenance are included as part of this service.

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	Vendors Who Sell and Install Appropriate Equipment

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Personal Emergency Response Systems (PERS)

Provider Category:
Agency

Provider Type:
Vendors Who Sell and Install Appropriate Equipment

Provider Qualifications

License *(specify)*:

Certificate *(specify)*:

Other Standard *(specify)*:
Vendor that meets the criteria to be a DSS performing provider.

Verification of Provider Qualifications

Entity Responsible for Verification:
Fiscal Intermediary

Frequency of Verification:
At start of services and 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:
Other Service

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

Service Title:
Specialized Medical Equipment and Supplies

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):*
Specialized medical equipment and supplies, including devices, controls and/or appliances specified in the services plan, that enable the individual to increase their abilities to perform activities of daily living, or to perceive, control or communicate in his or her environment within the community.

Items reimbursed with waiver funds are in addition to any medical equipment and supplies furnished under the State plan and exclude those items that are not of direct medical or remedial benefit to the participant. This service excludes services available under the Medicaid state plan. All items shall meet applicable standards of manufacture, design and installation.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Total Annual Individual Cost Limit $10,400
The social worker would assist the client to seek other funds such as from charitable organizations to complement state plan and waiver services.

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

- [ ] **Participant-directed as specified in Appendix E**
- [x] **Provider managed**

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

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

Provider Specifications:

Provider Category	Provider Type Title
Individual	Pharmacies
Agency	Medical Equipment Vendors
Agency	DME

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Specialized Medical Equipment and Supplies

Provider Category:
Individual
Provider Type:
Pharmacies
Provider Qualifications
License *(specify)*:

Certificate *(specify)*:
State of CT Dept. of Consumer Protection Pharmacy Practice Act : Regulations Concerning Practice of Pharmacy Section 20-175-4-6-7
Other Standard *(specify)*:

Verification of Provider Qualifications
Entity Responsible for Verification:
Fiscal Intermediary
Frequency of Verification:
At start of services and every two years.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Specialized Medical Equipment and Supplies

Provider Category:
Agency
Provider Type:
Medical Equipment Vendors
Provider Qualifications
License *(specify)*:

Certificate *(specify)*:

Other Standard *(specify)*:
Must meet the State of CT Standard to provide medical equipment supplies for the Department of Rehabilitation Services, Department of Developmental Services or Medicaid, have provider status for medical equipment and supplies or agency that obtains Medicaid performing provider status.
Verification of Provider Qualifications
Entity Responsible for Verification:
Fiscal Intermediary
Frequency of Verification:
At start of services and recertification every two years.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Specialized Medical Equipment and Supplies

Provider Category:
Agency
Provider Type:
DME
Provider Qualifications
License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*
Must meet the State of CT Standard to provide medical equipment supplies for the Department of Rehabilitation Services, Department of Developmental Services or Medicaid, have provider status for medical equipment and supplies or agency that obtains Medicaid performing provider status.
Verification of Provider Qualifications
Entity Responsible for Verification:
Fiscal Intermediary
Frequency of Verification:
At start of services and 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:
Other Service
As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.
Service Title:
Substance Abuse Programs

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):*
Reduces and/or eliminates substance abuse, which may interfere with the individual's ability to be maintained in the community. This service will be specifically designed to meet the needs of individuals with cognitive deficits, and will work with existing community support systems, such as Local Mental Health Authority, Alcoholics Anonymous, Narcotics Anonymous, to assist them in becoming more responsive to people with traumatic brain injuries. This role requires LADC and brain injury experience support modifications to traditional care supports. This could include supports provided in group day supports. Substance abuse programs shall include: an in-depth assessment of the interrelationship of the individual's abuse of substances and brain injury; a learning/behavioral assessment; development of a structured treatment plan; implementation of the plan; on-going education and training of the individual, family members, care-givers and other service providers around participant-specific sequelae; individualized relapse strategies; periodic reassessment of the plan; and, on-going support to the individual.

Substance abuse programs shall be provided on an outpatient basis in the individual's community. The individual's particular substance abuse plan may include both group and individual interventions and shall reflect the use of curricula and materials adopted from a traditional substance abuse program designed to meet the needs of individuals with traumatic brain injury. The substance abuse program provider shall communicate treatment regimens with all of the individual's other service providers. We utilize a distinct release of information for this purpose.
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	Substance abuse diagnostic and treatment centers that meet the qualifications below.
Individual	Self-Employed Private Providers (i.e., Licensed Psychologists, Certified Alcohol and Drug Counselors)
Agency	Rehabilitation Hospitals that meet the qualifications below.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Substance Abuse Programs

Provider Category:
Agency

Provider Type:
Substance abuse diagnostic and treatment centers that meet the qualifications below.
Provider Qualifications
License *(specify):*
State of CT Department of Public Health (if private facility)
Certificate *(specify):*
JCAHO (if public facility)
Other Standard *(specify):*
In addition to the aforementioned criteria:
Completed training concerning acquired brain injury given by a state agency, the fiduciary, community provider, Brain Injury Alliance of CT or Independent Living Centers.
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: Provider Specifications for Service

Service Type: Other Service
Service Name: Substance Abuse Programs

Provider Category:
Individual
Provider Type:
Self-Employed Private Providers (i.e., Licensed Psychologists, Certified Alcohol and Drug Counselors)
Provider Qualifications
License *(specify):*
Certified Alcohol and Drug Counselor
Licensed Clinical Social Worker
Licensed Pyschologists
Certificate *(specify):*

Other Standard *(specify):*
At least 1 year experience in assessment and treatment of individuals with brain injury and substance abuse
Ability to develop linkages with community support programs

Ability to work as a member of an interdisciplinary team.
Verification of Provider Qualifications
Entity Responsible for Verification:
Fiscal Intermediary
Frequency of Verification:
At start of service and recertification, every two years

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Substance Abuse Programs

Provider Category:
Agency
Provider Type:
Rehabilitation Hospitals that meet the qualifications below.
Provider Qualifications
License *(specify):*

Certificate *(specify):*
JCAHO
Other Standard *(specify):*
Staff with at least one year's experience in providing services to individuals with brain injury and substance abuse issues.

Verification of Provider Qualifications

Entity Responsible for Verification:
Fiscal Intermediary
Frequency of Verification:
At start of services and 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:
Other Service
As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.
Service Title:
Transportation

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):*
Transportation consists of mobility services offered in accordance with the individual's service plan to allow him or her to access ABI waiver services. ABI funds may not be used for this purpose when public transportation is available or when friends, family, neighbors and/or community agencies are able to provide transportation free of charge. All reasonable transportation alternatives must be explored prior to receiving approval for ABI transportation services.

Transportation may be provided by a family member between home and a waiver-funded vocational setting when transportation is not otherwise available and is the most cost-effective alternative.

When authorized, this service is in addition to medical transportation services required under 42CFR 440.170(a), if applicable, and shall not replace them.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:

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

- [x] **Participant-directed as specified in Appendix E**
- [x] **Provider managed**

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

- [ ] **Legally Responsible Person**
- [x] **Relative**
- [ ] **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Individual	Individual Provider
Agency	Livery Service Agency

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Transportation

Provider Category:
Individual
Provider Type:
Individual Provider
Provider Qualifications
License *(specify):*
Valid driver's license
Certificate *(specify):*

Other Standard *(specify):*
The provider must possess a valid CT driver's license and provide evidence of automobile insurance.
Verification of Provider Qualifications
Entity Responsible for Verification:
Fiscal Intermediary
Frequency of Verification:
At approval, and when license and insurance are due for renewal or expiration every two years.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Transportation

Provider Category:
Agency
Provider Type:
Livery Service Agency
Provider Qualifications
License *(specify):*
DOT livery license
Certificate *(specify):*

Other Standard *(specify):*
Subcontractor for Medicaid Transportation Broker
The provider must possess a valid CT driver's license and provide evidence of automobile insurance.
Verification of Provider Qualifications
Entity Responsible for Verification:
Fiscal Intermediary
Frequency of Verification:
At approval, when license and insurance are due for renewal or expiration.

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:
Other Service
As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.
Service Title:
Vehicle Modification Services

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):*
Alterations made to a vehicle, which is the individual's primary means of transportation when such modifications are necessary to improve the waiver participant's independence and inclusion in the community and to avoid institutionalization. The vehicle may be owned by the individual, a family member with whom the individual lives or has consistent and on-going contact, or a non-relative who provides primary long-term support to the individual and is not a paid provider of such services.

The following are specifically excluded: 1) adaptations or improvements to the vehicle that are of general utility, and are not of direct medical or remedial benefit to the individual; 2) purchase or lease of a vehicle; and 3) regularly scheduled upkeep and maintenance of a vehicle except upkeep and maintenance of the modifications.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Total Annual Individual Cost Limit $10,000.00

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

- [ ] **Participant-directed as specified in Appendix E**
- [x] **Provider managed**

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

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

Provider Specifications:

Provider Category	Provider Type Title
Individual	Approved State of CT Dept of Rehabilitation ServicesVehicle Modification Vendor

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Vehicle Modification Services

Provider Category:
Individual
Provider Type:
Approved State of CT Dept of Rehabilitation ServicesVehicle Modification Vendor
Provider Qualifications
License *(specify):*
DMV dealers and/or repairers license
Certificate *(specify):*

Other Standard *(specify):*
Must be an approved State of Connecticut Department of Rehabilitation Services vendor.
Verification of Provider Qualifications

Entity Responsible for Verification:
Fiscal Intermediary
Frequency of Verification:
At time of service with recertification every two years.

Appendix C: Participant Services

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

b. Provision of Case Management Services to Waiver Participants. Indicate how case management is furnished to waiver participants (*select one*):

- ○ **Not applicable** - Case management is not furnished as a distinct activity to waiver participants.
- ◉ **Applicable** - Case management is furnished as a distinct activity to waiver participants.
  Check each that applies:
  - ☑ **As a waiver service defined in Appendix C-3.** *Do not complete item C-1-c.*
  - ☐ **As a Medicaid State plan service under §1915(i) of the Act (HCBS as a State Plan Option).** *Complete item C-1-c.*
  - ☐ **As a Medicaid State plan service under §1915(g)(1) of the Act (Targeted Case Management).** *Complete item C-1-c.*
  - ☑ **As an administrative activity.** *Complete item C-1-c.*

c. Delivery of Case Management Services. Specify the entity or entities that conduct case management functions on behalf of waiver participants:

Effective 5/1/16,the department will no longer be providing case management as a waiver service and offering it to participants as an administrative service. The case management waiver service functions are added to the scope of the case management claimed as administrative match instead. The selected contractors will be selected as the result of a competitive procurement and will perform comprehensive assessments, develop service plans, and monitor the effectiveness of the service plan. The case manager will also serve as the team leader in all team meetings.
The administratively claimed case management will incorporate the functions that were provided by the waiver service provider until 5/1/16 resulting in no diminution of support to the waiver participant. The case manager would be required to hold a Masters degree in social work, human services, Counseling or Rehabilitation Counseling. If the degree is in social work, LCSW or LMSW licensure is required. The case manager may also be a nurse with a minimum of a bachelor's degree. The agency that provides the case management must have a minimum of 5 years experience in the provision of case management in a home and community based setting and the individual case manager must have at least two years of case management experience in health care or human services settings. Additionally the case manager 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. When selecting the contractors from the responses to the procurement, the department will assign a higher points value to those respondents that have experience working with persons with acquired brain injuries.
All new contractors will be provided with a comprehensive initial training program presented by clinicians working with persons with brain injuries. Over the course of the first year, two additional training programs will be required of all contractors. The Brain Injury Alliance of CT will provide these training programs.

Appendix C: Participant Services

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

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

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

Specify: (a) the types of positions (e.g., personal assistants, attendants) for which such investigations must be conducted; (b) the scope of such investigations (e.g., state, national); and, (c) the process for ensuring that mandatory investigations

have been conducted. State laws, regulations and policies referenced in this description are available to CMS upon request through the Medicaid or the operating agency (if applicable):

DSS requires any persons serving as household employees* providing personal care assistance and companion services to a consumer submit to a State of Connecticut criminal background check. Transportation providers also are subject to the criminal background check.

DSS has the discretion to refuse payments for household employees performing services who have been convicted of a felony, as defined in section 53a-25 of the Connecticut General Statutes, involving forgery under section 53a-137 of the Connecticut General Statutes; robbery under section 53a-133 of the Connecticut General Statutes; larceny under sections 53a-119, 53a-122, 53a-123 and 53a-124 of the Connecticut General Statutes; or of a violation of section 53a-290 to 53a-296, inclusive of the Connecticut General Statutes; involving vendor fraud, section 53-20 of the Connecticut General Statutes involving cruelty to persons; sections 53a-70, 53a-70a, 53a-70b, 53a-71, 53a-72a, 53a-72b, or 53a-73a of the Connecticut General Statutes involving sexual assault; section 53a-59 of the Connecticut General Statutes involving assault; section 53a-59a of the Connecticut General Statutes involving assault of an elderly, blind, disabled, pregnant or mentally retarded person; and sections 53a-320 to 53a-323, inclusive, of the Connecticut General Statutes involving abuse of elderly, blind, disabled or mentally retarded persons.
This review is carried out by the fiduciary intermediary in which the contract requires that as part of consideration for employment by any ABI Waiver participant, they process background checks for Household Employee Provider Directory applicants upon submission of the Provider Directory application. The nature of the criminal activity revealed by the background check including, but not limited to, check fraud, theft, abuse, or assault may result in disqualification from continued enrollment in the Provider Directory, and consideration for employment by any ABI Waiver participant.

DSS will conduct an annual audit involving a sample of FI records to ensure criminal background checks and other required documents are on file.
We require quarterly reports for all new hires showing if background check was done.
All providers are checked against the OIG sanctioned provider list. If licensed, we check the DPH provider license.

*Household Employees: providers who perform chore, companion, homemaker, personal care assistance, independent living skills training and respite services and who are not employed by an agency.

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

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

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

Appendix C: Participant Services

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

c. Services in Facilities Subject to §1616(e) of the Social Security Act. *Select one:*

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

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

d. Provision of Personal Care or Similar Services by Legally Responsible Individuals. A legally responsible individual is any person who has a duty under State law to care for another person and typically includes: (a) the parent (biological or adoptive) of a minor child or the guardian of a minor child who must provide care to the child or (b) a spouse of a waiver participant. Except at the option of the State and under extraordinary circumstances specified by the State, payment may not be made to a legally responsible individual for the provision of personal care or similar services that the legally responsible individual would ordinarily perform or be responsible to perform on behalf of a waiver participant. *Select one*:

- (●) **No. The State does not make payment to legally responsible individuals for furnishing personal care or similar services.**
- ( ) **Yes. The State makes payment to legally responsible individuals for furnishing personal care or similar services when they are qualified to provide the services.**

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

e. Other State Policies Concerning Payment for Waiver Services Furnished by Relatives/Legal Guardians. Specify State policies concerning making payment to relatives/legal guardians for the provision of waiver services over and above the policies addressed in Item C-2-d. *Select one*:

- ( ) **The State does not make payment to relatives/legal guardians for furnishing waiver services.**
- (●) **The State makes payment to relatives/legal guardians under specific circumstances and only when the relative/guardian is qualified to furnish services.**

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

The Department does not pay the family members of participants to perform any waiver services except for Respite and transportation. The Department does not pay legally liable relatives or relatives of Conservators of Person nor Conservators of Estate to provide care. In some circumstances, this may be a non-legally liable relative, who is not related to the consumer's Conservator of Person or Conservator of Estate. The participant or their conservator must sign timesheets to confirm the date(s) and time(s) services were performed. The fiscal intermediary reviews timesheets for accuracy and whether they match the allocation in the service plan. Any discrepancy results in a notification to DSS, prior to the issuance of payment. Family members must meet the same qualifications as unrelated providers. Any reported concerns regarding fraudulent billing is addressed as it would be with other service providers (e.g., investigation, provider termination, etc.) Family members will be selected at the request of the recipient.

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

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

- ( ) **Other policy.**

Specify:

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

The Connecticut Department of Social Services contracts with a fiscal intermediary to conduct outreach activities in order to increase awareness of the ABI Waiver Program within the provider community and to recruit qualified providers to serve the ABI population. ABI Waiver Service Provider information is posted on the Fiscal IntermediaryŁs Website. The Department establishes qualifications for each provider type, and publishes the qualifications in the DepartmentŁs ABI Waiver Program Provider Manual. Outreach activities include:
1. Identifying those areas of the state in which service deficits exist;

2. Tailoring outreach approaches to best recruit the types of providers most needed to serve the ABI population on a regional and statewide basis;

3. Conducting at least one outreach session every twelve months in each of the DepartmentŁs three regions during the contract period;

4. Conducting at least one community service provider outreach session each quarter during the contract period;

5. Utilizing appropriate methods to publicize outreach activities including but not limited to newsletters, individual contacts, direct mailings, print or other media advertisements, or other methods of communication as appropriate to each activity; and

6. Maintaining a log of potential providers who attend each activity or who are contacted through the outreach effort, including the date and place of each activity, the number of individuals who attend or are contacted, the number of individuals who subsequently participate in training, and the number of individuals, by specialty type, subsequently enrolled as Qualified Providers.
The MMIS provider website has provider enrollment information for prospective providers as well.

Appendix C: Participant Services

Quality Improvement: Qualified Providers

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: Qualified Providers**

The state demonstrates that it has designed and implemented an adequate system for assuring that all waiver services are provided by qualified providers.

i. **Sub-Assurances:**

a. ***Sub-Assurance: The State verifies that providers initially and continually meet required licensure and/or certification standards and adhere to other standards prior to their furnishing waiver services.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory 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 waiver providers meeting licensure/certification standards prior to delivery of services. Numerator=waiver providers meeting licensure/certification standards prior to delivery of services. Denominator= total number of waiver providers requiring licensure/certification.

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):*
☐ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☑ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☑ **Other** Specify: Fiscal Intermediary	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

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):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☑ **Other** Specify: Fiscal Intermediary	☐ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Number and percent ofnon licensed/non certified providers, by provider type, meeting provider training requirments. Numerator= number of providers meeting provider training requirments. Denominator=total number of providers.

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):*
☐ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☑ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☑ **Other** Specify: Fiscal Intermediary	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

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):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☑ **Other** Specify: Fiscal Intermediary	☐ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Number and percent of waiver providers reviewed for ongoing licensure/certification standards. Numerator=Number of waiver providers reviewed for ongoing licensure/certification standards. Denominator= Number of waiver providers requiring ongoing licensure/certification.

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):*
☐ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☑ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☑ **Other** Specify: Fiscal Intermediary	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

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):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☑ **Other** Specify: Fiscal Intermediary	☐ **Annually**
	☐ **Continuously and Ongoing**
	☑ **Other** Specify: Every two years.

b. ***Sub-Assurance: The State monitors non-licensed/non-certified providers to assure adherence to waiver requirements.***

For each performance measure the State will use to assess compliance with the statutory 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 non-licensed/non-certified waiver providers meeting waiver requirements prior to service provision. Numerator=Number of non-licensed/non-certified waiver providers meeting waiver requirements prior to service provision. Denominator=Number of non-licensed/non-certified waiver providers.

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):*
☐ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☑ **Other** Specify: Fiscal Intermediary	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

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):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☑ **Other** Specify: Fiscal Intermediary	☐ **Annually**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

c. ***Sub-Assurance: The State implements its policies and procedures for verifying that provider training is conducted in accordance with state requirements and the approved waiver.***

For each performance measure the State will use to assess compliance with the statutory 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 waiver non licensed/non certified providers who complete pre-requisite training prior to service provision. Numerator=Number of waiver providers who complete pre-requisite training prior to service provision. Numerator=Number of waiver providers required to complete pre-requisite training prior to service provision.

Data Source (Select one):
Training verification records
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):*
☐ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☑ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☑ **Other** Specify: Fiscal Intermediary	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

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):*
☐ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☑ **Other** Specify: Fiscal Intermediary	☐ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

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 fiscal intermediary provides quarterly documentation of outreach activities to recruit providers for the registry and the result of the outreach efforts. Additionally, the fiscal intermediary has a Program Compliance Supervisor who investigates potential fraud claims and provides the Department with a written summary and report of all claims. These claims are tracked through the department's critical incident system.

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.
An assigned HCBS unit staff member serves as the quality assurance officer for the ABI Waiver program. She/He is available daily for contact with the fiscal intermediary for the purpose of resolving any discrepancies or issues related to contract compliance. For example, if a consumer calls with a complaint that they were not trained on the managing of their provider, she/he would be in contact with the fiscal intermediary to resolve the complaint. If any case manager s believes a report to be potential fraud, it is referred to a HCBS unit who decides if it should be referred to the Fraud and Recoveries Unit. Any correspondence done in written form is retained for future reference.

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):*
☐ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☑ **Other** Specify: Fiscal Intermediary	☐ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

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 Qualified Providers that are currently non-operational.

- (●) **No**
- ( ) **Yes**

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

Appendix C: Participant Services

C-3: Waiver Services Specifications

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

Appendix C: Participant Services

C-4: Additional Limits on Amount of Waiver Services

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

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

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

- [ ] **Limit(s) on Set(s) of Services.** There is a limit on the maximum dollar amount of waiver services that is authorized for one or more sets of services offered under the waiver.
  Furnish the information specified above.
- [ ] **Prospective Individual Budget Amount.** There is a limit on the maximum dollar amount of waiver services authorized for each specific participant.
  Furnish the information specified above.
- [ ] **Budget Limits by Level of Support.** Based on an assessment process and/or other factors, participants are assigned to funding levels that are limits on the maximum dollar amount of waiver services.
  Furnish the information specified above.
- [ ] **Other Type of Limit.** The State employs another type of limit.
  Describe the limit and furnish the information specified above.

Appendix C: Participant Services

C-5: Home and Community-Based Settings

Explain how residential and non-residential settings in this waiver comply with federal HCB Settings requirements at 42 CFR 441.301 (c)(4)-(5) and associated CMS guidance. Include:

1. Description of the settings and how they meet federal HCB Settings requirements, at the time of submission and in the future.
2. Description of the means by which the state Medicaid agency ascertains that all waiver settings meet federal HCB Setting requirements, at the time of this submission and ongoing.

Note instructions at Module 1, Attachment #2, HCB Settings Waiver Transition Plan for description of settings that do not meet requirements at the time of submission. Do not duplicate that information here.

Please see Main Module, attachment 2

Appendix D: Participant-Centered Planning and Service Delivery

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

State Participant-Centered Service Plan Title:
Connecticut Acquired Brain Injury Home and Community-Based Waiver Service Plan (W-1131)

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

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

  Specify qualifications:

  Effective 5/1/16 the department proposes to contract for administrative case management for this waiver and eliminate case management as a waiver service. The case manager would be required to hold a Masters degree in social work, human services, Counseling or Rehabilitation Counseling. If the degree is in social work, LCSW or LMSW licensure is required. The case manager may also be a nurse with a minimum of a bachelor's degree. The agency that provides the case management must have a minimum of 5 years experience in the provision of case management in a home and community based setting and the individual case manager must have at least two years of case management experience in health care or human services settings. Additionally the case manager 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. When selecting the contractors from the responses to the procurement, the department will assign a higher points value to those respondents that have experience working with persons with acquired brain injuries.
  All new contractors will be provided with a comprehensive initial training program presented by clinicians working with persons with brain injuries. Over the course of the first year, two additional training programs will be required of all contractors. The Brain Injury Alliance of CT will provide these training programs.

- ☐ **Social Worker**

  Specify qualifications:

- ☐ **Other**

  Specify the individuals and their qualifications:

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

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

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

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

Department contracted case managers are required to assist every ABI Waiver participant (participant) in developing a Person-Centered Service Plan. This individualized plan is written through a team process that includes the participant, his or her conservator, as applicable, and other relevant stakeholders as directed by the participant. The ABI Waiver brochure that outlines the program includes a section that addresses person-centered planning. It states, the ABI waiver is based on a person-centered model. This means that you are the essential participant in developing a Service Plan that will fulfill your needs in the community.

Next, the waiver participant is designated as the Employer of Record for household employees receiving payments under the ABI Waiver Program. As such, the participant is responsible for hiring, directing, managing, and, if necessary, firing their private providers. This responsibility is outlined in the W-988, ABI Waiver Program Rights and Responsibilities Form.

Measures are in place to aid participants and their families in accessing needed services and actively participating in processes that result in the receipt of care. For example, the Department contracts with the Brain Injury Alliance of Connecticut, Inc. (BIAC) for the purpose of providing consultation, advocacy, resource facilitation, support, information, training and outreach to persons with brain injury and their families. BIAC's services through this contract are intended to enable participants to advocate for themselves for access to brain injury programs and community-based supports. In addition to direct advocacy, telephonic support, newsletter and web-based information dissemination, BIAC is funded to conduct numerous trainings and community education programs. These knowledge enhancement opportunities are not only directed to service professionals to aid in their provision of respectful, individualized and effective care to persons with brain injury, but also targeted to participants. Training includes, but is not limited to, topics such as Brain Injury 101 and the Person-Centered Planning Process.

The Person-Centered Planning Process training covers issues such as client choice, networking, and team building. Through the ABI Waiver fiscal intermediary, the Person-Centered Planning training is extended to Providers of services to persons with brain injury. At least one advanced training session per calendar quarter addressing Person-Centered Planning is conducted for Providers to increase their expertise in supporting client-directed care.

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

the plan is updated, including when the participant's needs change. State laws, regulations, and policies cited that affect the service plan development process are available to CMS upon request through the Medicaid agency or the operating agency (if applicable):

In order to be eligible for ABI Waiver Services, consumers are required to exhibit a verifiable need for cueing or physical assistance in two or more activities of daily living (ADLs). Case managers, 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. Clinical staff in the HCBS unit review completed Plans of Care (POC) and approve the plan based on their review of eligibility, service adequacy and responsiveness to the waiver participant's needs.

Case managers are expected to schedule their first client visit within seven days of receiving assignment of a waiver applicant case. Initial care plans are developed using results form a neuropsychological report and standardized form. This form requires plan development informed by the following constellations of care:

--Health --Risk Indicators
--Life Planning --Functional Assessment
--Behavioral Issues --Community-Based Supports (formal and informal)
--Communication

Plan of Care documents include service preferences and include the use of natural/community supports, state plan services, and waiver services. The DSS case managers share the description of service information with consumers so that they are informed about the array of supports available. The specific, proposed services for each client, followed by the reason for selecting the service(s), the goal(s) expected to be achieved, and the timeframe for which the service is needed are also elements of the POC.

The case manager, consumers, and the consumer's circle of support (family, caregivers, service providers, natural supports, and other relevant parties of the consumer's choosing) meet monthly, in most instances, to assess and monitor, through an interdisciplinary team process, service implementation, care efficacy, client progress, and safety. At such meetings, care plans are adjusted congruent with a client's current identified needs. Proposed changes to a client's person-centered POC, as determined by the aforementioned team process, are signed by the consumer, and implemented as long as the costs fall within the program limits.

The ABI waiver program is managed on a case-by-case basis, reflective of an approach to ensure that individual consumer presentations and needs are supported congruent with the eligible population standards. This service operates under ongoing oversight checks and balances built in through 24/7 availability of the care management provider, fiscal agent coordination and reporting, and system service documentation. All client specific actions are documented in the consumer's case record. The departments electronic data base tracks referrals, status, critical incidents, timeliness of assessments and reassessments and serves as a real time communication from the social worker to the department.

The State's requirement for documented client choice regarding institutional versus community-based services is evidenced through consumer attestation and signature as part of the waiver application process. A process is also in place to ensure that consumers can affect individualized provider choice. Case managers share with waiver consumers the provider listing, which is developed by a DSS contracted fiduciary. This listing identifies providers by service type and geographic coverage area. Clients are afforded the opportunity to speak with and/or interview prospective providers prior to selection. The participant selects agencies to provide services and is ultimately the employer of record for household employees and has responsibility for hiring, managing and firing his or her providers.
The minimum requirement for team meetings is quarterly. Waiver and non-waiver supports are discussed at the team meeting and incorporated into the plan of care.

Appendix D: Participant-Centered Planning and Service Delivery

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

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

The responsibility to assure health and welfare is balanced with the waiver participant's right to select their services and providers. It is imperative to accurately identify the services and supports that are needed to ensure the health and welfare of the waiver participant. During the service plan development process, the case manager, the consumer/conservator and the team members (e.g., providers and other stakeholders) collaborate to assess the consumer's level of skill, and identify risk

factors including: inadequate supervision, social isolation, inability to summon assistance, emotional and behavioral issues, and communication capabilities. This information is used to provide the background necessary to identify areas of potential risk to the waiver participant. When risk issues are identified, members of the service planning team (e.g., case manager, conservator, cognitive behaviorist, medical provider), provide feedback to the waiver participant regarding the area(s) of concern (e.g., ADL and IADL management) and members exchange ideas on how to mitigate risk. The waiver participant has the right to accept, reject or modify recommendations that address risk.

Back-up plans are included in the POC. Typically there are family and community supports that are incorporated into a POC. If this is not possible, services are backed-up by providers who deliver the same service.

If a waiver participant's choices are such that the waiver program is concerned that it will not be able to assure the waiver participant's health and welfare, this concern is clearly discussed with the waiver participant. If the waiver participant's health and welfare can be assured, then the waiver participant can remain on the waiver. If this is not possible, then the waiver participant is issued a Notice of Action (NOA), indicating discontinuance from the waiver. The consumer is informed that they have a right to a fair hearing, pursuant to Medicaid rules and the NOA includes information about their fair hearing rights.

Appendix D: Participant-Centered Planning and Service Delivery

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

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

Case managers share with waiver consumers the provider listing, which is developed by a DSS contracted fiduciary. This listing identifies providers by service type and geographic coverage area who meet the qualifications as set forth by DSS to service waiver participants. The case managers facilitate opportunities for participants to speak with and/or interview prospective providers prior to selection. Program participants are able to contact the fiscal intermediary to get an updated and customized listing of the provider directory. For household employees, a background check is conducted by the fiscal intermediary and the results are shared with the consumer to aid in their selection.

Appendix D: Participant-Centered Planning and Service Delivery

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

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

The staff of DSS' HCBS unit, Connecticut's Medicaid agency, directly approves the developed service plan.

Appendix D: Participant-Centered Planning and Service Delivery

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

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

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

Specify the other schedule:

i. **Maintenance of Service Plan Forms.** Written copies or electronic facsimiles of service plans are maintained for a minimum period of 3 years as required by 45 CFR §92.42. Service plans are maintained by the following *(check each that applies):*

- ☑ **Medicaid agency**
- ☐ **Operating agency**
- ☑ **Case manager**

☐ **Other**
Specify:

Appendix D: Participant-Centered Planning and Service Delivery

D-2: Service Plan Implementation and Monitoring

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

Case Managers are responsible for the development, management, administration, and monitoring of the HCBS waiver participants. The case manager promotes participant choice, ensures the delivery of high quality services, assists in the development of needed services and oversees waiver cost-effectiveness, with the support of department staff. Collaboration with local and state government service providers and advocacy groups to develop a network of services and supports in the community is primarily facilitated through DSS HCBS unit staff. DSS, through contracted case managers, Medical Operations, Quality Assurance, and the Bureau of Rehabilitative Services, is the central component in managing and delivering the program objectives of deinstitutionalization, diversion, waiver administration and resource development. DSS is responsible for implementing the HCBS waiver and facilitating access to waiver program supports for eligible individuals.

Monitoring Methods & Frequency:
Oversight of service plan implementation is the responsibility of the case manager.
Progress notes/Monthly Provider Reports in the case management record detail the advancement of the supports for client and collaterals. Evidence is documented in the client's chart that the case manager and/or fiscal intermediary contact the client and/or providers by a means and frequency appropriate to the client's needs to confirm service delivery. Audit documentation indicates contact with client and/or providers occur to determine if services are:
--delivered as expected
--utilized by the client
--satisfactory to the client
--continue to be appropriate to the client's need
--result in positive outcomes
--utilized a back up plan if the need arose
--back up plan is still available to assist if needed

In addition, case manager, consumers, and the consumers' circle of support (family, caregivers, service providers, natural supports, and other relevant parties of the consumer's choosing) meet monthly, in some cases quarterly, to assess, through an interdisciplinary team process, care efficacy, client progress, risk assessment, health services needs and safety. At such meetings, care plans are adjusted congruent with the client's current identified needs. Proposed changes to a client's person centered plan of care, as determined by the aforementioned team process, are subject to review by the case manager's supervisor, and do not requirement department approval. However, the department will monitor and evaluate program compliance as part of its ongoing auditing process of the case management providers. The case managers will report any problems that affect a waiver participant's health and welfare in their monthly meetings with their supervisor. The supervisor must contact the DSS HCBS unit staff technical assistance to address problems related to health and safety.
Home Health Agencies coordinate health services with the case managers and our administrative service organization, CHN CT.

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

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

○ **Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare may provide other direct waiver services to the participant.**

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

Quality Improvement: Service Plan

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: Service Plan Assurance/Sub-assurances**

The state demonstrates it has designed and implemented an effective system for reviewing the adequacy of service plans for waiver participants.

i. **Sub-Assurances:**

a. ***Sub-assurance: Service plans address all participants assessed needs (including health and safety risk factors) and personal goals, either by the provision of waiver services or through other means.***

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 service plans that address participants' goals as indicated in the assessment. Numerator=Number of service plans that address participants' goals as indicated in the assessment. Denominator=Total number of service plans.

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):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = 95%
☑ **Other** Specify: Fiscal Intermediary	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☑ **Other** Specify:	

	Twice per waiver cycle	

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):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☑ **Other** Specify: Fiscal Intermediary	☑ **Annually**
	☐ **Continuously and Ongoing**
	☑ **Other** Specify: Twice per 5 year waiver cycle.

Performance Measure:
Number and percent of service plans that address participant risk factors. Numerator= Number of service plans that address participant risk factors. Denominator= total number of service plans.

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):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

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):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Number and percent of service plans that identify an emergency back-up plan.
Numerator=Number of service plans that identify an emergency back-up plan.
Denominator=Total number of service plans.

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):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:

	☐ **Other** Specify:	

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):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☑ **Continuously and Ongoing**
	☐ **Other** Specify:

b. ***Sub-assurance: The State monitors service plan development in accordance with its policies and procedures.***

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 service plans that are adequate and appropriate to participant needs as addressed in the assessment. Numerator:Number of service plans that are adequate and appropriate to participant needs as addressed in the assessment. Denominator= Total Number of Service Plans.

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):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	

		☑ **Representative Sample** Confidence Interval = 95%
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

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):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

c. ***Sub-assurance: Service plans are updated/revised at least annually or when warranted by changes in the waiver participants needs.***

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 Service Plans that were reviewed and updated as warranted on or before the participants annual review date. Numerator: Number of Service Plans

that were reviewed and updated as warranted on or before the participants annual review date. Denominator= total number of service plans.

Data Source (Select one):
Other
If 'Other' is selected, specify:
System hoc reports.

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):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

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):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

d. ***Sub-assurance: Services are delivered in accordance with the service plan, including the type, scope, amount, duration and frequency specified in the service plan.***

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' records reviewed who received services specified in service plan (type, scope, amount, duration and frequency. Numerator= Number of participants' records reviewed who received services specified in service plan (type, scope, amount, duration and frequency). Denominator= Total number of service plans.

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):*
☐ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☑ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☑ **Other** Specify: Fiscal Intermediary	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

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):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

e. ***Sub-assurance: Participants are afforded choice: Between waiver services and institutional care; and between/among waiver services and providers.***

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 with a freedom of choice form completed and signed stating that they were offered a choice between waiver services and institutional care. Numerator=Number of participants with a freedom of choice form completed and signed stating that they were offered a choice between waiver services and institutional care. Denominator=Total number of service plans.

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):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other**	☐ **Annually**	☐ **Stratified**

Specify:		Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

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):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☑ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Number and percent of clients educated about the full range of services and choices of providers available as evidenced by their signature the "Rights and Responsibilities Form." Numerator= Number of clients educated about the full range of services and choices of providers available as evidenced by their signature the "Rights and Responsibilities Form." Denominator= number of 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):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =

☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

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):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☑ **Continuously and Ongoing**
	☐ **Other** Specify:

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.
There is a system of checks and balances in place that all Service Plans must be approved and signed by the departments HCBS unit clinical staff prior to services being authorized to begin and annually as part of the reassessment process.

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 service plan assessment and review process works on a system of checks and balances.
Documentation is not approved by the DSS HCBS unit CO until all parts of the service plan are complete, and are in compliance with the waiver requirements. If a supervisor does not agree with a plan, the case manager will conduct another home visit and reassess the client needs with the client. If there is still no agreement, the case manager supervisor will conduct a joint home visit prior to adjusting the plan of care. Should the consumer not agree with the service change they may request a fair hearing.

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):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☑ **Other** Specify: Case management provider	☐ **Annually**
	☑ **Continuously and Ongoing**
	☐ **Other** Specify:

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 Service Plans that are currently non-operational.

◉ **No**

○ **Yes**
Please provide a detailed strategy for assuring Service Plans, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix E: Participant Direction of Services

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

◉ **Yes. This waiver provides participant direction opportunities.** Complete the remainder of the Appendix.

○ **No. This waiver does not provide participant direction opportunities.** Do not complete the remainder of the Appendix.

CMS urges states to afford all waiver participants the opportunity to direct their services. Participant direction of services includes the participant exercising decision-making authority over workers who provide services, a participant-managed budget or both. CMS will confer the Independence Plus designation when the waiver evidences a strong commitment to participant direction.

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

○ **Yes. The State requests that this waiver be considered for Independence Plus designation.**

◉ **No. Independence Plus designation is not requested.**

Appendix E: Participant Direction of Services

E-1: Overview (1 of 13)

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

Participants have the authority to and are supported to direct and manage their own services to the extent they wish and are able. The case manager and other waiver providers partner with the waiver participant, and anyone he/she chooses, in the development of the participant Service Plan (SP). During the SP development process, the waiver participant is supported and encouraged to lead and fully participate in the process. The waiver participant attends team meetings and contributes to service plan revision decisions. Options for self direction are offered to the participant by the case manager at the initial

assessment, monthly or quarterly meetings and annual reviews. Additional relevant information about DSS participant direction is as follows:
-Service Plans are signed by the waiver participant and are maintained in each participant's file.
-Participants are the employer of record for household employees and are responsible for hiring, firing, assignment of duties and signing of timesheets. Supports in these activities are provided to those who need it. Case managing services are included in the service plans of participants who need assistance with these activities.
-Participants are afforded the opportunity to speak with and/or interview prospective agency providers prior to selection.
-Participant direction is supported through the team planning process. Case Managers support the agenda by ensuring that participants' needs and preferences are addressed at each meeting.

Appendix E: Participant Direction of Services

E-1: Overview (2 of 13)

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

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

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

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

Specify these living arrangements:

Appendix E: Participant Direction of Services

E-1: Overview (3 of 13)

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

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

Specify the criteria

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

Case Managers and contracted providers (e.g., Brain Injury Alliance of Connecticut (BIAC) and Allied Community Resources (ACR)) provide information to waiver consumers regarding participant direction. After completing an assessment of the applicant's needs, the case manager assembles a person-centered team to help participants develop an appropriate Service Plan and provide a continuing source of support to participants after the plan has been implemented. The members of monthly service planning teams always include participant, conservator, if applicable, case manager, a cognitive behaviorist, other clinical staff as necessary and any other persons chosen by the participant. At these meetings the case manager supports the waiver participant's role in directing their services.
The ABI waiver supports participant direction through its contracts with ACR and BIAC. These contracts require that the providers offer monthly ABI provider training. This training must address person-centered planning that include elements that address client choice, networking, and team building. The Brain Injury Alliance of Connecticut is required to provide services that include advocacy supports; this includes providing consultation and resource facilitation to persons who have sustained a brain injury, their families, caregivers and service providers. BIAC's work includes the following:
-Disseminating information to the community related to brain injury.
-Facilitating monthly support groups throughout Connecticut to provide information and networking opportunities to clients and client families affected by brain injury
-Fielding calls from persons who have sustained a brain injury, their families, caregivers and service providers
-Facilitating a Providers Council with meetings 5 to 6 times per year to promote networking and information exchange between providers.
-Serving as an advocate who informs participants of their rights and supports them at team meetings, as needed.

Waiver participants are furnished information about the benefits, responsibilities, and potential liabilities associated with participant direction, when they elect to direct their services. Both DSS and the fiscal intermediary are responsible for furnishing this information. Case managers meet with consumers regarding their role and issue a rights and responsibility form for participant review and signature at the time of program assessment and annually once services are implemented. The fiscal intermediary provides training to waiver participants regarding the benefits and risks when training participants in the role as employers. Additional training is conducted as needed.

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

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

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

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

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

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

Waiver Service	Employer Authority	Budget Authority
Respite	☑	☐
Homemaker	☑	☐
Companion	☑	☐
Independent Living Skills Training	☑	☐
Chore	☑	☐
Cognitive Behavioral Programs	☑	☐
Transportation	☑	☐
ABI Recovery Assistant II	☑	☐
ABI Recovery Assistant	☑	☐

Appendix E: Participant Direction of Services

E-1: Overview (7 of 13)

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

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

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

☐ **Governmental entities**
☑ **Private entities**

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

Appendix E: Participant Direction of Services

E-1: Overview (8 of 13)

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

○ **FMS are covered as the waiver service specified in Appendix C-1/C-3**

The waiver service entitled:

◉ **FMS are provided as an administrative activity.**

Provide the following information

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

Fiscal Intermediary. Services were procured through a competitive bid process.

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

Contract Payment: Payment is made through a flat contract amount based on full-time equivalent expenses and costs of what they do. Not related to service costs.

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

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

- [x] **Assist participant in verifying support worker citizenship status**
- [x] **Collect and process timesheets of support workers**
- [x] **Process payroll, withholding, filing and payment of applicable federal, state and local employment-related taxes and insurance**
- [x] **Other**

Specify:

Provide Consumer training that includes, but is not limited to, advertising/recruiting, interviewing techniques, staff training, ongoing performance evaluations of PCAs and problem solving or termination of household employees. The training shall also include monitoring the quality of the plan implementation.

Supports furnished when the participant exercises budget authority:

- [ ] **Maintain a separate account for each participant's participant-directed budget**
- [ ] **Track and report participant funds, disbursements and the balance of participant funds**
- [ ] **Process and pay invoices for goods and services approved in the service plan**
- [ ] **Provide participant with periodic reports of expenditures and the status of the participant-directed budget**
- [ ] **Other services and supports**

Specify:

Additional functions/activities:

- [x] **Execute and hold Medicaid provider agreements as authorized under a written agreement with the Medicaid agency**
- [x] **Receive and disburse funds for the payment of participant-directed services under an agreement with the Medicaid agency or operating agency**
- [ ] **Provide other entities specified by the State with periodic reports of expenditures and the status of the participant-directed budget**
- [ ] **Other**

Specify:

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

DSS is responsible for the monitoring an assessment of performance for the FMS. The following activities support this effort:
--Review of quarterly and ad hoc reports from the fiscal intermediary
--Annual on-site visits to review operational and administrative functions
--Ongoing correspondence between the fiscal intermediary and DSS staff regarding progress on deliverables (e.g., claims processing, training schedules, numbers of credential providers, etc.)
--A bi-annual survey administered to waiver participants regarding the FMS's performance
--Random audits of Medicaid Providers by DSS Quality Assurance Division

Appendix E: Participant Direction of Services

E-1: Overview (9 of 13)

j. Information and Assistance in Support of Participant Direction. In addition to financial management services, participant direction is facilitated when information and assistance are available to support participants in managing their services. These

supports may be furnished by one or more entities, provided that there is no duplication. Specify the payment authority (or authorities) under which these supports are furnished and, where required, provide the additional information requested *(check each that applies)*:

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

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

Case Management/Service Coordination

The Department of Social Service's (DSS) contracted case manager, who acts on behalf of the Medicaid Agency, will be the Coordinator providing information and support of participant direction. He/she must have a thorough knowledge of all the other services available through this waiver, as well as all the services and supports available through the regular State Medicaid program, and from all other state and federal funding. Sources of informal support are often the crucial determining factor if the waiver participant is to successfully remain in the community. The case manager's ability to make use of these informal supports is essential, and provides the greatest opportunity for creativity.

The case manager will also be responsible for the following functions:

1. completing an initial assessment and developing the service plan;
formally reviewing the Service Plan at least every twelve months;
2. maintaining records
3. assuring that the annual reassessment of eligibility and level of care;
4. initiating a re-evaluation of the level of care when the waiver participant has experienced a significant change in functioning;

* All Waiver participants receive administrative case management*

The case manager also:
1. responds to the individual by helping the participant to identify his or her unique wishes and needs;
2. promotes activities which will increase the individual's independence and life satisfaction through participation in meaningful activities;
3. assists in the inclusion of the individual in the community of his/her choice;
4. arranges for daily living supports and services to meet the individualŁs needs, including assistance in accessing entitlements and other funding sources;
5. provides advocacy for the participant to receive needed services; and
6. convenes crisis intervention, service planning in collaboration with the person centered team.

Throughout his/her involvement with the waiver participant, the case manager will support and encourage the waiver participant to increase his/her ability to problem solve, be in control of life situations, and be as independent as possible, for all services. This is balanced by the need to assure the waiver participant's health, safety, well-being and inclusion in the community. The waiver participant must be included in the decision-making process leading to the plan of care development. The case manager will complete an initial assessment, evaluate the level of care and, with the waiver participant, develop the service plan and coordinate the delivery of the service plan. The case manager will act as programmatic service coordinator.

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

Participant-Directed Waiver Service	Information and Assistance Provided through this Waiver Service Coverage
Prevocational Services	☐
Respite	☐
Case Management	☐
Homemaker	☐
Personal Care	☐
Companion	☐
Environmental Accessibility Modifications	☐

Participant-Directed Waiver Service	Information and Assistance Provided through this Waiver Service Coverage
Home Delivered Meals	☐
Independent Living Skills Training	☐
Supported Employment	☐
Chore	☐
Consultation Services	☐
Cognitive Behavioral Programs	☐
Community Living Support Services (CLSS)	☐
ABI Group Day	☐
Vehicle Modification Services	☐
Transportation	☐
ABI Recovery Assistant II	☐
ABI Recovery Assistant	☐
Specialized Medical Equipment and Supplies	☐
Personal Emergency Response Systems (PERS)	☐
Substance Abuse Programs	☐
Adult Day Health	☐

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

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

The contracted fiduciary agency is also responsible for the oversight and support of participant self-direction:

The fiduciary supports are procured and compensated through competitively bid contracts.
After assessment by the case manager and approval of waiver services, the fiduciary would explain the program as self-directed and client-centered. The consumer is trained that they are the employers who will hire, train and manage their own employees.
The fiduciary acts as the conduit to the Department of Labor and the Federal government, training the employer to complete the necessary paperwork to enable them to hire employees of their selection.
The consumer is trained how to complete the time sheets and when to submit them to the fiduciary for payment.
The fiduciary has a provider registry that is made available to the consumer to help and allow them to hire an employee of their choice.

The fiduciary is responsible to provide the Department with quarterly reports indicating the frequency in which the above services were provided. Additionally, they must provide to the department the results of an annual consumer satisfaction survey.

Appendix E: Participant Direction of Services

E-1: Overview (10 of 13)

k. Independent Advocacy *(select one)*.

○ **No. Arrangements have not been made for independent advocacy.**

◉ **Yes. Independent advocacy is available to participants who direct their services.**

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

DSS contracts with the Brain Injury Alliance of Connecticut, Inc. (BIAC) for the purpose of providing consultation, advocacy, resource facilitation, support, information, training and outreach to persons with brain injury and their families. BIAC's services through this contract are intended to enable participants to advocate for themselves for access to brain injury programs and community-based supports. In addition to direct advocacy, telephonic support (statewide toll-free number), newsletter and web-based information dissemination, BIAC is funded to conduct numerous trainings and community education programs. BIAC is accessible by telephone, internet, and community support groups held statewide. BIAC provides support both to groups and to individuals in need of support and advocacy.

Connecticut's Office of Protection and Advocacy (P & A) provides supports and advocacy for persons with disabilities. P & A also has a statewide toll-free number and a website.

Appendix E: Participant Direction of Services

E-1: Overview (11 of 13)

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

Participant direction can be voluntarily terminated. Agency based services are available as an alternative to participants who choose not to self direct. If a participant chooses to terminate self-direction, the case manager aids in the identification of agency provider and informal supports to support the consumer's need. The planning team process supports continuity of care by ensuring linkage to the appropriate service in a timely manner.

Appendix E: Participant Direction of Services

E-1: Overview (12 of 13)

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

Participant direction can be involuntarily terminated, when a consumer does not demonstrate the ability to manage their household employees. In this circumstance, a Notice of Action is issued and the consumer has a right to a fair hearing, pursuant to Medicaid rules. Agency based services or state plan Home Health Services, through the Medicaid program, replaces services for clients who do not wish to self-direct. If a participant chooses to terminate self-direction, the case manager aids in the identification of agency provider and informal supports to support the consumer's need. The planning team process supports continuity of care by ensuring linkages to the appropriate service in a timely manner.

Appendix E: Participant Direction of Services

E-1: Overview (13 of 13)

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

Table E-1-n

	Employer Authority Only	Budget Authority Only or Budget Authority in Combination with Employer Authority
Waiver Year	**Number of Participants**	**Number of Participants**
Year 1	10	
Year 2	11	
Year 3	12	
Year 4	13	
Year 5	14	

Appendix E: Participant Direction of Services

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

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

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

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

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

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

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

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

Specify how the costs of such investigations are compensated:

The fiscal intermediary, at no cost to the participant, performs this function. The results are forwarded to the waiver participant.

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

Specify:

Appendix E: Participant Direction of Services

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

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

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

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

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

Specify:

Appendix E: Participant Direction of Services

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

b. Participant - Budget Authority

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

ii. **Participant-Directed Budget** Describe in detail the method(s) that are used to establish the amount of the participant-directed budget for waiver goods and services over which the participant has authority, including how the method makes use of reliable cost estimating information and is applied consistently to each participant. Information about these method(s) must be made publicly available.

Appendix E: Participant Direction of Services

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

b. Participant - Budget Authority

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

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

Appendix E: Participant Direction of Services

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

b. Participant - Budget Authority

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

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

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

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

Appendix E: Participant Direction of Services

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

b. Participant - Budget Authority

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

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

Appendix F: Participant Rights

Appendix F-1: Opportunity to Request a Fair Hearing

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

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

Applicants for and recipients of services under the ABI waiver may request and receive a fair hearing, in accordance with the rules of the Department's Medical Assistance Program. Applicants receive a copy of the DSS W-1035, Freedom of Choice/Hearing Notification Form, during the first visit with the case manager. Fair Hearings are provided in the following circumstances when the Department:

1. Did not offer the choice of home and community-based services as an alternative to institutional care
2. Does not reach a determination of financial eligibility within the Department's standard of promptness;
3. Denies the application for any reasons other than the limitations on the number of individuals who can be served and/or funding limitations as established in the approved ABI waiver;
4. Disapproves the individual's service plan;
5. Denies or terminates a service of the individual's choice;
6. Denies or terminates payment to a qualified provider of the individual's choice; or
7. Discharges the individual from the ABI waiver program.

In accordance with Medicaid rules (Connecticut General Statutes, sections 17b-60 through 66), a Notice Of Action (NOA) is issued to waiver participants when any service is denied, reduced, suspended or terminated. The NOA and Freedom of Choice/Fair Hearing Notification are also provided in Spanish to support providing person with LEP or non-English proficiency.

Per the Department of Social Services Uniform Policy Manual (UP-91-8 1570.20), the Department does not terminate or reduce the

client's benefits until the Fair Hearing decision is reached if the client requests a Fair Hearing within the 10 day notice period. The client's benefits remain the same pending the Fair Hearing decision. Per DSS Uniform Policy Manual (UP-91-32 1570.10),the Department mails or gives adequate notice at least ten days prior to the date of the intended action if the Department intends to discontinue, terminate, suspend, or reduce benefits. The only exceptions to this policy are if the client dies or state or federal law supersede the Department's policy to continue benefits while awaiting a Fair Hearing decision.

The Department issues and publicizes all Fair Hearing policies and procedures in all client correspondence. At the time of application and at the time of any action affecting the client's benefits, the Department informs the client, in writing, of the right to a Fair Hearing; how the client can request a Fair Hearing; and that the requester may be self-representative, may use legal counsel, a relative, friend, or other spokesperson.

The Office of Legal Counsel, fair hearings unit, keeps a record of all fair hearings and the results of any cases heard.

Appendix F: Participant-Rights

Appendix F-2: Additional Dispute Resolution Process

a. **Availability of Additional Dispute Resolution Process.** Indicate whether the State operates another dispute resolution process that offers participants the opportunity to appeal decisions that adversely affect their services while preserving their right to a Fair Hearing. *Select one:*

- (●) **No. This Appendix does not apply**
- ( ) **Yes. The State operates an additional dispute resolution process**

b. **Description of Additional Dispute Resolution Process.** Describe the additional dispute resolution process, including: (a) the State agency that operates the process; (b) the nature of the process (i.e., procedures and timeframes), including the types of disputes addressed through the process; and, (c) how the right to a Medicaid Fair Hearing is preserved when a participant elects to make use of the process: State laws, regulations, and policies referenced in the description are available to CMS upon request through the operating or Medicaid agency.

Appendix F: Participant-Rights

Appendix F-3: State Grievance/Complaint System

a. **Operation of Grievance/Complaint System.** *Select one:*

- (●) **No. This Appendix does not apply**
- ( ) **Yes. The State operates a grievance/complaint system that affords participants the opportunity to register grievances or complaints concerning the provision of services under this waiver**

b. **Operational Responsibility.** Specify the State agency that is responsible for the operation of the grievance/complaint system:

c. **Description of System.** Describe the grievance/complaint system, including: (a) the types of grievances/complaints that participants may register; (b) the process and timelines for addressing grievances/complaints; and, (c) the mechanisms that are used to resolve grievances/complaints. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Appendix G: Participant Safeguards

Appendix G-1: Response to Critical Events or Incidents

a. Critical Event or Incident Reporting and Management Process. Indicate whether the State operates Critical Event or Incident Reporting and Management Process that enables the State to collect information on sentinel events occurring in the waiver program.*Select one:*

- (●) **Yes. The State operates a Critical Event or Incident Reporting and Management Process** *(complete Items b through e)*
- ( ) **No. This Appendix does not apply** *(do not complete Items b through e)*
  If the State does not operate a Critical Event or Incident Reporting and Management Process, describe the process that the State uses to elicit information on the health and welfare of individuals served through the program.

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

A. Under the Connecticut ABI Waiver, the quality of services provided is assured in several ways: maintaining established credentials for standards for prospective providers (including background checks for household employees) by a fiscal intermediary, which maintains the provider directory; an ongoing clinical review of the plan of care by a cognitive behavioral specialist working with the consumer's team; monitoring by the case manager at team meetings and through monthly provider reports; and a process for follow-up of reported incidents.
DSS has standard contract language that addresses incident reporting for clients served. This language states as follows: The contractor shall make immediate contact to family, case manager and cognitive behaviorist. The case manager shall submit to through the Department's web based system an incident report detailing situations that have compromised the health and/or safety of clients served in the program. The written incident report shall be submitted to the aforementioned parties no later than 5 PM next business day.
The report shall include but not be limited to: client name, staff involved, date, time, details of the incident, an explanation of corrective action taken, and standard operating procedure established to prevent future incidences. The Department has modified this language to be included in all service agreements for ABI Waiver Program providers.

The Department has developed a critical incident reporting form specific to the ABI Waiver. This incident reporting form has been fully deployed.

The HCBS quality improvement/quality management team reviews the incidents on a daily basis and provide feedback and direction to the case management provider for follow up.
A Critical Incident is defined as any situation in which the waiver participant experiences a perceived or actual threat to his/her health and welfare or to their ability to remain in the community. These incidents include:

Unexpected absence of the primary caregiver
Untimely death
Emergency room visit or unplanned hospitalization
Suicide attempt
Serious criminal allegation - client as victim
Serious criminal allegation - client as perpetrator
Allegations of abuse, neglect, or exploitation of client
Fire in residence with significant risk to client
Missing person reported to police
Misappropriation of client's funds
Seclusion
Restraint
Other (describe)

B. All members of the Waiver participant's care planning team and service agency staff members are required to report critical incidents. Recipients of Critical Incident reporters include:
- Participant's case manager
- Cognitive Behaviorist
- Participant and/or Conservator
- DSS Central Office

- Fiscal Intermediary

Reporting Methods and Timeframes:

The provider, pursuant to the Critical Incident form, shall immediately notify DSS by telephone under any of the following circumstances:

- The major unusual incident requires notification of a law enforcement agency;
- The major unusual incident requires notification of child protective services;
- The major unusual incident requires notification of elderly protective services;
- The provider has received inquiries from the media regarding a major unusual incident that has not been previously reported; or
- The major unusual incident raises immediate concerns regarding the individual's health and safety such that more immediate notification regarding the incident is necessary.

The form requires providers to submit a written incident report to the DSS by 5 p.m. the next business day following the provider's initial knowledge of any major unusual incident. By 5 p.m. on the business day immediately following receipt of the written incident report submitted by the provider, DSS shall enter preliminary information regarding the incident through its online system.

c. **Participant Training and Education.** Describe how training and/or information is provided to participants (and/or families or legal representatives, as appropriate) concerning protections from abuse, neglect, and exploitation, including how participants (and/or families or legal representatives, as appropriate) can notify appropriate authorities or entities when the participant may have experienced abuse, neglect or exploitation.

At team meetings, case managers provide information to participants regarding the reporting of potential abuse, neglect or exploitation. Consumers, their representatives, and other stakeholders are informed that the case manager should be notified of any of the aforementioned issues with regard to participant safety.

The Department contracts with the Brain Injury Alliance of Connecticut to provide services that include advocacy supports. This includes providing consultation and resource facilitation to persons who have sustained a brain injury, their families, caregivers and service providers. This includes disseminating information to the community related to brain injury. Through this contract, the Brain Injury Alliance of Connecticut also facilitates support groups throughout Connecticut to provide support, information, and networking to clients and client families; fields calls from persons who have sustained a brain injury, their families, caregivers and service providers; and facilitates a Providers Council with meetings 5 or 6 times per year to promote networking and information exchange between providers. Through this vehicle (BIAC) information about the identification and reporting of abuse, neglect is disseminated to clients, families, and their representatives.

Consumers/representative are be informed of the necessity to report events at their annual service plan review meetings, or anytime during the waiver year that it seems necessary to reiterate this information. Documentation regarding the receipt of information about reporting actual or perceived matters that impact participants' safety and well-being will be obtained. All participants will sign the Rights and Responsibilities form to evidence that such information has been imparted.

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

The DSS HCBS unit investigates critical events or incidents, often in conjunction with the consumer's clinician who is best able to interview the consumer. Other parties are contacted and interviewed as appropriate. If a concern is raised about any matter that has come up while the consumer was under the programming of a provider, the provider is required to submit an incident report. The specific manner of follow-up for such concerns is determined by the nature of the allegation and the results of the investigation. Possible actions include the suspension or removal of a provider from the active directory. Action to ensure the safety of a waiver participant who is at imminent risk occurs immediately. Additional follow-up with other entities include, but are not limited to, DSS units/divisions (e.g., Quality Assurance, Medical Policy, Legal), law enforcement, and the Department of Public Health as may be necessary.

The Department has developed a data system to manage incident reporting and related follow-up and analysis. The database has the capability to track safety issues and can be queried and prompted with a tickler feature to ensure timely resolution.

When a waiver participant is age sixty or older and it is deemed appropriate to contact Protective Services for the Elderly (PSE) as part of the investigation, the case manager will assure this is done. In addition, police are notified if any criminal

action occurs. Any party involved in the investigation process may initiate contact with PSE or the police. All contacts with PSE and/or the police must be documented as part of the investigation process. PSE Statute (sections 17b-450 through 461) provides the framework for the investigation of abuse or neglect. The Department tracks follow-up in its case management database.

The timeframes for response and investigation commencement will as follows:

Priority	Response Time
Imminent	Immediate
Emergency	Same Business Day
Severe	Next Business Day
Non-Severe	Within 7 Working Days

Follow-up and reporting to all parties including the participant/representative and other relevant parties must be completed within 45 days of the reported event.

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

DSS is responsible for overseeing the reporting of and response to critical incidents or events that affect waiver participants. The Department directly administers this and follow-up frequency is continuous and ongoing.

Critical Incidents are used for program improvement: on the participant level, the individual's team shall take appropriate actions for the specific incident and shall track and analyze data for trends, and shall take or recommend subsequent actions (e.g., care plan changes, provider changes, treatment modifications, etc.).

On a system level, the Waiver Management team shall take appropriate actions for the specific incident and shall track and analyze data for trends, and shall take or recommend subsequent actions (policy changes/clarifications, provider actions, etc)

We track trends monthly through the tracking ability of the data base.

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (1 of 3)

a. **Use of Restraints.** *(Select one)*: *(For waiver actions submitted before March 2014, responses in Appendix G-2-a will display information for both restraints and seclusion. For most waiver actions submitted after March 2014, responses regarding seclusion appear in Appendix G-2-c.)*

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

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

At any time, a client, community provider or private citizen can report to DSS staff the use of Restraints or Seclusion. Because the use of Restraints and Restrictive Interventions is unauthorized and pursuant to Connecticut State Regulation 262-596 (d), the Department reserves the right to bar anyone who violates any rules or policies of the program. Any use of Restraints and Restrictive Interventions would be a violation of program rules resulting in the employee being barred as an authorized provider under the ABI Waiver II program and his/her name would be removed from the list of approved providers. Employers will also be encouraged and counseled to notify the police if the situation warrants such an intervention. Case manager home visits, observation and interview, is the methodology utilized to detect any unauthorized use of Restraints and Restrictive Interventions used for participants. Questions regarding restraints and seclusion have been added to our core standardized assessment that will be fully operational by 2017

This will be added to the rights and Responsibilities document and will be included in provider training.

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

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

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

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (2 of 3)

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

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

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

At any time, a client, community provider or private citizen can report to DSS staff the use of Restraints or Seclusion. Because the use of Restraints and Restrictive Interventions is unauthorized and pursuant to Connecticut State Regulation 262-596 (d), the Department reserves the right to bar anyone who violates any rules or policies of the program. Any use of Restraints and Restrictive Interventions would be a violation of program rules resulting in the employee being barred as and authorized provider under the ABI Waiver II program and his/her name would be removed from the list of approved providers. Employers will also be encouraged and counseled to notify the police if the situation warrants such an intervention. Case manager home visits, observation and interview, is the methodology utilized to detect any unauthorized use of Restraints and Restrictive Interventions used for participants.
This will be added to the rights and Responsibilities document and will be included in provider training.

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

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

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

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (3 of 3)

c. Use of Seclusion. *(Select one)*: *(This section will be blank for waivers submitted before Appendix G-2-c was added to WMS in March 2014, and responses for seclusion will display in Appendix G-2-a combined with information on restraints.)*

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

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

The case manager is responsible for assessing and detecting the unauthorized use of seclusion at the team meetings. Additional questions regarding restraints and seclusion have been added to our core standardized assessment to ensure periodic review.

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

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

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

Appendix G: Participant Safeguards

Appendix G-3: Medication Management and Administration (1 of 2)

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

a. **Applicability.** Select one:

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

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

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

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

Appendix G: Participant Safeguards

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

c. **Medication Administration by Waiver Providers**

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

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

○ **Not applicable.** *(do not complete the remaining items)*

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

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

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

○ **Providers that are responsible for medication administration are required to both record and report medication errors to a State agency (or agencies).**
Complete the following three items:

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

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

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

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

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

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

Appendix G: Participant Safeguards

Quality Improvement: Health and Welfare

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: Health and Welfare**
The state demonstrates it has designed and implemented an effective system for assuring waiver participant health and welfare. *(For waiver actions submitted before June 1, 2014, this assurance read "The State, on an ongoing basis, identifies, addresses, and seeks to prevent the occurrence of abuse, neglect and exploitation.")*
   i. **Sub-Assurances:**

a. ***Sub-assurance: The state demonstrates on an ongoing basis that it identifies, addresses and seeks to prevent instancesof abuse, neglect, exploitation and unexplained death.*** *(Performance measures in this sub-assurance include all Appendix G performance measures for waiver actions submitted before June 1, 2014.)*

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 and/or legal guardian who receive information about how to report abuse, neglect, and exploitation. Numerator=Number of participants and/or legal guardian who receive information about how to report abuse, neglect, and exploitation. Denominator=number of 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):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

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):*
☑ **State Medicaid Agency**	☐ **Weekly**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☑ **Other** Specify: Fiscal Intermediary	☐ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Number and percent of private employees who receive a criminal background check prior to service provision. Numerator= Number private employees who receive a criminal background check prior to service provision. Denominator= Number PCA and private employees.

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):*
☐ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☑ **Other** Specify: Fiscal Intermediary	☑ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

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):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☑ **Other** Specify: Fiscal Intermediary	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Number and percent of service plans that identify an emergency back-up plan.
Numerator=Number of service plans that identify an emergency back-up plan.
Denominator= total number of service plans.

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):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

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):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☑ **Other** Specify: Fiscal Intermediary	☐ **Annually**
	☑ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Number and percent of serious incident reports that are reported using the HCBS unit's critical incident reporting system within 48 hours as required by the waiver. Numerator= Number and percent of serious incident reports that are reported within 48 hours. Denominator: Number and percent of serious incident reports.

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):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

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):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☑ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
The number and percent of serious incident investigations that were completed in the timeframes specified in the waiver. Numerator=The number and percent of serious incident investigations that were completed in the timeframes specified in the waiver. Denominator=Total number of serious incident investigations.

Data Source (Select one):
Critical events and incident reports
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):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☑ **Other** Specify: Service providers	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

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):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

b. ***Sub-assurance: The state demonstrates that an incident management system is in place that effectively resolves those incidents and prevents further similar incidents to the extent possible.***

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 state policies and procedures for the use or prohibition of restrictive interventions (including restraints and seclusion) are followed.***

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.

d. ***Sub-assurance: The state establishes overall health care standards and monitors those standards based on the responsibility of the service provider as stated 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.

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.
When issues are identified, providers are required to submit a plan of correction with timeframes for completion. If a provider continues to have less than acceptable performance, they can be put on enhanced monitoring, or can be prohibited from serving any new participants until their performance has reached an acceptable level of quality, or can lose their status as a qualified provider for the service(s) with less than acceptable quality, and/or can be removed as a qualified provider altogether. HCBS clinical and administrative staff track the problem to resolution.

For fully self-directed services, procedures are in place to address issues unique to this service arrangement. For example, if an employee is identified by the fiscal intermediary as having a criminal conviction, a report is sent to the case manager, the Program Manager and the employer is notified. Since the waiver service is self-directed the consumer is able to decide to hire the staff person, by signing a release of liability form. If the Program Manager makes the decision that the crimes are too serious in nature to allow the hiring, they may refuse to allow the hiring pursuant to the State of Connecticut Regulation Sec. 17b-262-596 (c). All activities are tracked in the HCBS unit database for follow-up.

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):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☑ **Continuously and Ongoing**
	☐ **Other** Specify:

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 Health and Welfare that are currently non-operational.

◉ **No**
○ **Yes**
Please provide a detailed strategy for assuring Health and Welfare, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix H: Quality Improvement Strategy (1 of 2)

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

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

CMS recognizes that a state's waiver Quality Improvement Strategy may vary depending on the nature of the waiver target population, the services offered, and the waiver's relationship to other public programs, and will extend beyond regulatory requirements. However, for the purpose of this application, the State is expected to have, at the minimum, systems in place to measure and improve its own performance in meeting six specific waiver assurances and requirements.

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

Quality Improvement Strategy: Minimum Components

The Quality Improvement Strategy that will be in effect during the period of the approved waiver is described throughout the waiver in the appendices corresponding to the statutory assurances and sub-assurances. Other documents cited must be available to CMS upon request through the Medicaid agency or the operating agency (if appropriate).

In the QIS discovery and remediation sections throughout the application (located in Appendices A, B, C, D, G, and I) , a state spells out:

- The evidence based discovery activities that will be conducted for each of the six major waiver assurances;
- The *remediation* activities followed to correct individual problems identified in the implementation of each of the assurances;

In Appendix H of the application, a State describes (1) the *system improvement* activities followed in response to aggregated, analyzed discovery and remediation information collected on each of the assurances; (2) the correspondent *roles/responsibilities* of those conducting assessing and prioritizing improving system corrections and improvements; and (3) the processes the state will follow to continuously *assess the effectiveness of the OIS* and revise it as necessary and appropriate.

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

When the Quality Improvement Strategy spans more than one waiver and/or other types of long-term care services under the Medicaid State plan, specify the control numbers for the other waiver programs and/or identify the other long-term services that are addressed in the Quality Improvement Strategy. In instances when the QIS spans more than one waiver, the State must be able to stratify information that is related to each approved waiver program. Unless the State has requested and received approval from CMS for the consolidation of multiple waivers for the purpose of reporting, then the State must stratify information that is related to each approved waiver program, i.e., employ a representative sample for each waiver.

Appendix H: Quality Improvement Strategy (2 of 2)

H-1: Systems Improvement

a. System Improvements

i. Describe the process(es) for trending, prioritizing, and implementing system improvements (i.e., design changes) prompted as a result of an analysis of discovery and remediation information.

DSS has been implementing a system of checks and balances in order to establish consistent quality assurance within services provided to clients through this waiver. The state has been guided by state and federal regulations to assist in establishing procedures and the many varied data collection, aggregation and analysis processes that are currently utilized. Through the productive process of analysis, discovery, remediation and improvement, the state recognizes the

benefit to client services that can be obtained through continued system review and requisite improvements.

Through review of gathered data and reports, Waiver management and key stakeholders meet at least monthly to review trends, identify areas of focus and plan for the implementation of required program changes.

Core reports that are developed and shared are as follows:
Fiscal Intermediary Report: includes enrollment trends, expenditures, cost per member, and program performance to provide relevant stakeholders (e.g., participants, families, advocates, oversight committees, legislature and the public) with an overview of the previous year's activities, expenditures and program performance. These reports will be shared with the waiver advisory committee. Frequency: Quarterly and Annual

ABI Waiver Summary Report: includes waiver assurance quality indicators, findings and interpretation of quality indicators, steps taken/proposed to address challenges to provide relevant stakeholders (e.g., agency leadership, CMS, and oversight committees) with an overview of progress in meeting Waiver assurances. These reports will also be shared with the waiver advisory committee. Frequency: Annual

The use of these reports leads to the development of new/modified policy, form changes, training updates. The reports serve as an agenda for developing program change within Waiver management in the HCBS unit. Also, public input is sought through many arenas to help identify recommended areas of focus. To ensure public input, the Department will convene an Advisory committee consisting of both consumers and advocates that will review and comment on all quality assurance reports and activities, assessment methods and frequency and summaries of participant surveys.
The waiver advisory group will meet quarterly.
Other arenas include focus groups are held with other stakeholders such as participants at BIAC support groups and case managers in the field.

ii. System Improvement Activities

Responsible Party*(check each that applies):*	**Frequency of Monitoring and Analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☑ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Quality Improvement Committee**	☐ **Annually**
☐ **Other** Specify:	☑ **Other** Specify: continuous and ongoing

b. System Design Changes

i. Describe the process for monitoring and analyzing the effectiveness of system design changes. Include a description of the various roles and responsibilities involved in the processes for monitoring & assessing system design changes. If applicable, include the State's targeted standards for systems improvement.

The Department contracts with the fiscal intermediary to provide the following activity and compliance reports:
- administrative reports,
- fiscal reports,
- programmatic reports,
- Registry updates,
- reconciliation reports.

The fiscal intermediary will also :
- Provide an annual survey of Satisfaction/Quality/Evaluation with participants and providers and communicate on an as needed basis with all participants regarding the services received from the contractor.
-Use both telephone and print surveys to gather information. Surveys shall be conducted within sixty (60) days with all new Employers, conservators as appropriate, employees, case managers and any other involved organizations or individuals. Thereafter, surveys shall be solicited on a quarterly basis from a random sampling of 25% of active

Employers. The surveys shall address the level of satisfaction with the procedures of intake, training, payment, financial services, on-going contact, availability of providers and service delivery by the Waiver providers
-Address special concerns identified in the Waiver Program survey as soon as practical
-Summarize the survey information in quarterly annual reports to the Department.

Additionally, the Department will conduct its own Satisfaction Survey, with the results compiled by the fiscal intermediary. The results of this survey are shared with DSS staff and the fiscal intermediary to resolve and address any identified problems or needed systems changes.

ii. Describe the process to periodically evaluate, as appropriate, the Quality Improvement Strategy.

The HCBS Management team will, as needed, evaluate information presented by the Fiscal Intermediary. Most large program changes are implemented at Waiver renewal, however changes that make small modifications to procedure are implmented as needed.

Appendix I: Financial Accountability

I-1: Financial Integrity and Accountability

Financial Integrity. Describe the methods that are employed to ensure the integrity of payments that have been made for waiver services, including: (a) requirements concerning the independent audit of provider agencies; (b) the financial audit program that the state conducts to ensure the integrity of provider billings for Medicaid payment of waiver services, including the methods, scope and frequency of audits; and, (c) the agency (or agencies) responsible for conducting the financial audit program. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

The Department of Social Services has contracted with a fiscal intermediary to maintain the payment records for services received and billed under the ABI Waiver. The fiscal intermediary, Allied Community Resources, Inc. credentials all of the ABI waiver providers and will issue them a credentialing document that will be required when they enroll with HPE as a Medicaid provider. (ACR) ensures that all billed services for self directed services emanate from an approved consumer plan of care and submits appropriate claims to Hewlett Packard (HPE), who is a claims payment subcontractor of the Department. All claims for non self directed providers will be billed directly to HPE and compared against service authorizations entered into the web claims portal by the case management provider.

The DSS Office of Quality Assurance (QA) conducts financial audits of Medicaid providers and issues exceptions when appropriate for issues of non-compliance with the State's policy requirements. The Office of Quality Assurance activities extend to all DSS programs, and office staff persons are located at the central and regional DSS offices. Functions are grouped into three major areas of focus: audits, quality control, and fraud and recoveries.

All waiver providers are subject to audits performed by the QA. Overall audit demands and audit resources available to DSS QA impact the frequency of audits of waiver providers. These audits include ad hoc reviews when ACR or DSS HCBS staff, or case managers alert QA to potential issues.

Audits of payments to providers are most commonly performed on a universe of claims payments within a two year period. A random sample of 100 claims is chosen. The auditor reviews supporting documentation maintained by the provider and claims information maintained by the department. The purpose of the review is to determine if services and associated payments were made in accordance with applicable state regulations. Errors identified in the sample are extrapolated to the universe of paid claims to arrive at a financial audit adjustment.
The Connecticut Auditors of Public Accounts is responsible for conducting the independent audit as required by the Single Audit Act.
Using the list of ABI providers as of December 31, 2013 as a base for the number of potential ABI providers that need to be audited, the DSS Office of Quality Assurance expects to audit each significant ABI provider once every five years.

The FI has edits in care plan authorization and claims payment systems to ensure that approvals for duplicative services are not made.

Appendix I: Financial Accountability

Quality Improvement: Financial Accountability

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: Financial Accountability**
State financial oversight exists to assure that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver. *(For waiver actions submitted before June 1, 2014, this assurance read "State financial oversight exists to assure that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver.")*

i. **Sub-Assurances:**

a. ***Sub-assurance: The State provides evidence that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver and only for services rendered.*** *(Performance measures in this sub-assurance include all Appendix I performance measures for waiver actions submitted before June 1, 2014.)*

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 claims submitted for individuals enrolled in the waiver on the date services were rendered. Numerator=Number of claims submitted that were submitted for individuals enrolled in the waiver on the date services were rendered. Denominator=total number of claims submitted.

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):*
☐ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☑ **Other** Specify: Fiscal Intermediary	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

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):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☑ **Other** Specify: Fiscal Intermediary	☐ **Annually**
	☑ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Number and Percentage of waiver service claims paid that were specified in participants' service plans. Numerator: Number of waiver service claims paid that were specified in participants' service plans. Denominator= Total number of claims.

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):*
☐ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☑ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☑ **Other** Specify: Fiscal Intermediary	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

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):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☑ **Other** Specify: Fiscal Intermediary	☐ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

b. ***Sub-assurance: The state provides evidence that rates remain consistent with the approved rate methodology throughout the five year waiver cycle.***

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.

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.
DSS has contracted with a fiscal intermediary to maintain the payment records on services received and billed under the ABI waiver. The fiscal intermediary ensures that all billed services are within a consumers Plan of Care and submits appropriate claims to the department's MMIS system maintained by HPE. Department. EDS reviews the claim for Medicaid eligibility and other elements (i.e., hospitalization dates), before reimbursing the fiscal agent. The fiscal intermediary ensures that all services and corresponding claim payments are coded and properly documented. To ensure maximum reimbursement, the fiscal intermediary will report to DSS Central Office staff any difficulties with billing. HCBS staff will coordinate with EDS to resolve the payment issue. Additionally, the fiscal intermediary will generate, at the Departments request, a report identifying non-reimbursable charges with an explanation.

Finally, computerized service documentation system allows for the tracking of expenditures for each client (approved cost of the plan) as well as the total waiver program. HCBS staff and case managers are available to respond to questions, and clarify for the consumer any issues related to the Cost of Care Plan or the Medicaid application process. This may also involve coordinating with DSS eligibility staff, to ensure that the consumers application is approved in a timely manner.
Effective 4/1/16 with this amendment, the providers will be directly enrolled with the MMIS contractor once credentialed by the fiscal intermediary. The claims will process through a portal where the authorized service plan is maintained. This process will immediately notify the provider of any billing issues and allows for timely notification and correction by department staff.

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.

DSS staff assigned to the ACR contract is responsible to ensure that communication occurs on a daily basis with the fiscal intermediary. He/she is the liaison between the fiscal intermediary and eligibility and will communicate any issues that need to be resolved and follow up to insure they are resolved. If the issue is not something that can be resolved, he will bring it to the attention on the Waiver Program Manager who will intervene.

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):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☑ **Other** Specify: Fiscal intermediary	☐ **Annually**
	☑ **Continuously and Ongoing**
	☐ **Other** Specify:

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 Financial Accountability that are currently non-operational.

◉ **No**

○ **Yes**

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

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (1 of 3)

a. **Rate Determination Methods.** In two pages or less, describe the methods that are employed to establish provider payment rates for waiver services and the entity or entities that are responsible for rate determination. Indicate any opportunity for public comment in the process. If different methods are employed for various types of services, the description may group services for which the same method is employed. State laws, regulations, and policies referenced in the description are available upon request to CMS through the Medicaid agency or the operating agency (if applicable).

Pursuant to Connecticut Department of Social Services Provider manual. All schedules of payment for coverable Medical Assistance Program goods and services shall be established by the commissioner and paid by the department in accordance with all applicable federal and state statutes and regulations. Waiver service rates are based on a trended 2.5% increase on rates established in the initial ABI waiver. Input on the waiver, including rates, were afforded to all parties who commented on the ABI Waiver application. This includes consumers, family, case managers, and providers. Service rate information is available on the care plan cost grid as well as through the fiscal intermediary. Consumers, provider organizations and DSS staff have had the opportunity to review the Waiver application and rates pursuant to the public notice. The Waiver application has been reviewed and approved by the committees of cognizance of the Connecticut state legislature after a lengthy public hearing in which stakeholders had the ability to testify and comment.The rate setting methodology is the same for all services. Waiver service rates are based on direct and indirect costs of providing Waiver services. The rate structure for the program consists of 1) fee-for-service billing from an established fee schedule that pays uniform rates across providers; 2) usual and customary rates established individually with providers based on special provider needs such as serving hazardous urban areas which require accompaniment by security personnel. The only variance is for self directed services where the participant has the ability to set the pay rate within the parameters defined in the collective bargaining agreement that impacts companions. The rate is now determined by a collective bargaining agreement and ranges from $10 to $12.50 per hour. All applicable employer taxes are added to the pay rate to determine the Medicaid rate. In addition, as the result of the new

collective bargaining agreement for companions, there is a requirement for both a training and paid time off funds to be disbursed through the fiscal intermediary.
Costs related to Paid Time Off (PTO) Fund and Training Fund will be claimed through an administrative claim and those costs will not be included in the waiver service rates. The PTO Fund and Training Fund payments will be made based upon the number of unduplicated clients receiving a paid Medicaid Waiver service during the claiming quarter. The quarterly per client PTO Fund payment will be calculated by taking the quarterly allocation for PTO payments and dividing by the number of clients receiving a paid Medicaid Waiver service. The quarterly per client Training Fund payment will be calculated by taking the quarterly allocation for PTO payments and dividing by the number of clients receiving a paid Medicaid Waiver service. Quarterly per client payments for PTO Fund and Training Fund shall not exceed 5% of quarterly Medicaid Waiver service costs. When the PCA is provided by an agency, the agency determines the rate of pay but the maximum allowable rate for the service is established by the department in its fee schedule. Other than the self hire companion, rates do not vary for different providers of waiver services. Rates are usually prospective. If retroactive rate setting should occur, this will result in mass adjustments during a claim cycle to either compensate providers for a rate increase or recoupments if rates are decreased. During the life of this waiver, service rates may be adjusted based on legislatively approved increases or decreases to the Department's appropriation.
Oversight of the ABI rate determination method is conducted by the DSS Reimbursement and CON Unit through a review of ABI Waiver rates for reasonableness in comparison to other HCBS comparable waiver services. Additionally, DSS Financial and Management Analysis Unit conducts a review of the data.

b. Flow of Billings. Describe the flow of billings for waiver services, specifying whether provider billings flow directly from providers to the State's claims payment system or whether billings are routed through other intermediary entities. If billings flow through other intermediary entities, specify the entities:

The Department has engaged with its MMIS provider HP to develop a web-based claims portal where the case manager enters the authorized service plan into the portal and the providers bill claims through the portal. Claims are checked against the service plan authorized by the care manager. Services that were not authorized will deny. All agency based waiver providers are now enrolling directly with the Department through an enrollment wizard in the HP system. One statewide fiscal intermediary will perform all credentialing functions and providers will be unable to enroll without producing the credentialing document. Self directed providers will continue to submit time sheets to the fiscal intermediary who will bill through the portal. This direct relationship between waiver providers and the department will enable improved communication and monitoring of providers' performance. The care plan portal will allow only authorized services to pay ensuring compliance with the plan of care. HP will be producing reports that will compare authorized services to actual paid claims so that areas or providers needing follow up can be identified. This also allows for trending analysis of utilization patterns. Problematic agencies are identified and remediation plans are initiated. The case management provider bills for the case management services and assessment services. Claims are submitted to HP Enterprise Services (formerly EDS) which operates the Department's MMIS system. Allied Community Resources is the fiscal intermediary who bills HP Enterprise Services (EDS) directly for self directed services. Home Health Agencies and Assisted Living Service Agencies may also bill the MMIS system (HP Enterprises) directly.Payments are made by the Medicaid agency directly to the providers of waiver and State plan services. There are provider agreements between the DSS and each provider of services under the waiver. Payments for self directed services are made by the fiscal intermediary on the client's behalf. The FI then bills the states MMIS contractor. Payments for all waiver and other State plan services are made through Connecticut's approved Medicaid Management Information System (MMIS). DSS pays providers through the same fiscal agent used in the rest of the Medicaid program.

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (2 of 3)

c. Certifying Public Expenditures *(select one)*:

- (●) **No. State or local government agencies do not certify expenditures for waiver services.**
- ( ) **Yes. State or local government agencies directly expend funds for part or all of the cost of waiver services and certify their State government expenditures (CPE) in lieu of billing that amount to Medicaid.**

***Select at least one*:**

☐ **Certified Public Expenditures (CPE) of State Public Agencies.**

Specify: (a) the State government agency or agencies that certify public expenditures for waiver services; (b) how it is assured that the CPE is based on the total computable costs for waiver services; and, (c) how the State verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51 (b).*(Indicate source of revenue for CPEs in Item I-4-a.)*

☐ **Certified Public Expenditures (CPE) of Local Government Agencies.**

Specify: (a) the local government agencies that incur certified public expenditures for waiver services; (b) how it is assured that the CPE is based on total computable costs for waiver services; and, (c) how the State verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51(b). *(Indicate source of revenue for CPEs in Item I-4-b.)*

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (3 of 3)

d. Billing Validation Process. Describe the process for validating provider billings to produce the claim for federal financial participation, including the mechanism(s) to assure that all claims for payment are made only: (a) when the individual was eligible for Medicaid waiver payment on the date of service; (b) when the service was included in the participant's approved service plan; and, (c) the services were provided:

The Medicaid agency pays providers through the same fiscal agent used for the rest of the Medicaid program.
** DSS has contracts with a fiscal intermediary to maintain the payment records on self directed services received and billed under the ABI Waiver. The MMIS billing portal will ensure that all ABI waiver services billed emanate from an approved consumer POC and submits appropriate claims to MMIS through the claims payment subcontractor of the Department. Providers are required to obtain client signature for services and this is reviewed upon audit by DSS Division of Quality Assurance. The MMIS provider reviews the claims for Medicaid eligibility and other elements (i.e., spend-down requirements) before reimbursing the provider.It is the responsibility of the case manager to develop a plan of care in conjunction with the client and their circle of support, to prevent client care plans from exceeding cost caps and to ensure that designated services are actually being provided. Self directed services require signature on timesheets. Agencies are required to retain record of service delivery in their files. Proof of service delivery can be detected upon audit by DSS Quality Assurance through record review of agency files and Fiscal Intermediary records.

e. Billing and Claims Record Maintenance Requirement. Records documenting the audit trail of adjudicated claims (including supporting documentation) are maintained by the Medicaid agency, the operating agency (if applicable), and providers of waiver services for a minimum period of 3 years as required in 45 CFR §92.42.

Appendix I: Financial Accountability

I-3: Payment (1 of 7)

a. Method of payments -- MMIS (*select one*):

◉ **Payments for all waiver services are made through an approved Medicaid Management Information System (MMIS).**

○ **Payments for some, but not all, waiver services are made through an approved MMIS.**

Specify: (a) the waiver services that are not paid through an approved MMIS; (b) the process for making such payments and the entity that processes payments; (c) and how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:

○ **Payments for waiver services are not made through an approved MMIS.**

Specify: (a) the process by which payments are made and the entity that processes payments; (b) how and through which system(s) the payments are processed; (c) how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:

○ **Payments for waiver services are made by a managed care entity or entities. The managed care entity is paid a monthly capitated payment per eligible enrollee through an approved MMIS.**

Describe how payments are made to the managed care entity or entities:

Appendix I: Financial Accountability

I-3: Payment (2 of 7)

b. Direct payment. In addition to providing that the Medicaid agency makes payments directly to providers of waiver services, payments for waiver services are made utilizing one or more of the following arrangements (*select at least one*):

☐ **The Medicaid agency makes payments directly and does not use a fiscal agent (comprehensive or limited) or a managed care entity or entities.**

☑ **The Medicaid agency pays providers through the same fiscal agent used for the rest of the Medicaid program.**

☐ **The Medicaid agency pays providers of some or all waiver services through the use of a limited fiscal agent.**

Specify the limited fiscal agent, the waiver services for which the limited fiscal agent makes payment, the functions that the limited fiscal agent performs in paying waiver claims, and the methods by which the Medicaid agency oversees the operations of the limited fiscal agent:

☐ **Providers are paid by a managed care entity or entities for services that are included in the State's contract with the entity.**

Specify how providers are paid for the services (if any) not included in the State's contract with managed care entities.

Appendix I: Financial Accountability

I-3: Payment (3 of 7)

c. Supplemental or Enhanced Payments. Section 1902(a)(30) requires that payments for services be consistent with efficiency, economy, and quality of care. Section 1903(a)(1) provides for Federal financial participation to States for expenditures for services under an approved State plan/waiver. Specify whether supplemental or enhanced payments are made. *Select one:*

◉ **No. The State does not make supplemental or enhanced payments for waiver services.**

○ **Yes. The State makes supplemental or enhanced payments for waiver services.**

Describe: (a) the nature of the supplemental or enhanced payments that are made and the waiver services for which these payments are made; (b) the types of providers to which such payments are made; (c) the source of the non-Federal share of the supplemental or enhanced payment; and, (d) whether providers eligible to receive the supplemental or enhanced payment retain 100% of the total computable expenditure claimed by the State to CMS. Upon request, the State will furnish CMS with detailed information about the total amount of supplemental or enhanced payments to each provider type in the waiver.

Appendix I: Financial Accountability

I-3: Payment (4 of 7)

d. Payments to State or Local Government Providers. *Specify whether State or local government providers receive payment for the provision of waiver services.*

- (●) **No. State or local government providers do not receive payment for waiver services.** Do not complete Item I-3-e.
- ( ) **Yes. State or local government providers receive payment for waiver services.** Complete Item I-3-e.

Specify the types of State or local government providers that receive payment for waiver services and the services that the State or local government providers furnish:

Appendix I: Financial Accountability

I-3: Payment (5 of 7)

e. Amount of Payment to State or Local Government Providers.

Specify whether any State or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed its reasonable costs of providing waiver services and, if so, whether and how the State recoups the excess and returns the Federal share of the excess to CMS on the quarterly expenditure report. *Select one:*

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

- ( ) **The amount paid to State or local government providers is the same as the amount paid to private providers of the same service.**
- ( ) **The amount paid to State or local government providers differs from the amount paid to private providers of the same service. No public provider receives payments that in the aggregate exceed its reasonable costs of providing waiver services.**
- ( ) **The amount paid to State or local government providers differs from the amount paid to private providers of the same service. When a State or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed the cost of waiver services, the State recoups the excess and returns the federal share of the excess to CMS on the quarterly expenditure report.**

Describe the recoupment process:

Appendix I: Financial Accountability

I-3: Payment (6 of 7)

f. Provider Retention of Payments. Section 1903(a)(1) provides that Federal matching funds are only available for expenditures made by states for services under the approved waiver. *Select one:*

- (●) **Providers receive and retain 100 percent of the amount claimed to CMS for waiver services.**
- ( ) **Providers are paid by a managed care entity (or entities) that is paid a monthly capitated payment.**

Specify whether the monthly capitated payment to managed care entities is reduced or returned in part to the State.

Appendix I: Financial Accountability

I-3: Payment (7 of 7)

g. Additional Payment Arrangements

i. **Voluntary Reassignment of Payments to a Governmental Agency.** *Select one:*

- (●) **No. The State does not provide that providers may voluntarily reassign their right to direct payments to a governmental agency.**
- ( ) **Yes. Providers may voluntarily reassign their right to direct payments to a governmental agency as provided in 42 CFR §447.10(e).**

Specify the governmental agency (or agencies) to which reassignment may be made.

ii. **Organized Health Care Delivery System.** *Select one:*

- (●) **No. The State does not employ Organized Health Care Delivery System (OHCDS) arrangements under the provisions of 42 CFR §447.10.**
- ( ) **Yes. The waiver provides for the use of Organized Health Care Delivery System arrangements under the provisions of 42 CFR §447.10.**

Specify the following: (a) the entities that are designated as an OHCDS and how these entities qualify for designation as an OHCDS; (b) the procedures for direct provider enrollment when a provider does not voluntarily agree to contract with a designated OHCDS; (c) the method(s) for assuring that participants have free choice of qualified providers when an OHCDS arrangement is employed, including the selection of providers not affiliated with the OHCDS; (d) the method(s) for assuring that providers that furnish services under contract with an OHCDS meet applicable provider qualifications under the waiver; (e) how it is assured that OHCDS contracts with providers meet applicable requirements; and, (f) how financial accountability is assured when an OHCDS arrangement is used:

iii. **Contracts with MCOs, PIHPs or PAHPs.** *Select one:*

- (●) **The State does not contract with MCOs, PIHPs or PAHPs for the provision of waiver services.**
- ( ) **The State contracts with a Managed Care Organization(s) (MCOs) and/or prepaid inpatient health plan(s) (PIHP) or prepaid ambulatory health plan(s) (PAHP) under the provisions of §1915(a)(1) of the Act for the delivery of waiver and other services. Participants may voluntarily elect to receive waiver and other services through such MCOs or prepaid health plans. Contracts with these health plans are on file at the State Medicaid agency.**

  Describe: (a) the MCOs and/or health plans that furnish services under the provisions of §1915(a)(1); (b) the geographic areas served by these plans; (c) the waiver and other services furnished by these plans; and, (d) how payments are made to the health plans.

- ( ) **This waiver is a part of a concurrent §1915(b)/§1915(c) waiver. Participants are required to obtain waiver and other services through a MCO and/or prepaid inpatient health plan (PIHP) or a prepaid ambulatory health plan (PAHP). The §1915(b) waiver specifies the types of health plans that are used and how payments to these plans are made.**

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (1 of 3)

a. **State Level Source(s) of the Non-Federal Share of Computable Waiver Costs.** Specify the State source or sources of the non-federal share of computable waiver costs. *Select at least one*:

- [x] **Appropriation of State Tax Revenues to the State Medicaid agency**

☐ **Appropriation of State Tax Revenues to a State Agency other than the Medicaid Agency.**

If the source of the non-federal share is appropriations to another state agency (or agencies), specify: (a) the State entity or agency receiving appropriated funds and (b) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if the funds are directly expended by State agencies as CPEs, as indicated in Item I-2-c:

☐ **Other State Level Source(s) of Funds.**

Specify: (a) the source and nature of funds; (b) the entity or agency that receives the funds; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by State agencies as CPEs, as indicated in Item I-2-c:

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (2 of 3)

b. Local Government or Other Source(s) of the Non-Federal Share of Computable Waiver Costs. Specify the source or sources of the non-federal share of computable waiver costs that are not from state sources. *Select One*:

◉ **Not Applicable**. There are no local government level sources of funds utilized as the non-federal share.

○ **Applicable**
Check each that applies:

☐ **Appropriation of Local Government Revenues.**

Specify: (a) the local government entity or entities that have the authority to levy taxes or other revenues; (b) the source(s) of revenue; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement (indicate any intervening entities in the transfer process), and/or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2-c:

☐ **Other Local Government Level Source(s) of Funds.**

Specify: (a) the source of funds; (b) the local government entity or agency receiving funds; and, (c) the mechanism that is used to transfer the funds to the State Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2-c:

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (3 of 3)

c. Information Concerning Certain Sources of Funds. Indicate whether any of the funds listed in Items I-4-a or I-4-b that make up the non-federal share of computable waiver costs come from the following sources: (a) health care-related taxes or fees; (b) provider-related donations; and/or, (c) federal funds. *Select one*:

◉ **None of the specified sources of funds contribute to the non-federal share of computable waiver costs**

○ **The following source(s) are used**
Check each that applies:

- [ ] **Health care-related taxes or fees**
- [ ] **Provider-related donations**
- [ ] **Federal funds**

For each source of funds indicated above, describe the source of the funds in detail:

Appendix I: Financial Accountability

I-5: Exclusion of Medicaid Payment for Room and Board

a. **Services Furnished in Residential Settings.** *Select one:*

- (●) **No services under this waiver are furnished in residential settings other than the private residence of the individual.**
- ( ) **As specified in Appendix C, the State furnishes waiver services in residential settings other than the personal home of the individual.**

b. **Method for Excluding the Cost of Room and Board Furnished in Residential Settings.** The following describes the methodology that the State uses to exclude Medicaid payment for room and board in residential settings:
Do not complete this item.

Appendix I: Financial Accountability

I-6: Payment for Rent and Food Expenses of an Unrelated Live-In Caregiver

Reimbursement for the Rent and Food Expenses of an Unrelated Live-In Personal Caregiver. *Select one:*

- (●) **No. The State does not reimburse for the rent and food expenses of an unrelated live-in personal caregiver who resides in the same household as the participant.**
- ( ) **Yes. Per 42 CFR §441.310(a)(2)(ii), the State will claim FFP for the additional costs of rent and food that can be reasonably attributed to an unrelated live-in personal caregiver who resides in the same household as the waiver participant. The State describes its coverage of live-in caregiver in Appendix C-3 and the costs attributable to rent and food for the live-in caregiver are reflected separately in the computation of factor D (cost of waiver services) in Appendix J. FFP for rent and food for a live-in caregiver will not be claimed when the participant lives in the caregiver's home or in a residence that is owned or leased by the provider of Medicaid services.**

The following is an explanation of: (a) the method used to apportion the additional costs of rent and food attributable to the unrelated live-in personal caregiver that are incurred by the individual served on the waiver and (b) the method used to reimburse these costs:

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (1 of 5)

a. **Co-Payment Requirements.** Specify whether the State imposes a co-payment or similar charge upon waiver participants for waiver services. These charges are calculated per service and have the effect of reducing the total computable claim for federal financial participation. *Select one:*

- (●) **No. The State does not impose a co-payment or similar charge upon participants for waiver services.**
- ( ) **Yes. The State imposes a co-payment or similar charge upon participants for one or more waiver services.**

i. **Co-Pay Arrangement.**

Specify the types of co-pay arrangements that are imposed on waiver participants (*check each that applies*):

Charges Associated with the Provision of Waiver Services *(if any are checked, complete Items I-7-a-ii through I-7-a-iv):*

- ☐ **Nominal deductible**
- ☐ **Coinsurance**
- ☐ **Co-Payment**
- ☐ **Other charge**

Specify:

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (2 of 5)

a. **Co-Payment Requirements.**

ii. **Participants Subject to Co-pay Charges for Waiver Services.**

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (3 of 5)

a. **Co-Payment Requirements.**

iii. **Amount of Co-Pay Charges for Waiver Services.**

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (4 of 5)

a. **Co-Payment Requirements.**

iv. **Cumulative Maximum Charges.**

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (5 of 5)

b. **Other State Requirement for Cost Sharing.** Specify whether the State imposes a premium, enrollment fee or similar cost sharing on waiver participants. *Select one*:

- ◉ **No. The State does not impose a premium, enrollment fee, or similar cost-sharing arrangement on waiver participants.**
- ○ **Yes. The State imposes a premium, enrollment fee or similar cost-sharing arrangement.**

Describe in detail the cost sharing arrangement, including: (a) the type of cost sharing (e.g., premium, enrollment fee); (b) the amount of charge and how the amount of the charge is related to total gross family income; (c) the groups of participants subject to cost-sharing and the groups who are excluded; and, (d) the mechanisms for the collection of cost-sharing and reporting the amount collected on the CMS 64:

Appendix J: Cost Neutrality Demonstration

J-1: Composite Overview and Demonstration of Cost-Neutrality Formula

Composite Overview. Complete the fields in Cols. 3, 5 and 6 in the following table for each waiver year. The fields in Cols. 4, 7 and 8 are auto-calculated based on entries in Cols 3, 5, and 6. The fields in Col. 2 are auto-calculated using the Factor D data from the J-2-d Estimate of Factor D tables. Col. 2 fields will be populated ONLY when the Estimate of Factor D tables in J-2-d have been completed.

Level(s) of Care: Hospital, Nursing Facility, ICF/IID

Col. 1	Col. 2	Col. 3	Col. 4	Col. 5	Col. 6	Col. 7	Col. 8
Year	Factor D	Factor D'	Total: D+D'	Factor G	Factor G'	Total: G+G'	Difference (Col 7 less Column4)
1	93207.73	14285.16	107492.89	168295.05	15379.59	183674.64	76181.75
2	106555.19	14389.70	120944.89	193086.87	14863.06	207949.93	87005.04
3	110935.40	13980.96	124916.36	198658.25	14925.85	213584.10	88667.74
4	114989.33	14162.18	129151.51	205294.63	15183.73	220478.36	91326.85
5	119167.23	14358.50	133525.73	211099.01	15537.47	226636.48	93110.75

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (1 of 9)

a. **Number Of Unduplicated Participants Served.** Enter the total number of unduplicated participants from Item B-3-a who will be served each year that the waiver is in operation. When the waiver serves individuals under more than one level of care, specify the number of unduplicated participants for each level of care:

Table: J-2-a: Unduplicated Participants

Waiver Year	Total Unduplicated Number of Participants (from Item B-3-a)	Distribution of Unduplicated Participants by Level of Care (if applicable)		
		Level of Care: Hospital	Level of Care: Nursing Facility	Level of Care: ICF/IID
Year 1	105	52	52	1
Year 2	180	76	100	4
Year 3	255	100	148	7
Year 4	330	124	196	10
Year 5	405	148	244	13

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (2 of 9)

b. **Average Length of Stay.** Describe the basis of the estimate of the average length of stay on the waiver by participants in item J-2-a.

Average Length of Stay (LOS) was derived by the following method:
The base length of stay for each level of care was obtained from the CMS 372 report for the exising ABI Waiver for calendar year 2011.

Factor D decreases from Year 1 to Year 2 because of a significant change in the case mix from predominantly high DMHAS utilizers at the CDH level of care in Year 1 to mostly lower utilizers in Years 2. The case mix is more stable in Years 2 -5 with estimated costs increasing year over year. The decrease in the average length of stay in Year 2 is due to a change in the rate at which recipients enter the waiver, which impacts the average length of stay.

The base length of stay has been adjusted to reflect the admissions of new entrants and individuals transitioning from the Department of Mental Health and Addiction Services and Money Follows the Person over the course of the five waiver years.

c. **Derivation of Estimates for Each Factor.** Provide a narrative description for the derivation of the estimates of the following factors.

i. **Factor D Derivation.** The estimates of Factor D for each waiver year are located in Item J-2-d. The basis for these estimates is as follows:

The estimated number of users and units per user are based on CY 2011 utilization obtained from the CMS 372S Lag Report for the existing ABI Waiver and adjusted based on guidance from program staff regarding above average utilzers transitioning from DMHAS at the hospital level of care. Estimates for services not included in the existing ABI Waiver are based on anticipated utilization provided by program staff upon review of individual care plans. Cost per unit was obtained from the proposed fee schedule for the ABI Waiver II.

ii. **Factor D' Derivation.** The estimates of Factor D' for each waiver year are included in Item J-1. The basis of these estimates is as follows:

Factor D' was based on the CMS-372S report for the existing ABI Waiver for calendar year 2011 and adjusted for above average utitilizers transitioning from DMHAS at the hospital level of care. The historic cost data was trended forward using actual CPI trends. Inflation projection is based on the published June 2013 Consumer Price Index for Medical Care at 3.4%. Factor D does not include the cost of prescribed drugs that will be furnished to Medicare/Medicaid dual eligibles under the provision of Part D.

iii. **Factor G Derivation.** The estimates of Factor G for each waiver year are included in Item J-1. The basis of these estimates is as follows:

Factor G is based on CMS 372T - ABI Waiver Lag Report: CY 2011. The Factor G value in the 372T was adjusted for the longer length of stay seen in existing ABI Waiver population. Costs were trended forward using the published June 2013 Consumer Price Index for Nursing Home Care at 2.5%.

iv. **Factor G' Derivation.** The estimates of Factor G' for each waiver year are included in Item J-1. The basis of these estimates is as follows:

Factor G' was based on the CMS 372T - ABI Waiver Lag Reports: CY 2011. The historic cost data were trended forward using actual CPI trends. Inflation projection is based on the published June 2013 Consumer Price Index for Medical Care at 3.4%.

Component management for waiver services. If the service(s) below includes two or more discrete services that are reimbursed separately, or is a bundled service, each component of the service must be listed. Select "*manage components*" to add these components.

Waiver Services	
ABI Group Day	
Adult Day Health	
Case Management	
Homemaker	
Personal Care	
Prevocational Services	
Respite	
Supported Employment	
ABI Recovery Assistant II	
ABI Recovery Assistant	
Chore	
Cognitive Behavioral Programs	
Community Living Support Services (CLSS)	
Companion	

Waiver Services	
Consultation Services	
Environmental Accessibility Modifications	
Home Delivered Meals	
Independent Living Skills Training	
Personal Emergency Response Systems (PERS)	
Specialized Medical Equipment and Supplies	
Substance Abuse Programs	
Transportation	
Vehicle Modification Services	

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (5 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 1

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
ABI Group Day Total:						**48640.00**
ABI Group Day	per hour	5	608.00	16.00	**48640.00**	
Adult Day Health Total:						**0.00**
Full Day - Approved Medical Model Provider	full day	0	0.00	70.22	**0.00**	
Full Day - Non-Medical Model Provider	full day	0	0.00	66.18	**0.00**	
Half Day	half day	0	0.00	44.54	**0.00**	
Case Management Total:						**5893.80**
Case Management	per hour	6	55.00	17.86	**5893.80**	
Homemaker Total:						**14451.36**
Homemaker	per 15 min	7	506.00	4.08	**14451.36**	
Personal Care Total:						**270013.08**
Agency PCA - Quarter Hour	per 15 min	12	4477.00	4.72	**253577.28**	
Agency PCA - Overnight 12 Hours	per 12 hours	0	0.00	132.00	**0.00**	
				GRAND TOTAL:		**9786811.91**
				Total Estimated Unduplicated Participants:		**105**
				Factor D (Divide total by number of participants):		**93207.73**
				Average Length of Stay on the Waiver:		246

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Agency PCA - Per Diem 24 Hours	per 24 hours	0	81.00	180.00	0.00	
Personal Care	per 15 min	2	2382.00	3.45	16435.80	
Prevocational Services Total:						1160292.00
Prevocational Services	per hour	56	570.00	36.35	1160292.00	
Respite Total:						579.50
Respite	per hour	1	50.00	11.59	579.50	
Supported Employment Total:						1016636.80
Supported Employment	per hour	38	736.00	36.35	1016636.80	
ABI Recovery Assistant II Total:						2809014.84
ABI Recovery Assistant II	per 15 min	69	7844.00	5.19	2809014.84	
ABI Recovery Assistant Total:						1517296.20
ABI Recovery Assistant	per 15 min	46	5838.00	5.65	1517296.20	
Chore Total:						432.48
Chore	per 15 min	1	106.00	4.08	432.48	
Cognitive Behavioral Programs Total:						145353.60
In-person visit	per hour	98	18.00	82.40	145353.60	
Non-face-to-face	per 15 minutes	0	0.00	17.00	0.00	
Community Living Support Services (CLSS) Total:						85654.80
Community Living Support Services (CLSS)	per 12 hours	8	165.00	64.89	85654.80	
Companion Total:						137250.30
Companion	per 15 min	10	3781.00	3.63	137250.30	
Consultation Services Total:						60000.00
Consultation Services	per item	24	1.00	2500.00	60000.00	
Environmental Accessibility Modifications Total:						80000.00
Environmental Accessibility Modifications	per item	8	1.00	10000.00	80000.00	
Home Delivered Meals Total:						10117.80
Home Delivered Meals					10117.80	

GRAND TOTAL:	9786811.91
Total Estimated Unduplicated Participants:	105
Factor D (Divide total by number of participants):	93207.73
Average Length of Stay on the Waiver:	246

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
	per double meal	5	231.00	8.76		
Independent Living Skills Training Total:						**2344151.25**
Independent Living Skills Training	per hour	85	765.00	36.05	**2344151.25**	
Personal Emergency Response Systems (PERS) Total:						**9626.10**
Personal Emergency Response Systems (PERS)	per month	30	11.00	29.17	**9626.10**	
Specialized Medical Equipment and Supplies Total:						**60000.00**
Specialized Medical Equipment and Supplies	per item	6	1.00	10000.00	**60000.00**	
Substance Abuse Programs Total:						**50.00**
Substance Abuse Programs	per hour	1	1.00	50.00	**50.00**	
Transportation Total:						**1358.00**
Transportation	per mile	2	2716.00	0.25	**1358.00**	
Vehicle Modification Services Total:						**10000.00**
Vehicle Modification Services	per item	1	1.00	10000.00	**10000.00**	
				GRAND TOTAL:		**9786811.91**
				Total Estimated Unduplicated Participants:		**105**
				Factor D (Divide total by number of participants):		**93207.73**
				Average Length of Stay on the Waiver:		246

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (6 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 2

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
ABI Group Day Total:						**64864.80**
ABI Group Day	per hour	5	792.00	16.38	**64864.80**	
Adult Day Health Total:						**9060.66**
Full Day - Approved Medical Model Provider	full day	1	126.00	71.91	**9060.66**	
Full Day - Non-Medical Model Provider	full day	0	0.00	67.77	**0.00**	
Half Day	half day	0	0.00	45.61	**0.00**	
Case Management Total:						

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
						7608.64
Case Management	per hour	13	32.00	18.29	**7608.64**	
Homemaker Total:						**35810.06**
Homemaker	per 15 min	13	659.00	4.18	**35810.06**	
Personal Care Total:						**730052.28**
Agency PCA - Quarter Hour	per 15 min	23	6064.00	4.83	**673649.76**	
Agency PCA - Overnight 12 Hours	per 12 hours	1	300.00	135.17	**40551.00**	
Agency PCA - Per Diem 24 Hours	per 24 hours	1	86.00	184.32	**15851.52**	
Personal Care	per 15 min	0	0.00	3.53	**0.00**	
Prevocational Services Total:						**2229180.24**
Prevocational Services	per hour	92	651.00	37.22	**2229180.24**	
Respite Total:						**1543.10**
Respite	per hour	2	65.00	11.87	**1543.10**	
Supported Employment Total:						**1929484.80**
Supported Employment	per hour	60	864.00	37.22	**1929484.80**	
ABI Recovery Assistant II Total:						**5242435.56**
ABI Recovery Assistant II	per 15 min	116	8511.00	5.31	**5242435.56**	
ABI Recovery Assistant Total:						**2477708.91**
ABI Recovery Assistant	per 15 min	67	6387.00	5.79	**2477708.91**	
Chore Total:						**1479.72**
Chore	per 15 min	3	118.00	4.18	**1479.72**	
Cognitive Behavioral Programs Total:						**312417.00**
In-person visit	per hour	171	7.00	105.00	**125685.00**	
Non-face-to-face	per 15 minutes	171	56.00	19.50	**186732.00**	
Community Living Support Services (CLSS) Total:						**286598.85**