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 waiver's target population. Waiver services complement and/or supplement the services that are available to participants through the Medicaid State plan and other federal, state and local public programs as well as the supports that families and communities provide.

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

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

1. Major Changes

Describe any significant changes to the approved waiver that are being made in this renewal application:
The most significant change in this waiver is the addition of Personal Care Assistant services as both a consumer directed model as well as agency with choice to allow our clients the greatest flexibility in securing needed services. We are also proposing to add Assistive Technology as a waiver service. In preparation for the waiver renewal,we reevaluated our quality assurance/quality improvement activities and have initiated some significant changes. We have initiated a Quality Assurance Committee comprised of both Access Agency and Alternate Care Unit staff. In that committee, we are developing new procedures to address and enhance our current quality management activities. A waiver of statewideness is not being requested because our Assisted Living service, although not available in all Connecticut towns, is widely available and accessible to waiver participants. There are no clients remaining from the Fairfield County Pilot Project that were included in the previous waiver renewal.
Our goal in making these changes is to offer a wider range of service options, to increase consumer choice and offer greater flexibility in choice of services to our waiver participants. The state sees these changes as a major effort toward its rebalancing goal.

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*):
Home and Community Based Services Waiver for Elders

C. **Type of Request: renewal**

☐ **Migration Waiver** - this is an existing approved waiver

☑ **Renewal of Waiver:**

Provide the information about the original waiver being renewed

Base Waiver Number: 0140

Amendment Number (if applicable):

Effective Date: *(mm/dd/yy)* 07/01/05

Draft ID: **CT.20.05.00**

Renewal Number: 05

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

E. **Proposed Effective Date:** *(mm/dd/yy)*

07/01/10

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:

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

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

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

1. Request Information (3 of 3)

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

Select one:

◉ **Not applicable**

○ **Applicable**

Check the applicable authority or authorities:

☐ **Services furnished under the provisions of §1915(a)(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:

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.

The Department of Social Services, as the state Medicaid agency pursuant to CT General Statutes (CGS) 17b-1, operates the Home and Community Based Services Waiver according to CGS 17b-342 for individuals age 65 and over to enable frail elders to be deinstitutionalized or diverted from nursing home placement. This past year, the Department engaged in a research project with the University of CT to evaluate the waiver with the goal of enhancing the service package, identifying system gaps and resources in order to create more flexible service options and to reduce the number of program participants who ultimately find themseleves in a nursing home on a long term basis. The research identified that many factors contributed to nursing home placement but most significant were the lack of home care services on nights and weekends and the lack of flexible service providers who could do both hands on as well as non hands on care. A significant challenge identified was the number of clients with mental health and/or substance abuse issues and the lack of available services to meet those needs. Some recommendations that came out of this study were adding PCA services, mental health and substance abuse training for case managers and better coordination with hospital discharge planners. Consequently, in addition to the range of services previously provided, we are requesting to add PCA as a consumer directed service and adding assistive technology as a waiver service.

The Department's Alternate Care Unit administers the waiver, accepts applications, does the initial level of care determination and refers the client to a contracted case management provider for the initial evaluation, confirmation of the level of care and development of the service plan. DSS is responsible for determining both financial and functional eligibility for the waiver. The case management providers maintain monthly contact with the clients and are required to do semi-annual face to face evaluations with the comprehensive evaluation being required annually. The case management organizations are also responsible for subcontracting with the direct care provider agencies and also process the claims and submit them for payment through the state's MMIS. With the addition of the PCA service a fiscal intermediary will be needed to process the weekly payroll. Quality assurance and improvement activities are conducted by both the care management agencies and the Department. The Department has extensive reporting requirements of the case management agencies including quarterly quality assurance summaries.

Services provided by the waiver include Case Management, Homemaker, Companion, Chore, Adult Day Health,Personal Emergency Response Systems, Respite, Transportation, Home Delivered Meals, Mental Health Counseling and Environmental Accessibility Adaptations. The new services that are being added are assistive Technology and Personal Care Assistant. Personal care will be available to clients either as a fully self directed model or as agency with choice.

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/MR.

C. Room and Board. In accordance with 42 CFR §441.310(a)(2), FFP is not claimed for the cost of room and board except when: (a) provided as part of respite services in a facility approved by the State that is not a private residence or (b) claimed as a portion of the rent and food that may be reasonably attributed to an unrelated caregiver who resides in the same household as the participant, as provided in **Appendix I**.

D. Access to Services. The State does not limit or restrict participant access to waiver services except as provided in **Appendix C**.

E. Free Choice of Provider. In accordance with 42 CFR §431.151, a participant may select any willing and qualified provider to furnish waiver services included in the service plan unless the State has received approval to limit the number of providers under the provisions of §1915(b) or another provision of the Act.

F. **FFP Limitation**. In accordance with 42 CFR §433 Subpart D, FFP is not claimed for services when another third-party (e.g., another third party health insurer or other federal or state program) is legally liable and responsible for the provision and payment of the service. FFP also may not be claimed for services that are available without charge, or as free care to the community. Services will not be considered to be without charge, or free care, when (1) the provider establishes a fee schedule for each service available and (2) collects insurance information from all those served (Medicaid, and non-Medicaid), and bills other legally liable third party insurers. Alternatively, if a provider certifies that a particular legally liable third party insurer does not pay for the service(s), the provider may not generate further bills for that insurer for that annual period.

G. **Fair Hearing:** The State provides the opportunity to request a Fair Hearing under 42 CFR §431 Subpart E, to individuals: (a) who are not given the choice of home and community- based waiver services as an alternative to institutional level of care specified for this waiver; (b) who are denied the service(s) of their choice or the provider(s) of their choice; or (c) whose services are denied, suspended, reduced or terminated. **Appendix F** specifies the State's procedures to provide individuals the opportunity to request a Fair Hearing, including providing notice of action as required in 42 CFR §431.210.

H. **Quality 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:
The state sought public input from multiple sources in preparation of the renewal. A presentation was done for the Money Follows the Person Steering Committee which is a mix of consumers, providers and advocates. Another presentation was done for the CT Council of Persons With Disabilities, seeking input on the expansion of PCA services and the addition of consumer direction to the waiver. A presentation was also made to the Home Care Advisory Committee consisting primarily of the provider network including the CT Home Care Association and the Adult Day Care Association of CT. Finally, a presentation was done for the State Long Term Care Planning Committee which was broadcast statewide by the CT Television Network.
The Department has solicited input from the two tribal nations in Connecticut. Both tribes were provided with a copy of the Notice of Intent that was published in the CT Law Journal and were provided copies of the waiver application via email. Neither of the tribes responded.

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:	Medical Care Administration Program Manager
Agency:	Department of Social Services
Address:	25 Sigourney Street
Address 2:	
City:	Hartford
State:	**Connecticut**
Zip:	06106

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

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

Signature:	
	State Medicaid Director or Designee
Submission Date:	

Last Name:	Schaefer
First Name:	Mark
Title:	Director of Medical Care Administration
Agency:	Department of Social Services
Address:	25 Sigourney Street
Address 2:	
City:	Hartford
State:	**Connecticut**
Zip:	06106
Phone:	(860) 424-5067
Fax:	(860) 424-5799

E-mail: mark.schaefer@ct.gov

Attachment #1: Transition Plan

Specify the transition plan for the waiver:

Additional Needed Information (Optional)

Provide additional needed information for the waiver (optional):

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:
   Alternate Care 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.:*
The department contracts with Access Agencies as defined in CGS 17b-342(b). The Access Agency is required to hire appropriate staff to perform case management functions. The case managers conduct the initial assessment of the client for the purpose of developing a comprehensive plan of care and confirming the level of care determination that has been made by Department staff. Once the initial plan is developed, department approval of the plan is required. From that point forward, the Access Agency can modify plans as long as the plan remains within the nursing home cost cap. The Access Agency performs a supervisory level review of service plans. As part of the case management process, the Access Agency is responsible to evaluate the utilization of the authorized services. The Access Agency is also responsible to recruit providers and assist them in the Department's enrollment process. They contract directly with the waiver service providers, bill services on their behalf through the state's MMIS and reimburse the providers for services provided. The Access Agencies have extensive quality assurance and quality improvement plans in place. The plans are presented to the Department for review at the time the contract is awarded. The contract for the Access Agencies is awarded 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 Alternate Care Unit is responsible for overseeing the contractual operations of the Access Agencies. This is done through on site administrative reviews as well as clinical record reviews, client and provider visits and consumer satisfaction surveys. Monitoring of reporting requirements takes place on a monthly basis. The Department's Division of Quality Assurance also conducts regular audits to ensure the Access Agencies' compliance with billing and claims submission.

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:
The Department oversees performance of contracted entities by conducting comprehensive client record reviews through onsite or desk audit reviews. These reviews monitor access agency compliance with state and federal law in additon to contractual compliance. The department reviews 100% of assessment outcomes on new client admissions to the program to verify level of care and authorize the service plan. The Access Agencies are also contractually obligated to provide reports to the department either monthly, quarterly, semiannually or annually. Receipt of the reports is tracked by Alternate Care Unit staff and the reports are analyzed to identify any possible trends. Appropriate remedial actions are taken if needed.

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 State's quality improvement strategy, provide information in the following fields to detail the State's 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/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

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 Access Agencies that receive both a clinical and administrative review by Department staff in an eighteen month period.

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 entity	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☑ **Other** Specify: every 18 months	

Data Source (Select one):
Provider performance monitoring
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 Access Agency	☐ **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: Every 18 months

Performance Measure:
Number and percentage of required aggregate reports recieved from the Access Agencies in the time frame required in their contract.

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: contracted entity	☑ **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.
ACU unit staff meetings are held as needed to collaborate and diseminate information with regards to waiver functions. Access Agency meetings are held on a bi-monthly basis. These meetings are used as a forum to exchange information and identify any problems/issues or trends occuring in the waiver program.
Multiple levels of record review occur on a regular basis. The Access Agency supervisors review records and the Department is requiring that a uniform tool be established for aggregate quarterly reporting to the Department. The Access Agencies also have an external quarterly audit process where outside professionals perform record reviews. That data is provided to the Department in an annual summary report.
In addition, department staff perform record audits of all the Access Agencies on a rotating basis to measure compliance with contract deliverables and quality of care provided to waiver participants.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the State's 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 problems are identified, communications both written and within meetings provide opportunities for resolution of issues of concern. Audits result in issuance of formal reports and minutes are generated for meetings.

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 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.
Sampling of chart reviews is not a representative sample. Remediation is to increse the number of client chart reviews to reduce the margin of error and increase our confidence level. Given our waiver population of 9500, with a 5% margin of error, a confidence level of 95%, we intend to increse our sampling size to approach 370, spread over the 5 areas of the state. As staffing at this time allows for minimally operational QA activities, it is the intent to increase the sampling size over the next 3 years to meet our goals.

Appendix B: Participant Access and Eligibility

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

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

Target Group	Included	Target SubGroup	Minimum Age	Maximum Age	
				Maximum Age Limit	No Maximum Age Limit
◉ Aged or Disabled, or Both - General					
	☑	Aged	65		☑
	☐	Disabled (Physical)			
	☐	Disabled (Other)			
○ Aged or Disabled, or Both - Specific Recognized Subgroups					
	☐	Brain Injury			☐
	☐	HIV/AIDS			☐
	☐	Medically Fragile			☐
	☐	Technology Dependent			☐
○ Mental Retardation or Developmental Disability, or Both					
	☐	Autism			☐
	☐	Developmental Disability			☐
	☐	Mental Retardation			☐
○ Mental Illness					
	☐	Mental Illness			
	☐	Serious Emotional Disturbance			

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

c. **Transition of Individuals Affected by Maximum Age Limitation.** When there is a maximum age limit that applies to individuals

who may be served in the waiver, describe the transition planning procedures that are undertaken on behalf of participants affected by the age limit *(select one)*:

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

Specify:

Appendix B: Participant Access and Eligibility

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

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

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

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

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

Specify the percentage:

- ( ) **Other**

Specify:

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

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

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

- ( ) **The following dollar amount:**

Specify dollar amount:

The dollar amount *(select one)*

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

Specify the formula:

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

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

Specify percent:

○ **Other:**

Specify:

Appendix B: Participant Access and Eligibility

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

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

DSS refers the prospective client to an Access Agency for the initial assessment and development of the plan of care. The care manager is responsible to develop the plan to maintain the client's health and safety while staying within the institutional cost cap. This is done in consultation with the client and/or their responsible party. The development of the care plan is based on a multidimensional assessment that covers the domains of health, function, psychosocial, cognition, environment, support system and finances. Risk factors are identified and mitigated through service plans. Once the plan is agreed upon, the costs are determined. Each service on the plan of care is evaluated to determine if a back-up plan is necessary to ensure client health and/or safety. If an applicant's health and safety needs cannot be met, they are denied access to the waiver. The applicant, if denied, receives a Medicaid Notice of Action (NOA) advising of their rights to a hearing.

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:

Services beyond the monthly cap may be authorized on a short term basis to meet health and safety needs as long as there is evidence that the plan on an annualized basis will be equal to or less than the cost of nursing facility care. Applicants whose needs cannot be met within the caps are assisted in accessing other state plan services but are determined to be ineligible for the waiver. The client is issued a NOA and advised of their right to a fair hearing. Services are continued at the clients request while the hearing decision is pending. Clients are given a minimum of 10 days notice of any adverse action.

☐ **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	13935
Year 2	14400
Year 3	14850
Year 4 (renewal only)	15280
Year 5 (renewal only)	15695

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 (renewal only)	
Year 5 (renewal only)	

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).**

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:

Applications are processed on a first come first serve basis. There is no waiting list for the waiver program. Applicants are screened by Alternate Care Unit nurses and social workers for level of care, financial eligibility, and whose care needs are consistent with the need for institutionalization. Applicants must have three critical needs in order to qualify functionally for the waiver. The critical needs are bathing, dressing, toileting, transferring, eating, meal preparation and medication administration. Medicaid waiver financial eligibility is determined prior to the initiation of 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:

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

Specify:

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

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

Select one and complete Appendix B-5.

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

Check each that applies:

- ☑ **A special income level equal to:**

Select one:

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

Specify percentage:

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

Specify dollar amount:

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

Select one:

○ **100% of FPL**

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

Specify percentage amount:

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

Specify:

Appendix B: Participant Access and Eligibility

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

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

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

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

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

◉ **Use spousal post-eligibility rules under §1924 of the Act.**
(Complete Item B-5-c (209b State) and Item B-5-d)

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

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

Appendix B: Participant Access and Eligibility

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

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

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

Appendix B: Participant Access and Eligibility

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

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

The State uses more restrictive eligibility requirements than SSI and uses the post-eligibility rules at 42 CFR 435.735 for individuals

who do not have a spouse or have a spouse who is not a community spouse as specified in §1924 of the Act. Payment for home and community-based waiver services is reduced by the amount remaining after deducting the following amounts and expenses from the waiver participant's income:

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

- (●) **The following standard included under the State plan**

  (*select one*):

  - ( ) **The following standard under 42 CFR §435.121**

    Specify:

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

    (*select one*):

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

      Specify percentage:
    - ( ) **A dollar amount which is less than 300%.**

      Specify dollar amount:
  - (●) **A percentage of the Federal poverty level**

    Specify percentage: 200
  - ( ) **Other 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:

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 4)

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

The State uses the post-eligibility rules of §1924(d) of the Act (spousal impoverishment protection) to determine the contribution of a participant with a community spouse toward the cost of home and community-based care if it determines the individual's eligibility under §1924 of the Act. There is deducted from the participant's monthly income a personal needs allowance (as specified below), a community spouse's allowance 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-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: 1

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:

The initial Level of Care evaluation is performed by nurses and social workers employed by DSS in the Alternate Care Unit utilizing the health screen form W-1506. The client is referred to the Access Agency that performs a comprehensive assessment

and submits a summary of that assessment to Department's Utilization Review staff for review to confirm the level of care. Level of care reevaluations are conducted by Access Agency Care Managers with oversight by the Department's Utilization Review staff.

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:

Alternate Care Unit staff that conduct the inital level of care evaluations are either Utilization Review Nurses or Social Workers with experience in long term care.

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

Care managers shall have the following additional qualifications:

1.demonstrated interviewing skills which include the professional judgment to probe as necessary to uncover underlying concerns of the applicant;

2.demonstrated ability to establish and maintain empathic relationships;

3.experience in conducting social and health assessments;

4. knowledge of human behavior, family/caregiver dynamics, human development and disabilities;

5.awareness of community resources and services;

6.the ability to understand and apply complex service reimbursement issues; and

7. the ability to evaluate, negotiate and plan for the costs of care options.

8.Care management supervisors shall meet all the qualifications of a care manager plus have demonstrated supervisory ability, and at least one year of specific experience in conducting assessments, developing care plans and monitoring home and community based services.

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 W-1506 Uniform Health screen is utilized to determine nursing facility level of care. Nursing Facility Level of Care is defined as an individual requiring assistance with three or more critical needs. There are a total of seven critical needs that qualify for NF LOC. They are bathing, dressing, toileting, transferring, eating/feeding, meal preparation and medication administration. Additionally, cognitive status and behavioral problems are part of the health screen. Applicants with 4 or more errors on the mental status exam and behavioral challenges may qualify for the waiver with two critical needs in addition to the cognitive deficits and behavioral challenges. Meal preparation and medication adminstration have been part of the level of care screen since the inception of the waiver, since medication mismanagement and nutritional deficits are often contributing factors in nursing home placement.

The reevaluation of the level of care utilizes the same criteria as the initial level of care determination.

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.

In addition to the information contained in the Uniform Health screen, additional information is required for the department to authorize Medicaid payment for nursing facility level of care. The W-10 or interagency referral is used to determine nursing facility level of care because it includes the physician certification required prior to Medicaid payment for NF care. The W-10 also includes data regarding the skilled needs of a patient such as wound care, IV therapies or other therapies. Medication

information is also part of the W-10 process but is not data that is collected on the health screen.

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:

The same care manager who conducts the initial evaluation visits the client for the annual reevaluation and conducts a comprehensive, multidimentional assessment. After completion of the assessment, they are required to specify the level of care based on the findings of the reevaluation. The department reviews a random sample of reevaluations that summarize the reevaluation findings. Plans of care are also reviewed to evaluate if services meet the identified needs.

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):*

The department maintains an electronic data base of all clients and their reevaluation schedule. Six weeks prior to the beginning of the month when reevaluations are due, the Department sends the list of reevaluations due to be completed. Compliance with this is also audited by the Department via record review.

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:

Records are retained in both the Alternate Care Unit of the Department of Social Services as well as in the offices of the Access Agencies. The Department's policy for record retention is seven years.

Appendix B: Evaluation/Reevaluation of Level of Care

Quality Improvement: Level of Care

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

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

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/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

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 applicants who receive an initial telephone level of care screening by clinical staff of ACU to validate the need for institutional level of care prior to the reciept of services.

Data Source (Select one):
Analyzed collected data (including surveys, focus group, interviews, etc)
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 levels of care of enrolled participants are reevaluated at least annually or as specified in the approved waiver.***

Performance Measures

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

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 clients who are reevaluated at least annually for level of care.

Data Source (Select one):
Reports to State Medicaid Agency on delegated
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 Access Agencies	☑ **Annually**	☐ **Stratified** Describe Group: [ ]
	☐ **Continuously and Ongoing**	☐ **Other** Specify: [ ]
	☐ **Other** Specify: [ ]	

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 entity	☐ **Annually**	☐ **Stratified** Describe Group:

	☐ **Continuously and Ongoing**	☑ **Other** Specify: 5% of all records will have a supervisory review
	☐ **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: contracted Access Agencies	☐ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Number and percent of clients for whom ACU clinical staff reviews reassessment summary data for accuracy of level of care.

Data Source (Select one):
Analyzed collected data (including surveys, focus group, interviews, etc)
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 access agencies	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☑ **Other** Specify: 10% of

		reassessments due each month
	☐ 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 participants whose total plan of care has been modified to reflect significant changes in the participants'condition.

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 = ☐ **Stratified** Describe Group:
☑ **Other** Specify: contracted entity	☐ **Annually**	
	☑ **Continuously and Ongoing**	☑ **Other** Specify: 5% of records each quarter
	☐ **Other** Specify:	

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 entity	☐ **Annually**	☐ **Stratified** Describe Group: [ ]
	☑ **Continuously and Ongoing**	☑ **Other** Specify: non-representative sample of each Access Agency every 18 months
	☐ **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: contracted agency	☐ **Annually**
	☐ **Continuously and Ongoing**
	☑ **Other** Specify: every 18 months

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/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

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 initial level of care determinations that are made by ACU clinical staff utilizing standardized forms.

Data Source (Select one):
Other
If 'Other' is selected, specify:
standardized forms maintained in program electronic data base

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 waiver participants who are assessed and reassessed utilizing the W-1507, the Modified Community Care Assessment

Data Source (Select one):
Analyzed collected data (including surveys, focus group, interviews, etc)
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 entity	☐ **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.
Every client who is seeking waiver services, is initially screened for Level of Care by Alternate Care Unit Clinical staff. The level of care is confimed by the Access Agency staff when completing the comprehensive, initial face to face assessment. The Alternate Care Unit conducts onsite or desk audit reviews of access agency and Assisted Living client records. Client in-home visits are conducted by Alternate Care Unit Quality Assurance staff on a sampling of both Access Agency and Assisted Living clients. Onsite visits to waiver service providers are also made to collect information. Client satisfaction surveys are

conducted to allow individuals a means to provide feedback on the quality of the services received. The Home Care Advisory Committee, comprised of a wide range of providers and advocates and a client representative, meets semi-annually with Department staff to discuss current issues affecting elders statewide.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the State's 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.

Individual concerns regarding the health and safety of clients is reported to QA staff. QA staff investigate the basis of the complaint/referral, consult with the Unit Manager, and make a determination if corrective action is pursued by the access agency or ALSA. QA staff monitors until satisfactory resolution is achieved. Any final recommendations are made with consultation of the manager. Aditionally, QA staff monitor non health and safety complaints until satifactory resolution is obtained. In 10/2008 a collaborative meeting with the Department and Assisted Living Association of CT was held to discuss compliance with required DSS documentation.

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 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.

Sampling of chart reviews is not a representative sample. Remediation is to increase the number of Access Agency chart reviews to reduce the margin of error and increase our confidence level. Given our waiver population of 9500, with a 5% margin of error, a confidence level of 95%, we intend to increase our sampling size to approach 370, spread over the 5 areas of the state. As staffing at this time allows for minimally operational QA activiites, it is the intent to increase the sampling size over the next 3 years to meet our goals. Staffing has prohibited DSS from conducting appropriate sampling size of ALSA record reviews. Our goal is to increase sampling size of ALSA onsite record reviews to monitor improvement as a result of the collaborative efforts of the Department and ALSA Association. Onsite reviews will be conducted of 100% of ALSA facilities identified as problematic; staffing constraints have prohibited us from conducting optimum level of reviews, however, as staffing increases, the expectation is to implement reviews within the next 3 years.

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).

As part of the inital evaluation conducted by the care manager, the client is offered a choice of a home and community based service plan or institutional services. Each client is asked to sign an Informed Consent form (W-889) where they are advised of their choice between community services or institutional care. They are advised that an assessment must be completed in order to access services under the waiver. A copy of the consent form is left with the client.

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.

The freedom of choice form W889 is retained in the client's record for seven years. The form is maintained in the Access Agencies records and is audited for in the department's annual audit.

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 home care request form is available in Spanish. The Alternate Care Unit has Spanish speaking staff to handle inquiries and referrals to the program. The Department also has language line services available with interpreters for a wide array of languages. The Access Agencies have bilingual case managers including Spanish, Russian, Italian and French. Non-English speaking waiver applicants may bring an interpreter of their choice to any meeting with the case manager. This is not a requirement but an option available to clients should they so choose. No person can be denied access to waiver services 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	Adult Day Health
Statutory Service	Care Management
Statutory Service	Homemaker
Statutory Service	Personal Care Assistant (PCA)
Statutory Service	Respite
Other Service	Assisted Living
Other Service	Assistive Technology
Other Service	Chore services
Other Service	Companion
Other Service	Environmental Accesibility Adaptations
Other Service	Home delivered Meals
Other Service	Mental Health Counseling
Other Service	Personal Emergency Response Systems
Other Service	Transportation

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):

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one :

- (•) **Service is included in approved waiver. There is no change in service specifications.**
- ( ) **Service is included in approved waiver. The service specifications have been modified.**
- ( ) **Service is not included in the approved waiver.**

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. Meals provided as part of these services shall not constitute a full nutritional regimen.

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 located in a hospital or long term care facility licensed by the Department of Public Health, with ready access to a registered nurse from such hospital or long term care facility or the program nurse is supervised by a registered nurse who can be reached by telephone at any time during the operating day and who can be called to the center if needed within one half hour of the request. The program nurse is responsible for administering medications as needed and assuring that the participant's nursing services are coordinated with other services provided in the adult day health center, health and social services currently received at home or provided by existing community health agencies and personal physicians;

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.

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

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

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

May be provided up to seven times per week.

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

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

☑ **Provider managed**

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

☐ **Legally Responsible Person**

☐ **Relative**

☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Provider agency

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Adult Day Health

Provider Category:
Agency

Provider Type:
Provider agency

Provider Qualifications

License *(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 minimum of one to seven. Staffing shall be adequate to meet the needs of the client base. Volunteers shall be included in the ratio only when they conform to the same standards and requirements as paid staff.

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.

Certificate *(specify):*
Certification required by the Adult Day Care Association of CT. Certification is for 3 years.

Other Standard *(specify):*
n/a

Verification of Provider Qualifications

Entity Responsible for Verification:
Access Agency enrolling the provider must ensure that the Day Care Program is certified by the association. The department maintains an ongoing list of certified Adult Day Programs and shares that information with the Access Agencies, other waiver personnel and Department social work staff who also might refer clients for the service.

Frequency of Verification:
Every two years

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:
Statutory Service

Service:
Case Management

Alternate Service Title (if any):
Care Management

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one :

- (•) **Service is included in approved waiver. There is no change in service specifications.**
- ( ) **Service is included in approved waiver. The service specifications have been modified.**
- ( ) **Service is not included in the approved waiver.**

Service Definition *(Scope)*:
Services that assist participants in gaining access to needed waiver and other State plan services, as well as medical, social, educational and other services, regardless of the funding source for the services to which access is gained. Care managers additionally are responsible to monitor the ongoing provision of services in the participants plan of care and continually monitor that the client's health annd safety needs are being addressed. They complete the initial and annual assessment and reassessment of an individuals' needs in order to develop a comprehensive plan of care. They confirm the initial level of care determination done by Department staff and reassess the level of care annually and maintain documentation for department review. Care Managers also explain opportunites for participant directed services options to participants. For clients who are able to direct their own services, Department nurses and social workers perform the annual reassessments and level of care determinations.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Service may be billed on a per diem basis as long as the client remains in a community based setting. The Departments allows for a status review vist by the case manager when the client is in a hospital or nursing facility setting when the purpose of that visit is to reevaluate the total plan of care needs upon discharge back to the community based setting.

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	Access Agency

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Care Management

Provider Category:

Agency

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

Care managers shall have the following additional qualifications:
demonstrated interviewing skills which include the professional judgment to probe as necessary to uncover underlying concerns of the applicants; demonstrated ability to establish and maintain empathic relationships; experience in conducting social and health assessments;
knowledge of human behavior, family/caregiver dynamics, human development and disabilities; awareness of community resources and services; the ability to understand and apply complex service reimbursement issues; and the ability to evaluate, negotiate and plan for the costs of care options.
Certificate *(specify):*
The registered nurse shall hold a license to practice nursing in the State of CT. Care Managers are encouraged but not required to be certified as a long term care manager.
Other Standard *(specify):*
See above
Verification of Provider Qualifications
Entity Responsible for Verification:
The Access Agency is responsible to ensure that employees meet the requirements specified in 17b-342-1(h)(1)(A). Department staff audit the Access Agencies for compliance with employee qualifications.
Frequency of Verification:
Upon employment and as part of the Case Manager's annual performance appraisal.

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):

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one :

- (•) **Service is included in approved waiver. There is no change in service specifications.**
- ( ) **Service is included in approved waiver. The service specifications have been modified.**
- ( ) **Service is not included in the approved waiver.**

Service Definition *(Scope):*
Services consisting of general household activities (meal preparation, laundry and routine household care) provided by a trained homemaker, when the individual regularly responsible for these activities is temporarily absent or unable to manage the home and care for him or herself or others in the home. Homemakers shall meet such standards of education and training as are established by the State for the provision of these activities.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	Provider agency

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Homemaker

Provider Category:
Agency

Provider Type:
Provider agency

Provider Qualifications

License *(specify)*:
N/A

Certificate *(specify)*:
Certification required from the Department of Consumer Protection.

Other Standard *(specify)*:

Verification of Provider Qualifications

Entity Responsible for Verification:
The Access Agency is responsible for verifying the certification prior to initiating enrollment of the agency.

Frequency of Verification:
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:
Personal Care

Alternate Service Title (if any):
Personal Care Assistant (PCA)

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one :

- ○ **Service is included in approved waiver. There is no change in service specifications.**
- ○ **Service is included in approved waiver. The service specifications have been modified.**
- ◉ **Service is not included in the approved waiver.**

Service Definition *(Scope):*
One or more persons assisting an elder with tasks that the individual would typically do for him/herself in the absence of a disability. Such tasks may be performed at home or in the community. Such services may include physical or verbal assistance to the consumer in accomplishing any Activity of Daily Living (ADL), or Instrumental Activities of Daily Living (IADL). ADL's include bathing, dressing, toileting, transferring, and feeding.

PCAs may be members of the individual's family who meet the training requirements specified by the Department, except that the personal care provider may not be the participant's spouse, the participant's conservator/legal guardian, or a relative of the participant's conservator/legal guardian.
The plan of care that is developed focuses on unmet needs. When family members who reside with waiver participants are paid as PCAs, the plan of care will be developed to address needs that are not currently being met by the family member. Examples of needs that would be assessed as met by the family member residing with the waiver participant might be usual household activities including but not limited to services such as meal preparation, laundry, shopping and housekeeping.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Overnight and per diem PCA services are subject to approval by Alternate Care Unit Utilization Review staff. PCA services shall be cost effective on an individual basis when compared with Home Health Aide, Homemaker and Companion services.

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	Provider agencies
Individual	Private Provider

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Personal Care Assistant (PCA)

Provider Category:
Agency
Provider Type:
Provider agencies
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) section 19a-490 of the 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 CT..
Other Standard *(specify):*
The PCA hired by the agency shall meet all of the same qualifications as an individual PCA as follows:
• 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 the plan

Verification of Provider Qualifications

Entity Responsible for Verification:
Provider agency and Access Agency.

Frequency of Verification:
At the time of employment

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Personal Care Assistant (PCA)

Provider Category:
Individual

Provider Type:
Private Provider

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*
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
A pre-eomployment criminal background check will be conducted on individual personal care assistants. The fiscal intermediary is responsible for ensuring the background check is completed and that the results are shared with the waiver participant.

Verification of Provider Qualifications

Entity Responsible for Verification:
Fiscal Intermediary

Frequency of Verification:
At the initiation of service

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):

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one :

◉ **Service is included in approved waiver. There is no change in service specifications.**

○ **Service is included in approved waiver. The service specifications have been modified.**

○ **Service is not included in the approved waiver.**

Service Definition *(Scope)*:
Services provided to individuals unable to care for themselves; furnished on a short-term basis because of the absence or need for relief of those persons normally providing the care. In home respite providers shall include but are not limited to homemakers, companions or Home Health aides. Services may be provided in the home or outside of the home including but not limited to a licensed or certified facility such as a Rest Home with Nursing supervision or Chronic and Convalescent Nursing Home.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Respite services provided in a licensed facility are limited to 30 days per calendar year per recipient. In home respite services are limited to 720 hours per year per recipient.

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

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

☑ **Provider managed**

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

☐ **Legally Responsible Person**

☐ **Relative**

☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Provider agency

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Respite

Provider Category:
Agency
Provider Type:
Provider agency
Provider Qualifications
License *(specify)*:
For respite in a facility, either Rest Home with Nursing supervision or Chronic and Convalescent Nursing Home, facilities must be licensed by the CT Department of Public Health.
Licensing is not applicable to Homemakers and Companions.
Certificate *(specify)*:
N/A
Other Standard *(specify)*:

Verification of Provider Qualifications
Entity Responsible for Verification:
Access Agency for in home respite and CT Department of Public Health for facilities.
Frequency of Verification:
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:

Assisted Living

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one :

- (•) **Service is included in approved waiver. There is no change in service specifications.**
- ( ) **Service is included in approved waiver. The service specifications have been modified.**
- ( ) **Service is not included in the approved waiver.**

Service Definition *(Scope):*

Personal care and services, homemaker, chore, attendant care, companion services, medication oversight, therapeutic social and recreational programming, provided in a home-like environment in a Managed Residential Community, in conjunction with residing in the community. A managed residential community is a living arrangement consisting of private residential units that provides a managed group living environment including housing and services. A private residential unit means a living arrangement belonging to the participant that includes a private full bath within the unit and facilities and equipment for the preparation and storage of food. This service includes 24 hour on-site response staff to meet scheduled or unpredictable needs in a way that promotes maximum dignity and independence, and to provide supervision, safety and security. Other individuals or agencies may also furnish care directly, or under arrangement with the Managed Residential Community, but the care provided by these other entities supplements that provided by the community care facility and does not supplant it.

Personalized care is furnished to individuals who reside in their own living units (which may include dually occupied units when both occupants consent to the arrangement) which includes kitchenette and living rooms and which contain bedrooms and toilet facilities. The consumer has a right to privacy. Living units may be locked at the discretion of the consumer, except when a physician or mental health professional has certified in writing that the consumer is sufficiently cognitively impaired as to be a danger to self or others if given the opportunity to lock the door. Each living unit is separate and distinct from each other. The facilities have a central dining room, living room or parlor, and common activity center(s)(which may also serve as living rooms or dining rooms). The consumer retains the right to assume risk, tempered only by the individual's ability to assume responsibility for that risk. Care must be furnished in a way which fosters the independence of each consumer. Routines of care provision and service delivery must be consumer-driven to the maximum extent possible, and treat each person with dignity and respect.

Care plans will be developed based on the individual's service needs. There are four levels of service provided in assisted living facilities based on the consumer's combined needs for personal care and nursing services. The four levels are occasional which is 1-3.75 hours per week of service, limited which is 4-8.75 hours per week of service, moderate which is 9-14.75 hours per week of service and extensive which is 15-25 hours per week of service.

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

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

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	Assisted Living Service Agency

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Assisted Living

Provider Category:
Agency

Provider Type:
Assisted Living Service Agency

Provider Qualifications

License *(specify):*
The Assisted Living Service Provider (ALSA) is licensed by the CT Department of Public Health in accordance with chaper 368v. Regulations regarding a Managed Residential Community and the ALSA are found in Regulations of the State of CT agencies in 19-13-D104 and 19-13-D105.

Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:
MMIS contractor and Department Quality Assurance staff

Frequency of Verification:
At the time of enrollment as a Medicaid provider and bi-annually thereafter.

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:
Assistive Technology

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- ○ **Service is included in approved waiver. There is no change in service specifications.**
- ○ **Service is included in approved waiver. The service specifications have been modified.**
- ◉ **Service is not included in the approved waiver.**

Service Definition *(Scope):*
An item, piece of equipment, or product system, whether acquired commercially, modified, or customized, that is used to increase, maintain,monitor or improve functional capabilities of participants to perform Activity of Daily Living (ADL), or Instrumental Activities of Daily Living. (IADL). Assistive technology service means a service that directly assists a participant in the selection, acquisition, or use of an assistive technology device.
A. Services consisting of purchasing, leasing, or otherwise providing for the acquisition of assistive technology devices.
B. Services consisting of selecting, designing, fitting, customizing, adapting, applying, maintaining, repairing, or replacing assistive technology devices.
C. Training or technical assistance for the participant or for the direct benefit of the participant receiving the service, and where appropriate, the family members, guardians, advocates or authorized representatives of the participants.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Care plans will be developed based on the needs identified in the comprehensive assessment The cost of the Assistive Technology cannot exceed the yearly cost of the service it replaces. When an assistive technology device is identified that will support the waiver participant's independent functioning, the services will be reduced commensurate with the cost of the service it replaces. This reduction will be made with consideration of the waiver participant's health and safety needs. the

service shall be capped at an annual cost of $1000.

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	Agency
Agency	Pharmacies

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Assistive Technology

Provider Category:
Agency

Provider Type:
Agency

Provider Qualifications

License *(specify)*:
For telemonitoring services must be a Home Health Agency licensed in the state of Connecticut as specified in Subsection (k) section 19a-490 of the general statutes

Certificate *(specify)*:

Other Standard *(specify)*:
Medicaid provider status for assistive technology and supplies or agency that obtains Medicaid performing provider status

Verification of Provider Qualifications

Entity Responsible for Verification:
Access Agency

Frequency of Verification:
at the start of service

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Assistive Technology

Provider Category:
Agency

Provider Type:
Pharmacies

Provider Qualifications

License *(specify)*:
State of CT Department of Consumer Protection Pharmacy Practice Act: Regulations concerning practice of pharmacy Sec. 20-175-4-6-7

Certificate *(specify)*:

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:
Access Agency

Frequency of Verification:
at the initiation of the service

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 services

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- (•) **Service is included in approved waiver. There is no change in service specifications.**
- ( ) **Service is included in approved waiver. The service specifications have been modified.**
- ( ) **Service is not included in the approved waiver.**

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

Specify applicable (if any) limits on the amount, frequency, or duration of this service:
When an individual requires one-time only unique or specialized services in order to maintain a healthy and safe environment, they may receive highly skilled chore services which include but are not limited to moving, extensive cleaning or extermination services. Highly skilled chore services are subject to prior authorization by the department.

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	Provider Agency
Individual	Licensed Contractor

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Chore services

Provider Category:
Agency

Provider Type:
Provider Agency

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*
If provider is a homemaker/companion/chore agency, they must be registered with the Department of Consumer Protection. Chore services providers shall demonstrate the ability to meet the needs of the individual seeking services.

Verification of Provider Qualifications

Entity Responsible for Verification:
Access Agency

Frequency of Verification:
At the time of enrollment and biannually thereafter.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Chore services

Provider Category:
Individual

Provider Type:
Licensed Contractor

Provider Qualifications

License *(specify):*
Electrician, plumbers and other contractors must hold the appropriate license to perform highly skilled chore services.

Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:
Access Agency

Frequency of Verification:
At the time of service

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

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one :

- (•) **Service is included in approved waiver. There is no change in service specifications.**
- ( ) **Service is included in approved waiver. The service specifications have been modified.**
- ( ) **Service is not included in the approved waiver.**

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

(A) escorting an individual to recreational activities or to necessary medical, dental or business appointments;

(B) reading to or for an individual;

(C) supervising or monitoring an individual during the self-performance of activities of daily living such as meal preparation and consumption, dressing, personal hygiene, laundry and simple household chores;

(D) reminding an individual to take self-administered medications;

(E) providing monitoring to ensure the safety of an individual;

(F) assisting with telephone calls and written communications; and

(G) reporting changes in an individual's needs or condition to the supervisor or care manager.

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	Provider agency

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Companion

Provider Category:
Agency

Provider Type:

Provider agency

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

In order to provide companion services and receive reimbursement from the Connecticut Home Care Agency must be registered as a provider of Companion Services with the Department of Consumer Protection in the state of CT.

The companion employed by the agency shall be at least eighteen (18) years of age, be of good health, have the ability to read, write and follow instructions, be able to report changes in a person's condition or needs to the department, the access agency, or the agency or organization that contracted the persons to perform such functions and shall maintain confidentiality and complete required record-keeping of the employer or contractor of services.

Companion services are not licensed or regulated and shall be provided by a person hired by an agency or organization. Certain relatives of the client cannot be provider of services as defined in section 17b-342-1(b)29) of the Regulations of Connecticut State Agencies. Providers shall demonstrate the ability to meet the needs of the service recipient. The access agency or a department designee shall also ensure that the services provided are appropriate for companion services and are not services which should be provided by a licensed provider of home health services.

Companion service agencies or organizations shall abide by the standards and requirements as described in the performing provider agreement and sub-contract with the department or any authorized entity.

Any homemaker-companion agency must register with the Department of Consumer Protection pursuant to sections 20-671 to 20-680, inclusive, of the Connecticut General Statutes.

Verification of Provider Qualifications

Entity Responsible for Verification:

Access Agency

Frequency of Verification:

Upon enrollment as a performing provider and bi-annually thereafter

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 Accesibility Adaptations

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- (•) **Service is included in approved waiver. There is no change in service specifications.**
- ( ) **Service is included in approved waiver. The service specifications have been modified.**
- ( ) **Service is not included in the approved waiver.**

Service Definition *(Scope):*

Minor Home Modifications required by the individual's plan of care which are necessary to ensure health, welfare and safety of the individuals to function with greater indeopendence in their home and without which the individual would require institutionalization. Such adaptations may include the installation of hand rails and grab bars in the tub area, widening of doors and installation of ramps.Excluded are those adaptations or improvements to the home which are of general utility and are not of

direct medical or remedial benefit to the individuals such as carpeting, roof repair or air conditioning. Adaptations which add to the total square footage of the home are excluded from this benefit. All services shall be provided in accordance with applicable state or local building codes. Adaptations are excluded if the residence is owned by someone other than the participant and the adaptations would be the responsibility of the owner/landlord.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:
This service is subject to prior authorization by Department staff

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Individual	Non relative able to meet the individual's needs

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Environmental Accesibility Adaptations

Provider Category:
Individual

Provider Type:
Non relative able to meet the individual's needs

Provider Qualifications

License *(specify)*:

Certificate *(specify)*:
. The vendor or contractor shall provide all services, materials, and labor that are necessary to complete the project/minor home modification(s) as indicated.
2. The vendor or contractor must be registered with the Department of Consumer Protection to do business in the State of Connecticut.
3. The vendor or contractor must show evidence of a valid home improvement registration and evidence of worker's compensation (if applicable) and liability insurance, at the time they provide an estimate for the project.
4. If applicable, the vendor or contractor must apply for, obtain, and pay for all permits. All work done shall be done per applicable codes, regulations and standards of construction, including American National Standards Institute (ANSH) standards for barrier-free access and safety requirement.
5. The vendor or contractor shall warranty all work, including labor and materials, for one year from the date of acceptance and thereafter, one year from the date of completion of the project.
6. When equipment is required to make the home accessible, a separate vendor may provide and install the equipment.

Other Standard *(specify)*:

Verification of Provider Qualifications

Entity Responsible for Verification:
Access Agency

Frequency of Verification:
prior to the provision of service

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

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one :

- (●) **Service is included in approved waiver. There is no change in service specifications.**
- ( ) **Service is included in approved waiver. The service specifications have been modified.**
- ( ) **Service is not included in the approved waiver.**

Service Definition *(Scope):*

Home delivered meals, or "meals on wheels," include the preparation and delivery of one or two meals for persons who are unable to prepare or obtain nourishing meals on their own.

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

No more than two meals per day up to seven times per week as specified in the individual service plan.

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	Home Delivered Meals Providers

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:

Home Delivered Meals Providers

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Reimbursment for home delivered meals shall be available under the Connecticut Home Care Program only to providers which provide meals that meet a minimum of one-third of the current daily recommended dietary allowance and requirements as established by the Food and Nutrition Board of the National Academy of Sciences National Research Council.

All "meals on wheels" providers shall provide their menus to the department, contracted agencies or department designee for review and approval. Quality assurance and quality control shall be performed by the department's contracted providers to ensure that the "meals on wheels" service providers are in compliance with the dietary requirements and the requirements for the preparation and storage and delivery of food based on the department policies for the elderly nutrition program and Title (III) of the Older American's Act.

Verification of Provider Qualifications

Entity Responsible for Verification:
Access Agency

Frequency of Verification:
at the time of enrollment as a provider and biannually thereafter

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:
Mental Health Counseling

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one :

- (•) **Service is included in approved waiver. There is no change in service specifications.**
- ( ) **Service is included in approved waiver. The service specifications have been modified.**
- ( ) **Service is not included in the approved waiver.**

Service Definition *(Scope):*
Mental Health Counseling Services are professional counseling services provided to help resolve or enable the eligible individual to cope with individual, family, and/or environmentally related problems and conditions. Counseling focuses on issues such as problems in maintaining a home in the community, relocation within the community, dealing with long term disability, substance abuse, and family relationships.
The department shall pay for mental health services conforming to accepted methods of diagnosis and treatment, including:

(A) mental health evaluation and assessment;

(B) individual counseling;

(C) group counseling; and

(D) family counseling.

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

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	Masters Level or Licensed Social Worker or Counselor

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Mental Health Counseling

Provider Category:
Individual

Provider Type:
Masters Level or Licensed Social Worker or Counselor

Provider Qualifications

License *(specify):*
For purposes of receiving reimbursement under the Connecticut Home Care Program, a mental health counseling provider shall be a licensed independent social worker as defined in Connecticut General Statutes 20-195m or a Licensed Professional Councelor as defined in section 20-195aa of the Connecticut General Statutes, and shall have experience and training in providing mental health services to the elderly.

Certificate *(specify):*

Other Standard *(specify):*
A a social worker who holds a masters degree from an accredited school of social work, or an individual who has a masters degree in counseling, psychology or psychiatric nursing and has experience in providing mental health services to the elderly may also provide mental health counceling.

Verification of Provider Qualifications

Entity Responsible for Verification:
Access Agency

Frequency of Verification:
At time of enrollment as a performing provider and bi-annually thereafter

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

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one :

◉ **Service is included in approved waiver. There is no change in service specifications.**

○ **Service is included in approved waiver. The service specifications have been modified.**

○ **Service is not included in the approved waiver.**

Service Definition *(Scope):*
PERS is an electronic device which enables certain individuals at high risk of institutionalization to secure help in an emergency. The individual may also wear a portable "help" button to allow for mobility. The system is connected to the

person's phone and programmed to signal a response center once a "help" button is activated. The response center is staffed by trained professionals. PERS services are limited to those individuals who live alone, or who are alone for significant parts of the day, and have no regular caregiver for extended periods of time, and who would otherwise require extensive routine supervision.

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 PERS equipment

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Personal Emergency Response Systems

Provider Category:
Agency

Provider Type:
Vendors who sell and install appropriate PERS equipment

Provider Qualifications

License *(specify)*:

Certificate *(specify)*:

Other Standard *(specify)*:
Vendor that has an approved contract through DSS as a performing provider

Verification of Provider Qualifications

Entity Responsible for Verification:
Access Agency

Frequency of Verification:
At the initiation of the contract and biannually thereafter

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

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one :

- (●) **Service is included in approved waiver. There is no change in service specifications.**
- ( ) **Service is included in approved waiver. The service specifications have been modified.**
- ( ) **Service is not included in the approved waiver.**

Service Definition *(Scope):*
Transportation services provide access to medical services, social services, community services and appropriate social or recreational facilities that are essential to help some individuals avoid institutionalization by enabling these individuals to retain their role as community members. This service is offered in addition to medical transportation offered under the state plan and shall not replace it.
(A) These services are provided when transportation is required to promote and enhance independent living and self-support; and

(B) Transportation services may be provided by taxi, livery, bus, invalid coach, volunteer organization or individuals. They shall be reimbursed when they are necessary to provide access to needed community based services or community activities as specified in the approved plan of care.
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	Commercial Transportation Providers
Individual	Individual Provider

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Transportation

Provider Category:
Agency
Provider Type:
Commercial Transportation Providers
Provider Qualifications
License *(specify):*
In order to receive payment from the Connecticut Home Care Program, all commercial transportation providers shall be regulated carriers and meet all applicable state and federal permit and licensure requirements, and vehicle registration requirements. Commercial transportation providers shall also meet all applicable Medicaid program enrollment requirements
Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications
Entity Responsible for Verification:

Access Agency
Frequency of Verification:
At the time of enrollment and bi-annually thereafter

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):*

Certificate *(specify):*

Other Standard *(specify):*
There are no enrollment requirements for private transportation. Private transportation is defined as transportation by a vehicle owned by a volunteer organization, or a private individual, provided the vehicle is not used for commercial carriage. The provider must possess a valid CT driver's license and provide evidence of automobile insurance.

Verification of Provider Qualifications

Entity Responsible for Verification:
Access Agency
Frequency of Verification:
At the time of enrollment and biannually thereafter

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:

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 employed as a Personal Care Assistant for this waiver submit to a State of Connecticut criminal background check.

DSS has the discretion to refuse payments for Personal Care Assistants 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, 53a124 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-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 PCA Waiver participant, they process background checks for PCA Provider Registry applicants upon submission of the Provider Registry 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 Registry, and consideration for employment by the PCA Waiver Participant. The same requirements will apply to Recovery Assistants.

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).**

Appendix C: Participant Services

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 allows for a Personal Care Assistant to be a family member. The Department does not pay legally liable relatives or relatives of Conservators of Person (COP) or Conservators of Estate (COE) to provide care. A COP is appointed by the Probate court to supervise the personal affairs of an individual including the arrangement for medical needs and ensuring the individual has nutritious meals, clothing, safe and adequate housing, personal hygiene and is protected from physical abuse or harm. A COE is also appointed by the Probate Court to supervise the financial affairs of an individual found to be incapable of managing his/her own affairs to the extent that property is jeopardized unless management is provided. PCA participants are able to select qualified providers for Personal Care Assistants. In some circumstances, this may be a non-legally liable relative, who is not related to the consumer's Conservator of Person or Conservator of Estate. The participant or their conservator must sign timesheets, to confirm the dates and times services were performed. The fiscal intermediary reviews timesheets for accuracy and whether they match the allocation in the service plan. Any discrepancy results in the notification to DSS, prior to the issuance of payment. Family members must meet the same qualifications as unrelated providers. Any reported concerns regarding fraudulent billing are addressed as it would be with other service vendors. (e.g., investigation, provider termination, etc.) When a participant resides with a family member who is being paid to provide PCA services, reimbursement will be available for hands on care only and not for usual household functions including but not limited to laundry, cleaning, shopping and meal preparation. The development of the service plan is based on assessed unmet needs. If family members are already providing IADL assistance, they will not be eligble to be reimbursed for those tasks as a PCA.

- ( ) **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 access agency is responsible to recruit, train, and assist with the enrollment process of qualified providers. They are mandated in their contract with the Department to establish working relationships with community providers and provide education to potential providers about the program services. All willing providers are sent an initial enrollment packet when requested. When inquiries from potential providers come directly to the Department, they are referred to the Access Agency who will initiate the enrollment process. For PCA services, the Connecticut Department of Social Services contracts with fiscal intermediary to conduct outreach activities in order to increase awareness of the Personal Care Assistants within the community and to recruit qualified providers to serve the PCA populations. Outreach activities include:

1. Identifying those areas of the state in which services deficits exist;
2. Tailoring outreach approaches to best recruit the types of providers most needed to serve the PCA population on a regional and statewide basis;
3. Conducting at least one outreach session every twelve months in each of the Department's 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 contracts, direct mailings, print or other media advertisements, or other methods of communication as appropriate to each activity; and
6. Maintaining a registry 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.

Appendix C: Participant Services

Quality Improvement: Qualified Providers

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

a. **Methods for Discovery: 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/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

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 Dept clinical staff licensure that is verified initially and annually.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Department of Public Health Records for Registered Nurses and Social Workers

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: Initially and annually thereafter

Performance Measure:
Number and percent of Adult Day Centers that are certified through peer review by the CT Adult Day Care Association.

Data Source (Select one):
Reports to State Medicaid Agency on delegated Administrative functions
If 'Other' is selected, specify:
ADC certification listing is provided to the department quarterly by the Day Care Association updating the certification status

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: CT Adult Day Care Association		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: CT Adult Day Care Association	☐ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

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

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

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 PCAs for whom criminal backgroung checks are conducted prior to providing personal care assistance services to waiver participants.

Data Source (Select one):
Reports to State Medicaid Agency on delegated Administrative functions
If 'Other' is selected, specify:
Report from 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: contracted fiduciary agency	☐ **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: 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/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

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 service providers who receive training that they request of HP Services(formerly Electronic Data Systems) the state's MMIS contractor.

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*	**Frequency of data collection/generation***(check*	**Sampling Approach***(check each that applies):*

each that applies):	*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 entity	☐ 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: contracted entity	☐ Annually
	☑ Continuously and Ongoing
	☐ Other Specify: [ ]

Performance Measure:
Number and percent of access agencies that have performed contractual expectations regarding provider training.

Data Source (Select one):
Provider performance monitoring
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: Access Agencies	☐ **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: Every 18 months

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 Department cross matches providers with the HHS-OIG Fraud Protection and Detection Exclusion list to block participation of providers found on this list. Access Agencies perform checks of staff licensure routinely at time of annual performance review.
The Access Agencies are required to have procedures in place to verify that subcontractors meet all of the criteria to be a waiver provider. They must provide documentation that the subcontractor meets Department standards and requirements to assure provider eligibility, adherence to program requirements and standards, quality of service delivery and that services are delivered in accordance with participants'plans of care.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the State's 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.
Performing provider agencies have a grievance procedure that they may follow in the event they believe they have not been treated appropriately by the Access Agency. In circumstances such as these, the provider may contact the manager of the Alternate Care Unit who will review the situation and make appropriate interventions. The Access Agencies are contractually obligated to assist providers in meeting the provider qualifications needed to be a participating provider. They offer training programs both for existing providers as well as for providers who wish to enroll. Documentation of the grievances and all of the accompanying correspondance is maintained in a central file in the Alternate Care Unit.

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: Access Agency	☐ 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.
Access Agencies are currently monitoring staff and provider licensure, certification or qualifications at time of hire and renewal. Over the next three years, the Department will incorporate an expanded administrative review of audits to include verification that licensure, certification and qualifications are monitored and documented as required through contracts, policies and procedures.

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.

As specified in CGS 17b-342(a), the annualized cost of the community based services(waiver services) shall not exceed sixty percent of the weighted average cost of care in skilled nursing facilities. Costs may go up to one hundred percent of

the average cost of nursing homes when the waiver services are combined with state plan home and community based services. Per PA 09-64 The sixty percent limit will not apply to PCA services. PCA services are provided within the 100% NF cap as long as services provided are more cost effective on an individual basis when compared to existing state plan services.

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

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

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

Appendix D: Participant-Centered Planning and Service Delivery

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

State Participant-Centered Service Plan Title:
Total Plan of Care

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:

☑ **Social Worker.**
Specify qualifications:

Clients who choose not to have care management services are determined to be "self directed." For these clients, Department staff may perform the annual reevaluation and level of care determination and authorize the service plan. Staff who perform these functions are either Registered Nurses licensed to practice nursing in the State of CT or Social Workers who meet the same qualifications as the Care Managers as specified in Appendix C-1/C-3

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

Appendix D: Participant-Centered Planning and Service Delivery

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

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

◉ **Entities and/or individuals that have responsibility for service plan development may not provide other direct waiver**

services to the participant.

○ **Entities and/or individuals that have responsibility for service plan development may provide other direct waiver services to the participant.**

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

Appendix D: Participant-Centered Planning and Service Delivery

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

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

At the point of intake, applicants to the waiver program are asked to identify a "responsible party" or other person they would like to have present for the assessment visit. When the care manager calls to make the appointment, he/she generally calls the person identified on the referral as wanting to be present for the assessment visit. The visit is scheduled at a time convenient for both the client and the person or persons they wish to be included in the visit. The care manager discusses with the potential participant, their choices between home care and institutional services. The care manager is expected to fully inform the applicant about services available and different agencies. The client is provided a W-990, The CT Home Care Program for Elders, Your Rights and Responsibilities. This document outlines choice of services, providers, the participant's right to participate in and have control over their services, their rights will be respected by service providers and they should expect high quality in the care or services they receive. The client is asked to sign an Informed Consent Form (W-889)that explains their choices in detail and are given a copy of the document as well as other documents they sign. Participants are required to sign a copy of their Total Plan of Care indicating their agreement with the service plan.

Appendix D: Participant-Centered Planning and Service Delivery

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

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

Once the referral is processed by Alternate Care Unit staff and the client appears to meet functional and financial eligibility criteria for the waiver, the referral is sent to an Access Agency for the initial evaluation. The Care Manager meets with the client and his or her representative and explains the program prior to initiating the assessment. If the client consents, the care manager initiates the assessment. The uniform assessment instrument (W-1507A) evaluates 7 domains: health, function, psychosocial, environment, cognition, support system and finances. Risk indicators are discussed with the client and/or their representative. Over the past year, a quality improvement group has been convened consisting of both Alternate Care Unit and Access Agency Staff. The goal was to update the assessment instrument to add fall risk assessment questions and new questions to capture data on preventive care and disease management. We expect to implement those changes within the second or third year of the waiver renewal.
Based on the assessment, needs are identified and service options are discussed with the participant and their representative. Options regarding service providers are presented for the client to choose their servies and providers.
The assessment is utilized to develop client centered goals and plans are developed that assist the client in achieving those goals. The Department as part of its audit process, reviews records to ensure that client goals are identified and reviewed at least annually.
Once the plan is developed, the costs of the plan are calculated. The client and/or their representative is asked to sign off on the plan indicating their approval and/or agreement with it. The final plan of care is submitted to the department for utilization review and to ensure that needs and goals are addressed by the plan.
The Access Agencies are required by their contract with the department to perform monthly monitoring contacts with the clients and/or their representatives to evaluate the plan and if there are any changes that would necessitate a change in the plan. The contract

further requires that the Care Manager change the plan to reflect changes in client needs. This occurs on a continuous basis.
Regulations of CT State Agencies 17b-342(d)(7) state:
For the Connecticut Home Care Program, all home care services shall be included as part of a written plan of care developed initially and updated regularly by the access agency, the assisted living service agency, department staff or department designee. The plan of care shall specify the start date of services, services, type, frequency, cost, funding source and the providers of all home care services. The type and frequency of services contained in the plan of care shall be based upon the documented needs found in the assessment of the elderly person's needs and shall be reimbursed by the department only when it is determined that each service is needed in order to avoid institutional placement. For any services where the client would be at risk if the schedule of the service varied, a back-up plan shall be identified in the total plan of care. Services not included as part of the approved plan of care or not covered by sections 17b-342-1 to 17b-342-5, inclusive, of the Regulations of Connecticut State Agencies are not eligible for reimbursement from the Connecticut Home Care Program.
The client's individualized plan of care must be signed by the client or the client's representative.

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 choose their services and their 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 Care Manager, the participant and his/her representative, and any other person identified by the participant collaborate to assess individuals from a multidimentional perspective as well as any risk factors including: inadequate supervision, social isolation, cognitive impairment, fall risk, 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, the Care Manager discusses this issue with their Supervisor and/or interdisciplinary team and then provides feedback to the waiver participant regarding the area(s) of concern. This allows the participant and the care manager to have a dialogue and exchange of ideas on how to mitigate the risk by developing a back up plan in collaboration with the participant and/or their representative. The waiver participant has the right to accept, reject or modify recommendations that address risk. In addition, all participants are required to have, and document on the service plan, an emergency back up plan, if a provider does not report to work.

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 participant is informed that they have a right to a fair hearing, pursuant to Medicaid rules and the NOA includes information about their right to a fair hearing.

Appendix D: Participant-Centered Planning and Service Delivery

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

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

During the development of the Total Plan of Care, participants will select providers from a list prepared by the Care Manager. The Access Agencies maintain the list of waiver providers according to geographic areas within the state, and the list may vary by geographic area. The Care Manager will describe the services available from providers on the list. Participants choose providers from the list and their signature on the total Plan of Care acknowledges freedom of choice.

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):

ACU staff review 100% of all new service plans and must authorize them in order to initiate service. Utilization Review Nurses match needs with services to ensure all health and safety needs are being met.
ACU staff conducts annual client record reviews for each of the three Access Agencies. Approximately one hundred (100) client records are randomly selected for review. The reviews include an examination of the client's most recent reassessment and confirm that the identified critical needs are consistent with the POC. The POC is reviewed to ensure that all identified needs are being met.
ACU staff conducts client satisfaction surveys in each of the five areas of the state that define the Access Agencies service areas.

ACU client record reviews are conducted to monitor contractual agreements. The Access Agencies are contractually obligated to conduct client record reviews including assessing appropriateness of POC and report annually to the Department of Social Services. Access Agencies must update the POC at the time of reassessment or when a significant change occurs in the client's status, and utilize care plans consistent with the program's Uniform Client Care Plan. The Uniform Client Care Plan identifies provider, type of service, number of hours provided, date service began, and date service was discontinued, noting the need for a back up plan. These services are monitored by the Department of Social Services through Quality Assurance and Client Satisfaction Annual Reports generated by the Access Agencies.
On annual reassessment, ACU staff select for review, every 10th care plan submitted monthly. The review consists of an evaluation of whether the plan is meeting health and safety needs of the participant and monitors outlier care plans,(utilization below 20% or above 80% of the cost limits.

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.

The Access Agency Care Managers are responsible for monitoring the implementation of the service plan and participant health and welfare. By contract, the Access Agency conducts monthly contacts with the client, the client's representative or provider by telephone or home visit. Monthly contacts verify that services in the plan of care meet current needs of the client, verify that services are being provided as specified in the plan of care, verify that the plan remains within cost limits, verify satisfaction with services, verify that client goals remain appropriate and revise goals as needed, identify any potential problems relating to participant's health, safety or participation in the waiver and implement corrective actions as needed, verify that the corrective action is effective and verify

that the informal support system remains active and provides the assistance noted on the Total Plan of Care.
The care managers are required to conduct face to face visits with the clients as often as needed but no less frequently than every six months.

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:

Appendix D: Participant-Centered Planning and Service Delivery

Quality Improvement: Service Plan

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

a. **Methods for Discovery: Service Plan Assurance/Sub-assurances**

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/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

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 reviewed by ACU staff that do not appear to meet identified needs at the time of the initial assessment.

Data Source (Select one):
Record reviews, off-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 access	☐ **Annually**	☐ **Stratified** Describe Group:

agencies		
	☑ **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 appropriately identify the need for back up plans.

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:
In addition, off site record reviews are also conducted

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 Access Agency	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☑ **Other** Specify: non-representative sample

	☐ **Other** Specify:	

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 = ☐ **Stratified** Describe Group:
☑ **Other** Specify: contracted entity	☑ **Annually**	☐ **Other** Specify: supervisory review of a minimum of 5% record review
	☐ **Continuously and Ongoing**	
	☐ **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 address client risk factors

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 Access Agency	☐ Annually	☐ Stratified Describe Group: [ ]
	☐ Continuously and Ongoing	☑ Other Specify: Supervisory review of a minimum of 5% of the records quarterly
	☐ Other Specify: [ ]	

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:
Record reviews may also be off site, desk reviews

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 Access Agency	☐ Annually	☐ Stratified Describe Group: [ ]
	☑ Continuously and Ongoing	☑ Other Specify: non-representative sample
	☐ 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: contracted access Agency	☐ **Annually**
	☐ **Continuously and Ongoing**
	☑ **Other** Specify: every 18 months

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

Performance Measures

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

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 contain signature of participant or their representative.

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:
Record reviews off site as well

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 access agency	☐ **Annually**	☐ **Stratified** Describe Group: [ ]
	☑ **Continuously and Ongoing**	☑ **Other** Specify:

		non representative sample
	☐ **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: Every 18 months

Performance Measure:
Number and percent of service plans that are within cost caps specified in the waiver.

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:
off site record reviews are also conducted

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: Access Agency	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☑ **Other** Specify: 100% review at initial assessment. Every 10th record at reassessment. a non-representative sample during on and off site record

		reviews
	☐ **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 participant's needs.***

Performance Measures

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

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 are updated and revised annually.

Data Source (Select one):
Analyzed collected data (including surveys, focus group, interviews, etc)
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 access agencies	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☑ **Other** Specify: every 10th record at annual reassessment and non-representative sample at the time of on or off site record reviews
	☐ **Other** Specify:	

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 = Confidence Interval =
☑ **Other** Specify: contracted Access Agency	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☑ **Other** Specify: 5% of the records per quarter
	☐ **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**

Contracted access agencies	
	☐ **Continuously and Ongoing**
	☑ **Other** Specify: Department on site audits will be conducted every 18 months.This is done in addition to the quarterly data that will be provided by the Access Agencies and aggregated by the department annually.

Performance Measure:
Number and percent of waiver participants reviewed whose service plans were revised, as needed to address changing needs.

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: Access Agency	☐ **Annually**	☐ **Stratified** Describe Group: [ ]
	☑ **Continuously and Ongoing**	☑ **Other** Specify: non representative sample
	☐ **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/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

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 clients who report recieving services as designated in plan of care.

Data Source (Select one):
Analyzed collected data (including surveys, focus group, interviews, etc)
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: non representative sample
	☐ **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: contracted Access Agencies	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Number and percent of clients for whom there is documentation that services were delivered as authorized

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:
As part of the required monthly monitoring contact, all clients are asked if services are being delivered as authorized. The record review of a 5% sample of records occurs quarterly.

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 = Confidence Interval =
☑ **Other** Specify: contracted Access Agency	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☑ **Other** Specify: supervisory record reviews occur quarterly on a sample of 5% of participants records the Department selects a non-representative sample.
	☐ **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: contracted Access Agency	☑ **Annually**
	☐ **Continuously and Ongoing**
	☑ **Other** Specify: DSS on and off site reviews occur every 18 months

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/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

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 clients informed of their right to decide between waiver services and institutionalization documented by the participant's signature on the W-889 Informed Consent form.

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:
Off-site record reviews are conducted also

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 Access Agencies	☐ **Annually**	☐ **Stratified** Describe Group: ☐
	☑ **Continuously and Ongoing**	☑ **Other** Specify: non-representative sample

	☐ **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 on the W-990 form, "Your Rights and Responsibilities."

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 = ☐ **Stratified** Describe Group:
☑ **Other** Specify: contracted Access Agencies	☐ **Annually**	
	☑ **Continuously and Ongoing**	☑ **Other** Specify: non representative sample
	☐ **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.
Feedback from contracted providers and Department staff is collected through scheduled bi-monthly meetings.
There are several levels of record audits and quality improvement/assurance activities that occur. The Access Agencies do supervisory record reviews and also have an external record review process in place as required by their contract with the Department. In addition, the department does a random sample of chart audits on a rotating basis in all of the Access Agencies every 18 months. Client chart audits identify inconsistencies in required documentation and identify trends.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the State's 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.
ACU facilitated formation of a committee charged with updating guidelines of collaborative efforts among Protective Services for Elders, DSS and Access Agencies which resulted in the development of updated operational protocols and best practice guidelines for clients who demonstrate self neglectful behaviors. The Department had audit findings that one of the Access Agencies did not adequately document services and interventions for some participants with mental health issues. The department arranged for a training for the Access Agency staff that included a sharing of community resources by staff of the state Department of Mental Health and Addiction Services. Audit feedback is provided to Access Agencies who respond with a plan of correction to ensure compliance.
Access agency data, based on supervisory record reviews, will be reported to ACU for quality assurance monitoring.
In addition, annually the Access Agency reports all quality assurance/improvement activities to the Department as required in their contract.

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 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.
The Department in collaboration with access agency supervisory staff, developed a tool for access agency supervisors to complete when performing record reviews and this has already been implemented. Over the course of the next year, data will be aggregated and adjustments will be made to the tool as necessary.
A committee, led by the DMHAS APRN Program Director of Geriatric Services, was established to discuss identified mental health issues of waiver clients. As a result, a network of community mental health support services has been established, additional training sessions for care managers have been planned. It is our goal over the next three years to gradually increase our sample size for record audits to move closer to what would constitute a representative sample.

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 will have several options for directing their own services to the extent they are able. If they are unable,they may designate a representative to act on their behalf. Clients may self direct PCA services and may choose to be the common law employer with the assistance of a Fiscal Intermediary or they may choose a co-employer option by utilizing agencies to secure services. Yet other clients may opt to manage their own services without the assistance of a care manager but in this circumstance,they do not have employer authority.
When the Care Manager completes the initial assessment, self directed options are explained as a potential service that the participant may choose. The participant is encouraged to have anyone that they choose, present for the assessment. During the assessment process, the participant is supported and encouraged to lead and fully participate in the planning process. Total Plans of Care are signed by the participant, confirming agreement on the plan and a copy is maintained in both the Care Manager and the Alternate Care Unit's file.
For participants who choose the common law employer option, the fiduciary agent assists with the enrollment process and provides training and support to the participant. For participants who choose the co-employer option, the agency that will provide the worker assists the participant. In both situations, common law and co-employer, the Care Manager may also assist the applicant in understanding the processes and procedures associated with employer authority.
These self direction opportunities represent a significant change in the operation of this waiver from previous years. This is being

done in response to a number of factors including the research that indicated a need for more flexible service options for clients, a desire to exercise greater control over services provided and the overall workforce shortage. CT has operated a state funded PCA Pilot program and legislation passed in 2009 mandates that the state seek federal approval to add PCA as a waiver service.

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

Specify the criteria

Appendix E: Participant Direction of Services

E-1: Overview (4 of 13)

e. Information Furnished to Participant. Specify: (a) the information about participant direction opportunities (e.g., the benefits of participant direction, participant responsibilities, and potential liabilities) that is provided to the participant (or the participant's

representative) to inform decision-making concerning the election of participant direction; (b) the entity or entities responsible for furnishing this information; and, (c) how and when this information is provided on a timely basis.

When a referral is being made to the waiver program, Alternate Care Unit staff provide information about the waiver program and services available including self direction opportunities. The Access Agency Care Manager, when completing the initial assessment and in the development of the plan of care, explains opportunities for self direction to the client. Opportunities for self direction in the waiver are both common law employer and co-employer options. Additionally, clients who desire to manage their own service plans, may opt not to have a Care Manager coordinate services for them. In that instance, they do not have employer authority but exercise control over their service plans. If the participant chooses not to self direct services independently, they can designate someone to act on their behalf.
Participants who opt for the common law employer option are assisted by a fiduciary agent in establishing the status as an employer. The fiduciary agent provides training to the participant and/or their representative regarding employer responsibilities. Participants may also choose a co-employer option and select workers from provider agencies.
The purpose of the two choices is to afford participants options for self direction that they would feel comfortable in assuming. In both cases, the particiapant may also be assisted and supported in the process by their Care Manager.
These options for participant direction respresent a significant change to the waiver from previous years. This is being done in response to the research done by the University of Connecticut that indicated that there was a need for more flexible service options and more choices for participants in order to prevent nursing home placement. An additional factor that contributed to the decision to add the participant directed services, is the workforce shortage in the state.
The state has offered PCA as a state funded pilot service for a number of years. Legislation passed in 2009 mandates that PCA be added as a service to the waiver, subject to federal approval.

Appendix E: Participant Direction of Services

E-1: Overview (5 of 13)

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

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

◉ **The State provides for the direction of waiver services by representatives.**

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

☑ **Waiver services may be directed by a legal representative of the participant.**

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

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

A participant may designate a representative to assist him/her to apply for an utilize the PCA Service. The representative may assist with paperwork, make telephone calls and can perform such functions as interviewing, hiring, scheduling and submitting time sheets. A person with a cognitive impairment who lacks the capacity to manage PCAs shall have a Power of Attorney or conservator to act on their behalf. In all cases, the Care Manager who monitors the overall effectiveness of the Total Plan of Care in meeting the health and safety needs of the participant shall evaluate if the representative is working in the best interest of the participant.

Appendix E: Participant Direction of Services

E-1: Overview (6 of 13)

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

Participant-Directed Waiver Service	Employer Authority	Budget Authority
Personal Care Assistant (PCA)	☑	☐

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 C1/C3**

The waiver service entitled:

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

Provide the following information

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

The fiscal intermediary services were procured through a competitive bidding process.

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

Payment is made via direct vendor contract with the fiscal intermediary. The contractor is the same vendor that is used for the Personal Care Assistance waiver for persons under age 65.

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:

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

Specify:

Provide consumer training that includes but is not limited to advertising/recruiting, interviewing techniques, PCA training, ongoing performance evaluations of PCA's and problem solving or termination of PCA's and Recovery Assistants. The training shall also include monitoring the quality of the PCA plan implementation.

Supports furnished when the participant exercises budget authority:

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

Specify:

Additional functions/activities:

- ☑ **Executes and holds Medicaid provider agreements as authorized under a written agreement with the Medicaid agency**
- ☑ **Receives and disburses funds for the payment of participant-directed services under an agreement with the Medicaid agency or operating agency**
- ☐ **Provides other entities specified by the State with periodic reports of expenditures and the status of the participant-directed budget**
- ☐ **Other**

Specify:

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 to monitor and assess the performance of the fiscal intermediary by the following methods.
• 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)
• A bi-annual survey administered to waiver participants regarding the FMS' performance
• Random audits of Medicaid Providers by DSS Quality Assurance Division
• Biweekly conference calls by contract manager with the fiscal intermediary to discuss ongoing operations, and review billing issues as well as issues with the consumers and PCA's.

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:

The Care Manager is responsible to complete the comprehensive assessment and develops the Total Plan of Care in collaboration with the participant and his or her representative if desired by the client. As part of the explanation of services options, PCA services are explained as options depending on the client's identified needs. Care Managers will explain the differences between

common law employer and co-employer options. Care managers will also facilitate referrals to either the Fiscal Intermediary or an agency for these participant directed service options.

☑ **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
Personal Care Assistant (PCA)	☐
Environmental Accesibility Adaptations	☐
Mental Health Counseling	☐
Assisted Living	☐
Care Management	☑
Personal Emergency Response Systems	☐
Companion	☐
Homemaker	☐
Respite	☐
Transportation	☐
Home delivered Meals	☐
Adult Day Health	☐
Assistive Technology	☐
Chore services	☐

☑ **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 Care Manager and approval for 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 PCA 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:

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:

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

Appendix E: Participant Direction of Services

E-1: Overview (12 of 13)

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

Each individual who self-directs by hiring his or her own workers has been trained by the fiscal intermediary that has also described the expectations of the participant. Termination of the participant's self-direction opportunity may be made when a participant or representative cannot adhere to the terms of the Agreement to participate in self direction Key terms are:
1. To participate in the development and implementation of the plan of care
2. To actively participate in the selection and ongoing monitoring of supports and services.
3. To understand that no one can be both a paid employee and the employer of record.
4. To authorize payments for services provided only to the recipient according to the individual plan.
5. To enter into an agreement with the provider agency/agencies or individual support worker(s) hired.
6. To submit timesheets to the fiscal intermediary on a weekly basis or within the agreed upon timeframe.
7. To participate in the Department's quality review process.
8. To use qualified vendors enrolled by the Department.
9. To ensure that each employee has read the required training materials and completed any individual specific training in the total plan of care prior to working with the person.
10. To not offer employment to any new employee until the criminal history background check has been completed.
11. To notify the Care Manager when the individual is no longer able to meet the responsibilities for self-directed services.

The individual acknowledges that the authorization and payment for services that are not rendered could subject him/her to Medicaid fraud charges under State and federal law. Breach of any of the above requirements with or without intent may disqualify the individual from self-directing services. Violations will result in training and warnings, until a consistent pattern of non-compliance could be documented. Intentional fraud is the only instance anticipated where involuntary termination of an individual from self-direction would be immediate.

Self directed services can be terminated if the participant does not comply with the agreed upon requirements. The care manager would coordinate the transition of services and assist the individual to choose a qualified provider to replace the directly hired staff, make the referrals to the new providers and ensure the seamless transition of services for the waiver participant.

Participant direction of self directed waiver services can be involuntarily terminated when a participant does not demonstrate the ability to manage his or her own PCA's and will not appoint a representative. The first option that would be explored would be whether other, non self directed, services could be utilized to meet the participant's identified needs. If a service plan could not be developed to meet the identified needs, a Notice of Action would be issued and the participant would then have the right to a fair hearing pursuant to Medicaid law. The care manager would have the responsibility to coordinate the transition of services from self directed to provider based services in a manner that would ensure a smooth transition for the participant.

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	342	
Year 2	722	
Year 3	1129	
Year 4 (renewal only)	1557	
Year 5 (renewal only)	2005	

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:

Agencies with choice would function as the managing provider for PCA services. The agencies might be Homemaker/Companion Agencies or Home Health Agencies.

☑ **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 performs this function on behalf of the participant. The cost is included in their administrative reimbursement.

- ☐ **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 participants under this Waiver may request and receive a fair hearing in accordance with the DSS' Medical Assistance Program. Applicants will receive a copy of the DSS W-889 Informed Consent Form and W-990, Your Rights and Responsibilities, during the first visit with the Care Manager. Participants are eligible for Fair Hearings in the following circumstances:
Participant was not offered the choice of home and community services as an alternative to institutional care;
DSS does not reach a determination of financial eligibility within standards of promptness;
DSS denies the application for the individual not meeting the level of care or other eligibility criteria;
DSS disapproves the individual's Plan of Care;
DSS denies or terminates a service of the individual's choice;
DSS denies or terminates a payment to a provider of the individual's choice; or
DSS discharges an individual from this Waiver.

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

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).

Connecticut employs strict protocols regarding the reporting of abuse, neglect, and exploitation. DSS has demanding and prescriptive procedures for incident and management reporting systems. These procedures are dictated by State statute and regulation. The objective is to identify, address and seek to prevent instances of abuse, neglect and exploitation. See the overview below for a summary of DSS procedures.

Overview
Persons served by this waiver are under the authority of the PSE Statute 17b-450-461 for Elders. There are two levels of reporting:
- Serious Incident involving abuse/neglect or other immediate risk to participant, and
- Sensitive Incident

Mandatory Reporters for both Serious Incidents involving abuse/neglect or other immediate risk to participant and Sensitive Incidents, include all staff employed directly by individual, provider or agency, including Care Manager and central office staff. In addition, clergy, police officers, social workers, medical professionals and nursing home staff are mandatory reporters for elders.

Time frames for reporting Serious Incidents involving abuse/neglect or other immediate risk to a participant are as follows:
Immediate contact to appropriate agency.
Written report no later than 5 PM next business day.
Immediate contact to family, Care Manager or service provider as appropriate.

Time frames for reporting Sensitive Incident are as follows:
Reported no later than 48 hours.

Below is a complete listing of resources that illustrate the ways that participants, family members, caregivers and/or legal representatives are provided information about protections from mistreatment, and are told how to report concerns or incidents of abuse, neglect and exploitation. Training is provided to all participants and involved family or other unpaid caregivers via transitional services and by Care Managers.

Department of Social Services (DSS)

DSS has standard contract language that addresses incident reporting for clients served. This language states as follows:

The Contractor shall submit to the Department's Program Manager an incident report detailing situations that have compromised the health and/or safety of clients served in the program. The incident report shall be submitted within five business days of the occurrence and 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.

DSS has developed a "Serious Reportable Incident" form. A Serious Reportable 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. Examples of serious reportable incidents are: unexpected absence of a primary caregiver, untimely death of a waiver participant, suicide attempt, criminal allegations with the waiver participant as either the victim or the perpetrator, misappropriation of the participant's funds, abuse or neglect of a waiver participant or a missing person.

In contrast, a Sensitive Situation is any one that does not fit within the above categories that needs to be brought to the attention of DSS, within 48 hours of the occurrence, that would potentially threaten the participant's health and welfare or ability to remain in the community, such as an admission into a substance abuse or psychiatric facility.

All members of the participant's care planning team, support staff and service agency staff members are required to report critical incidents. Recipients of Critical Incident reporters include:

Participant's Care Manager.
Participant and/or Conservator.
DSS Central Office (Program Manager/Quality assurance Nurse Consultant).
Participant's provider.

Reporting Methods and Timeframes
The provider, pursuant to the "Serious Reportable 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 elderly protective services.
& The provider has received inquiries from the media regarding a major unusual incident that has not been previously reported.
The major unusual incident raises immediate concerns regarding the individual's health and safety such that more immediate notification regarding the incident is necessary.

Response to Serious Events
All State departments involved with HCBS waivers initiate investigations of any serious issues. Other parties are contacted and interviewed as appropriate. If a concern were raised about any matter that has come up while the consumer was under the support of a provider, the provider would be 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 registry/approved provider list or reporting to law enforcement or licensure agencies (e.g., Department of Public Health). Action to ensure the safety of a participant who is at imminent risk occurs immediately (removal of provider and replacement with equivalent service provider). Additional follow-up with other entities include but are not limited to DSS units/divisions (e.g., Quality Assurance, Medical Policy, Legal), law enforcement, Department of Public Health may be necessary. Data from this system will be evaluated with information from the MFP emergency back up plan to assure coordination through the quality improvement committee.

When a participant in this waiver is a victim of abuse, neglect or exploitation, a referral to Protective Services for Elders is made. The care manager is responsible for ensuring that the report is made. 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 17b-450 - 461 provides the framework for the investigation of abuse or neglect.

The timeframes for response and investigation commencement will mirror the PSE program, which is as follows:

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

Abuse and Neglect

For persons aged 60 or older, Section 17b-451 of the Connecticut General Statutes requires medical professionals, social workers, police officers, clergy, and nursing home staff to report to the Department of Social Services any knowledge or suspicion of abuse, neglect, exploitation, or abandonment. In addition, friends, neighbors, family members, and acquaintances who suspect an elderly person is being abused, neglected, or exploited may call the closest office of the Department of Social Services.

An interagency workgroup comprised of Access Agency staff, DSS Protective Service Staff and ACU staff has met several times in the last year to update and evaluate the effectiveness of existing protocals for interagency collaboration around clients for whom allegations of abuse, neglect or exploitation have been made. The process is a formal one that requires written referrals to PSE and a

written decision back from PSE outlining their findings. The Quality Assurance Nurse Consultant in the Alternate Care Unit tracks the PSE referrals and responses. If necessary the PSE Program manager and ACU Manager discuss and collaborate on difficult client situations.

It is the intention of this waiver, to implement the web based critical incident reporting system that is being implemented in the Money Follows the Person Demonstration program. It is our goal, to implement that process for this waiver in SFY 2012.

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.

Training is provided to all participants and involved family or other unpaid caregivers via Care Managers on 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. Identification and the prevention of neglect, abuse and exploitation is a standard component of Care Manager orientation and training.
The DSS Training team additionally includes training on 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 in the following way:
Ongoing regional meetings with Protective Services (for persons 60 and over) regional staff, Care Manager and Fiscal Intermediary staff and ACU staff;
Conduct in-services, provide community presentations on the Home and Community Based Services Waiver for Elders, and maintain the units' information and resource line;
Program staff is encouraged to take advantage of state offered training programs in both technical skills and quality of life issues; and
The training team takes advantage of all requests to provide in–service training and presentations to community agencies, organizations, nursing facilities and hospitals statewide. In addition, when training needs are identified or program changes are made, the Department offers training as appropriate.

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.

Critical incident reporting comes to the Nurse Consultant who handles quality assurance for this waiver. She is supported in her efforts by one Licensed Clinical Social Worker. She reviews the report upon receipt and tracks responses from Protective Services for Elders if a referral has been made there. She is also the unit's liaison with the Protective Services Manager. A data base is maintained within ACU and analysis is done for trends. Problematic situations are addressed on an individual basis.

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.

See b above

Appendix G: Participant Safeguards

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

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

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

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

DSS investigates cases of abuse, neglect, abandonment and exploitation of the elderly and the disabled as noted above. Suspected use of restraints or seclusion which occurs in the home or community is reported to the state's 24 hour abuse hotline and investigations are completed within 24 hour or less. DSS also investigates complaints and incidents where restraints or seclusion are used in institutional settings. Investigation may be delegated to the Care Manager or conducted jointly with ACU staff. The use of restraints or seclusion is not allowed in the State of Connecticut.

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

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

agency or the operating agency (if applicable).

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

Appendix G: Participant Safeguards

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

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

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

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

DSS is responsible for investigating reports of abuse, neglect, abandonment and exploitation of the elderly and the disabled. Incidents of restrictive interventions which occur in the home or community are reported to the state's 24 hour abuse hotline and investigations are completed within 24 hour or less. Incidents which occur in institutional facilities would also be investigated by DSS as well. Investigations may be delegated to the Care Managers or conducted jointly with the ACU staff.

○ **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-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 State's quality improvement strategy, provide information in the following fields to detail the State's methods for discovery and remediation.

a. Methods for Discovery: Health and Welfare

The State, on an ongoing basis, identifies, addresses and seeks to prevent the occurrence of abuse, neglect and exploitation.

i. Performance Measures

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

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 serious incident reports that are reported to the ACU Nurse consultant within 48 hours as required by the waiver

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: Access Agency	☐ **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 participant records that indicate the participant has been apprised of their Rights and Responsibilities as evidenced by DSS form W-990 in participant's record.

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:
Off site record reviews are also conducted by Department staff

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: Access Agency	☐ Annually	☐ Stratified Describe Group:
	☑ Continuously and Ongoing	☑ Other Specify: non respresentative sample done by DSS staff also Access Agency supervisory record reviews are done quarterly on 5% of the the clients
	☐ 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: Access agency	☐ **Annually**
	☑ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Number and percent of clients who express that service providers are kind and respecful.

Data Source (Select one):
Analyzed collected data (including surveys, focus group, interviews, etc)
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: Access agency	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☑ **Other** Specify: 10% sample
	☐ **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: Access Agency	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
The number and percent of critical incidents regarding waiver participants requiring investigation by Protective Services for Elders

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: contracted access Agency	☐ 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: contracted Access Agency	☐ 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 Department holds Access Agency meetings bi-monthly for the purpose of disseminating information and dicussing issues of concern. Both Access Agencies and The Department staff conduct client satisfaction surveys to elicit client feedback regarding health and safety issues. Elder Protective Services, Alternate Care Unit and Access Agencies collaborate to identify and resolve health and safety concerns. The Alternate Care Unit Manager and/or Health and Safety Nurse Consultant have ongoing consultation and dialogue with the Protective Services for elders manager as needed on case by case basis.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the State's 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 committee of care managers, clinical staff and quality assurance staff convened to update the assessment instrument for collection of data related to health promotion, chronic disease management, and to implement best practices.
Discussions between access agencies, PSE and ACU staff with respect to informed risk versus self determination, i. e. what is an acceptable level of risk to both the client and the program.
All findings related to participant safeguards are entered into a data base within the Alternate Care Unit. Communications occur with the care manager and other Access Agency staff as appropriate for any corrective action or interventions. Access Agency staff monitor the waiver participants on a monthly basis and will continue to follow up on the identified problem as needed.

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: contracted access agency	☐ **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.
Health standard monitoring is already in place at the Access Agency level, but data aggregation and reporting including analysis for trending of this information will be initiated in ACU in SFY 2012. All assessment and reassessment data is transferred to the Department on an annual basis by the Access Agencies. Health promotion and prevention questions will be added to the Uniform Assessment Instrument and reported annually allowing for further analysis.
New guidelines for collaborative efforts among access agencies, ACU and PSE have been developed and implemented. Currently, critical incident reports are tracked manually and submitted in a paper based format. It is our intention to utilize the web based critical incident reporting system that is being developed for the MFP Demonstration Project. This will allow for easier aggregation of data and will also enhance our ability to produce summary reports. Access Agency and Alternate Care Unit staff have already begun training on the application and the waiver manager has had extensive input into the content of the data base. Our intention is to operationalize the web based system for this waiver by SFY 2012.

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 QMS 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 QMS* 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 QMS spans more than one waiver, the State must be able to stratify information that is related to each approved waiver program.

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.

The State of Connecticut has been utilizing a comprehensive system of checks and balances in order to establish consistent quality assurance within services provided to clients through this waiver. The state has been guided by state and federal regulations to assist in establishing procedures and the many varied data collection, agregation and analysis processes that are currently utilized. Through the productive process of analysis, discovery, remediation and improvement, the state recognizes the benefit to client services that can be obtained through some system design changes.

Administrative Authority

Sampling size of client chart reviews is not a representative sample. Design change will include the increase of the number of chart reviews to reduce the margin of error and increase our confidence level. Given our waiver population of 9500, with a 5% margin of error, a confidence level of 95%, we intend to work toward incresing our sampling size to 370 client charts, spread over the 5 areas of the state. As staffing at this time allows for minimally operational QA activities, it is the intent to increase the sampling size over the next three years to meet our goals. We have also added a reporting requirement for the Access Agencies to provide a summary report of supervisory record reviews done on a regular basis.

Level of Care

As with the Administrative authority assurance, the sampling of client chart reviews is not a representative sample. Our intended remediation is to reduce the margin of error and increase confidence level by utilizing a sampling size of 370, spread over the 5 areas of the state. It is the intention of the Department to increase the sampling size over the next three years to meet our goals. The Department intends to increase sampling size of ALSA onsite record reviews to monitor improvement as a result of the colaborative efforts of the Department and the ALSA Association. Onsite reviews will be conducted of 100% of ALSA facilities identified as problematic; staffing constraints have prohibited us from conducting optimum level of reviews, however, as staffing increases, the expectation is to implement reviews within the next three years.

Qualified Providers

Access Agencies are currently monitoring staff and provider licensure, certification and qualifications at time of hire and renewal. Over the next three years, the Department will incorporate an expanded administrative review of audits to include verification that licensure, certification and qualifications are monitored and documented as required through contracts, policies and procedures.

Service Plan

A tool was developed for access agency supervisors to complete when conducting supervisory record reviews, and it's use has been implemented; over the course of the next year, data will be aggregated and adjustments will be made to the tool as necessary.

A committee, lead by the DMHAS APRN Program Director of Geriatric Services, was established to discuss identified mental health issues of waiver clients. As a result, a network of community mental health support services has been established, additional training sessions for care managers have been planned.

DSS will be adding a reporting requirement of the Access Agencies to provide data on the difference between services authorized and services actually delivered sorted by service type. This will allow for an analysis of trends and targeted remediation. This will be reported annually beginning SFY 2011.

Health and Welfare

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

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

We will be transitioning to a web based critical incident reporting system that was developed for the MFP Demonstration. This change is targeted for SFY 2012.

Financial Accountability

The State of Connecticut contracts with HP (formerly EDS) to employ a data system to ensure reimbursement is consistent with waiver requirements. The Department introduced the MMIS system Interchange for the purpose of upgrading the old claims processing system. It is now a Windows environment. The MMIS has now been certified by CMS. The provider relations unit oversees the contract with HP, as part of the medical operations process. They can make changes to procedure codes, edits and audits. Clients are identified by Medical Eligibility or Benefit Plan code. Providers are based on type and specialty. The system is designed to make sure it can be billed only for what is allowed through the edits and audits system. Currently, the report on the error rate by waiver provider does not exist. We will be requesting that this report be created by the MMIS provider on a semi annual basis. Problematic providers will be identified for potential additional training. We expect to have this report in place by the end of SFY 2011, the first year of this waiver renewal.

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: Contracted Access Agencies, ALSA facilities	☑ **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.

Administrative Authority

Representative sampling techniques will be employed by ACU Quality Assurance staff beginning with the next Access Agency Desk Audit. The scope and breadth of data analyzed with this method will increase exponentially given the added review of sub-contractor staff licensure, health standards trends and subcontractor information, having been previously aggregated at the subcontractor level, but not analyzed at the state level. Implementation of representative sampling techniques will be phased in over the course of three years as the state is experiencing staffing constraints which limit the ability of staff to multiply their work load. Aggregation and monitoring of data related to fall risk assessment, health promotion and chronic disease management activities will be implemented by the state in SFY 2012 by adding questions to the comprehensive assessment instrument.

Level of Care

Increased collaboration and compliance with required documentation is an ongoing process between ALSA's, the President of the Association of Assisted Living and ACU.

Qualified Providers

As mentioned above, expanded auditing by the state will review for sub-contractor staff licensure monitoring and documentation.

Service Plan

Access Agency Supervisory chart review information is now being reported to ACU Quality Assurance Staff quarterly for continued improvement in reporting, aggregation and analysis of information.

Access Agencies will provide annual reports to the state regarding services authorized vs. services received beginning SFY 2011. QA staff will monitor for trends and targeted remediation.

Health and Welfare

Improved collaboration and better communication between Protective Services for the Elderly, Department of Social Services and Access Agencies are an ongoing comittment regarding best practices with self neglecting clients. An updated version of best practices guidelines have been completed.

Overall a more global vision of service provision is embraced with the concept of an evolving scope and role for total quality assurance.

Financial Accountability

Currently, the report on the error rate by waiver provider does not exist. We will be requesting that this report be created by the MMIS provider on a semi annual basis. Problematic providers will be identified for potential additional training. We expect to have this report in place by the end of SFY 2011, the first year of this waiver renewal.

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

Evaluation of the Quality Improvement Strategy is continuous and ongoing. As reports from the Alternate Care Unit quality assurance staff are generated on all of the aggregated, analyzed data, they are scrutinized for trends and potential process improvements.

Ongoing dialog and opportunities for improved collaboration have been established in order to better serve this state's elder population. A QA workgroup composed of ACU staff and Access Agency Clinical Supervisors has been initiated to address ongoing QA/QI activities. This workgroup will meet as needed but minimally on an annual basis.

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 Auditors of Public Accounts monitor state agencies regarding fiscal and compliance matters. Auditors provide independent, unbiased and objective opinions and recommendations on the operation of state agencies and effectiveness in safeguarding resources. Financial-compliance auditing is the principal responsibility plus an examination of performance in order to determine the effectiveness of an agency in achieving its expressed legislative purpose. The Performance Audit Team devotes its time mainly to performance auditing, focusing on particular programs administered by a state agency. Findings are reported and discrepancies are identified and presented to the program and/or the provider. The Auditors follow up to make sure that changes are made to achieve compliance with state and federal regulations.

The Department's Quality Assurance Unit conducts annual onsite provider audits to ensure that state and federal funds are being expended appropriately. Financial statements, paid claims data, and other material are reviewed to assure that services were rendered and the agency is compliant with federal and state regulations and to detect fraud. Providers who are found out of compliance may be fined, terminated from the Medicaid program as a provider or given recommendations for improvement to achieve compliance.

The Office of Quality Assurance conducts audits of billings and claim payments of providers. The Medical Audit Unit of Quality Assurance takes a statistically valid sample of 100 paid waiver claims to test for compliance with applicable regulation, policy and contract language. They examine supporting documentation, including; time sheets; service orders, activity sheets; Plans of Care and other business records. Special audits can be initaiated if increased financial volume indicates a potential problem or if complaints have been received regarding a specific provider. Access Agencies are required to obtain independent financial audits annually. These reports are reveiwed by the Office of Quality Assurance and any identified weaknesses are addressed. In addition, the State Auditors of Public Accounts conduct audits of the Department's audit process in compliance with the Federal Single Audit Act Amendments of 1996 and the Federal Office of Management and Budget Circular A-133.

The Department's Provider Relations Unit monitors provider enrollment to assure that HP Enterprises, fiscal intermediary, is collecting and verifying required provider documentation prior to enrolling participating providers. These onsite audits are conducted every six months.

Appendix I: Financial Accountability

Quality Improvement: Financial Accountability

As a distinct component of the State's quality improvement strategy, provide information in the following fields to detail the State's 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.

i. Performance Measures

- (●) **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.**
- [x] **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: *Complete item I-3-e.*

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

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*:

☑ **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-2d Estimate of Factor D tables. Col. 2 fields will be populated ONLY when the Estimate of Factor D tables in J-2d have been completed.

Level(s) of Care: Nursing Facility

Col. 1	Col. 2	Col. 3	Col. 4	Col. 5	Col. 6	Col. 7	Col. 8
Year	Factor D	Factor D'	Total: D+D'	Factor G	Factor G'	Total: G+G'	Difference (Col 7 less Column4)
1	10878.50	6700.00	17578.50	55029.00	3539.00	58568.00	40989.50
2	11842.42	6928.00	18770.42	56955.00	3659.00	60614.00	41843.58
3	12866.26	7163.00	20029.26	58948.00	3784.00	62732.00	42702.74
4	13954.67	7407.00	21361.67	61012.00	3912.00	64924.00	43562.33
5	15095.05	7659.00	22754.05	63147.00	4045.00	67192.00	44437.95

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 Number Unduplicated Number of Participants (from Item B-3-a)	Distribution of Unduplicated Participants by Level of Care (if applicable)
		Level of Care:
		Nursing Facility
Year 1	13935	13935
Year 2	14400	14400
Year 3	14850	14850
Year 4 (renewal only)	15280	15280
Year 5 (renewal only)	15695	15695

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.

The length of stay was calculated by dividing the annual summary of client days by the annual unduplicated caseload (factor c). The client day count was derived by multiplying the total beginning of the month client caseload by the number of days in the month.

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (3 of 9)

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:

Factor D estimates are based on the projected recipients, service utilization, and proposed rates for each service under the waiver. Some of the utilization and costs per service assumptions were based on similar services in other waivers serving the population of persons with similar disabilities. Services such as Personal Care Assistance, and Assistive Technology services similar to other waivers were considered in the assumption of utilization.

An estimated cost per service is derived by multiplying these estimates by actual service rates. This dollar amount is then totaled and divided by the number of unduplicated recipients for an average cost per recipient. A utilization inflation factor is thereby applied to each subsequent year based on program history and assumptions based on best professional judgment.

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 CHC waiver for renewal year 3. The historic cost data were trended forward using actual CPI trends for medical care. Factor D' was based on 372 reports that exclude dual eligible clients pharmacy expenditures; therefore, Factor D' did not require additional adjustment.

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

Factor G was based on actual data from the W-372 report for the third year of the CHC waiver. The historic cost data were trended forward using actual CPI trends for nursing homes and adult day services.

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

Factor G' includes the cost of all other Medicaid services furnished while the individual is institutionalized. The factor was based on the W-372 report for the third year of the CHC waiver. The historic cost data were trended forward using actual CPI trends for medical care services. The factor does not include the costs of prescribed drugs that will be furnished to Medicare/Medicaid dual eligibles under the provisions of Part D.

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (4 of 9)

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
Adult Day Health
Care Management
Homemaker
Personal Care Assistant (PCA)
Respite
Assisted Living
Assistive Technology
Chore services
Companion
Environmental Accesibility Adaptations
Home delivered Meals
Mental Health Counseling
Personal Emergency Response Systems
Transportation

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
Adult Day Health Total:						**14706286.54**
Full Day - Approved Medical Model Provider	per day	1896	107.00	66.22	**13434183.84**	
Full Day - Non-Medical Model Provider	per day	185	109.00	62.18	**1253859.70**	
Half Day	half day	9	50.00	40.54	**18243.00**	
Care Management Total:						**21443434.24**
assessment	per day	8829	1.00	281.73	**2487394.17**	
reassessment	per day	174	1.00	211.30	**36766.20**	
status review	per day	4549	1.00	93.19	**423921.31**	
ongoing case management	per day	13378	281.00	4.92	**18495352.56**	
Homemaker Total:						**52131139.20**
Homemaker - Agency	per 15 minute	10388	1230.00	4.08	**52131139.20**	
Personal Care Assistant (PCA) Total:						**8698661.91**
PCA - Individual (Qtr Hour)	per 15 minute	77	6337.00	3.47	**1693183.03**	
PCA - Individual (Overnight - 12 hour)	per diem	35	150.00	110.00	**577500.00**	
PCA - Individual (Per Diem - 24 hour)	per diem	52	175.00	150.00	**1365000.00**	
PCA - Agency (Qtr Hour)	per 15 minute	92	6337.00	4.72	**2751778.88**	
PCA - Agency (Overnight - 12 hour)	per diem	34	150.00	132.00	**673200.00**	
PCA - Agency (Per Diem - 24 hour)	per diem	52	175.00	180.00	**1638000.00**	
Respite Total:						**299942.70**
Respite - Less than 24 hours	per 15 minute	95	687.00	3.18	**207542.70**	
Respite per diem	per diem	44	15.00	140.00	**92400.00**	
Assisted Living Total:						**4268700.00**
Assisted Living	per month	279	12.00	1275.00	**4268700.00**	
Assistive Technology Total:						**697000.00**
Assistive Technology	per unit	697	1.00	1000.00	**697000.00**	
Chore services Total:						**210740.16**
Chore - Agency	per 15 minute	349	148.00	4.08	**210740.16**	
Companion Total:						

						33832986.66
Companion - Agency	per 15 minute	6486	1437.00	3.63	33832986.66	
Environmental Accesibility Adaptations Total:						96000.00
Environmental Accesibility Adaptations	per unit	32	1.00	3000.00	96000.00	
Home delivered Meals Total:						10208569.80
Meals - Single	per meal	496	195.00	4.79	463288.80	
Meals - Double	per meal	5705	195.00	8.76	9745281.00	
Meals - Double (Kosher)	per meal	0	0.00	8.76	0.00	
Mental Health Counseling Total:						654193.89
Mental Health Counseling - Office Visit	per visit	10	28.00	44.34	12415.20	
Mental Health Counseling - Home Visit	per visit	547	21.00	55.87	641778.69	
Personal Emergency Response Systems Total:						4292368.58
PERS - Initial Installation	per month	4023	9.00	35.00	1267245.00	
PERS - Ongoing Service (One-Way)	per month	328	8.00	29.17	76542.08	
PERS - Ongoing Service (Two-Way)	per month	5055	10.00	58.33	2948581.50	
Transportation Total:						51925.00
Non-medical transportation (Agency)	per trip	124	12.00	20.00	29760.00	
Non-medical transportation (Private)	per mile	155	325.00	0.44	22165.00	
			GRAND TOTAL:			151591948.68
			Total Estimated Unduplicated Participants:			13935
			Factor D (Divide total by number of participants):			10878.50
			Average Length of Stay on the Waiver:			318

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
Adult Day Health Total:						16012379.36
Full Day - Approved Medical Model Provider	per day	1959	110.00	67.88	14627461.20	
Full Day - Non-Medical Model Provider	per day	191	112.00	63.73	1363312.16	

Half Day	half day	10	52.00	41.55	21606.00	
Care Management Total:						23258154.92
assessment	per day	9124	1.00	288.77	2634737.48	
reassessment	per day	180	1.00	216.60	38988.00	
status review	per day	4700	1.00	95.52	448944.00	
ongoing case management	per day	13824	289.00	5.04	20135485.44	
Homemaker Total:						54898957.96
Homemaker - Agency	per 15 minute	10366	1267.00	4.18	54898957.96	
Personal Care Assistant (PCA) Total:						19116920.86
PCA - Individual (Qtr Hour)	per 15 minute	162	6527.00	3.56	3764251.44	
PCA - Individual (Overnight - 12 hour)	per diem	74	150.00	112.75	1251525.00	
PCA - Individual (Per Diem - 24 hour)	per diem	110	175.00	153.75	2959687.50	
PCA - Agency (Qtr Hour)	per 15 minute	194	6527.00	4.84	6128591.92	
PCA - Agency (Overnight - 12 hour)	per diem	72	150.00	135.30	1461240.00	
PCA - Agency (Per Diem - 24 hour)	per diem	110	175.00	184.50	3551625.00	
Respite Total:						332145.24
Respite - Less than 24 hours	per day	98	708.00	3.36	233130.24	
Respite per diem	per diem	46	15.00	143.50	99015.00	
Assisted Living Total:						4516646.40
Assisted Living	per month	288	12.00	1306.90	4516646.40	
Assistive Technology Total:						720000.00
Assistive Technology	per unit	720	1.00	1000.00	720000.00	
Chore services Total:						228729.60
Chore - Agency	per 15 minute	360	152.00	4.18	228729.60	
Companion Total:						34872470.40
Companion - Agency	per 15 minute	6334	1480.00	3.72	34872470.40	
Environmental Accesibility Adaptations Total:						99000.00
Environmental Accesibility Adaptations	per unit	33	1.00	3000.00	99000.00	
Home delivered Meals Total:						11146641.93
Meals - Single	per meal	513	201.00	4.91	506284.83	
Meals - Double	per meal	5895	201.00	8.98	10640357.10	
Meals - Double (Kosher)	per meal	0	0.00	8.98	0.00	
Mental Health Counseling Total:						726306.54

Mental Health Counseling - Office Visit	per home visit	10	29.00	45.45	13180.50	
Mental Health Counseling - Home Visit	per visit	566	22.00	57.27	713126.04	
Personal Emergency Response Systems Total:						4546896.84
PERS - Initial Installation	per month	4157	9.00	35.88	1342378.44	
PERS - Ongoing Service (One-Way)	per month	339	8.00	29.90	81088.80	
PERS - Ongoing Service (Two-Way)	per month	5224	10.00	59.79	3123429.60	
Transportation Total:						55608.00
Non-medical transportation (Agency)	per trip	128	12.00	20.50	31488.00	
Non-medical transportation (Private)	per mile	160	335.00	0.45	24120.00	
				GRAND TOTAL:		170530858.05
				Total Estimated Unduplicated Participants:		14400
				Factor D (Divide total by number of participants):		11842.42
				Average Length of Stay on the Waiver:		318

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (7 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 3

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Day Health Total:						17393016.54
Full Day - Approved Medical Model Provider	per day	2021	113.00	69.58	15890193.34	
Full Day - Non-Medical Model Provider	per day	197	115.00	65.32	1479824.60	
Half Day	half day	10	54.00	42.59	22998.60	
Care Management Total:						25264256.79
assessment	per	9409	1.00	295.99	2784969.91	
reassessment	per day	185	1.00	221.99	41068.15	
status review	per day	4847	1.00	97.91	474569.77	
ongoing case management	per day	14256	298.00	5.17	21963648.96	
Homemaker Total:						57563132.40
Homemaker - Agency	per 15 minute	10306	1305.00	4.28	57563132.40	
Personal Care Assistant (PCA) Total:						31129178.12

PCA - Individual (Qtr Hour)	per 15 minute	254	6723.00	3.65	6232893.30	
PCA - Individual (Overnight - 12 hour)	per diem	115	150.00	115.57	1993582.50	
PCA - Individual (Per Diem - 24 hour)	per diem	172	175.00	157.59	4743459.00	
PCA - Agency (Qtr Hour)	per 15 minute	304	6723.00	4.96	10137208.32	
PCA - Agency (Overnight - 12 hour)	per diem	112	150.00	138.68	2329824.00	
PCA - Agency (Per Diem - 24 hour)	per diem	172	175.00	189.11	5692211.00	
Respite Total:						351825.66
Respite - Less than 24 hours	per day	101	729.00	3.34	245920.86	
Respite per diem	per diem	48	15.00	147.09	105904.80	
Assisted Living Total:						4774156.20
Assisted Living	per month	297	12.00	1339.55	4774156.20	
Assistive Technology Total:						743000.00
Assistive Technology	per unit	743	1.00	1000.00	743000.00	
Chore services Total:						249969.12
Chore - Agency	per 15 minute	372	157.00	4.28	249969.12	
Companion Total:						35697993.12
Companion - Agency	per 15 minute	6148	1524.00	3.81	35697993.12	
Environmental Accesibility Adaptations Total:						102000.00
Environmental Accesibility Adaptations	per unit	34	1.00	3000.00	102000.00	
Home delivered Meals Total:						12127647.69
Meals - Single	per meal	529	207.00	5.03	550800.09	
Meals - Double	per meal	6079	207.00	9.20	11576847.60	
Meals - Double (Kosher)	per meal	0	0.00	9.20	0.00	
Mental Health Counseling Total:						802483.00
Mental Health Counseling - Office Visit	per home visit	11	30.00	46.59	15374.70	
Mental Health Counseling - Home Visit	per visit	583	23.00	58.70	787108.30	
Personal Emergency Response Systems Total:						4805811.14
PERS - Initial Installation	per month	4287	9.00	36.78	1419082.74	
PERS - Ongoing Service (One-Way)	per month	349	8.00	30.65	85574.80	
PERS - Ongoing Service (Two-Way)	per month	5387	10.00	61.28	3301153.60	
Transportation Total:						59465.34
Non-medical transportation (Agency)	per trip	132	12.00	21.01	33279.84	
Non-medical transportation (Private)	per mile	165	345.00	0.46	26185.50	

GRAND TOTAL:	191063935.12
Total Estimated Unduplicated Participants:	14850
Factor D (Divide total by number of participants):	12866.26
Average Length of Stay on the Waiver:	319

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (8 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 4 *(renewal only)*

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Day Health Total:						18827980.78
Full Day - Approved Medical Model Provider	per day	2079	116.00	71.32	17199816.48	
Full Day - Non-Medical Model Provider	per day	203	118.00	66.95	1603720.30	
Half Day	half day	10	56.00	43.65	24444.00	
Care Management Total:						27349307.34
assessment	per day	9682	1.00	303.39	2937421.98	
reassessment	per day	191	1.00	227.54	43460.14	
status review	per day	4987	1.00	100.36	500495.32	
ongoing case management	per day	14669	307.00	5.30	23867929.90	
Homemaker Total:						60234733.44
Homemaker - Agency	per 15 minute	10209	1344.00	4.39	60234733.44	
Personal Care Assistant (PCA) Total:						44674055.25
PCA - Individual (Qtr Hour)	per 15 minute	350	6925.00	3.74	9064825.00	
PCA - Individual (Overnight - 12 hour)	per diem	159	150.00	118.46	2825271.00	
PCA - Individual (Per Diem - 24 hour)	per diem	237	175.00	161.53	6699456.75	
PCA - Agency (Qtr Hour)	per 15 minute	419	6925.00	5.08	14740001.00	
PCA - Agency (Overnight - 12 hour)	per diem	155	150.00	142.15	3304987.50	
PCA - Agency (Per Diem - 24 hour)	per diem	237	175.00	193.84	8039514.00	
Respite Total:						377931.63
Respite - Less than 24 hours	per day	104	751.00	3.42	267115.68	
Respite per diem	per diem	49	15.00	150.77	110815.95	

Assisted Living Total:						**5041802.88**
Assisted Living	per month	306	12.00	1373.04	**5041802.88**	
Assistive Technology Total:						**764000.00**
Assistive Technology	per unit	764	1.00	1000.00	**764000.00**	
Chore services Total:						**271670.76**
Chore - Agency	per 15 minute	382	162.00	4.39	**271670.76**	
Companion Total:						**36402491.00**
Companion - Agency	per 15 minute	5930	1570.00	3.91	**36402491.00**	
Environmental Accesibility Adaptations Total:						**105000.00**
Environmental Accesibility Adaptations	per unit	35	1.00	3000.00	**105000.00**	
Home delivered Meals Total:						**13163638.56**
Meals - Single	per meal	544	213.00	5.16	**597899.52**	
Meals - Double	per meal	6256	213.00	9.43	**12565739.04**	
Meals - Double (Kosher)	per meal	0	0.00	9.43	**0.00**	
Mental Health Counseling Total:						**882730.75**
Mental Health Counseling - Office Visit	per home visit	11	31.00	47.75	**16282.75**	
Mental Health Counseling - Home Visit	per visit	600	24.00	60.17	**866448.00**	
Personal Emergency Response Systems Total:						**5068448.84**
PERS - Initial Installation	per month	4411	9.00	37.70	**1496652.30**	
PERS - Ongoing Service (One-Way)	per month	359	8.00	31.42	**90238.24**	
PERS - Ongoing Service (Two-Way)	per month	5543	10.00	62.81	**3481558.30**	
Transportation Total:						**63517.78**
Non-medical transportation (Agency)	per trip	136	12.00	21.54	**35153.28**	
Non-medical transportation (Private)	per mile	170	355.00	0.47	**28364.50**	
				GRAND TOTAL:		**213227309.01**
				Total Estimated Unduplicated Participants:		**15280**
				Factor D (Divide total by number of participants):		**13954.67**
				Average Length of Stay on the Waiver:		319

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (9 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 5 *(renewal only)*

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Day Health Total:						20350368.38
Full Day - Approved Medical Model Provider	per day	2135	119.00	73.10	18572151.50	
Full Day - Non-Medical Model Provider	per day	209	122.00	68.62	1749672.76	
Half Day	half day	11	58.00	44.74	28544.12	
Care Management Total:						29518165.73
assessment	per day	9944	1.00	310.97	3092285.68	
reassessment	per day	196	1.00	233.23	45713.08	
status review	per day	5123	1.00	102.87	527003.01	
ongoing case management	per day	15067	316.00	5.43	25853163.96	
Homemaker Total:						62778240.00
Homemaker - Agency	per 15 minute	10080	1384.00	4.50	62778240.00	
Personal Care Assistant (PCA) Total:						59877051.66
PCA - Individual (Qtr Hour)	per 15 minute	451	7133.00	3.83	12321044.89	
PCA - Individual (Overnight - 12 hour)	per diem	205	150.00	121.42	3733665.00	
PCA - Individual (Per Diem - 24 hour)	per diem	305	175.00	165.57	8837298.75	
PCA - Agency (Qtr Hour)	per 15 minute	539	7133.00	5.21	20030819.27	
PCA - Agency (Overnight - 12 hour)	per diem	199	150.00	145.70	4349145.00	
PCA - Agency (Per Diem - 24 hour)	per diem	305	175.00	198.69	10605078.75	
Respite Total:						406596.18
Respite - Less than 24 hours	per day	107	774.00	3.51	290691.18	
Respite per diem	per diem	50	15.00	154.54	115905.00	
Assisted Living Total:						5302970.16
Assisted Living	per month	314	12.00	1407.37	5302970.16	
Assistive Technology Total:						785000.00
Assistive Technology	per unit	785	1.00	1000.00	785000.00	
Chore services Total:						295339.50
Chore - Agency	per 15 minute	393	167.00	4.50	295339.50	
Companion Total:						36868990.62
Companion - Agency	per 15 minute	5686	1617.00	4.01	36868990.62	
Environmental Accesibility Adaptations Total:						108000.00
Environmental Accesibility Adaptations	per unit	36	1.00	3000.00	108000.00	

Home delivered Meals Total:						**14254022.34**
Meals - Single	per meal	559	219.00	5.29	**647607.09**	
Meals - Double	per meal	6425	219.00	9.67	**13606415.25**	
Meals - Double (Kosher)	per meal	0	0.00	9.67	**0.00**	
Mental Health Counseling Total:						**968486.63**
Mental Health Counseling - Office Visit	per home visit	11	32.00	48.94	**17226.88**	
Mental Health Counseling - Home Visit	per visit	617	25.00	61.67	**951259.75**	
Personal Emergency Response Systems Total:						**5335937.88**
PERS - Initial Installation	per month	4531	9.00	38.64	**1575700.56**	
PERS - Ongoing Service (One-Way)	per month	369	8.00	32.21	**95083.92**	
PERS - Ongoing Service (Two-Way)	per month	5693	10.00	64.38	**3665153.40**	
Transportation Total:						**67662.72**
Non-medical transportation (Agency)	per trip	140	12.00	22.08	**37094.40**	
Non-medical transportation (Private)	per mile	174	366.00	0.48	**30568.32**	

GRAND TOTAL:	**236916831.80**
Total Estimated Unduplicated Participants:	**15695**
Factor D (Divide total by number of participants):	**15095.05**
Average Length of Stay on the Waiver:	319