# 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 only change being proposed for this waiver is the elimination of Independent Support Broker since that service is available based on assessed need through the state's 1915(K) option. No participants will be negatively impacted by this change.

We also are concurrently submitting a 1915b(4) waiver request to permit selective contracting for the care management service in which providers are selected as the result of a competitive procurement.

# 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**

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

○ **3 years** ◉ **5 years**

**Original Base Waiver Number: CT.0140**
**Draft ID: CT.020.07.00**

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

Regular Waiver

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

07/01/20

## 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 Individuals with Intellectual Disabilities (ICF/IID) (as defined in 42 CFR §440.150)**

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

## 1. Request Information (3 of 3)

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

Select one:

○ **Not applicable**

◉ **Applicable**

Check the applicable authority or authorities:

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

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

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

The state is requesting a 1915b(4) concurrent with this submission for selective contracting for the provision of the care management service.

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

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

☐ **§1915(b)(2) (central broker)**

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

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

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

Specify the nature of the state plan benefit and indicate whether the state plan amendment has been submitted or previously approved:

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

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

☐ **A program authorized under §1115 of the Act.**

*Specify the program:*

**H. Dual Eligiblity for Medicaid and Medicare.**

Check if applicable:

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

## 2. Brief Waiver Description

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

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. The Department's Community Options 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 ongoing 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 loading authorized service plans into the MMIS contractor portal so that enrolled providers can bill directly but only for services authorized as part of the care plan. The department contracts with a fiscal intermediary to credential the waiver providers. Providers then enroll directly with the Department. Their reenrollment is required every 2 years. 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, Adult Family Living/Foster Care, Companion, Chore, Adult Day Health,Personal Emergency Response Systems, Personal Care (Agency based), Assistive Technology, Respite, Transportation, Home Delivered Meals, Mental Health Counseling, Personal Care Assistant, and Environmental Accessibility Adaptations. Personal Care Assistant will be available to clients either as a self directed model through the state's 1915(k) option or through an agency as a waiver service.

We are removing Independent Support Broker as a service under this waiver as the service is available as needed under the state's Community First Choice 1915(k) option. No waiver participants will be negatively impacted by this change.

## 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,

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,

participant. The service plan is subject to the approval of the Medicaid agency. Federal financial participation (FFP) is not claimed for waiver services furnished prior to the development of the service plan or for services that are not included in the service plan.

**B. Inpatients**. In accordance with 42 CFR §441.301(b)(1)(ii), waiver services are not furnished to individuals who are in-patients of a hospital, nursing facility or ICF/IID.

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

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

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

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

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

**H. Quality Improvement**. The state operates a formal, comprehensive system to ensure that the waiver meets the assurances and other requirements contained in this application. Through an ongoing process of discovery, remediation and improvement, the state assures the health and welfare of participants by monitoring: (a) level of care determinations; (b) individual plans and services delivery; (c) provider qualifications; (d) participant health and welfare; (e) financial oversight and (f) administrative oversight of the waiver. The state further assures that all problems identified through its discovery processes are addressed in an appropriate and timely manner, consistent with the severity and nature of the problem. During the period that the waiver is in effect, the state will implement the Quality Improvement Strategy specified in **Appendix H**.

**I. Public Input.** Describe how the state secures public input into the development of the waiver:

Notice was published in the CT Law Journal on December 31,2019.. In addition to the CT law Journal posting, the Department posted the renewal notice on its web site on January 02, 2020 under Partners and vendors and can be seen at the following link:

https://portal.ct.gov/DSS/Health-And-Home-Care/Medicaid-Waiver-Applications/Medicaid-Waiver-Applications

No comments were received from the postings.

The Ct tribes were notified via email on December 20,2019. They did not have any comments

**J. Notice to Tribal Governments**. The state assures that it has notified in writing all federally-recognized Tribal

Medicaid waiver request or renewal request to CMS at least 60 days before the anticipated submission date is provided by Presidential Executive Order 13175 of November 6, 2000. Evidence of the applicable notice is available through the Medicaid Agency.

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

## 7. Contact Person(s)

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

**Last Name:** Bruni

**First Name:** Kathy

**Title:** Director Home and Community Based Services Unit

**Agency:** Department of Social Services

**Address:** 55 Farmington Ave.

**Address 2:**

**City:** Hartford

**State:** **Connecticut**

**Zip:** 06105

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

**Fax:** (860) 424-4963

**E-mail:** kathy.a.bruni@ct.gov

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

**Last Name:**

**First Name:**

**Title:**

**Agency:**

**Address:**

**Address 2:**

**City:**

**State:** **Connecticut**

**Zip:**

**Phone:** **Ext:** ☐ **TTY**

**Fax:**

**E-mail:**

## 8. Authorizing Signature

This document, together with 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:**

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

**Last Name:** McEvoy

**First Name:** Kate

**Title:** Director, Division of Health Services

**Address:** 55 Farmington Ave

**Address 2:**

**City:** Hartford

**State:** **Connecticut**

**Zip:** 06105

**Phone:** (860) 424-5383 **Ext:** ☐ **TTY**

**Fax:** (860) 424-4963

**E-mail:** kate.mcevoy@ct.gov

## Attachments

**Attachment #1: Transition Plan**

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

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

Specify the transition plan for the waiver:

Independent support Broker is available under the state's 1915(k) in the scope, frequency and duration necessary to address the individual's need for support in self direction

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

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

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

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

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

The state assures that this waiver amendment or renewal will be subject to any provisions or requirements included in the state's approved home and community-based settings Statewide Transition Plan. The state will implement any required changes by the end of the transition period as outlined in the home and community-based settings Statewide Transition Plan."

## Additional Needed Information (Optional)

Provide additional needed information for the waiver (optional):

# 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 | | |
| Statutory Service | Respite | | |
| Other Service | Adult Family Living | | |
| Other Service | Assisted Living | | |
| Other Service | Assistive Technology | | |
| Other Service | Bill Payer | | |
| Other Service | Care Transitions | | |
| Other Service | Chore Services | | |
| Other Service | Chronic Disease Self-Management Program | | |
| 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 | Recovery Assistant | | |
| 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):**

**HCBS Taxonomy:**

**Category 1:**

17 Other Services

**Sub-Category 1:**

17990 other

**Category 3:** **Sub-Category 3:**

**Category 4:** **Sub-Category 4:**

*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 and in the rate structure. Meals provided as part of these services shall not constitute a full nutritional regimen. Claims will denied by any Adult Day Health provider attempting to bill for transportation procedure codes. These procedure codes are not included on the Adult Day Health fee schedule and will deny as edits are built into the claim processing system to prevent duplicative transportation services for Adult Day Health from occurring.
Services Covered and Limitations
Payment for adult day services under the rate for a medical model is limited to providers that 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 adjacent to a long term care facility licensed by the Department of Public Health, with ready access to a registered nurse from such 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**

**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:**

The Department's fiscal intermediary 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

**HCBS Taxonomy:**

| Category 1: | Sub-Category 1: |
|---|---|
| 01 Case Management | 01010 case management |
| **Category 2:** | **Sub-Category 2:** |
| | |
| **Category 3:** | **Sub-Category 3:** |
| | |
| **Category 4:** | **Sub-Category 4:** |
| | |

*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 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 for monitoring the ongoing provision of services in the participant's 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 individual's 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 under the Medicaid state plan options to participants.
The Departments allows for a status review vist by the case manager when a waiver participant is in a hospital or nursing facility setting when the purpose of that visit is to reevaluate the total plan of care needs upon discharge back to the community based setting. This transitional care management service is provided one time in the first 45 days of a nursing home stay and/or one time only during a hospital stay. The reimbursement is based on a percentage of the rate for an initial assessment.
DSS implemented a tiered case management system. Tiered case management is based on client's level of need and the number and type of case management interventions required. TIER A clients, with the fewest needs, receive a quarterly contact and an annual reassessment. Leveling Criteria for TIER A is 3 or less care management interventions in a 6 month period. If 2 of those interventions are crisis interventions, client is automatically elevated to level 2. TIER B clients receive monthly monitoring, a six month field visit and an annual reassessment. Leveling criteria is 4-6 care management interventions in a 6 month period. TIER C clients, the highest level, receive monthly monitoring, quarterly field visits, six month visit, and an annual reassessment. Leveling criteria is 7 or more care management interventions in a 6 month period. There are four categories of case management intervention: Crisis Intervention, Service Brokerage and Advocacy, Risk Management and Client Engagement/Re-engagement. Crisis Intervention Efforts have two principle aims 1) Cushion the stressful event by immediate or emergency emotional or environmental first aid and 2) Strengthen the person in his or her coping through immediate therapeutic clarification and guidance during the crisis period. Examples of incidents that precipitate crisis interventions: suicide assessment, incidents of abuse, victimization, neglect, exploitation, imminent threat of homelessness. Service Brokerage and Advocacy requires that the Care Manager facilitate continual interaction between various segments of the service delivery system. When service breakdowns or requests for service changes occur, the Care Manager assists clients to ensure their rights to receive services based upon the person-centered model of care are upheld. Service brokerage and advocacy interventions include activities around finding and keeping providers for clients with difficult service needs, pre and post transitioning from an inpatient setting to the community, hospice and end of life care. Risk Management includes the identification of potential and perceived risks to the individual falling into four general categories; health, behavior, personal safety risks, and in-community risks. Managing these risks includes identification and documenting risks, developing written plans for addressing them, negotiating with clients the risks presented keeping client choice central to the process, and monitoring outcomes related to the risk. Client engagement refers to the process through which clients become active or involved in their care plans and participation in the program. The engagement process has several conceptualizations where interventions are designed to enhance client 1) receptivity, 2) expectancy 3) investment, 4) working relationship. Care management interventions are weighted according to complexity, severity and number of tasks required. Crisis intervention is weighted highest followed by Service Brokerage and Advocacy, Risk Management and Client Engagement/Re-engagement. Clients may move to a different tier based on their current needs with prior authorization from DSS. Care management per diem rates will be adjusted according to which tier the client is in.

**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. Care management per diem may not be billed when a client is in an institutional setting.
Prior authorization is required for a status review vist after the first 45 days of a nursing home stay.

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

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

☒ **Provider managed**

☐ **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 bachelors 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 empathetic 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):**

**HCBS Taxonomy:**

| Category 1: | Sub-Category 1: |
|---|---|
| 08 Home-Based Services | 08050 homemaker |
| **Category 2:** | **Sub-Category 2:** |
| | |
| **Category 3:** | **Sub-Category 3:** |
| | |
| **Category 4:** | **Sub-Category 4:** |
| | |

*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)*:

☒ **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 fiscal intermediary 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

the Medicaid agency or the operating agency (if applicable).

**Service Type:**

Statutory Service

**Service:**

Personal Care

**Alternate Service Title (if any):**

Personal Care Assistant

**HCBS Taxonomy:**

| **Category 1:** | **Sub-Category 1:** |
|---|---|
| 08 Home-Based Services | 08030 personal care |
| **Category 2:** | **Sub-Category 2:** |
| | |
| **Category 3:** | **Sub-Category 3:** |
| | |
| **Category 4:** | **Sub-Category 4:** |
| | |

*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):*

Assisting an elder with tasks that the individual would typically do for him/herself in the absence of a disability. Such tasks may be performed at home or in the community. The participant has co-employer authority and is responsible to direct the activities of the PCA. 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). ADLs include bathing, dressing, toileting, transferring, and feeding. IADLs include meal preparation, shopping, housekeeping, laundry and cueing/reminders for self medication administration. Transportation costs associated with the provision of personal care outside of the participant's home is billed separately and is not included in the scope of personal care.

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

Personal Care may not be provided to participants receiving Assisted Living Services as all of the functions of personal care are provided by the Assisted Living Service provider. The benefit plan for Assisted Living service recipients excludes personal care so that there could be no duplicative billing.

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

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

☐ **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: Personal Care Assistant**

**Provider Category:**

Agency

**Provider Type:**

Provider Agency

**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 Connecticut General Statutes.

**Certificate** *(specify):*

If the provider is a Homemaker/Companion Agency, it must be registered with the Department of Consumer Protection.

**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.
All agency PCAs must complete department sponsored curriculum and pass the exam upon completion of the curriculum. Agencies are required to maintain evidence of the passing test score in the individual's personnel record.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

Agency and fiscal intermediary

**Frequency of Verification:**

At the time of enrollment and every two years 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:**

Statutory Service

**Service:**

Respite

**Alternate Service Title (if any):**

**HCBS Taxonomy:**

| Category 1: | Sub-Category 1: |
|---|---|
| 17 Other Services | 17990 other |
| **Category 2:** | **Sub-Category 2:** |
| | |
| **Category 3:** | **Sub-Category 3:** |
| | |
| **Category 4:** | **Sub-Category 4:** |
| | |

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

**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 agencies of waiver services such as Homemaker/Companion Agencies or Home Health Agencies |
| Agency | Chronic and Convalescent Nursing Homes/Rest Homes with Nursing Supervision |

## 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 agencies of waiver services such as Homemaker/Companion Agencies or Home Health Agencies

**Provider Qualifications**

**License** *(specify)*:

Licensing is not applicable to Homemakers and Companions, however all requirements of a Homemaker/Companion Agency are applicable when providing respite services.
Home Health Agencies must be licensed by the CT Department of Public Health.

**Certificate** *(specify)*:

N/A

**Other Standard** *(specify)*:

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

Fiscal Intermediary for in home respite and CT Department of Public Health for facilities and Home Health Care Agencies.

**Frequency of Verification:**

Every 2 years

# Appendix C: Participant Services

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

**Service Type: Statutory Service**
**Service Name: Respite**

**Provider Category:**

Agency

**Provider Type:**

Chronic and Convalescent Nursing Homes/Rest Homes with Nursing Supervision

**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.

**Certificate** *(specify):*

**Other Standard** *(specify):*

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

CT Department of Public Health

**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:**

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:**

Adult Family Living

**HCBS Taxonomy:**

**Category 1:** 17 Other Services

**Sub-Category 1:** 17990 other

**Category 2:**

**Sub-Category 2:**

**Category 3:**

**Sub-Category 3:**

**Category 4:**

**Sub-Category 4:**

*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 supportive services (homemaker, chore, attendant services, meal preparation) that are furnished to waiver participants who reside in a private home by a principal caregiver who lives in the home. Adult Family Living is furnished to older adults who receive these services in conjunction with residing in the home. Service includes 24 hour response capability to meet scheduled or unpredictable resident needs to provide supervision, safety and security based on ADL, IADL, cognitive or behavioral needs. Service allocation is based on ADL, IADL, cognitive or behavioral needs. Services also include social and recreational activities and cueing or reminders to take medications. Separate payment will not be made for homemaker or chore services furnished to an individual receiving adult foster care services, since these are integral to and inherent in the provision of Adult Family Living services. Edits in the MMIS system do not allow these services to be billed when Adult Family Living is in place as a service. Four classifications of Adult Family Living service will be available under this Waiver:
Level 1: service provided to individuals who because of their impairments, require supervision on a daily basis and require cueing or supervision to perform ADLs and may also have cognitive or behavioral challenges
Level 2: services provided to individuals who require hands on assistance to perform 2 ADLs on a daily basis.
Level 3: services provided to individuals who require hands on assistance to perform 3 or more ADLs or 2 ADLs and co-occurring assistance for the management of challenging behaviors or cognitive deficits.
Level 4: services provided to individuals who require hands on assistance to perform 4 or more ADLs or 3 ADLs and co-occurring assistance for the management of challenging behaviors or cognitive deficits.
The agency that provides the Adult Family Living service will supervise the supports delivered by the direct care provider. This service may be provided in the home of either the care provider or the participant, whichever is preferable to the participant. The direct provider may be a relative of the client as long as they are not a legally liable relative. Adult Family Living is limited to no more than 3 participants in a home. The Adult Family Living provider may not administer medication but may supervise the participant's self-administration of medication. Payments made for Adult Family Living are not made for room and board, items of comfort or convenience, or the costs of home maintenance, upkeep and improvement. The methodology by which the costs of room and board are excluded from payments for Adult Family Living are described in Appendix I.

**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: Other Service**
**Service Name: Adult Family Living**

**Provider Category:**

Agency

**Provider Type:**

Provider Agency

**Provider Qualifications**

**License** *(specify)*:

N/A

**Certificate** *(specify)*:

N/A

**Other Standard** *(specify)*:

In order to be an Adult Family Living provider setting, the provider agency must certify that the home is regularly maintained and that the interior floors, walls, ceiling and furnishings must be clean and in good repair including the kitchen area, bathroom and participant's bedroom, ventilation, heating, lighting and stairs. The home should conform to all applicable building codes, health and safety codes and ordinances and meet the participant's need for privacy. The home should also be equipped with a fire extinguisher and an emergency first aid kit. It is the responsibility of the provider agency to ensure that the home meets all of these specifications. In addition, the agency is responsible to verify that the provider is at least 18 year of age, be in good health and able to follow written and verbal instruction, report changes in a participant's condition, maintain confidentiality and complete record keeping requirements specified by the provider agency. The provider agency will provide nursing oversight / supervision of the provision of care by the Adult Family Living/Foster Care provider on a minimum of a bi-monthly basis. Their role will include orientation, competency evaluations in the provision of daily care and ongoing continuing education for the direct caregiver. The agency provider as well as the care manager are responsible to assure the health and safety needs of the participant are met. The direct caregiver will provide nutritionally balanced meals and healthy snacks each day to the waiver participant, as dictated by their medical/nutritional needs. The reimbursement rate does not include room and board. The payment for room and board costs are negotiated between the direct service provider and the waiver participant. The provider agency in order to be credentialed to provide Adult Family Living/Foster Care must provide evidence of an ability to certify that the individual homes meet all of the requirements included in this description and can demonstrate an ability to monitor the delivery and quality of service provided to the waiver participant. The agency may also provide relief to the direct service provider or the care manager can provide relief through the provision of other waiver services. The provider agency bills the MMIS directly and is then responsible to pay the direct caregiver.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

Fiscal Intermediary

**Frequency of Verification:**

Upon enrollment 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:**

Assisted Living

**HCBS Taxonomy:**

| Category 1: | Sub-Category 1: |
| --- | --- |
| 17 Other Services | 17090 other |

**Category 2:** **Sub-Category 2:**

**Category 3:** **Sub-Category 3:**

**Category 4:** **Sub-Category 4:**

*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 rented by 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. Mental health counseling and the Personal Emergency Response System are services available to assisted living clients. Nursing and skilled therapy services are incidental rather than integral to the provision of assisted living services. Payment is not made for 24 hour skilled care. Federal financial participation is not available for room and board, items of comfort or convenience, or the costs of facility maintenance, upkeep and improvement. The methodology by which the costs of room and board are excluded from payments for assisted living services is described in Appendix I-5.

Personalized care is furnished to individuals who reside in their own living units (which may include dually occupied units when both occupants consent to the arrangement) which includes kitchenette and living rooms and which contain bedrooms and toilet facilities. The consumer has a right to privacy. Living units may be locked at the discretion of the consumer, except when a physician or mental health professional has certified in writing that the consumer is sufficiently cognitively impaired as to be a danger to self or others if given the opportunity to lock the door. Each living unit is separate and distinct from each other. The communities have a central dining room, living room or parlor, and common activity center(s)(which may also serve as living rooms or dining rooms). The consumer retains the right to assume risk, tempered only by the individual's ability to assume responsibility for that risk. Care must be furnished in a way which fosters the independence of each consumer. Routines of care provision and service delivery must be consumer-driven to the maximum extent possible, and treat each person with dignity and respect.
Care plans will be developed based on the individual's service needs. There are four levels of service provided in assisted living facilities based on the consumer's combined needs for personal care and nursing services. The four levels are occasional which is 1-3.75 hours per week of service, limited which is 4-8.75 hours per week of service, moderate which is 9-14.75 hours per week of service and extensive which is 15-25 hours per week of service. Level of service assigned depends upon the volume and extent of services needed by each individual and is not a limitation of service.

Assisted Living services are provided 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.

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

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

**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 | 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

**HCBS Taxonomy:**

| **Category 1:** | **Sub-Category 1:** |
|---|---|
| 14 Equipment, Technology, and Modifications | 14031 equipment and technology |
| **Category 2:** | **Sub-Category 2:** |
| | |
| **Category 3:** | **Sub-Category 3:** |
| | |
| **Category 4:** | **Sub-Category 4:** |
| | |

*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 Activities of Daily Living (ADLs) or Instrumental Activities of Daily Living (IADLs). 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. Costs will be capped at no more than $15,000 over a three year period.

**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 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 Connecticut 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:**

Fiscal Intermediary

**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:**

Fiscal Intermediary

**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:**

Bill Payer

**HCBS Taxonomy:**

| Category 1: | Sub-Category 1: |
|---|---|
| 17 Other Services | 17990 other |
| **Category 2:** | **Sub-Category 2:** |
| | |
| **Category 3:** | **Sub-Category 3:** |
| | |
| **Category 4:** | **Sub-Category 4:** |

*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):*

A bill payer is a trained agency staff member who is paired with a client that is having difficulty managing their routine monthly finances. Staff member assists with writing checks that client signs, budgeting, paying bills on time, balancing checkbook, Social Security and Medicare questions and problems. The person can assist with applications for financial assistance programs, medical insurance claims and other financial matters including applications for senior housing and medical insurance. Electronic bill payment is permitted as part of this service.

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

Service is limited to 3 hours per month.

**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 |

## Appendix C: Participant Services

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

**Service Type: Other Service**
**Service Name: Bill Payer**

**Provider Category:**

Agency

**Provider Type:**

Agency

**Provider Qualifications**

**License** *(specify)*:

**Certificate** *(specify)*:

If the agency provider is a Homemaker/Companion Agency, they must be registered with the Department of Consumer Protection.

Agency providing bill payer service is bonded and insured against fraudulent behavior. Bill payer's activities are overseen by the agency administrator or their designee. Cases are regularly reviewed and coaching is provided to the bill payer as needed. Online banking and bill paying is an option as part of this service

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

Fiscal Intermediary

**Frequency of Verification:**

At the time of enrollment and every two years 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:**

Care Transitions

**HCBS Taxonomy:**

| Category 1: | Sub-Category 1: |
|---|---|
| 13 Participant Training | 13010 participant training |
| **Category 2:** | **Sub-Category 2:** |
| | |
| **Category 3:** | **Sub-Category 3:** |
| | |
| **Category 4:** | **Sub-Category 4:** |
| | |

*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 Definition** *(Scope)*:

An evidence-based set of actions designed to ensure health care coordination, continuity and avoidance of preventable poor outcomes in vulnerable participants as they move between institutional and home and community based settings. Core activities include: building a trusting relationship, facilitating coaching and teaching, helping participants identify "red flags" to prevent readmissions, understand contributing factors for current admission, scheduling timely follow up with primary care provider, partnering with hospital care coordinators to enhance continuity of care. Service includes either a home visit or telephone follow up no more than 72 hours after discharge.

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

Available only to those who have been enrolled in the waiver as an active participant which means they are receiving waiver services. Not available to waiver applicants. Limited to no more than one unit in 60 days. Cannot be billed concurrently with a status review.

**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 | Access Agency |

## Appendix C: Participant Services

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

**Service Type: Other Service**
**Service Name: Care Transitions**

**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 bachelors degree in nursing, health, social work, gerontology or a related field may be substituted for one year of experience. A licensed social worker is preferred for this service but not required.

**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)*:

**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:**

At the time of hire and annually at the time of 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:**

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

**HCBS Taxonomy:**

| Category 1: | Sub-Category 1: |
|---|---|
| 08 Home-Based Services | 08060 chore |
| **Category 2:** | **Sub-Category 2:** |
| | |
| **Category 3:** | **Sub-Category 3:** |
| | |
| **Category 4:** | **Sub-Category 4:** |
| | |

*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**

☒ **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 | Licensed Contractor |
| Agency | Provider Agency |

## 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:**

Fiscal intermediary

**Frequency of Verification:**

At the time of service

## 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:**

Fiscal intermediary

**Frequency of Verification:**

At the time of enrollment 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:**

Chronic Disease Self-Management Program

**HCBS Taxonomy:**

| Category 1: | Sub-Category 1: |
|---|---|
| 13 Participant Training | 13010 participant training |
| **Category 2:** | **Sub-Category 2:** |
| | |
| **Category 3:** | **Sub-Category 3:** |
| | |
| **Category 4:** | **Sub-Category 4:** |
| | |

*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 Chronic Disease Self-Management Program (Live-Well) is a workshop given two and a half hours, once a week, for six weeks, in community settings such as senior centers, churches, libraries and hospitals. People with different chronic health problems attend together. Workshops are facilitated by two trained leaders, one or both of whom are non-health professionals with chronic diseases themselves.
Subjects covered include:
1) techniques to deal with problems such as frustration, fatigue, pain and isolation, 2) appropriate exercise for maintaining and improving strength, flexibility, and endurance, 3) appropriate use of medications, 4) communicating effectively with family, friends, and health professionals, 5) nutrition, 6) decision making, and 7) how to evaluate new treatments.
The program is helpful for people with chronic conditions, as it gives them the skills to coordinate all the things needed to manage their health, as well as to help them keep active in their lives. The therapeutic goals of the service are adjustment to serious impairments, maintenance or restoration of physical functioning, self management of chronic disease, acquisition of skills to address minor depression, management of personal care and development of skills to work with care providers including behavior management. The program is also available in Spanish and is called Tomando Control de su Salud.

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

The program provides up to six sessions of two hours each. The participant is strongly encouraged to attend all six sessions. The service is limited to one six session service per calendar year.

**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 | Individual Chronic Disease Self Management Trainer |
| Agency | Agency |

## Appendix C: Participant Services

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

**Service Type: Other Service**
**Service Name: Chronic Disease Self-Management Program**

**Provider Category:**
Individual
**Provider Type:**

Individual Chronic Disease Self Management Trainer

**Provider Qualifications**

**License** *(specify)*:

**Certificate** *(specify)*:

Certification in an evidence-based chronic disease self management training program such as the Stanford University Chronic Disease Self Management Program (CDSMP).

**Other Standard** *(specify):*

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

Fiscal Intermediary

**Frequency of Verification:**

Upon initial contracting and every two years thereafter

## Appendix C: Participant Services

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

**Service Type: Other Service**

**Service Name: Chronic Disease Self-Management Program**

**Provider Category:**

Agency

**Provider Type:**

Agency

**Provider Qualifications**

**License** *(specify):*

**Certificate** *(specify):*

**Other Standard** *(specify):*

Individual Employee Qualification: Certification in an evidence- based chronic disease self-management training program such as the Stanford University Chronic Disease Self Management Program.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

Provider agency and fiscal intermediary

**Frequency of Verification:**

Upon initial contracting and every two years thereafter

# C-1/C-3: Service Specification

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

**Service Type:**

Other Service

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

**Service Title:**

Companion

**HCBS Taxonomy:**

| Category 1: | Sub-Category 1: |
|---|---|
| 08 Home-Based Services | 08040 companion |
| **Category 2:** | **Sub-Category 2:** |
| | |
| **Category 3:** | **Sub-Category 3:** |
| | |
| **Category 4:** | **Sub-Category 4:** |
| | |

*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**

☒ **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**

**Certificate** *(specify):*

**Other Standard** *(specify):*

In order to provide companion services and receive reimbursement from the Connecticut Home Care program, 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. 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:**

Fiscal intermediary

**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

**HCBS Taxonomy:**

| Category 1: | Sub-Category 1: |
|---|---|
| 14 Equipment, Technology, and Modifications | 14020 home and/or vehicle accessibility adaptations |
| **Category 2:** | **Sub-Category 2:** |
| | |
| **Category 3:** | **Sub-Category 3:** |
| | |
| **Category 4:** | **Sub-Category 4:** |
| | |

*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 independence in the 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 individual 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 |
|---|---|

# 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):*

1. The vendor or contractor shall provide all services, materials, and labor that are necessary to complete the project/minor home modification(s) as indicated.
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 workers' 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 (ANSI) 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:**

Fiscal intermediary

**Frequency of Verification:**

prior to the provision of service

# Appendix C: Participant Services

## C-1/C-3: Service Specification

the Medicaid agency or the operating agency (if applicable).

**Service Type:**

Other Service

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

**Service Title:**

Home Delivered Meals

**HCBS Taxonomy:**

| **Category 1:** | **Sub-Category 1:** |
|---|---|
| 06 Home Delivered Meals | 06010 home delivered meals |
| **Category 2:** | **Sub-Category 2:** |
| | |
| **Category 3:** | **Sub-Category 3:** |
| | |
| **Category 4:** | **Sub-Category 4:** |
| | |

*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. Meals on Wheels providers include delicatessens, Family Services Agencies, Community Action Agencies, Catholic Charities, Town Social Services, visiting nurse agencies, assisted living agencies, senior centers, and soup kitchens. Meals must meet a minimum of one-third for single meals and two-thirds for double meals of the daily recommended allowance and requirements as established by the Food and Nutrition Academy of Sciences National Reasearch Council. Special diet meals are available such as diabetic, cardiac,low sodium and renal as are ethnic meals such as Hispanic and Kosher meals. Liquid supplements, such as Ensure, are generally unavailable as the home delivered meals. There is one Community Action Agency in Northwest CT that provides liquid supplement meal replacement.

**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. Liquid supplements are covered by the CT Medicaid program with prior authorization for clients who are tube fed.

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

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

☐ **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 waiver 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 Americans Act.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

Fiscal intermediary

**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

**HCBS Taxonomy:**

| **Category 1:** | **Sub-Category 1:** |
|---|---|
| 10 Other Mental Health and Behavioral Services | 10060 counseling |
| **Category 2:** | **Sub-Category 2:** |
| | |
| **Category 3:** | **Sub-Category 3:** |
| | |
| **Category 4:** | **Sub-Category 4:** |
| | |

*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**
☒ **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 | Community Agency |
| 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:**

Community Agency

**Provider Qualifications**
**License** *(specify)*:

The community agency may provide this service utilizing licensed providers.For purposes of receiving reimbursement under the Connecticut Home Care Program, the agency must utilize a mental health counseling provider who is a licensed clinical social worker as defined in Connecticut General Statutes 20-195m or a Licensed Professional Counselor as defined in section 20-195aa of the Connecticut General Statutes, and shall have experience and training in providing mental health services to persons with disabilities.

**Certificate** *(specify):*

**Other Standard** *(specify):*

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

Fiscal Intermediary

**Frequency of Verification:**

At time of enrollment and every two years thereafter

## 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 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**

Fiscal intermediary

**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

**HCBS Taxonomy:**

| **Category 1:** | **Sub-Category 1:** |
|---|---|
| 14 Equipment, Technology, and Modifications | 14010 personal emergency response system (PERS) |
| **Category 2:** | **Sub-Category 2:** |
| | |
| **Category 3:** | **Sub-Category 3:** |
| | |
| **Category 4:** | **Sub-Category 4:** |
| | |

*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 24/7. PERS services are limited to those individuals who live alone, or who are alone for significant parts of the day, and have no regular caregiver for extended periods of time, and who would otherwise require extensive routine supervision. Installation, upkeep and maintenance of the device is provided.

**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

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

**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:**

Recovery Assistant

**HCBS Taxonomy:**

| Category 1: | Sub-Category 1: |
|---|---|
| 08 Home-Based Services | 08030 personal care |
| **Category 2:** | **Sub-Category 2:** |
| | |
| **Category 3:** | **Sub-Category 3:** |
| | |
| **Category 4:** | **Sub-Category 4:** |
| | |

*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):*

A flexible range of supportive assistance provided face-to-face in accordance with a Waiver, the service that enables a participant to maintain a home/apartment, encourages the use of existing natural supports, and fosters involvement in social and community activities. Service activities include: performing household tasks, providing instructive assistance, or cuing to prompt the participant to carry out tasks (e.g., meal preparation; routine household chores, cleaning, laundry, shopping, and bill-paying; and participation in social and recreational activities), and providing supportive companionship. The Recovery Assistant may also provide instruction or cuing to prompt the participant to dress appropriately and perform basic hygiene functions; supportive assistance and supervision of the participant; and short-term relief in the home for a participant who is unable to care for himself/herself when the primary caregiver is absent or in need of relief. The Recovery Assistant service is provided to persons with a mental health or substance abuse diagnosis.

**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: Other Service**
**Service Name: Recovery Assistant**

**Provider Category:**

Agency

**Provider Type:**

Provider Agency

**Provider Qualifications**

**License** *(specify)*:

**Certificate** *(specify)*:

Recovery Assistant must have certification from the Dept. of Mental Health and Addiction Services in order to be a provider of this service.

**Other Standard** *(specify)*:

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

Fiscal intermediary and provider agency

**Frequency of Verification:**

At the time of employment and every two years 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

**HCBS Taxonomy:**

| Category 1: | Sub-Category 1: |
|---|---|
| 15 Non-Medical Transportation | 15010 non-medical transportation |
| **Category 2:** | **Sub-Category 2:** |
| | |
| **Category 3:** | **Sub-Category 3:** |
| | |
| **Category 4:** | **Sub-Category 4:** |
| | |

*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 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:**

Adult Day Health providers cannot bill the transportation procedure code. Transportation is a separate and distinct procedure code and that service is not contracted to be provided by Adult Day Care providers thus preventing duplicate billing.

**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 | 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:**

Fiscal intermediary

**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:**

Fiscal intermediary

**Frequency of Verification:**

At the time of enrollment and biannually thereafter

## 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.*
- ☐ **As a primary care case management system service under a concurrent managed care authority.** *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):

Homemaker/Companion agencies that provide Homemaker, Companion and chore Services must register with the CT Department of Consumer Protection in order to be credentialed to provide services under the waiver as required in Chapter 400 Sections 20-670-680.
Sec. 20-678 specifies that prospective employees of Homemaker/Companion agencies are required to submit to comprehensive background check. Written statements re prior criminal convictions or disciplinary action.
Maintenance and inspection of records. On or after January 1, 2012, each homemaker-companion agency, prior to extending an offer of employment or entering into a contract with a prospective employee, shall require such prospective employee to submit to a comprehensive background check. In addition, each homemaker-companion agency shall require that such prospective employee complete and sign a form which contains questions as to whether the prospective employee was convicted of a crime involving violence or dishonesty in a state court or federal court in any state; or was subject to any decision imposing disciplinary action by a licensing agency in any state, the District of Columbia, a United States possession or territory or a foreign jurisdiction. Any prospective employee who makes a false written statement regarding such prior criminal convictions or disciplinary action shall be guilty of a class A misdemeanor. Each homemaker-companion agency shall maintain a paper or electronic copy of any materials obtained during the comprehensive background check and shall make such records available for inspection upon request of the Department of Consumer Protection.
Sec. 20-675. Disciplinary actions against homemaker-companion agency. Grounds. Notice and hearing. (a) The Commissioner of Consumer Protection may revoke, suspend or refuse to issue or renew any certificate of registration as a homemaker-companion agency or place an agency on probation or issue a letter of reprimand for: (1) Conduct by the agency, or by an employee of the agency while in the course of employment, of a character likely to mislead, deceive or defraud the public or the commissioner; (2) engaging in any untruthful or misleading advertising; (3) failure of such agency that acts as a registry to comply with the notice requirements of section 20-679a; or (4) failing to perform a comprehensive background check of a prospective employee or maintain a copy of materials obtained during a comprehensive background check, as required by section 20-678.
The contracted fiscal intermediary also conducts on site audits annually of 10% of the enrolled providers. Their review includes a review as to whether the background checks have been completed as required.

**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.*

☐ **Self-directed**

☐ **Agency-operated**

**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 care manager monitors the appropriateness and effectiveness of the services provided as part of their required monthly monitoring contract. 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. 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.).

○ **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 fiscal intermediary is responsible to recruit, train, and assist with the enrollment process of qualified providers. The MMIS contractor also facilitates the enrollment process for providers using a web based enrollment program. The fiscal intermediary is 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 fiscal intermediary who will initiate the enrollment process. Additionally, the state's MMIS contractor maintains a web site that provides extensive information to prospective providers. The website is ctdssmap.com. The application and instructions can be downloaded from the website. The provider is given a specific list of accompanying required documentation with their provider enrollment application.
Provider relations and enrollment specialists within the MMIS contractor attempt to make the process as efficient as possible and provide providers with assistance during the enrollment process. The usual timeframe for enrollment is approximately 60 days but may be extended if the provider requests additional time to collect the required information.

# Appendix C: Participant Services

## Quality Improvement: Qualified Providers

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

**a. Methods for Discovery: Qualified Providers**

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

**i. Sub-Assurances:**

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

**Performance Measures**

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

*For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the*

*method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.*

**Performance Measure:**
**Number and percent of enrolled Adult Day Centers that are certified through peer review by the CT Adult Day Care Association. Numerator=number of enrolled Adult Day Centers certified Denominator= number of Adult Day Centers enrolled**

**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**<br>Confidence Interval = |
| ☒ **Other**<br>Specify:<br>CT Adult Day Care Association | ☐ **Annually** | ☐ **Stratified**<br>Describe Group: |
| | ☐ **Continuously and Ongoing** | ☐ **Other**<br>Specify: |
| | ☐ **Other**<br>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**<br>Specify:<br>CT Adult Day Care Association | ☐ **Annually** |
| | ☐ **Continuously and Ongoing** |
| | ☐ **Other**<br>Specify: |

**Performance Measure:**
**Number and percent of new waiver providers meeting licensure/certification standards prior to furnishing waiver services. Numerator=new waiver providers meeting licensure/certification standards prior to furnishing waiver services. Denominator= total number of new waiver providers requiring licensure/certification.**

**Data Source** (Select one):
**Reports to State Medicaid Agency on delegated Administrative functions**
If 'Other' is selected, specify:

| **Responsible Party for data collection/generation** *(check each that applies):* | **Frequency of data collection/generation** *(check each that applies):* | **Sampling Approach** *(check each that applies):* |
|---|---|---|
| ☐ **State Medicaid Agency** | ☐ **Weekly** | ☒ **100% Review** |
| ☐ **Operating Agency** | ☐ **Monthly** | ☐ **Less than 100% Review** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** | ☐ **Representative Sample**<br>Confidence Interval = |
| ☒ **Other**<br>Specify: | ☐ **Annually** | ☐ **Stratified**<br>Describe Group: |

| | | |
|---|---|---|
| fiscal intermediary | | |
| | ☒ **Continuously and Ongoing** | ☐ **Other** Specify: |
| | ☐ **Other** Specify: | |

**Data Aggregation and Analysis:**

| **Responsible Party for data aggregation and analysis** *(check each that applies):* | **Frequency of data aggregation and analysis***(check each that applies):* |
|---|---|
| ☒ **State Medicaid Agency** | ☐ **Weekly** |
| ☐ **Operating Agency** | ☐ **Monthly** |
| ☐ **Sub-State Entity** | ☒ **Quarterly** |
| ☒ **Other** Specify: fiscal intermediary | ☐ **Annually** |
| | ☐ **Continuously and Ongoing** |
| | ☐ **Other** Specify: |

**Performance Measure:**
**Number and percent of waiver providers that continue to meet licensure/certification standards. Numerator=waiver providers that continue to meet licensure/certification standards. Denominator= total number of waiver providers requiring licensure/certification.**

**Data Source** (Select one):
**Reports to State Medicaid Agency on delegated Administrative functions**
If 'Other' is selected, specify:

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

**Data Aggregation and Analysis:**

| **Responsible Party for data aggregation and analysis** *(check each that applies):* | **Frequency of data aggregation and analysis***(check each that applies):* |
|---|---|
| ☒ **State Medicaid Agency** | ☐ **Weekly** |
| ☐ **Operating Agency** | ☐ **Monthly** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** |
| ☒ **Other** Specify: | ☒ **Annually** |

| **Responsible Party for data aggregation and analysis** *(check each that applies):* | **Frequency of data aggregation and analysis***(check each that applies):* |
|---|---|
| fiscal intermediary | |
| | ☒ **Continuously and Ongoing** |
| | ☐ **Other**<br>Specify: |

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

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

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

**Performance Measure:**
**Number & percent of non-licensed/non-certified waiver providers that continue to meet waiver provider qualifications when re-credentialed every 2 years. Numerator=number of non-licensed, non-certified waiver providers reviewed that continue to meet waiver qualifications at re-credentialing. Denominator: number of non-licensed, non-certified waiver providers reviewed for re-credentialing.**

**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**<br>Confidence Interval = |

| | | |
|---|---|---|
| | | |
| ☒ **Other**<br>Specify:<br>fiscal intermediary | ☐ **Annually** | ☐ **Stratified**<br>Describe Group: |
| | ☒ **Continuously and Ongoing** | ☐ **Other**<br>Specify: |
| | ☐ **Other**<br>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**<br>Specify:<br>fiscal intermediary | ☐ **Annually** |
| | ☐ **Continuously and Ongoing** |
| | ☐ **Other**<br>Specify: |

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

*For each performance measure the State will use to assess compliance with the statutory assurance,*

*complete the following. Where possible, include numerator/denominator.*

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

**Performance Measure:**
**Number and Percent of waiver providers who complete contractually required training from the fiscal intermediary. Numerator=Number of waiver providers who complete contractually required training. Denominator: number of waiver providers who were required to complete training**

**Data Source** (Select one):
**Other**
If 'Other' is selected, specify:
**Training verification records**

| **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**<br>Confidence Interval = |
| ☒ **Other**<br>Specify:<br>fiscal intermediary | ☐ **Annually** | ☐ **Stratified**<br>Describe Group: |
| | ☐ **Continuously and Ongoing** | ☐ **Other**<br>Specify: |
| | ☐ **Other**<br>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**<br>Specify:<br>fiscal intermediary | ☐ **Annually** |
| | ☐ **Continuously and Ongoing** |
| | ☐ **Other**<br>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 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. Enrolled Connecticut Medical Assistance Program providers are required to perform criminal background checks on all of their employees prior to employment. Providers are responsible for verifying staff credentials, i.e., training completed, degree programs and licensure prior to employment.

**b. Methods for Remediation/Fixing Individual Problems**

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

The Fiscal Intermediary is 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. The MMIS contractor operates a provider assistance call center to provide information and guidance to providers experiencing difficulty with the enrollment process and getting set up in the web-based system.

**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**<br>Specify:<br>Fiscal Intermediary | ☐ **Annually** |
| | ☒ **Continuously and Ongoing** |
| | ☐ **Other**<br>Specify: |

**c. Timelines**

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

◉ **No**

○ **Yes**

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

## Appendix C: Participant Services

### C-3: Waiver Services Specifications

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

## Appendix C: Participant Services

### C-4: Additional Limits on Amount of Waiver Services

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

◉ **Not applicable-** The state does not impose a limit on the amount of waiver services except as provided in Appendix C-3.

○ **Applicable** - The state imposes additional limits on the amount of waiver services.

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

☐ **Limit(s) on Set(s) of Services.** There is a limit on the maximum dollar amount of waiver services that is authorized for one or more sets of services offered under the waiver.
*Furnish the information specified above.*

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

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

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

# Appendix C: Participant Services

## C-5: Home and Community-Based Settings

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

1. Description of the settings and how they meet federal HCB Settings requirements, at the time of submission and in the future.

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

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

This section has been approved by CMS in the waiver amendment CT 0140.R05.03 that was approved in February of 2015.

The state has assessed both residential and non-residential settings for compliance with the CMC final rules. The state has determined that all of the services in this waiver fully comport with the HCBS settings requirements including Adult Day Health, Adult Family Living and Assisted Living. The state engaged in a comprehensive evaluation process and has planned remediation and ongoing monitoring activities. The information below provides the description of the processes the state engaged in to reach this conclusion and also outlines some steps that state plans on taking to ensure compliance ongoing.

The state provides services to residents of Residential Care Homes (RCH), a setting licensed by the Department of Public Health. There is a great deal of variation in the settings across the state. Our initial review suggests that some of the RCHs fully comport with the settings requirement while others need to make changes in order to come into compliance. Our assessment will also tell us if we have settings that are non-compliant. In those cases, DSS staff will visit each location and do further assessment and discuss remediation efforts before taking any further actions that will impact waiver participants. Ultimately the participant may need to choose between receiving waiver services, moving or remaining in their current setting without waiver services.

To begin its assessment of Residential Care Homes (RCHs), DSS identified the number of participants residing in RCHs. Our analysis identified 254 participants residing in RCHs. RCHs vary widely in their appearance, size and home like qualities. DSS recognizes that some RCHs are fully compliant with the HCB settings requirements while others will need to make changes to become compliant. To determine whether RCHs are in compliance with the HCB settings requirements, DSS took a number of steps. First, all care managers were trained on the final rule and were introduced to a survey to be utilized from September 1, 2014 through February 28, 2015 when performing the annual or semi-annual reassessment of participant's residing in an RCH (assessments take place at the RCH). The survey asks participants questions about the RCH in the following five categories: choice of residence, community access and integration, living space (e.g., physical access, ability to control schedule, privacy, choice regarding meals, etc.), staff interactions and privacy, and services (the participant's experience with services). Care managers will evaluate if the setting was clearly chosen by the participant as part of the person centered plan. DSS also developed and distributed a survey to all RCHs to do a self-assessment of compliance. This survey includes questions similar to the participant survey in the same five categories. In addition, DSS developed a brief survey for care managers to provide their perspective on RCH's compliance with the HCB settings rule. Review of the findings from the various surveys will help DSS identify areas that changes will need to be made to bring RCHs into full compliance. All of the survey data will be analyzed and it is anticipated that some on site evaluations will need to be done by DSS staff.
On November 19, 2014 DSS conducted a training for the RCH association to ensure understanding of the HCB settings requirements. DSS will also work with DPH, which licenses RCHs, to update regulatory documents to assure compliance with the HCB settings requirements. This will be accomplished by December 31, 2015. DSS will also add language to its program regulations to reflect the HCB settings requirements by December 31, 2015. One of the most challenging areas is the CMS expectation that the participant have access to food at any time. DPH and local public health departments have requirements that prohibit residents having ongoing access to the kitchens. As a result, each setting will need to determine different ways that this requirement can be met. Some initial ideas include the resident's ability to have a small refrigerator in their rooms.

DSS will review the results of the RCH surveys to identify homes that might not be fully compliant with the HCB settings requirements. DSS anticipates that some RCHs are not fully compliant with the HCB settings requirements. Therefore, in addition to the general remediation and monitoring activities listed above, DSS will work with individual providers identified as potentially not compliant to address any non-compliance. DSS will inform individual RCHs of non-compliance items and request the RCH to submit a corrective action plan (CAP) that identifies the steps the RCH will take to remediate the identified issues and the timelines for each step and anticipated compliance. DSS will require the RCH to provide periodic updates on its progress. DSS is working with a stakeholder group that includes the United States Department of Housing and Urban Development (HUD) to assist housing providers, including RCHs, comply with the HCB settings requirements. One of the planned initiatives is to provide a competitive grant to RCHs that are affiliated with nursing facilities to help them comply with the HCB settings requirements.

If an RCH is unable or unwilling to comply with the HCB settings requirements, DSS will notify the care manager(s) for the affected participant(s), and the care manager will help the participant select and then transition to a setting that meets the HCB settings requirements. DSS assures that it will provide reasonable notice and due process to any participant that needs to transition to another setting. DSS anticipates that the relocation process will take approximately six months. Through the person centered planning process the care manager will ensure that the participant is provided information about alternative settings that comply with HCB settings requirements and makes an informed choice of an alternative setting. The care manager will ensure that all services are in place in advance of a participant's transition and will monitor the transition to ensure successful placement

encourage participants to transition to a setting that complies with the HCB settings requirements, some participants may choose to remain in their current setting and disenroll from the waiver.

If DSS determines that an RCH has the effect of isolating participants from the broader community but otherwise has the qualities of HCB settings, DSS will submit information to CMS for heightened scrutiny review.

To ensure ongoing compliance, as part of the initial assessment of participants for enrollment in this waiver, care managers (who have been trained on the new rule) will evaluate the RCH's compliance with the HCB settings requirements using a checklist that ensures the setting meets the HCB settings requirements, including:

- The participant has a lease;
- The participant has privacy including lockable doors;
- The participant has a choice of roommates;
- The participant has freedom to control his/her own schedule;
- The participant is free to have visitors; and
- The setting is integrated into the community and facilitates access to community activities such as movies, shopping, and recreational activities.

Similar to the evaluation at initial assessment, if a participant chooses to move into an RCH, the care manager will use the checklist to ensure the setting meets the HCB settings requirements.
Also, on an ongoing basis, as part of their home visits, care managers will evaluate the RCH's compliance with the HCB settings requirements. This will ensure that all settings where individuals receive services will continue to meet the HCB settings requirements on an ongoing basis. If at any time (during initial assessment, when a participant moves to a RCH, or during a home visit) the care manager determines that an RCH is not compliant with the HCB settings requirements, the care manager will discuss this with the participant and offer the participant alternative settings that are compliant. If the applicant/participant chooses to reside in the non-compliant setting, he/she would not be eligible for the HCBS program.

Adult Family Living- This service is provided in the home of the participant or of the caregiver. This service comports with CMS requirements as:
- it is selected as a service by the individual from a range of available services and qualified providers.
- the participant understands that selecting this service setting also means they are selecting this service provider as part of a bundled rate
-additional home and community based services are selected by the participant from a range of qualified service providers to address a need identified in the person centered planning process

The setting is chosen by the waiver participant as part of the person centered planning process. The rate for the service is a bundled rate but the participant has free choice of qualified providers for any other services provided in addition to the Adult Family Living Provider.
The Department is in the process of assessing the credentialing language for this service against the requirements in the new CMS rule and will adjust the credentialing requirements to ensure compliance with regard to the settings characteristics specified in the new rule. This will be accomplished by 6/30/15.
In the interim, as case managers complete person centered assessments for new waiver participants, they will be responsible to assess the setting's compliance with the required settings characteristics.
The provider for this service is agency based therefore the provider does not own or control the home in which the waiver participant resides.

Assisted Living- this service fully comports with CMS requirements as:
-the setting is integrated in and supports and facilitates access to the greater community
- facilitate interaction with non-Medicaid participants
-has lockable doors facilitating privacy
- each participant has a lease
-if the participate chooses to share a unit, they have freedom to choose their roommate
-the participants have control over their own schedule and are free to decorate their unit as they choose
-the unit has kitchen facilities in each allowing access to food at any time
-visitors are permitted at any time

choosing this setting provides a specified service provider that provides a bundled services
- additional services may be selected by the participant from a list of qualified service providers.

Based on several assessment activities, DSS has concluded that Assisted Living providers are in compliance with the new HCB settings requirements. DSS reviewed the Department of Public Health (DPH) regulation for Assisted Living Services and determined that the HCB settings requirements are specified in the DPH regulations, so DSS determined that the regulations comply with the new HCB settings requirements, and no changes need to be made to the regulations. This also indicates that the providers are aware of and in compliance with the HCB settings requirements. The regulations for assisted living are very clear that persons reside in individual units, with cooking facilities, and have the protection of a lease agreement. In addition to reviewing the regulations, DSS met with representatives of the Connecticut Assisted Living Association and confirmed that all communities are required to have leases with their tenants.

As part of DSS' ongoing quality assurance efforts, DSS staff complete audits of assisted living providers. Each year, DSS audits two to three different communities. The audit process includes interviews with HCBS participants. DSS staff have directly observed that settings are compliant with HCB setting requirements. Participants have privacy in their units, have access to food at any time, and can have visitors at any time, and the setting is physically accessible.

Although DSS has concluded that Assisted Living is fully compliant with the HCB settings requirements, DSS will implement remediation and monitoring activities to ensure ongoing compliance.

The state has assessed this service and the CMS final rules requirements are specified in the Department of Public Health regulations. To complete this assessment process, the state met with representatives of the Assisted Living provider Association and confirmed that all communities are required to have leases with their tenants. We also will review our own regulations and ensure that language is included in the regulations that specifies the requirements included in the final rule. This will be completed by 12/31/15. Although DSS has concluded that Assisted Living complies with the HCB settings requirements, DSS will strengthen the language in its program regulations to specifically reflect the HCB settings requirements. In addition, DSS has incorporated review for compliance with HCB settings requirements in its regular quality assurance audits of assisted living providers. Each year DSS audits two to three different communities. Our visits will include an evaluation of compliance with the HCBS settings requirements. The audit includes interviews with HCBS participants.

Adult Day Health: this service comports with CMS requirements as it is:
- chosen by the participant from a selection of services from qualified providers
- it is selected by the participant as part of the person centered planning process
- it facilitates integration to community activities
- it facilitates interaction with non-Medicaid recipients
- the certification process emphasizes participants' rights to privacy, dignity and respect.

The state has assessed the Adult Day Health Service with regard to the new settings requirements. Initially, the state met with the Adult Day Care Association certification team to discuss the certification process. It was determined that the process, although it does look at the home-like setting, could have stronger language that comports with the CMS final rules specifications. By 06/30/15, the state will work with the association to include language in the certification standards that includes language from the final rules.

In addition, in collaboration with the ADC Association, the Department specifically reviewed weekly and monthly calendars for programs that were adjacent to or on the grounds of a non-public facility. There are several programs located adjacent to a facility and others that are on the grounds of communities that have a range of levels of care ranging from complete independent living to nursing home. In all cases, the activities calendars indicated that the program serves to facilitate integration into the community and interaction with non-HCBS program participants. For example, one Adult Day Health provider had activities such as a trip to the Hartford Symphony, games, outdoor gardening, movies, religious services, bocce, an outing to a restaurant for lunch, shopping, reiki, manicures, a picnic at a local park as well as other club type activities. DSS staff have also visited a number of Adult Day Health providers and overall were quite impressed by the quality and range of programming and services offered. To further review compliance of Adult Day Health providers located adjacent to or on the grounds of a private nursing facility, DSS developed and distributed a brief survey for care managers to complete to provide their perspective on the compliance of these Adult Day Health providers with the HCB settings requirements. Care managers were asked to assess nine statements that reflected the HCB settings requirements. For example, "Participants socialize with their peer, including non-HCBS participants, and engage in various interactive activities." The care managers were given a choice of five response options for each statement: Completely False; Partially False; Neither True nor False; Partially True; and Completely True. Each

Overall, care managers reported that these Adult Day Health centers comply with the HCB settings requirements reflected in the survey. Responses from all centers averaged an aggregate score of four or higher for each statement in the survey. The lowest aggregate response score was 4.19 for the statement "The center supports participant access to the surrounding community (not on the grounds of the nursing facility), e.g., through walking groups and/or field trips." One center received an average score of three for that statement, and another center received an average score of two. DSS will follow up with these two centers. No other center received a score below a four on any of the statements. Some of the providers are located on the grounds of a community that offers a range of services from independent living to skilled nursing. A couple of others are located adjacent to nursing homes so that health services such as physical or occupational therapy can be provided to the participant. As a service that addresses health care needs, this is an appropriate setting and in no way impacts or limits access into the community but instead makes additional services available to the waiver participant.

Based on DSS' review of the service definition and certification standards, direct observation, review of weekly and monthly schedules of activities, and analysis of survey data supplied by care managers, DSS has concluded that Adult Day Health fully comports with the HCB settings requirements.

While DSS has determined that Adult Day Health complies with the HCB settings requirements, DSS will follow up with the two centers that received a score below a four on a statement on the Adult Day Health survey described above and work with them on a quality improvement plan. Also, DSS will work with the certification committee of the ADC association to include, by June 30, 2015, language in their certification standards to more clearly reflect the HCB settings requirements. DSS will also revise its own program regulations to reflect the HCB settings requirements. This will be accomplished by December 31, 2015. In order to ensure ongoing compliance, visits to Adult Day Health providers will be integrated into DSS' ongoing quality assurance activities.

# Appendix J: Cost Neutrality Demonstration

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

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

**Level(s) of Care: 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 | 28425.58 | 8309.00 | 36734.58 | 69073.00 | 8448.00 | 77521.00 | 40786.42 |
| 2 | 29673.03 | 8674.00 | 38347.03 | 71145.00 | 8820.00 | 79965.00 | 41617.97 |
| 3 | 30973.28 | 9056.00 | 40029.28 | 73280.00 | 9208.00 | 82488.00 | 42458.72 |
| 4 | 32335.41 | 9454.00 | 41789.41 | 75478.00 | 9613.00 | 85091.00 | 43301.59 |
| 5 | 33749.95 | 9870.00 | 43619.95 | 77743.00 | 10036.00 | 87779.00 | 44159.05 |

# Appendix J: Cost Neutrality Demonstration

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

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

**Table: J-2-a: Unduplicated Participants**

| Waiver Year | Total Unduplicated Number of Participants (from Item B-3-a) | Distribution of Unduplicated Participants by Level of Care (if applicable) |
|---|---|---|
| | | Level of Care: |
| | | Nursing Facility |
| Year 1 | 17707 | 17707 |
| Year 2 | 18186 | 18186 |
| Year 3 | 18753 | 18753 |
| Year 4 | 19324 | 19324 |
| Year 5 | 19897 | 19897 |

# 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 projected average length of stay for each of the five renewal years is the same as that reported on the 372 Report for the July 1, 2018 - June 30, 2019 period.

# 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

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

Factor D was estimated applying projected caseloads and Length of Stay to the utilization reported in the Initial 372 report for July 1, 2018 - June 30, 2019.The historical cost data were trended forward by 4.4% for each renewal year, based on the published September 2019 Consumer Price index for Medical Care.The Year 1 cost per unit data for Home Delivered Meals is based on legislative rate increases.

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:

The factor D' was calculated by applying CPI to the Initial 372 report for July 1, 2018 - June 30, 2019.The historical cost data were trended forward for each renewal year using 4.4% based on the published September 2019 Consumer Price index for Medical Care.

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:

The factor G was calculated by applying CPI to the Initial 372 report for July 1, 2018 - June 30, 2019. Inflation projection for Factor G is based on the published September 2019 Consumer Price Index for Nursing Home Care at: 3.0%

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:

The factor G' was calculated by applying CPI to the Initial 372 report for July 1, 2018 - June 30, 2019. The historical cost data were trended forward by 4.4% for each renewal year, based on the published September 2019 Consumer Price index for Medical Care.

## 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 | |
| Respite | |
| Adult Family Living | |
| Assisted Living | |
| Assistive Technology | |
| Bill Payer | |
| Care Transitions | |
| Chore Services | |
| Chronic Disease Self-Management Program | |
| Companion | |
| Environmental Accesibility Adaptations | |
| Home Delivered Meals | |

| Waiver Services | |
|---|---|
| Personal Emergency Response Systems | |
| Recovery Assistant | |
| Transportation | |

# Appendix J: Cost Neutrality Demonstration

## J-2: Derivation of Estimates (5 of 9)

**d. Estimate of Factor D.**

**ii. Concurrent §1915(b)/§1915(c) Waivers, or other authorities utilizing capitated arrangements (i.e., 1915(a), 1932(a), Section 1937).** 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. If applicable, check the capitation box next to that service. 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 | Capi-tation | Unit | # Users | Avg. Units Per User | Avg. Cost/ Unit | Component Cost | Total Cost |
|---|---|---|---|---|---|---|---|
| **Adult Day Health Total:** | | | | | | | 14180394.24 |
| Adult Day Health | ☐ | per day | 1964 | 92.00 | 78.48 | 14180394.24 | |
| **Care Management Total:** | | | | | | | 25679634.30 |
| Care Management | ☐ | per day | 17949 | 285.00 | 5.02 | 25679634.30 | |
| **Homemaker Total:** | | | | | | | 28734315.48 |
| Homemaker | ☐ | per 15 minutes | 6684 | 949.00 | 4.53 | 28734315.48 | |
| **Personal Care Assistant Total:** | | | | | | | 315527259.80 |
| Personal Care Assistant | ☐ | per 15 minutes | 9778 | 6170.00 | 5.23 | 315527259.80 | |
| **Respite Total:** | | | | | | | 2362897.04 |
| Respite | ☐ | per 15 min | 469 | 887.00 | 5.68 | 2362897.04 | |
| **Adult Family Living Total:** | | | | | | | 56430757.08 |
| Adult Family Living | ☐ | per day | 2276 | 229.00 | 108.27 | 56430757.08 | |
| **Assisted Living Total:** | | | | | | | 5060946.06 |
| Assisted Living | ☐ | per month | | | | 5060946.06 | |

| | |
|---|---|
| **GRAND TOTAL:** | 503331830.38 |
| Total: Services included in capitation: | |
| Total: Services not included in capitation: | 503331830.38 |
| **Total Estimated Unduplicated Participants:** | 17707 |
| **Factor D (Divide total by number of participants):** | 28425.58 |
| Services included in capitation: | |
| Services not included in capitation: | 28425.58 |

| Waiver Service/ Component | Capi-tation | Unit | # Users | Avg. Units Per User | Avg. Cost/ Unit | Component Cost | Total Cost |
|---|---|---|---|---|---|---|---|
| | | | 746 | 129.00 | 52.59 | | |
| **Assistive Technology Total:** | | | | | | | **238299.40** |
| Assistive Technology | ☐ | per unit | 202 | 1.00 | 1179.70 | **238299.40** | |
| **Bill Payer Total:** | | | | | | | **102102.00** |
| Bill Payer | ☐ | per 15 min | 238 | 78.00 | 5.50 | **102102.00** | |
| **Care Transitions Total:** | | | | | | | **49495.08** |
| Care Transitions | ☐ | per unit | 316 | 1.00 | 156.63 | **49495.08** | |
| **Chore Services Total:** | | | | | | | **205504.00** |
| Chore Services | ☐ | per unit | 160 | 190.00 | 6.76 | **205504.00** | |
| **Chronic Disease Self-Management Program Total:** | | | | | | | **3302.40** |
| Chronic Disease Self-Management Program | ☐ | per session | 10 | 6.00 | 55.04 | **3302.40** | |
| **Companion Total:** | | | | | | | **39886240.59** |
| Companion | ☐ | per 15 min | 4363 | 2073.00 | 4.41 | **39886240.59** | |
| **Environmental Accesibility Adaptations Total:** | | | | | | | **150706.98** |
| Environmental Accesibility Adaptations | ☐ | per session | 27 | 1.00 | 5581.74 | **150706.98** | |
| **Home Delivered Meals Total:** | | | | | | | **8007952.00** |
| Home Delivered Meals | ☐ | per day | 4990 | 160.00 | 10.03 | **8007952.00** | |
| **Mental Health Counseling Total:** | | | | | | | **585333.00** |
| Mental Health Counseling | ☐ | per session | 652 | 15.00 | 59.85 | **585333.00** | |
| **Personal Emergency Response Systems Total:** | | | | | | | **6052450.50** |

| | |
|---|---|
| **GRAND TOTAL:** | **503331830.38** |
| Total: Services included in capitation: | |
| Total: Services not included in capitation: | 503331830.38 |
| **Total Estimated Unduplicated Participants:** | 17707 |
| **Factor D (Divide total by number of participants):** | 28425.58 |
| Services included in capitation: | |
| Services not included in capitation: | 28425.58 |
| **Average Length of Stay on the Waiver:** | 307 |

| Waiver Service/ Component | Capi-tation | Unit | # Users | Avg. Units Per User | Avg. Cost/ Unit | Component Cost | Total Cost |
|---|---|---|---|---|---|---|---|
| Personal Emergency Response Systems | ☐ | per month | 10370 | 9.00 | 64.85 | 6052450.50 | |
| **Recovery Assistant Total:** | | | | | | | **73920.00** |
| Recovery Assistant | ☐ | per 15 min | 5 | 2400.00 | 6.16 | **73920.00** | |
| **Transportation Total:** | | | | | | | **320.43** |
| Transportation | ☐ | per unit | 3 | 1.00 | 106.81 | **320.43** | |

| | |
|---|---|
| **GRAND TOTAL:** | **503331830.38** |
| Total: Services included in capitation: | |
| Total: Services not included in capitation: | 503331830.38 |
| **Total Estimated Unduplicated Participants:** | **17707** |
| **Factor D (Divide total by number of participants):** | **28425.58** |
| Services included in capitation: | |
| Services not included in capitation: | 28425.58 |
| **Average Length of Stay on the Waiver:** | 307 |

# Appendix J: Cost Neutrality Demonstration

## J-2: Derivation of Estimates (6 of 9)

**d. Estimate of Factor D.**

**ii. Concurrent §1915(b)/§1915(c) Waivers, or other concurrent managed care authorities utilizing capitated payment arrangements.** 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. If applicable, check the capitation box next to that service. 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 | Capi-tation | Unit | # Users | Avg. Units Per User | Avg. Cost/ Unit | Component Cost | Total Cost |
|---|---|---|---|---|---|---|---|
| **Adult Day Health Total:** | | | | | | | **15210796.08** |
| Adult Day Health | ☐ | per day | 2018 | 92.00 | 81.93 | **15210796.08** | |
| **Care Management Total:** | | | | | | | **27521783.10** |
| Care Management | ☐ | per day | 18186 | 285.00 | 5.31 | **27521783.10** | |
| **Homemaker Total:** | | | | | | | **30810917.28** |
| Homemaker | ☐ | | | | | **30810917.28** | |

| | |
|---|---|
| **GRAND TOTAL:** | **539633761.34** |
| Total: Services included in capitation: | |
| Total: Services not included in capitation: | 539633761.34 |
| **Total Estimated Unduplicated Participants:** | **18186** |
| **Factor D (Divide total by number of participants):** | **29673.03** |
| Services included in capitation: | |
| Services not included in capitation: | 29673.03 |

| Waiver Service/ Component | Capi-tation | Unit | # Users | Avg. Units Per User | Avg. Cost/ Unit | Component Cost | Total Cost |
|---|---|---|---|---|---|---|---|
| | | per 15 minutes | 6864 | 949.00 | 4.73 | | |
| **Personal Care Assistant Total:** | | | | | | | **338330592.60** |
| Personal Care Assistant | ☐ | per 15 minutes | 10043 | 6170.00 | 5.46 | **338330592.60** | |
| **Respite Total:** | | | | | | | **2530016.71** |
| Respite | ☐ | per 15 min | 481 | 887.00 | 5.93 | **2530016.71** | |
| **Adult Family Living Total:** | | | | | | | **60490604.19** |
| Adult Family Living | ☐ | per day | 2337 | 229.00 | 113.03 | **60490604.19** | |
| **Assisted Living Total:** | | | | | | | **5424888.60** |
| Assisted Living | ☐ | per month | 766 | 129.00 | 54.90 | **5424888.60** | |
| **Assistive Technology Total:** | | | | | | | **254943.27** |
| Assistive Technology | ☐ | per unit | 207 | 1.00 | 1231.61 | **254943.27** | |
| **Bill Payer Total:** | | | | | | | **109243.68** |
| Bill Payer | ☐ | per 15 min | 244 | 78.00 | 5.74 | **109243.68** | |
| **Care Transitions Total:** | | | | | | | **52980.48** |
| Care Transitions | ☐ | per unit | 324 | 1.00 | 163.52 | **52980.48** | |
| **Chore Services Total:** | | | | | | | **219989.60** |
| Chore Services | ☐ | per unit | 164 | 190.00 | 7.06 | **219989.60** | |
| **Chronic Disease Self-Management Program Total:** | | | | | | | **3447.60** |
| Chronic Disease Self-Management Program | ☐ | per session | 10 | 6.00 | 57.46 | **3447.60** | |
| **Companion Total:** | | | | | | | **42729919.80** |
| Companion | ☐ | per 15 min | 4481 | 2073.00 | 4.60 | **42729919.80** | |
| **Environmental Accesibility Adaptations** | | | | | | | **163165.52** |

| | |
|---|---|
| **GRAND TOTAL:** | **539633761.34** |
| Total: Services included in capitation: | |
| Total: Services not included in capitation: | 539633761.34 |
| **Total Estimated Unduplicated Participants:** | **18186** |
| **Factor D (Divide total by number of participants):** | **29673.03** |
| Services included in capitation: | |
| Services not included in capitation: | 29673.03 |
| **Average Length of Stay on the Waiver:** | 307 |

| Waiver Service/ Component | Capi-tation | Unit | # Users | Avg. Units Per User | Avg. Cost/ Unit | Component Cost | Total Cost |
|---|---|---|---|---|---|---|---|
| **Total:** | | | | | | | |
| Environmental Accesibility Adaptations | ☐ | per unit | 28 | 1.00 | 5827.34 | **163165.52** | |
| **Home Delivered Meals Total:** | | | | | | | **8585400.00** |
| Home Delivered Meals | ☐ | per day | 5125 | 160.00 | 10.47 | **8585400.00** | |
| **Mental Health Counseling Total:** | | | | | | | **627924.00** |
| Mental Health Counseling | ☐ | per session | 670 | 15.00 | 62.48 | **627924.00** | |
| **Personal Emergency Response Systems Total:** | | | | | | | **6489654.30** |
| Personal Emergency Response Systems | ☐ | per month | 10651 | 9.00 | 67.70 | **6489654.30** | |
| **Recovery Assistant Total:** | | | | | | | **77160.00** |
| Recovery Assistant | ☐ | per 15 min | 5 | 2400.00 | 6.43 | **77160.00** | |
| **Transportation Total:** | | | | | | | **334.53** |
| Transportation | ☐ | per unit | 3 | 1.00 | 111.51 | **334.53** | |

| | |
|---|---|
| **GRAND TOTAL:** | **539633761.34** |
| Total: Services included in capitation: | |
| Total: Services not included in capitation: | 539633761.34 |
| **Total Estimated Unduplicated Participants:** | **18186** |
| **Factor D (Divide total by number of participants):** | **29673.03** |
| Services included in capitation: | |
| Services not included in capitation: | 29673.03 |
| **Average Length of Stay on the Waiver:** | 307 |

# Appendix J: Cost Neutrality Demonstration

## J-2: Derivation of Estimates (7 of 9)

**d. Estimate of Factor D.**

**ii. Concurrent §1915(b)/§1915(c) Waivers, or other concurrent managed care authorities utilizing capitated payment arrangements.** 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. If applicable, check the capitation box next to that service. 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 | Capi-tation | Unit | # Users | Avg. Units Per User | Avg. Cost/ Unit | Component Cost | Total Cost |
|---|---|---|---|---|---|---|---|
| **Adult Day Health Total:** | | | | | | | **16367020.80** |
| Adult Day Health | ☐ | per day | 2080 | 92.00 | 85.53 | **16367020.80** | |
| **Care Management Total:** | | | | | | | **29609111.70** |
| Care Management | ☐ | per day | 18753 | 285.00 | 5.54 | **29609111.70** | |
| **Homemaker Total:** | | | | | | | **33182088.68** |
| Homemaker | ☐ | per 15 minutes | 7078 | 949.00 | 4.94 | **33182088.68** | |
| **Personal Care Assistant Total:** | | | | | | | **364174995.00** |
| Personal Care Assistant | ☐ | per 15 minutes | 10355 | 6170.00 | 5.70 | **364174995.00** | |
| **Respite Total:** | | | | | | | **2723302.88** |
| Respite | ☐ | per 15 min | 496 | 887.00 | 6.19 | **2723302.88** | |
| **Adult Family Living Total:** | | | | | | | **65123020.00** |
| Adult Family Living | ☐ | per day | 2410 | 229.00 | 118.00 | **65123020.00** | |
| **Assisted Living Total:** | | | | | | | **5841481.20** |
| Assisted Living | ☐ | per month | 790 | 129.00 | 57.32 | **5841481.20** | |
| **Assistive Technology Total:** | | | | | | | **273875.40** |
| Assistive Technology | ☐ | per unit | 213 | 1.00 | 1285.80 | **273875.40** | |
| **Bill Payer Total:** | | | | | | | **117739.44** |
| Bill Payer | ☐ | per 15 min | 252 | 78.00 | 5.99 | **117739.44** | |
| **Care Transitions Total:** | | | | | | | **57187.85** |
| Care Transitions | ☐ | per unit | 335 | 1.00 | 170.71 | **57187.85** | |
| **Chore Services Total:** | | | | | | | **236650.70** |
| Chore Services | ☐ | per unit | 169 | 190.00 | 7.37 | **236650.70** | |
| **Chronic Disease Self-Management** | | | | | | | **3959.34** |

| | |
|---|---|
| **GRAND TOTAL:** | **580841969.24** |
| Total: Services included in capitation: | |
| Total: Services not included in capitation: | 580841969.24 |
| **Total Estimated Unduplicated Participants:** | 18753 |
| **Factor D (Divide total by number of participants):** | 30973.28 |
| Services included in capitation: | |
| Services not included in capitation: | 30973.28 |

| Waiver Service/ Component | Capi-tation | Unit | # Users | Avg. Units Per User | Avg. Cost/ Unit | Component Cost | Total Cost |
|---|---|---|---|---|---|---|---|
| **Program Total:** | | | | | | | |
| Chronic Disease Self-Management Program | ☐ | per session | 11 | 6.00 | 59.99 | 3959.34 | |
| **Companion Total:** | | | | | | | 45970848.00 |
| Companion | ☐ | per 15 min | 4620 | 2073.00 | 4.80 | 45970848.00 | |
| **Environmental Accesibility Adaptations Total:** | | | | | | | 176428.46 |
| Environmental Accesibility Adaptations | ☐ | per unit | 29 | 1.00 | 6083.74 | 176428.46 | |
| **Home Delivered Meals Total:** | | | | | | | 9240659.20 |
| Home Delivered Meals | ☐ | per day | 5284 | 160.00 | 10.93 | 9240659.20 | |
| **Mental Health Counseling Total:** | | | | | | | 676108.95 |
| Mental Health Counseling | ☐ | per session | 691 | 15.00 | 65.23 | 676108.95 | |
| **Personal Emergency Response Systems Total:** | | | | | | | 6986505.96 |
| Personal Emergency Response Systems | ☐ | per month | 10983 | 9.00 | 70.68 | 6986505.96 | |
| **Recovery Assistant Total:** | | | | | | | 80520.00 |
| Recovery Assistant | ☐ | per 15 min | 5 | 2400.00 | 6.71 | 80520.00 | |
| **Transportation Total:** | | | | | | | 465.68 |
| Transportation | ☐ | per trip | 4 | 1.00 | 116.42 | 465.68 | |

| | |
|---|---|
| **GRAND TOTAL:** | 580841969.24 |
| Total: Services included in capitation: | |
| Total: Services not included in capitation: | 580841969.24 |
| **Total Estimated Unduplicated Participants:** | 18753 |
| **Factor D (Divide total by number of participants):** | 30973.28 |
| Services included in capitation: | |
| Services not included in capitation: | 30973.28 |
| **Average Length of Stay on the Waiver:** | 307 |

# Appendix J: Cost Neutrality Demonstration

## J-2: Derivation of Estimates (8 of 9)

**d. Estimate of Factor D.**

**ii. Concurrent §1915(b)/§1915(c) Waivers, or other concurrent managed care authorities utilizing capitated payment arrangements.** Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units

next to that service. 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**

| Waiver Service/ Component | Capi-tation | Unit | # Users | Avg. Units Per User | Avg. Cost/ Unit | Component Cost | Total Cost |
|---|---|---|---|---|---|---|---|
| **Adult Day Health Total:** | | | | | | | 17612273.92 |
| Adult Day Health | ☐ | per day | 2144 | 92.00 | 89.29 | 17612273.92 | |
| **Care Management Total:** | | | | | | | 31832425.20 |
| Care Management | ☐ | per day | 19324 | 285.00 | 5.78 | 31832425.20 | |
| **Homemaker Total:** | | | | | | | 35717550.96 |
| Homemaker | ☐ | per 15 minutes | 7294 | 949.00 | 5.16 | 35717550.96 | |
| **Personal Care Assistant Total:** | | | | | | | 391748416.50 |
| Personal Care Assistant | ☐ | per 15 minutes | 10671 | 6170.00 | 5.95 | 391748416.50 | |
| **Respite Total:** | | | | | | | 2933770.24 |
| Respite | ☐ | per 15 min | 512 | 887.00 | 6.46 | 2933770.24 | |
| **Adult Family Living Total:** | | | | | | | 70074906.84 |
| Adult Family Living | ☐ | per day | 2484 | 229.00 | 123.19 | 70074906.84 | |
| **Assisted Living Total:** | | | | | | | 6283559.04 |
| Assisted Living | ☐ | per month | 814 | 129.00 | 59.84 | 6283559.04 | |
| **Assistive Technology Total:** | | | | | | | 295323.60 |
| Assistive Technology | ☐ | per unit | 220 | 1.00 | 1342.38 | 295323.60 | |
| **Bill Payer Total:** | | | | | | | 126262.50 |
| Bill Payer | ☐ | per 15 min | 259 | 78.00 | 6.25 | 126262.50 | |
| **Care Transitions Total:** | | | | | | | 61485.90 |
| Care Transitions | ☐ | per unit | 345 | 1.00 | 178.22 | 61485.90 | |

| | |
|---|---|
| **GRAND TOTAL:** | 624849381.84 |
| Total: Services included in capitation: | |
| Total: Services not included in capitation: | 624849381.84 |
| **Total Estimated Unduplicated Participants:** | 19324 |
| **Factor D (Divide total by number of participants):** | 32335.41 |
| Services included in capitation: | |
| Services not included in capitation: | 32335.41 |
| **Average Length of Stay on the Waiver:** | 307 |

| Waiver Service/ Component | Capi-tation | Unit | # Users | Avg. Units Per User | Avg. Cost/ Unit | Component Cost | Total Cost |
|---|---|---|---|---|---|---|---|
| **Chore Services Total:** | | | | | | | **254231.40** |
| Chore Services | ☐ | per unit | 174 | 190.00 | 7.69 | **254231.40** | |
| **Chronic Disease Self-Management Program Total:** | | | | | | | **4133.58** |
| Chronic Disease Self-Management Program | ☐ | per session | 11 | 6.00 | 62.63 | **4133.58** | |
| **Companion Total:** | | | | | | | **49446460.53** |
| Companion | ☐ | per 15 min | 4761 | 2073.00 | 5.01 | **49446460.53** | |
| **Environmental Accesibility Adaptations Total:** | | | | | | | **190542.60** |
| Environmental Accesibility Adaptations | ☐ | per unit | 30 | 1.00 | 6351.42 | **190542.60** | |
| **Home Delivered Meals Total:** | | | | | | | **9940392.00** |
| Home Delivered Meals | ☐ | per day | 5445 | 160.00 | 11.41 | **9940392.00** | |
| **Mental Health Counseling Total:** | | | | | | | **727308.00** |
| Mental Health Counseling | ☐ | per session | 712 | 15.00 | 68.10 | **727308.00** | |
| **Personal Emergency Response Systems Total:** | | | | | | | **7515732.87** |
| Personal Emergency Response Systems | ☐ | per month | 11317 | 9.00 | 73.79 | **7515732.87** | |
| **Recovery Assistant Total:** | | | | | | | **84120.00** |
| Recovery Assistant | ☐ | per 15 min | 5 | 2400.00 | 7.01 | **84120.00** | |
| **Transportation Total:** | | | | | | | **486.16** |
| Transportation | ☐ | per unit | 4 | 1.00 | 121.54 | **486.16** | |

| | |
|---|---|
| **GRAND TOTAL:** | **624849381.84** |
| Total: Services included in capitation: | |
| Total: Services not included in capitation: | 624849381.84 |
| **Total Estimated Unduplicated Participants:** | **19324** |
| **Factor D (Divide total by number of participants):** | **32335.41** |
| Services included in capitation: | |
| Services not included in capitation: | 32335.41 |
| **Average Length of Stay on the Waiver:** | 307 |

# Appendix J: Cost Neutrality Demonstration

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

**d. Estimate of Factor D.**

**ii. Concurrent §1915(b)/§1915(c) Waivers, or other concurrent managed care authorities utilizing capitated payment arrangements.** 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. If applicable, check the capitation box next to that service. 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**

| Waiver Service/ Component | Capi-tation | Unit | # Users | Avg. Units Per User | Avg. Cost/ Unit | Component Cost | Total Cost |
|---|---|---|---|---|---|---|---|
| **Adult Day Health Total:** | | | | | | | **18927761.68** |
| Adult Day Health | ☐ | per day | 2207 | 92.00 | 93.22 | **18927761.68** | |
| **Care Management Total:** | | | | | | | **34193989.35** |
| Care Management | ☐ | per day | 19897 | 285.00 | 6.03 | **34193989.35** | |
| **Homemaker Total:** | | | | | | | **38414476.10** |
| Homemaker | ☐ | per 15 minutes | 7510 | 949.00 | 5.39 | **38414476.10** | |
| **Personal Care Assistant Total:** | | | | | | | **420974595.90** |
| Personal Care Assistant | ☐ | per 15 minutes | 10987 | 6170.00 | 6.21 | **420974595.90** | |
| **Respite Total:** | | | | | | | **3150606.26** |
| Respite | ☐ | per 15 min | 527 | 887.00 | 6.74 | **3150606.26** | |
| **Adult Family Living Total:** | | | | | | | **75307971.33** |
| Adult Family Living | ☐ | per day | 2557 | 229.00 | 128.61 | **75307971.33** | |
| **Assisted Living Total:** | | | | | | | **6753131.94** |
| Assisted Living | ☐ | per month | 838 | 129.00 | 62.47 | **6753131.94** | |
| **Assistive Technology Total:** | | | | | | | **316725.44** |
| Assistive Technology | ☐ | per unit | 226 | 1.00 | 1401.44 | **316725.44** | |
| **Bill Payer Total:** | | | | | | | **135993.78** |

| | |
|---|---|
| **GRAND TOTAL:** | **671522814.32** |
| Total: Services included in capitation: | |
| Total: Services not included in capitation: | 671522814.32 |
| **Total Estimated Unduplicated Participants:** | **19897** |
| **Factor D (Divide total by number of participants):** | **33749.95** |
| Services included in capitation: | |
| Services not included in capitation: | 33749.95 |
| Average Length of Stay on the Waiver: | 307 |

| Waiver Service/ Component | Capitation | Unit | # Users | Avg. Units Per User | Avg. Cost/ Unit | Component Cost | Total Cost |
|---|---|---|---|---|---|---|---|
| Bill Payer | ☐ | per 15 min | 267 | 78.00 | 6.53 | 135993.78 | |
| **Care Transitions Total:** | | | | | | | 66051.30 |
| Care Transitions | ☐ | per unit | 355 | 1.00 | 186.06 | 66051.30 | |
| **Chore Services Total:** | | | | | | | 273100.30 |
| Chore Services | ☐ | per unit | 179 | 190.00 | 8.03 | 273100.30 | |
| **Chronic Disease Self-Management Program Total:** | | | | | | | 4315.74 |
| Chronic Disease Self-Management Program | ☐ | per session | 11 | 6.00 | 65.39 | 4315.74 | |
| **Companion Total:** | | | | | | | 53146454.58 |
| Companion | ☐ | per 15 min | 4902 | 2073.00 | 5.23 | 53146454.58 | |
| **Environmental Accesibility Adaptations Total:** | | | | | | | 205557.28 |
| Environmental Accesibility Adaptations | ☐ | per unit | 31 | 1.00 | 6630.88 | 205557.28 | |
| **Home Delivered Meals Total:** | | | | | | | 10684699.20 |
| Home Delivered Meals | ☐ | per day | 5607 | 160.00 | 11.91 | 10684699.20 | |
| **Mental Health Counseling Total:** | | | | | | | 781744.50 |
| Mental Health Counseling | ☐ | per session | 733 | 15.00 | 71.10 | 781744.50 | |
| **Personal Emergency Response Systems Total:** | | | | | | | 8079724.08 |
| Personal Emergency Response Systems | ☐ | per month | 11653 | 9.00 | 77.04 | 8079724.08 | |
| **Recovery Assistant Total:** | | | | | | | 105408.00 |
| Recovery Assistant | ☐ | per 15 min | 6 | 2400.00 | 7.32 | 105408.00 | |
| **Transportation** | | | | | | | 507.56 |

| | |
|---|---|
| **GRAND TOTAL:** | 671522814.32 |
| Total: Services included in capitation: | |
| Total: Services not included in capitation: | 671522814.32 |
| **Total Estimated Unduplicated Participants:** | 19897 |
| **Factor D (Divide total by number of participants):** | 33749.95 |
| Services included in capitation: | |
| Services not included in capitation: | 33749.95 |

| Waiver Service/ Component | Capi-tation | Unit | # Users | Avg. Units Per User | Avg. Cost/ Unit | Component Cost | Total Cost |
|---|---|---|---|---|---|---|---|
| **Total:** | | | | | | | |
| Transportation | ☐ | per unit | 4 | 1.00 | 126.89 | **507.56** | |

| | |
|---|---|
| **GRAND TOTAL:** | **671522814.32** |
| Total: Services included in capitation: | |
| Total: Services not included in capitation: | 671522814.32 |
| **Total Estimated Unduplicated Participants:** | **19897** |
| **Factor D (Divide total by number of participants):** | **33749.95** |
| Services included in capitation: | |
| Services not included in capitation: | 33749.95 |
| **Average Length of Stay on the Waiver:** | 307 |