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

PURPOSE OF THE HCBS WAIVER PROGRAM

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

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

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

1. Major Changes

Describe any significant changes to the approved waiver that are being made in this renewal application:

As part of the renewal application the Department of Social Services and the Department of Developmental Services are proposing the following changes to the Employment and Day Supports Medicaid Waiver:

1) Adding a service titled “Virtual Health Consultation”. This service is tailored to meet the unique needs of individuals supported by DDS by providing timely specialized telehealth assessments when a participant's primary care physician is unavailable or unable to determine the most appropriate clinical course of action. The service ensures greater access to both routine and specialized medical care that might otherwise be challenging to obtain through traditional means and helps reduce unnecessary emergency room visits, while promoting efficient and accessible care.
2) Adding a certificate of completion as a provider qualification in lieu of a high school diploma or GED for the Peer Support waiver service. Peer Support is a unique waiver service in that it provides support and advocacy from individuals with intellectual disability who are qualified to provide the service. A certificate of completion is a portfolio a student’s accomplishments during high school who are unable to graduate even with an Individual Education Plan (IEP) in place.
3) Technical and administrative clarifications, including those revisions requested by CMS.

No current enrollees will be negatively impacted by the changes proposed in the applications.

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 section 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*):

Employment and Day Supports Waiver

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**

Draft ID: **CT.015.03.00**

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

Regular Waiver

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

04/01/26

PRA Disclosure Statement

The purpose of this application is for states to request a Medicaid Section 1915(c) home and community-based services (HCBS) waiver. Section 1915(c) of the Social Security Act authorizes the Secretary of Health and Human Services to waive certain specific Medicaid statutory requirements so that a state may voluntarily offer HCBS to state-specified target group(s) of Medicaid beneficiaries who need a level of institutional care that is provided under the Medicaid state plan. Under the Privacy Act of 1974 any personally identifying information obtained will be kept private to the extent of the law.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0449 (Expires: July 31, 2027). The time required to complete this information collection is estimated to average 163 hours per response for a new waiver application and 78 hours per response for a renewal application, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

1. Request Information (2 of 3)

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

☐ **Hospital**

Select applicable level of care

○ **Hospital as defined in 42 CFR § 440.10**

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

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

☐ **Nursing Facility**

Select applicable level of care

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

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

○ **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 section 1915(a)(1)(a) of the Act and described in Appendix I**

☐ **Waiver(s) authorized under section 1915(b) of the Act.**

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

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

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

☐ **section 1915(b)(2) (central broker)**

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

☐ **section 1915(b)(4) (selective contracting/limit number of providers)**

☐ **A program operated under section 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 section 1915(i) of the Act.**

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

☐ **A program authorized under section 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 Employment and Day Supports waiver is designed to support individuals who live with family or in their own homes and have a strong natural support system. This includes children under the age of 21 with complex medical needs who would otherwise require institutional placement and individuals over the age of 18 who require career development, supported employment or community based day supports, respite, and/or behavioral supports to remain in their own or their family home.

This waiver includes traditional service-delivery and participant-directed options including employer of record and agency with choice models and establishes the CT Level of Need Assessment and Screening Tool as the method to determine that an individual meets the Level of Care criterion for enrollment in the waiver.

The Department of Social Services (DSS) is the Single State Medicaid Agency responsible for oversight of the DDS waivers. The Department of Developmental Services is the operating authority through an executed Memorandum of Understanding between the two state departments. Both departments are cabinet level agencies. DDS operates the waiver as a state operated system with state employees delivering targeted case management services, and operational functions carried out either through a central office or through one of three state regional offices. Services are delivered through an array of private service vendors through contracts or through a fee for service system, by DDS directly, and through the use of consumer-direction with waiver participants serving as the employer of record, or through the selection of an Agency with Choice model.

Participants can utilize their allocated funds in three ways: 1) self-direction whereby funds are used to self-manage services; 2) use the funding allocation to obtain services under a rate based system from a qualified service provider; 3) use the funds to obtain services from a qualified service provider through a Purchase of Service contract. Individuals who choose to hire their own staff directly have their funds managed through a Fiscal Intermediary. Individuals who choose to have their supports provided by a qualified provider may have an authorization reimbursed through a contract or through a fiscal intermediary.

Specific to Individualized Day Support Service and the Adult Companion Service the HCBS are provided to meet needs of the individual that are not met through the provision of acute care hospital services; The HCBS are in addition to, and may not substitute for, the services the acute care hospital is obligated to provide; The HCBS must be identified in the individual's person-centered service plan; and The HCBS will be used to ensure smooth transitions between acute care setting and community-based settings and to preserve the individual's functional abilities. When such services are provided in an acute care setting temporarily, the planning and support team shall continue to engage in a discharge plan. Rates for such services in an acute care setting are the same for the traditional settings identified in Appendix C.

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 section 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 section 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 section 1902(a)(1) of the Act *(select one)*:

- (●) **No**
- ( ) **Yes**

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

☐ **Geographic Limitation.** A waiver of statewideness is requested in order to furnish services under this waiver only to individuals who reside in the following geographic areas or political subdivisions of the state.
Specify the areas to which this waiver applies and, as applicable, the phase-in schedule of the waiver by geographic area:

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

5. Assurances

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

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

1. As specified in **Appendix C**, adequate standards for all types of providers that provide services under this waiver;

2. Assurance that the standards of any state licensure or certification requirements specified in **Appendix C** are met for services or for individuals furnishing services that are provided under the waiver. The state assures that these requirements are met on the date that the services are furnished; and,

3. Assurance that all facilities subject to section 1616(e) of the Act where home and community-based waiver services are provided comply with the applicable state standards for board and care facilities as specified in **Appendix C**.

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

C. Evaluation of Need: The state assures that it provides for an initial evaluation (and periodic reevaluations, at least annually) of the need for a level of care specified for this waiver, when there is a reasonable indication that an individual might need such services in the near future (one month or less) but for the receipt of home and community-based services under this waiver. The procedures for evaluation and reevaluation of level of care are specified in **Appendix B**.

D. Choice of Alternatives: The state assures that when an individual is determined to be likely to require the level of care specified for this waiver and is in a target group specified in **Appendix B**, the individual (or, legal representative, if applicable) is:

1. Informed of any feasible alternatives under the waiver; and,

2. Given the choice of either institutional or home and community-based waiver services. **Appendix B** specifies the procedures that the state employs to ensure that individuals are informed of feasible alternatives under the waiver and given the choice of institutional or home and community-based waiver services.

E. Average Per Capita Expenditures: The state assures that, for any year that the waiver is in effect, the average per capita expenditures under the waiver will not exceed 100 percent of the average per capita expenditures that would have been made under the Medicaid state plan for the level(s) of care specified for this waiver had the waiver not been granted. Cost-neutrality is demonstrated in **Appendix J**.

F. Actual Total Expenditures: The state assures that the actual total expenditures for home and community-based waiver and other Medicaid services and its claim for FFP in expenditures for the services provided to individuals under the waiver will not, in any year of the waiver period, exceed 100 percent of the amount that would be incurred in the absence of the waiver by the state's Medicaid program for these individuals in the institutional setting(s) specified for this waiver.

G. Institutionalization Absent Waiver: The state assures that, absent the waiver, individuals served in the waiver would receive the appropriate type of Medicaid-funded institutional care for the level of care specified for this waiver.

H. Reporting: The state assures that annually it will provide CMS with information concerning the impact of the waiver on the type, amount and cost of services provided under the Medicaid state plan and on the health and welfare of waiver participants. This information will be consistent with a data collection plan designed by CMS.

I. Habilitation Services. The state assures that prevocational, educational, or supported employment services, or a combination of these services, if provided as habilitation services under the waiver are: (1) not otherwise available to the individual through a local educational agency under the Individuals with Disabilities Education Act (IDEA) or the Rehabilitation Act of 1973; and, (2) furnished as part of expanded habilitation services.

J. Services for Individuals with Chronic Mental Illness. The state assures that federal financial participation (FFP) will not be claimed in expenditures for waiver services including, but not limited to, day treatment or partial hospitalization, psychosocial rehabilitation services, and clinic services provided as home and community-based services to individuals with chronic mental illnesses if these individuals, in the absence of a waiver, would be placed in an IMD and are: (1) age 22 to 64; (2) age 65 and older and the state has not included the optional Medicaid benefit cited in 42 CFR § 440.140; or (3) age 21 and under and the state has not included the optional Medicaid benefit cited in 42 CFR § 440.160.

6. Additional Requirements

Note: Item 6-I must be completed.

A. Service Plan. In accordance with 42 CFR § 441.301(b)(1)(i), a participant-centered service plan (of care) is developed for each participant employing the procedures specified in **Appendix D**. All waiver services are furnished pursuant to the service plan. The service plan describes: (a) the waiver services that are furnished to the participant, their projected frequency and the type of provider that furnishes each service and (b) the other services (regardless of funding source, including state plan services) and informal supports that complement waiver services in meeting the needs of the participant. The service plan is subject to the approval of the Medicaid agency. Federal financial participation (FFP) is not claimed for waiver services furnished prior to the development of the service plan or for services that are not included in the service plan.

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

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

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

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

F. FFP Limitation. In accordance with 42 CFR Part 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. 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 Part 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:

For the renewal effective 4/1/2026, the state published notice on both the DSS and DDS web sites beginning November 1, 2025 for 30 days.

The notice was published in the CT Law Journal on October 28, 2025. The two CT tribes were notified via email.

The public comment period was for 30 days beginning on November 1, 2025 through November 30, 2025.

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

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

7. Contact Person(s)

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

Last Name: Weston

First Name: Christine

Title: Director, Community Options, Division of Health Services

Agency: Department of Social Services

Address: 55 Farmington Ave

Address 2:

City: hartford

State: **Connecticut**

Zip: 06106

Phone: (860) 424-5173 **Ext:** ☐ **TTY**

Fax: (860) 424-4963

E-mail: Christine.Weston@ct.gov

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

Last Name: Ostaszewski

First Name: krista

Title: Health Management Administrator

Agency: Department of Developmental Services

Address: 460 Capitol Avenue

Address 2:

City: hartford

State: **Connecticut**

Zip: 06106

Phone: (860) 250-8454 **Ext:** ☐ **TTY**

Fax: (860) 707-1813

E-mail: krista.ostaszewski@ct.gov

8. Authorizing Signature

This document, together with Appendices A through J, constitutes the state's request for a waiver under section 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:

First Name:

Title:

Agency:

Address:

Address 2:

City:

State: **Connecticut**

Zip:

Phone:

Ext: **TTY**

Fax:

E-mail:

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:

n/a

Additional Needed Information (Optional)

Provide additional needed information for the waiver (optional):

DDS has received approval to consolidate reporting of all Assurances and Sub-Assurances across the 3 1915(c) HCBS I/DD Waivers (0426,0437 and 0881). Reporting combines sampling using a Random Sampling Methodology, and combines evidentiary reporting using an agreed upon reporting schedule. DDS will continue to support remediation using current methodologies and will implement the Overall Quality Improvement Strategy as outlined in the waiver.

***

Due to character limit Appendix I-3c amendment detail can be found here:

1) Stabilization payments for qualified day provider types covered under this waiver

Explanation of payments: DDS pays a series of payments to providers over the ARPA period. The first payment was made March 2022, the next payment was made September into October 2022 and another payment was made in September of 2023. This budget is the DDS portion of the total state funding as referenced in page 4 of the Initial HCBS Spending Plan Projection section of the approved CT ARPA spending plan. The associated budget for these payments will be distributed proportionally across all provider types covered under the three DDS Medicaid waivers.

Staffing shortages have been identified statewide in all facets of the DDS provider network. To this end, funds will be distributed proportionally to all current qualified providers proportional to the authorizations of the individuals supported by such providers The intent of the payments is to assist qualified providers impacted by the pandemic, as well as to assist with recruitment and retention of provider staff. The state will require qualified providers in receipt of such payments to attest that such funds were used for the purposes outlined in this waiver section.

Services impacted: All services will be impacted except the following services: Adult Day Health, Assistive Technology, Independent Support Broker, Environmental Modifications, Individual Goods and Services, all Self-Directed Services, Interpreter, Peer Support, Personal Emergency Response System, Vehicle Modifications, Specialized Medical Equipment, Training, Counseling and Support for Unpaid Caregivers.

2) Payments for qualified day provider types covered under this waiver to modernize billing processes and systems

Explanation of payment: DDS pays a series of payments to providers over the ARPA period. The first payment was made March 2022, the next payment was made September into October 2022 and the last payment was made in September of 2023. Payments will be made proportionally to DDS providers for the purpose noted in this provision, based on previous service payments to ensure all providers receive a fair share of these funds. The funding referenced in this provision is the DDS portion of the state funding as referenced on page 4 of the Initial HCBS Spending Plan Projection section of the approved CT ARPA spending plan. The state will require qualified providers in receipt of such payments to attest that such funds were used for the purposes outlined here.

The remainder of this budget will go toward technology improvements that include software replacement to improve public reporting of HCBS metrics and, if necessary, updating system licenses. This remainder will be a part of what DDS already claims for administrative costs because the expenditures would be state agency based administrative costs.

Services impacted: All services will be impacted except the following services: Adult Day Health, Assistive Technology, Independent Support Broker, Environmental Modifications, Individual Goods and Services, all Self-Directed Services, Interpreter, Peer Support, Personal Emergency Response System, Vehicle Modifications, Specialized Medical Equipment, Training, Counseling and Support for Unpaid Caregivers.

3) Incentive-based outcome payments to any qualified day provider covered under this waiver listed above that submits a transition plan that is approved by DDS.

The transition plan must include transitioning waiver participants from a congregate day setting (Day Support Option, Group Supported Employment, Transitional Services) toward a more community and integrated, employment-based setting.

All approved transition plans will promote the independence of the individual and will articulate an anticipated result in at least one of the following outcomes:
a) Moving out of a non-employment day setting into a setting that works toward competitive integrated community employment
b) Moving into a setting that works toward competitive integrated community employment
c) Moving out of a group employment setting toward a more independent competitive integrated community employment-

based setting
d) Increasing the support hours of a day setting that works toward competitive integrated community employment to ensure continued independence
e) Transitioning support hours from a non-employment day setting with the intent of moving such hours toward a setting that works toward competitive integrated community employment.

DDS will require the qualified provider to submit the plan through the authorized template. A qualified provider that submitted a plan after 2/1/2023 and before 9/30/2024 and is approved by DDS will be eligible for the outcome payment. The payments will cease once all the funds, as noted below, are expended.

Explanation of payment: A one-time incentive-based outcome payment will be based on the scope of the plan. Providers that submit a plan for transforming one employment or day program within their agency will receive a payment . A provider that submits a plan for transforming two programs within the agency will receive a payment . A provider that submits a plan for transforming three or more programs within their agency will receive a larger set payment. The budget is the DDS portion of the total state funding as referenced on page 4 of the Initial HCBS Spending Plan Projection section of the approved CT ARPA spending plan. Payments are expected to be made to providers within 90 days of when the above criteria is met.

Services impacted: This impacts all qualified employment and day program providers as applicable that meet the criteria outlined above.

4) Incentive-based outcome payments to any day provider covered under this waiver listed above that transitions a waiver participant from a from a congregate day setting (Day Support Option , Group Supported Employment, Transitional Services) toward a more community-based employment setting, as identified in the approved transition plan.

All transitions will promote the independence of the individual and will result in at least one of the following outcomes:
a) Moving out of a non-employment day setting into a setting that works toward competitive integrated community employment
b) Moving out of a group employment setting toward a more independent competitive integrated community employment-based setting.

DDS will require a minimum stay of 60 days in the community-based employment setting in order for the congregate day provider to receive the outcome payment. The payments will cease once all the funds, as noted below, are expended.

Explanation of payment: One-time incentive-based outcome payments will be be paid out over the ARPA period across the relevant services as long as the criteria outlined above is met. The budget is the DDS portion of the total state funding as referenced on page 4 of the Initial HCBS Spending Plan Projection section of the approved CT ARPA spending plan. Payments are expected to be made to providers within 90 days of when the above criteria is met.

Services impacted: This impacts all qualified employment and day program providers as applicable that meet the criteria outlined above.

5) Incentive-based outcome payments to any qualified day provider covered under this waiver listed above that completes one of the following objectives, as part of the approved transition plan to the satisfaction of the DDS.

Defined objectives include the following:
a) Restructuring a day program to provide new supports that now focus on employment-based services
b) Restructuring a day program to support new individuals with specialized or complex medical needs and are in need of day support (as defined as an unmet day need)
c) Ending a subminimum wage arrangement for individuals supported in the program to minimum wage arrangement.

Explanation of payment: A qualified provider that successfully achieves one of the listed objectives after 2/1/2023 and before 3/31/2025, as verified by DDS, will be eligible for the outcome payment. A provider that achieves one of the listed objectives will receive a payment. The budget is the DDS portion of the total state funding as referenced on page 4 of the Initial HCBS Spending Plan Projection section of the approved CT ARPA spending plan. Payments are expected to be made to providers within 90 days of when the above criteria is met.

Services impacted: This impacts all employment and day program providers as applicable that meet the criteria outlined above.

6) Incentive payment for any DDS qualified provider that completes the National Core Indicator IDD State of the Workforce

Survey

This payment does NOT need to be a component of an approved plan. Payment for completion will be a flat payment once verification of completion is received by DDS.

Explanation of payment: A qualified provider that successfully submits the NCI Survey after 2/1/2023 and before 3/31/2025 for each of the surveys completed for the respective year of the annual survey, as verified by DDS, will be eligible for an outcome payment. A provider that submits the annual survey will receive a payment. The budget is the DDS portion of the total state funding as referenced on page 4 of the Initial HCBS Spending Plan Projection section of the approved CT ARPA spending plan. Payments are expected to be made to providers within 90 days of when the above criteria is met.

Services impacted: This impacts all qualified providers that meet the criteria outlined above.

7) Incentive payment for any DDS qualified provider for each job coach or job developer that completes training expectations consistent with professional standards from accepted accreditation or certification entities such as the Association of People Supporting Employment First (APSE), Association of Community Rehabilitation Educators (ACRE), or other similarly recognized organizations

This payment does NOT need to be a component of an approved plan. Payment for completion will be a flat outcome payment per employee trained up to a total per qualified provider agency, once verification of completion is received by DDS. The incentive payment also includes reimbursement for the cost of such training, separate from the outcome payment. Trainings noted are not a requirement to become a qualified waiver provider under CT DDS.

Explanation of payment: A qualified provider that successfully submits the training expectations for each job coach or developer that completes the training expectations consistent with professional standards from accepted accreditation or certification after 2/1/2023 and before 3/31/2025, as verified by DDS, will be eligible for an incentive payment. A provider that completes the training expectations will receive a one-time outcome payment per employee up to a total of per provider agency. The incentive payment also includes reimbursement for the cost of such training, separate from the outcome payment. The budget is the DDS portion of the total state funding as referenced on page 4 of the Initial HCBS Spending Plan Projection section of the approved CT ARPA spending plan. Payments are expected to be made to providers within 90 days of when the above criteria is met.

Services impacted: This impacts all qualified providers that meet the criteria outlined above

8) Incentive payment for any DDS qualified provider that has one or more of their staff complete training certification expectations consistent with Technology First SHIFT LLC, Rehabilitation Engineering and Assistive Technology Society of North America (RESNA) Assistive Technology professional, or other similarly recognized organizations that focus on utilization of assistive technology.

This payment does NOT need to be a component of an approved plan. Payment for completion will be a flat outcome payment per employee and up to a total per qualified provider agency, once verification of completion is received by DDS The incentive payment also includes reimbursement for the cost of such training, separate from the outcome payment. Trainings noted are not a requirement to become a qualified waiver provider under CT DDS.

Explanation of payment: A qualified provider that submits the successful assistive technology training for one or more staff after 2/1/2023 and before 3/31/2025, as verified by DDS will be eligible for an incentive payment. A provider that completes the training expectations will receive a one-time outcome payment per employee up to a total per qualified provider agency. The incentive payment also includes reimbursement for the cost of such training, separate from the outcome payment. The budget is the DDS portion of the total state funding as referenced on page 4 of the Initial HCBS Spending Plan Projection section of the approved CT ARPA spending plan. Payments are expected to be made to providers within 90 days of when the above criteria are met.

Services impacted: This impacts all qualified providers that meet the criteria outlined above.

9) Temporary enhanced rate/rate increases for specific employment waiver service authorizations covered under this waiver

All enhanced rate/rate increases will promote the independence of the individual and will result in at least one of the following outcomes:
a) Moving out of a non-employment day setting into a setting that works toward competitive integrated community employment

b) Moving into a setting that works toward employment
c) Moving out of a group employment setting toward a more independent competitive integrated community employment-based setting
d) Increasing the support hours of a day setting that works toward competitive integrated community employment to ensure continued independence
e) Transitioning support hours from a non-employment day setting with the intent of moving such hours toward a setting that works toward competitive integrated community employment.

Explanation of increase: A qualified provider that transitions individuals in accordance with their approved transition plan will receive a temporary enhanced rate above the service rate. This enhanced rate is based on either an individual's current or previous service rate specific to the outcomes identified above. Generally, the average percentage increase will be 100 percent. Increases will be evaluated based on the effectiveness of this initiative. A single transition may qualify for more than one of the enhanced rates associated with the outcomes identified above. The budget is the DDS portion of the total state funding as of 2/2023 referenced on page 4 of the Initial HCBS Spending Plan Projection section of the approved CT ARPA spending plan.

Services impacted: This impacts all employment and day program service rates as applicable that meet the criteria outlined above.

Appendix A: Waiver Administration and Operation

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

○ **The waiver is operated by the state Medicaid agency.**

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

○ **The Medical Assistance Unit.**

Specify the unit name:

(Do not complete item A-2)

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

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

(Complete item A-2-a).

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

Specify the division/unit name:

Department of Developmental Services

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

Appendix A: Waiver Administration and Operation

2. Oversight of Performance.

a. Medicaid Director Oversight of Performance When the Waiver is Operated by another Division/Unit within the State Medicaid Agency. When the waiver is operated by another division/administration within the umbrella agency designated as the Single State Medicaid Agency. Specify (a) the functions performed by that

division/administration (i.e., the Developmental Disabilities Administration within the Single State Medicaid Agency), (b) the document utilized to outline the roles and responsibilities related to waiver operation, and (c) the methods that are employed by the designated State Medicaid Director (in some instances, the head of umbrella agency) in the oversight of these activities:

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

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

The Department of Social Services (DSS) and Department of Developmental Services (DDS) utilize a Memorandum of Understanding to identify assigned waiver operational and administrative functions in accordance with waiver requirements. the memorandum of understanding is reviewed every five years or sooner if needed. This coincides with the duration of the waiver. DSS is the single state Medicaid agency responsible for the overall administration of the HCBS Waiver and assuring that federal reporting and procedural requirements are satisfied. DSS reviews the delegated waiver and administrative functions generally on a quarterly basis to ensure compliance with the MOU. In carrying out these responsibilities, DSS performs the following functions:

1. Coordinates communication with federal officials concerning the waiver; Specifies and approves policies and procedures and consults with DDS in the implementation
of such policies and procedures, that are necessary and appropriate for the administration and operation of the waiver in accordance with federal regulations and
guidance;
2. Monitors waiver operations for compliance with federal regulations including, the areas of waiver eligibility determinations, service quality
systems, plans of care, qualification of providers, and fiscal controls and accountability;
3. Determines Medicaid eligibility for potential waiver recipients/enrollee;
4. Establishes, in consultation and cooperation with DDS, the rates of reimbursement for services provided under the waiver;
5. Assists with the billing process for waiver services, completes billing process and claims for FFP for such services;
6. Prepares and submits, with assistance from DDS, all reports required by CMS or other federal agencies regarding the waiver; and,
7. Administers the hearing process through which an individual may request a reconsideration of any decisions that affect eligibility or the denial of waiver
services as provided under federal law.

As the operating agency,
DDS is responsible for the following components of the program:
1. Conducts initial assessments and required re-assessments of potential waiver enrollees/recipients using uniform assessment instrument(s), documentation
and procedure to establish whether an individual meets all eligibility criteria including that set forth as part of the evaluation and criteria in 42 CFR Sec.
441.302;
2. Documents individual plans of care for waiver recipients in format(s) approved by DSS, which set forth: (1) individual service needs, (2) waiver services
necessary to meet such needs, (3) the authorized service provider(s), and (4) the amount of waiver services authorized for the individual;
3. Establishes and maintains quality assurance and improvement systems designed to assure the ongoing recruitment of qualified providers of waiver services and
documents adherence to all applicable state and federal laws and regulations pertaining to health and welfare consistent with the assurance made in the approved
waiver application(s);
4. Develops and amends as necessary, training materials, activities, and initiatives sufficient to provide relevant DDS staff, waiver recipients, and potential
waiver recipients, information and instruction related to participation in the waiver program;
5. Maintains and enhances, as necessary, a billing system which: a.)Identifies the source documents that providers use to verify service delivery in accordance with
individual plans of care; b.)Assures that the data elements required by CMS for Federal Financial Participation (FFP) are collected and maintained at the time of
service delivery; c.)Provides computerized billing system(s) with audit capacity to identify problems and permit timely resolution; and d.)Issues complete and
accurate billing information and data to DSS in accordance with the schedules mutually established by the departments;
6. Maintains service delivery records in sufficient detail to assure that waiver services provided were authorized by individual plans of care and delivered by
qualified providers in accordance with the waiver(s);
7. Provides ongoing support and performs periodic audit and assessment of providers of waiver services;

8. Establishes and maintains a person-centered component to the evaluation and improvement activities associated with waiver services;
9. Establishes, maintains and documents the delivery of case management and broker services as indicated in the individual plan of care;
10. Establishes and maintains a system that provides for continuous monitoring of the provision of waiver services to assure compliance with applicable health and welfare standards and evaluates individual outcomes and satisfaction;
11. Approves the waiver services and settings in which such services are provided;
12. Provides payment for such services from the annual budget allocation to DDS;
13. Assists DSS in establishing and maintaining rates of reimbursement for waiver services;
14. Assists DSS in the preparation of all waiver-related reports and communications with CMS; and,
15. Consults with DSS regarding all waiver-related activities and initiatives including waiver applications and waiver amendments. DSS receives quarterly reports from DDS as outlined in Appendix H (Quality Management) and meets with DDS on a quarterly basis to review key operating agency activities. DSS meets with DDS on an as needed basis to review individual or systemic issues as they arise. DSS prepares the annual 372 reports.

Appendix A: Waiver Administration and Operation

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

◉ **Yes. Contracted entities perform waiver operational and administrative functions on behalf of the Medicaid agency and/or operating agency (if applicable).**
Specify the types of contracted entities and briefly describe the functions that they perform. *Complete Items A-5 and A-6.:*

MMIS system operated through a contract between DSS and Gainwell (formerly DXC). DDS contracts with Fiscal Intermediaries to support individuals who serve as the employer of record, and to process invoices and makes payment for services for DDS.

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

Appendix A: Waiver Administration and Operation

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

◉ **Not applicable**

○ **Applicable** - Local/regional non-state agencies perform waiver operational and administrative functions.
Check each that applies:

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

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

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

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

Appendix A: Waiver Administration and Operation

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

Department of Developmental Services

Appendix A: Waiver Administration and Operation

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

1. The DDS Fiscal Intermediaries are monitored by DDS per the terms of the contract. This includes quarterly meeting with DDS, maintenance of a complaint log by DDS,
an audit of the organization as a whole by a licensed independent certified public accountant and submitted to the Department annually, with agreed upon procedures for the
management of the DDS funds under the control of the fiscal intermediary.
2. The fiscal intermediary is subject to audit by the Department, agents of the Department, and the State of Connecticut's Auditors of Public Accounts. Records must be made
available in CT for the audit.
3. A copy of the most recent financial statement, with an opinion letter from a CPA with a CT license or by a CPA in the state the vendor performs business in, is required as
a part of the RFP proposal.
4. Fiscal Intermediaries must submit a cost report as requested for rate analysis.

Appendix A: Waiver Administration and Operation

7. **Distribution of Waiver Operational and Administrative Functions.** In the following table, specify the entity or entities that have responsibility for conducting each of the waiver operational and administrative functions listed (*check each that applies*):
In accordance with 42 CFR § 431.10, when the Medicaid agency does not directly conduct a function, it supervises the performance of the function and establishes and/or approves policies that affect the function. All functions not performed directly by the Medicaid agency must be delegated in writing and monitored by the Medicaid Agency. *Note: More than one box may be checked per item. Ensure that Medicaid is checked when the Single State Medicaid Agency (1) conducts the function directly; (2) supervises the delegated function; and/or (3) establishes and/or approves policies related to the function.* Note: Medicaid eligibility determinations can only be performed by the State Medicaid Agency (SMA) or a government agency delegated by the SMA in accordance with 42 CFR § 431.10. Thus, eligibility determinations for the group described in 42 CFR § 435.217 (which includes a level-of-care evaluation, because meeting a 1915(c) level of care is a factor of determining Medicaid eligibility for the group) must comply with 42 CFR § 431.10. Non-governmental entities can support administrative functions of the eligibility determination process that do not require discretion including, for example, data entry functions, IT support, and implementation of a standardized level-of-care evaluation tool. States should ensure that any use of an evaluation tool by a non-governmental entity to evaluate/determine an individual's required level-of-care involves no discretion by the non-governmental entity and that the development of the requirements, rules, and policies operationalized by the tool are overseen by the state agency.

Function	Medicaid Agency	Other State Operating Agency	Contracted Entity
Participant waiver enrollment	☒	☐	☐
Waiver enrollment managed against approved limits	☒	☒	☐
Waiver expenditures managed against approved levels	☒	☒	☒
Level of care waiver eligibility evaluation	☒	☒	☐
Review of Participant service plans	☒	☒	☐
Prior authorization of waiver services	☒	☒	☐
Utilization management	☒	☒	☐
Qualified provider enrollment	☒	☒	☐
Execution of Medicaid provider agreements	☒	☐	☐
Establishment of a statewide rate methodology	☒	☐	☐
Rules, policies, procedures and information development governing the waiver program	☒	☒	☐
Quality assurance and quality improvement activities	☒	☒	☐

Appendix A: Waiver Administration and Operation

Quality Improvement: Administrative Authority of the Single State Medicaid Agency

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

a. Methods for Discovery: Administrative Authority

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

i. Performance Measures

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

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

Where possible, include numerator/denominator.

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

Performance Measure:
Number and percent of waiver policies and procedures approved by DSS prior to implementation. Numerator=number of new DDS policies and procedures approved by DSS Denominator=number of new DDS policies and procedures

Data Source (Select one):
Presentation of policies or procedures
If 'Other' is selected, specify:

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

Data Aggregation and Analysis:

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

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

Performance Measure:
Number and percent of records reviewed by DSS that met the Level of Care requirements conducted by DDS as required in the DDS/DSS MOU. Numerator=number of records reviewed by Medicaid Agency that met Level of Care requirements. Denominator=number of records reviewed by Medicaid Agency.

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

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☒ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☒ **Other** Specify: DDS CT sends DSS 45 records per quarter total 180 per year this was the agreed upon upon by the State Medicaid Agency.

	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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

b. Methods for Remediation/Fixing Individual Problems

i. Describe the state's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction and the state's method for analyzing information from individual problems, identifying systemic deficiencies, and implementing remediation actions. In addition, provide information on the methods used by the state to document these items.

Individual specific findings are entered into the —My QSRǁ **data application and communicated to the service provider or case manager as appropriate for corrective action on an individual basis. The CM Supervisor monitors case management follow-up.**

Provider systemic findings are presented and monitored for corrective action by the Regional Resource Management Unit during provider performance review meetings.

DDS system wide data is presented to the DDS Systems Design Committee. QI plans may be developed that address case management, service providers and system issues depending on the findings.

DSS meets with DDS managers on a quarterly basis to discuss findings and make recommendations for system improvement.

ii. Remediation Data Aggregation

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

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

c. Timelines

When the state does not have all elements of the quality improvement strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Administrative Authority that are currently non-operational.

◉ **No**

○ **Yes**

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

Appendix B: Participant Access and Eligibility

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

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

Target Group	Included	Target Sub Group	Minimum Age	Maximum Age	
				Maximum Age Limit	No Maximum Age Limit
☐ **Aged or Disabled, or Both - General**					
	☐	**Aged**			☐
	☐	**Disabled (Physical)**			
	☐	**Disabled (Other)**			
☐ **Aged or Disabled, or Both - Specific Recognized Subgroups**					
	☐	**Brain Injury**			☐
	☐	**HIV/AIDS**			☐

Target Group	Included	Target Sub Group	Minimum Age	Maximum Age	
				Maximum Age Limit	No Maximum Age Limit
	☐	Medically Fragile			☐
	☐	Technology Dependent			☐
☒ Intellectual Disability or Developmental Disability, or Both					
	☐	Autism			☐
	☒	Developmental Disability	18		☒
	☒	Intellectual Disability	3		☒
☐ Mental Illness					
	☐	Mental Illness			☐
	☐	Serious Emotional Disturbance			

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

Eligibility for services from the Department of Developmental Services is based on CGS 1-1g which requires eligible individuals to have an IQ of 69 or lower concurrent with deficits in adaptive behavior during the developmental period. Also included are those determined eligible for DDS services as a result of a hearing conducted by DDS according to the Uniform Administrative Procedures Act or administrative determination of the Commissioner.

Developmental Disability as a target group is limited to individuals who are developmentally disabled who currently reside in general NFs, but who have been shown, as a result of the Pre-Admission Screening and Annual Resident Review process mandated by P.L. 100-203 to require active treatment at the level of an ICF/IID
Additional target groups children with significant medical needs who would require institutionalization without waiver services such as respite, adults who reside in the family home or adults who do not require 24/7 services in order to remain in their own homes. These individuals have significant natural supports, generic community services and/or state plan services available to them in addition to the services available under this waiver.

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

◉ **Not applicable. There is no maximum age limit**

○ **The following transition planning procedures are employed for participants who will reach the waiver's maximum age limit.**

Specify:

Appendix B: Participant Access and Eligibility

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

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

○ **No Cost Limit.** The state does not apply an individual cost limit. *Do not complete Item B-2-b or item B-2-c.*

○ **Cost Limit in Excess of Institutional Costs.** The state refuses entrance to the waiver to any otherwise eligible

individual when the state reasonably expects that the cost of the home and community-based services furnished to that individual would exceed the cost of a level of care specified for the waiver up to an amount specified by the state. *Complete Items B-2-b and B-2-c.*

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

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

Specify the percentage:

○ **Other**

Specify:

○ **Institutional Cost Limit.** Pursuant to 42 CFR § 441.301(a)(3), the state refuses entrance to the waiver to any otherwise eligible individual when the state reasonably expects that the cost of the home and community-based services furnished to that individual would exceed 100% of the cost of the level of care specified for the waiver. *Complete Items B-2-b and B-2-c.*

◉ **Cost Limit Lower Than Institutional Costs.** The state refuses entrance to the waiver to any otherwise qualified individual when the state reasonably expects that the cost of home and community-based services furnished to that individual would exceed the following amount specified by the state that is less than the cost of a level of care specified for the waiver.

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

Individuals are placed on this waiver based on assessed need. If needs exceed the cost limit of $75,000 the individual would
not be placed on this waiver. If the needs of an individual on this waiver change and additional funding is required they would
be considered for additional temporary funding or placement on one of the other DDS waivers.

The cost limit is based on the CT DDS Level of Need Assessment and Screening Tool (LON) funding allocation for day/employments supports to ensure the health and safety of the participants and ensures access to day/employment supports regardless of the persons level of need.

The allocation is based on the assessed need using the LON and DDS CT funding guidelines published and used by DDS Planning and Allocation Team (PRAT).

The Utilization Resource Review (URR) team process is used to safeguard if an amount exceeds the individual cost limit. The increase is reviewed on a case by case basis with an intermittent review established by the URR team and based on documented need as supported by medical or behavioral documentation.

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

◉ **The following dollar amount:**

Specify dollar amount: 75000

The dollar amount *(select one)*

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

Specify the formula:

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

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

Specify percent:

○ **Other:**

Specify:

Appendix B: Participant Access and Eligibility

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

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

Prospective funding allocations are based on the individual's assessed level of need using the CT Level of Need Assessment and Screening Tool (LON). The team submits a request for services to the Regional Planning and Allocation Team. Based on the findings of the LON Assessment, the PRAT notifies the team of the funding allocations. The team initiates the Individual Planning process in advance of enrollment in a DDS waiver. If the team determines that the initial allocation is insufficient to meet the individuals needs, the team submits a request for utilization review to the PRAT for consideration. The PRAT determines if a higher funding amount is justified and if the funding amount falls within the overall limits of the Employment and Day Supports (EDS) waiver. If approved, the participant will complete enrollment in the Employment and Day Supports waiver and the Individual budget is reviewed and authorizations to initiate services are processed. If the PRAT does not approve the higher funding request, the individual is provided opportunity to informally negotiate a resolution and is simultaneously notified of his/her fair hearing rights as a result of being denied enrollment in the DDS Employment and Day Supports waiver. If the PRAT agrees the individual requires higher funding than is permitted in the Employment and Day Supports waiver prior to enrollment, the PRAT will consider the individual for eligibility in the either the DDS Individual and Family Support waiver or the DDS Comprehensive Support waiver following the DDS priority assignment procedures in the management of the DDS waiting list.

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

☒ **The participant is referred to another waiver that can accommodate the individual's needs.**

☒ **Additional services in excess of the individual cost limit may be authorized.**

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

The case manager submits to the PRAT a request for additional services/funding and an updated Level of Need Assessment supporting the request. The PRAT may authorize funding up to the amount associated with the participants newly determined Level of Need. If the request exceeds the overall limit of the Employment and Day Supports (EDS) Waiver, the PRAT can authorize funding up to $20,000 more than the EDS waiver limit on a non-annualized basis to meet the participants immediate needs while other alternatives are coordinated or to meet emergency needs that are not expected to be long-term (i.e. enhanced supports due acute medical needs of the participant, or a temporary change in the capacity of natural supports). If the need for additional is expected to be long term the individual will be placed on one of the other DDS waivers. If additional funding is not authorized the individual is informed that he/she can request an informal resolution by requesting a Programmatic Administrative Review with the Regional Director, and/or a Fair Hearing with DSS or can be referred to an ICF/IID setting.

☐ **Other safeguard(s)**

Specify:

Appendix B: Participant Access and Eligibility

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

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

Table: B-3-a

Waiver Year	Unduplicated Number of Participants
Year 1	2491
Year 2	2703
Year 3	2915
Year 4	3127
Year 5	3339

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

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

◉ **The state limits the number of participants that it serves at any point in time during a waiver year.**

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

Table: B-3-b

Waiver Year	Maximum Number of Participants Served At Any Point During the Year
Year 1	2350
Year 2	

Waiver Year	Maximum Number of Participants Served At Any Point During the Year
	2550
Year 3	2750
Year 4	2950
Year 5	3150

Appendix B: Participant Access and Eligibility

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

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

○ **Not applicable. The state does not reserve capacity.**

◉ **The state reserves capacity for the following purpose(s).**

Purpose(s) the state reserves capacity for:

Purposes	
High School Graduates	

Appendix B: Participant Access and Eligibility

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

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

High School Graduates

Purpose *(describe):*

Individuals who are graduating from high school and who will require employment or day supports.

Describe how the amount of reserved capacity was determined:

Historical data on the number of high school graduates whose assessed CT DDS Level of Need Assessment and Screening Tool indicates that their needs can be met with the funding level and range of services available in this waiver.

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

Waiver Year	Capacity Reserved
Year 1	200
Year 2	200
Year 3	200
Year 4	200
Year 5	200

Appendix B: Participant Access and Eligibility

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

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

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

e. Allocation of Waiver Capacity.

Select one:

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

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

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

The State DDS uses a priority system to select individuals for entrance to the DDS waivers. The DDS utilizes findings from the CT DDS Level of Need Assessment and Screening Tool and collects findings on additional questions pertaining to individual and caregiver status. The system assigns either an Emergency, Urgent or Future Need status as a result of the screening tools. Those identified as an Emergency are given first priority to the appropriate waiver program when slots are available. The Urgent category is afforded the next priority. Beyond the reserved capacity, emergency status and those in the Urgent category, applicants are managed on a first come, first serve basis. Individuals who are dissatisfied with category assignment may request in writing to the Commissioner of DDS an administrative hearing pursuant to sub-section (e), section 17a-210, G.S., or, may initiate an informal dispute resolution process, Programmatic Administrative Review (PAR) set forth in DDS procedure No. I.F.PR.011. Individuals who request a PAR may also request a Fair Hearing at any time.

Appendix B: Participant Access and Eligibility

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

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

Appendix B: Participant Access and Eligibility

B-4: Eligibility Groups Served in the Waiver

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

- ( ) **Section 1634 State**
- ( ) **SSI Criteria State**
- (●) **209(b) State**

2. Miller Trust State.

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

- (●) **No**
- ( ) **Yes**

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

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

- [ ] **Parents and Other Caretaker Relatives (42 CFR § 435.110)**
- [ ] **Pregnant Women (42 CFR § 435.116)**
- [ ] **Infants and Children under Age 19 (42 CFR § 435.118)**
- [ ] **SSI recipients**
- [x] **Aged, blind or disabled in 209(b) states who are eligible under 42 CFR § 435.121**
- [x] **Optional state supplement recipients**
- [ ] **Optional categorically needy aged and/or disabled individuals who have income at:**

  Select one:

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

    Specify percentage: [ ]

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

  Specify:

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

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

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

  Select one and complete Appendix B-5.

  - ( ) **All individuals in the special home and community-based waiver group under 42 CFR § 435.217**

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

Check each that applies:

☒ **A special income level equal to:**

Select one:

◉ **300% of the SSI Federal Benefit Rate (FBR)**

○ **A percentage of FBR, which is lower than 300% (42 CFR § 435.236)**

Specify percentage:

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

Specify dollar amount:

☒ **Aged, blind and disabled individuals who meet requirements that are more restrictive than the SSI program (42 CFR § 435.121)**

☐ **Medically needy without spend down in states which also provide Medicaid to recipients of SSI (42 CFR § 435.320, § 435.322 and § 435.324)**

☐ **Medically needy without spend down in 209(b) States (42 CFR § 435.330)**

☐ **Aged and disabled individuals who have income at:**

Select one:

○ **100% of FPL**

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

Specify percentage amount:

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

Specify:

Appendix B: Participant Access and Eligibility

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

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

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

Note: For the period beginning January 1, 2014 and extending through September 30, 2027 (or other date as required by law), the following instructions are mandatory. The following box should be checked for all waivers that furnish waiver services to the 42 CFR § 435.217 group effective at any point during this time period.

☒ **Spousal impoverishment rules under section 1924 of the Act are used to determine the eligibility of individuals with a community spouse for the special home and community-based waiver group. In the case of a participant with a community spouse, the state uses *spousal* post-eligibility rules under section 1924 of the Act.**

Complete Items B-5-e (if the selection for B-4-a-i is SSI State or section 1634) or B-5-f (if the selection for B-4-a-i is 209b State) and Item B-5-g unless the state indicates that it also uses spousal post-eligibility rules for the time period after September 30, 2027 (or other date as required by law).

Note: The following selections apply for the time period after September 30, 2027 (or other date as required by law) (select one).

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

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

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

○ **Use regular post-eligibility rules under 42 CFR § 435.726 (Section 1634 State/SSI Criteria State) or under § 435.735 (209b State)**
(Complete Item B-5-c (209b State). Do not complete Item B-5-d)

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

Appendix B: Participant Access and Eligibility

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

Note: The following selections apply for the time period after September 30, 2027 (or other date as required by law).

b. Regular Post-Eligibility Treatment of Income: Section 1634 State and SSI Criteria State after September 30, 2027 (or other date as required by law).

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

Appendix B: Participant Access and Eligibility

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

Note: The following selections apply for the time period after September 30, 2027 (or other date as required by law).

c. Regular Post-Eligibility Treatment of Income: 209(b) State or after September 30, 2027 (or other date as required by law).

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

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

○ **The following standard included under the state plan**

(*select one*):

○ **The following standard under 42 CFR § 435.121**

Specify:

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

(*select one*):

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

Specify percentage:

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

Specify dollar amount:

- ○ **A percentage of the Federal poverty level**

Specify percentage:

- ○ **Other standard included under the state plan**

Specify:

- ○ **The following dollar amount**

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

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

Specify:

- ◉ **Other**

Specify:

200% of the federal poverty level

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

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

Specify:

Specify the amount of the allowance (*select one*):

- ○ **The following standard under 42 CFR § 435.121**

Specify:

○ **Optional state supplement standard**

○ **Medically needy income standard**

○ **The following dollar amount:**

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

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

Specify:

iii. Allowance for the family (*select one*):

○ **Not Applicable (see instructions)**

○ **AFDC need standard**

◉ **Medically needy income standard**

○ **The following dollar amount:**

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

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

Specify:

○ **Other**

Specify:

iv. Amounts for incurred medical or remedial care expenses not subject to payment by a third party, specified in 42 CFR § 435.735:

a. Health insurance premiums, deductibles and co-insurance charges

b. Necessary medical or remedial care expenses recognized under state law but not covered under the state's Medicaid plan, subject to reasonable limits that the state may establish on the amounts of these expenses.

Select one:

○ **Not Applicable (see instructions)** *Note: If the state protects the maximum amount for the waiver participant, not applicable must be selected.*

◉ **The state does not establish reasonable limits.**

○ **The state establishes the following reasonable limits**

Specify:

Appendix B: Participant Access and Eligibility

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

Note: The following selections apply for the time period after September 30, 2027 (or other date as required by law).

d. Post-Eligibility Treatment of Income Using Spousal Impoverishment Rules after September 30, 2027 (or other date as required by law)

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

i. Allowance for the personal needs of the waiver participant

(*select one*):

○ **SSI standard**

○ **Optional state supplement standard**

○ **Medically needy income standard**

○ **The special income level for institutionalized persons**

◉ **A percentage of the Federal poverty level**

Specify percentage: 200

○ **The following dollar amount:**

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

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

Specify formula:

○ **Other**

Specify:

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

Select one:

- (●) **Allowance is the same**
- ( ) **Allowance is different.**

Explanation of difference:

iii. Amounts for incurred medical or remedial care expenses not subject to payment by a third party, specified in 42 CFR § 435.726 or 42 CFR § 435.735:

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

Select one:

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

Appendix B: Participant Access and Eligibility

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

Note: The following selections apply for the period beginning January 1, 2014 and extending through September 30, 2027 (or other date as required by law).

e. Regular Post-Eligibility Treatment of Income: Section 1634 State or SSI Criteria State – January 1, 2014 through September 30, 2027 (or other date as required by law).

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

Appendix B: Participant Access and Eligibility

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

Note: The following selections apply for the period beginning January 1, 2014 and extending through September 30, 2027 (or other date as required by law).

f. Regular Post-Eligibility Treatment of Income: 209(b) State – January 1, 2014 through September 30, 2027 (or other date as required by law).

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

Appendix B: Participant Access and Eligibility

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

Note: The following selections apply for the period beginning January 1, 2014 and extending through September 30, 2027 (or other date as required by law).

g. Post-Eligibility Treatment of Income Using Spousal Impoverishment Rules – January 1, 2014 through September 30, 2027 (or other date as required by law).

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

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

Appendix B: Participant Access and Eligibility

B-6: Evaluation/Reevaluation of Level of Care

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

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

i. Minimum number of services.

The minimum number of waiver services (one or more) that an individual must require in order to be determined to need waiver services is: 1

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

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

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

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

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

Specify the entity:

- ( ) **Other**

Specify:

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

Case managers, CM Supervisors or other DDS Managers or clinicians who meet the following QIDP standards:

An individual who has received: at least a bachelors degree from a college or university (master and doctorate degrees are also acceptable) and has received academic credit for a major or minor coursework concentration in a human services field. Human services field includes all any academic disciplines associated with the study of: human behavior (e.g., psychology, sociology, speech communication, gerontology etc.), human skill development (e.g., education, counseling, human development), humans and their cultural behavior (e.g., anthropology), or any other study of services related to basic human care needs (e.g., rehabilitation counseling), or the human condition (e.g., literature, the arts) and who has demonstrated competency to do the job.

Ongoing competency is evaluated through supervision, training and oversight provided by a Supervisor of Case Management and Annual Performance Review is required for all case managers.

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

There is reasonable indication that the person, but for the provision of waiver services would require placement in an ICF/IID. The person requires assistance due to one or more of the following:

1. Has a physical or medical disability requiring substantial and/or routine assistance as well as habilitative support in performing self-care and daily activities.
2. Has a deficit in self-care and daily living skills requiring habilitative training.
3. Has a maladaptive social and/or interpersonal patterns to the extent that he/she is incapable of conducting self-care or activities of daily living without habilitative training.

This determination is made through a planning and support team process utilizing the CT Level of Need Assessment and Screening Tool (LON). Development of the LON was funded through a CMS Systems Change Grant. The LON is a comprehensive assessment of an individual's level of support needs and identification of risk areas in the following domains: Health/Medical, PICA, Behavior, Psychiatric, Criminal/Sexual, Seizure, Mobility, Safety, Comprehension and Understanding, Social Life, Communication, Personal Care, and Daily Living. The Composite Score on the CT LON is be used to validate the participants Level of Care. A Composite score of 1 or greater on this tool is required in order to show that the participant requires an ICF/IID Level of Care. The scoring algorithm used to calculate the Composite score incorporates the scores from the domains listed above and results in an overall score ranging from 1 to 8.

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

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

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

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

This determination is made through a planning and support team process utilizing the CT Level of Need Assessment and Screening Tool (LON). Development of the LON was funded through a CMS Systems Change Grant. The LON is a comprehensive assessment of an individual's level of support needs and identification of risk areas in the following domains: Health/Medical, PICA, Behavior, Psychiatric, Criminal/Sexual, Seizure, Mobility, Safety, Comprehension and Understanding, Social Life, Communication, Personal Care, and Daily Living. The Composite Score on the CT LON is be used to validate the participants Level of Care. A Composite score of 1 or greater on this tool is required in order to show that the participant requires an ICF/IID Level of Care. The scoring algorithm used to calculate the Composite score incorporates the scores from the domains listed above and results in an overall score ranging from 1 to 8. The DDS case manager with the Individual Support Team completes the initial, or reviews the existing, CT LON assessment and makes updates as required by changes in the individual. The score on the CT LON determines whether or not the participant meets, or continues to meet, the ICF/IID Level of Care.

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

- ○ **Every three months**
- ○ **Every six months**
- ◉ **Every twelve months**
- ○ **Other schedule**

  Specify the other schedule:

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

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

  Specify the qualifications:

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

The CT automated consumer information system (CAMRIS) maintains the date of the last Individual Annual Plan review. The Level of Care determination is completed at the time of each review. The case manager and case manager supervisor use this system as a tickler system.

Individual Plan data is reviewed quarterly by Central Office staff and distributed to appropriate regional staff with a timeframe for correction. In addition, Supervisors of Case Management conduct Quality Service Reviews (QSR) which include eveluation of the timeliness of the Individual Plan, including the Level of Care determination. If the QSR identifies that the LOC is either not completed or not current a corrective action plan (CAP) is developed with specific follow-up and timeframes provided. The QSR computer application tracks these CAPs.

j. Maintenance of Evaluation/Reevaluation Records. Per 42 CFR § 441.303(c)(3), the state assures that written and/or electronically retrievable documentation of all evaluations and reevaluations are maintained for a minimum period of 3 years as required in 45 CFR § 92.42. Specify the location(s) where records of evaluations and reevaluations of level of care are maintained:

All evaluations and re-evaluations are available in the DDS web-based application for the LON. LON evaluations and re-evaluations are available in the DDS case management record. The initial evaluations are also maintained in the individuals DSS records.

Appendix B: Evaluation/Reevaluation of Level of Care

Quality Improvement: Level of Care

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

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

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

i. Sub-Assurances:

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

Performance Measures

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

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

Performance Measure:
Number and percent of waiver applicants who had a Level of Care/Need assessment to identify ICF/IID LOC prior to receipt of services. Numerator=number of waiver applicants who had Level of Care/Need assessment indicating ICF/IID need. Denominator=number of waiver applicants

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

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

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

Data Aggregation and Analysis:

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

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

Performance Measures

For each performance measure the state will use to assess compliance with the statutory assurance (or sub-

assurance), complete the following. Where possible, include numerator/denominator.

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

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

Performance Measures

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

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

Performance Measure:
Number and percentage of initial Level of Care assessments that were completed as required by the State. Numerator=number of initial Level of Care assessment required by the State. Denominator=number of initial Level of Care assessment required to be completed.

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

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

	☒ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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

b. Methods for Remediation/Fixing Individual Problems

i. Describe the state's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction and the state's method for analyzing information from individual problems, identifying systemic deficiencies, and implementing remediation actions. In addition, provide information on the methods used by the state to document these items.

The CO Waiver Policy and Enrollment Unit notifies the Regional Case Management Supervisor of findings from individual

initial enrollment reviews and record audits. Corrective actions are completed in the Regional Offices and reported back to the CO Waiver Policy and Enrollment Unit.

The Case Manager Supervisor ensures remediation of any individual or case manager specific issues identified in the LOC determination review.

ii. Remediation Data Aggregation

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

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

c. Timelines

When the state does not have all elements of the quality improvement strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Level of Care that are currently non-operational.

◉ **No**

○ **Yes**

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

Appendix B: Participant Access and Eligibility

B-7: Freedom of Choice

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

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

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

Individuals seeking services from DDS are notified of the alternatives available under the waiver and are informed of their option to choose institutional or waiver services by the DDS case manager. This decision is documented on Form 222, Service Selection Form. The State provides individuals with the HCBS waiver Fact Sheet, and with the Guide to Understanding the DDS HCBS Waivers for Individuals and Families at the annual planning meeting, and both are available on the DDS web site.

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

DDS case management record and DSS record.

Appendix B: Participant Access and Eligibility

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

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

The State DDS prepares HCBS waiver informational materials in English and Spanish and posts both to the DDS web site. Additionally, the DDS utilizes a Language Interpreter service to ensure that all individuals who call the DDS at the Central Office or Regional locations will have language interpreter service immediately upon the call. DDS policy states that language interpretation service will be provided free of charge at all intake, formal planning meetings, hearings or informal dispute resolution process sessions. Once enrolled in an HCBS waiver, interpreter services are also included as a covered waiver service for other purposes as detailed in the plan.

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	**Blended Supports**		
Statutory Service	**Group Day Supports aka Community Based Day Support Options**		
Statutory Service	**Individual Supported Employment**		
Statutory Service	**Prevocational Services**		
Statutory Service	**Respite**		
Supports for Participant Direction	**Independent Support Broker**		
Supports for Participant Direction	**Peer Support**		
Other Service	**Assistive Technology**		
Other Service	**Behavioral Support Services**		
Other Service	**Customized Employment Supports**		
Other Service	**Employment Transitional Services**		
Other Service	**Environmental Modifications**		
Other Service	**Group Supported Employment**		
Other Service	**Home Delivered Meals**		
Other Service	**Individual Direct Goods and Services**		
Other Service	**Individualized Day Support**		
Other Service	**Interpreter**		
Other Service	**Personal Emergency Response System (PERS)**		

Service Type	Service
Other Service	Remote Supports Services
Other Service	Specialized Medical Equipment and Supplies
Other Service	Training, Counseling and Support Services for Unpaid Caregivers
Other Service	Transportation
Other Service	Vehicle Modifications
Other Service	Virtual Health Consultation

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Statutory Service

Service:

Adult Day Health

Alternate Service Title (if any):

HCBS Taxonomy:

Category 1:	Sub-Category 1:
04 Day Services	04050 adult day health
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):*

Adult day health services are provided through a community-based program designed to meet the needs of cognitively and physically impaired adults through a structure, comprehensive program that provides a variety of health, social and related support services including socialization, supervision and monitoring, personal care and nutrition in a protective setting during any part of a day. There are two different models of adult day health services: the social model and the medical model. Both models shall include the minimum requirements described in Section 17b-342-2(b)(2) of the DSS regulations. In order to qualify as a medical model, adult day health services shall also meet the requirements described in Section 17b-

342-2(b)(3) of the DSS regulations. May not be provided at the same time as Community Based Day Support Options, Individualized Day Supports, Supported Employment, or Respite.

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**

☐ **Remote/via Telehealth**

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

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 Agencies

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Provider must meet the requirements of Section 17b-342-2(b)(2) of the DSS regulations. Providers of the medical model of Adult Day Health must also meet the requirements of Section 17b-342-2(b)(3) of the DSS regulations
The agency must ensure that all employees meet the following qualifications:
Prior to Employment
·18 yrs of age
·criminal background check
·registry check
·have ability to communicate effectively with the individual/family
·have ability to complete record keeping as required by the employer
Prior to being alone with the Individual:
·demonstrate competence in knowledge of DDS policies and procedures: abuse/neglect; incident reporting; client rights and confidentiality; handling fire and other emergencies; prevention of sexual abuse; knowledge of approved and prohibited physical management techniques
·demonstrate competence/knowledge in topics required to safely support the individual as described in the Individual Plan
·demonstrate competence, skills, abilities, education and/or experience necessary to achieve the specific training outcomes

as described in the Individual Plan
·ability to participate as a member of the circle if requested by the individual
·demonstrate understanding of Person Centered Planning
·Medication Administration*
* if required by the individual supported

Verification of Provider Qualifications

Entity Responsible for Verification:

DSS Contracted Fiscal Agencies

Frequency of Verification:

Every 3 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:

Habilitation

Alternate Service Title (if any):

Blended Supports

HCBS Taxonomy:

Category 1:	**Sub-Category 1:**
04 Day Services	04020 day habilitation
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):*

This service provides assistance with the acquisition, improvement and/or retention of skills and provides necessary support to achieve personal habilitation outcomes that enhance an individuals ability to live or work in their community as specified in the plan of care. This service includes a combination of habilitation and personal support activities as they would naturally occur during the course of a day. This service is not available for use in licensed settings. The service may be delivered in a personal home (ones own or family home), work that is based in the community. This a separate and distinct service. Payments for Blended Supports do not include room and board. May not be provided at the same time as Adult Day Health, Prevocational services, Group Supported employment, Transitional Services, Group Day, Individualized Day Supports, Peer Support, Individual Supported Employment and Respite.

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**
- ☐ **Remote/via Telehealth**

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	DDS or Private Provider
Individual	Direct Hire/Individual

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Blended Supports

Provider Category:

Agency

Provider Type:

DDS or Private Provider

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

The agency will ensure that employees meet the following qualifications:
Prior to Employment
- 18 yrs of age
- criminal background check
- registry check
- have ability to communicate effectively with the individual/family
- have ability to complete record keeping as required by the employer

Prior to being alone with the Individual:

• demonstrate competence in knowledge of DDS policies and procedures: abuse/neglect; incident reporting; client rights and confidentiality; handling fire and other emergencies, prevention of sexual abuse, knowledge of approved and prohibited physical management techniques
• demonstrate competence/knowledge in topics required to safely support the individual as described in the Individual Plan
• demonstrate competence, skills, abilities, education and/or experience necessary to achieve the specific training outcomes as described in the Individual Plan
• ability to participate as a member of the circle if requested by the individual
• demonstrate understanding of Person Centered Planning
• Medication Administration*
* if required by the individual supported

Verification of Provider Qualifications

Entity Responsible for Verification:

DDS or Designee

Frequency of Verification:

Initial

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Blended Supports

Provider Category:

Individual

Provider Type:

Direct Hire/Individual

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

The FI will verify that employees meet the following qualifications:
Prior to Employment
• 18 yrs of age
• criminal background check
• registry check
• have ability to communicate effectively with the individual/family
• have ability to complete record keeping as required by the employer

Prior to being alone with the Individual:
• demonstrate competence in knowledge of DDS policies and procedures: abuse/neglect; incident reporting; client rights and confidentiality; handling fire and other emergencies, prevention of sexual abuse, knowledge of approved and prohibited physical management techniques
• demonstrate competence/knowledge in topics required to safely support the individual as described in the Individual Plan
• demonstrate competence, skills, abilities, education and/or experience necessary to achieve the specific training outcomes as described in the Individual Plan
• ability to participate as a member of the team if requested by the individual
• demonstrate understanding of Person Centered Planning
• Medication Administration*

* if required by the individual supported

Verification of Provider Qualifications

Entity Responsible for Verification:

FI or DDS Designee

Frequency of Verification:

Prior to employment

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Statutory Service

Service:

Day Habilitation

Alternate Service Title (if any):

Group Day Supports aka Community Based Day Support Options

HCBS Taxonomy:

Category 1:	Sub-Category 1:
04 Day Services	04020 day habilitation
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 and supports leading to the acquisition, improvement and/or retention of skills and abilities to prepare an individual for work and/or community participation, or support meaningful socialization, leisure and retirement activities. This service is provided by a qualified provider in a facility-based program or appropriate community locations. Transportation to and from home is included as part of this waiver service. The agency rate is adjusted for transportation costs based on mileage and type of vehicle required. This service may not be provided at the same time as Individualized Day Supports, Individual

or Group Supported Employment, Adult Day Health or Respite.

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

This service is limited to no more than 8 hours per day. The Per Diem rate is utilized for participants who regularly receive this service for five and a half hours or more per day.

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

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

☒ **Provider managed**

☐ **Remote/via Telehealth**

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

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Group Day Supports aka Community Based Day Support Options

Provider Category:

Agency

Provider Type:

Provider Agencies

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

The agency meets the qualifications described in DDS Procedure PR.015 Qualifying Providers. In addition, the agency ensures that employees meet the following qualifications prior to employment:
·18 yrs of age
·criminal background check
·registry check
·have ability to communicate effectively with the individual/family
·have ability to complete record keeping as required by the employer
The agency ensures that employees meet the following qualifications prior to being alone with the Individual:
·demonstrate competence in knowledge of DDS policies and procedures: abuse/neglect; incident reporting; client rights and confidentiality; handling fire and other emergencies, prevention of sexual abuse, knowledge of approved and prohibited physical management techniques
·demonstrate competence/knowledge in topics required to safely support the individual as described in the Individual Plan
·demonstrate competence, skills, abilities, education and/or experience necessary to achieve the specific training outcomes as described in the Individual Plan
·ability to participate as a member of the circle if requested by the individual
·demonstrate understanding of Person Centered Planning

·Medication Administration*
* if required by the individual supported

Verification of Provider Qualifications

Entity Responsible for Verification:

DDS or designee

Frequency of Verification:

Initial and every 2 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:

Supported Employment

Alternate Service Title (if any):

Individual Supported Employment

HCBS Taxonomy:

Category 1:	Sub-Category 1:
03 Supported Employment	03021 ongoing supported employment, individual
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):*

Individual supported employment consists of intensive, ongoing supports that enable participants, for whom competitive employment at or above the minimum wage is unlikely absent the provision of supports, and who because of their disabilities, need supports to perform in a regular work setting. Can include face-to-face interactions including Face Time or

comparable technology(such as IPAD, IPHONE) in accordance with all HIPAA requirements that are designed to promote ongoing engagement of waiver participants towards the participant's personal goals. Individual supported employment may include assisting the participant to locate a job or develop a customized job on behalf of the participant. Individual supported employment is conducted in a variety of community settings where persons without disabilities are employed. Individual supported employment includes activities needed to sustain paid work by participants, including supervision and training. When Individual supported employment services are provided at a work site where persons without disabilities are employed, payment is made only for adaptations, supervision and training required by participants receiving waiver services as a result of their disabilities but does not include payment for supervisory activities rendered as a normal part of the business setting. Individual supported employment does not include sheltered work or similar types of vocational services furnished in specialized facilities. Individual supported employment services may be furnished to participants who are paid at a rate more than minimum wage, provided that the participant requires Individual supported employment services in order to sustain employment. Individual supported employment services may be furnished by a co-worker or other job-site personnel provided that the services which are furnished are not part of the normal duties of the co-worker or other personnel and those individuals meet the pertinent qualifications for providers of the service. Individual supported employment may include services and supports that assist the participant in achieving self-employment through the operation of a business. However, Medicaid funds may not be used to defray the expenses associated with starting up or operating a business.

FFP will not be claimed for incentive payments, subsidies, or unrelated vocational training expenses such as the following:

1. Incentive payments made to an employer to encourage or subsidize the employer's participation in a Individual supported employment program;
2. Payments that are passed through to users of Individual supported employment programs;
3. Payments for vocational training that is not directly related to a participant's supported employment.

Individual supported employment services furnished under the waiver are not available under a program funded by either program funded by either the Rehabilitation Act of 1973 or P.L. 94-142.

Transportation to and from the participant's home is included in this service. The agency rate is adjusted for transportation costs based on mileage and type of vehicle required.

May not be provided at the same time as Community Day Supports, Group Supported Employment, Individualized Day Supports, or Respite.

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

Generally limited to 40 hours per week unless a prior approval has been issued and it is documented in the Individual Plan.

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

- ☒ **Participant-directed as specified in Appendix E**
- ☒ **Provider managed**
- ☒ **Remote/via Telehealth**

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 or DDS public operated program
Individual	Individuals Hired by Participants who Self Direct

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Individual Supported Employment

Provider Category:

Agency

Provider Type:

Provider Agencies or DDS public operated program

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

The agency meets the qualifications described in DDS Procedure PR.015 Qualifying Providers. In addition the agency ensures that employees meet the following qualifications:
Prior to Employment
·21 years of age
·criminal background check
·registry check
·have ability to communicate effectively with the individual/family
·have ability to complete record keeping as required by the employer
Prior to being alone with the individual
·demonstrate competence in knowledge of DDS policies and procedures: abuse/neglect; incident reporting; human rights and confidentiality; handling fire and other emergencies, prevention of sexual abuse.
·demonstrate competence, skills, abilities, education and/or experience necessary to achieve the specific outcomes as described in the IP
·ability to participate as a member of the circle if requested by the individual
·Medication Administration*
* if required by the individual supported

Verification of Provider Qualifications

Entity Responsible for Verification:

DDS or designee

Frequency of Verification:

Initial and every 2 years thereafter.

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Individual Supported Employment

Provider Category:

Individual

Provider Type:

Individuals Hired by Participants who Self Direct

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

The Fiscal Intermediary ensures that employees meet the following qualifications:
Prior to Employment:

·21 years of age
·criminal background check
·registry check
·have ability to communicate effectively with the individual/family
·have ability to complete record keeping as required by the employer
Prior to being alone with the individual:
·demonstrate competence in knowledge of DDS policies and procedures: abuse/neglect; incident reporting; human rights and confidentiality; handling fire and other emergencies, prevention of sexual abuse.
·demonstrate competence/knowledge in topics required to safely support the individual as described in the Individual Plan
·demonstrate competence, skills, abilities, education and/or experience necessary to achieve the specific outcomes as described in the IP
·ability to participate as a member of the circle if requested by the individual
·Medication Administration*
* if required by the individual supported

Verification of Provider Qualifications

Entity Responsible for Verification:

FI and DDS

Frequency of Verification:

FI Prior to employment
DDS Quality Management staff conduct an annual Quality Service Review on a sample of consumer directed persons. Review includes verification of training qualifications.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Statutory Service

Service:

Prevocational Services

Alternate Service Title (if any):

HCBS Taxonomy:

Category 1:	Sub-Category 1:
04 Day Services	04010 prevocational services
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):*

Service Definition (Scope):
Services provide learning, work experiences, and training that develop and teach general skills to assist an individual in preparing for competitive and integrated employment. Service includes teaching such concepts as compliance, attendance, task completion, problem solving and safety that help develop general, non-job-task-specific strengths and skills that contribute to employability. The service also includes supporting general work activities, career assessment and career planning. Services are not job-task oriented, but instead, aimed at a generalized result. Services are reflected in the participants individual plan with outcomes and timelines towards integrated community employment. An annual community based assessment will be completed for each individual and reviewed by DDS Personnel.
Documentation is maintained in the file of each individual receiving this service that the service is not available under a program funded under section 110 of the Rehabilitation Act of 1973 or the IDEA (20 U.S.C. 1401 et seq.).May not be provided at the same time as Adult Day Health, Group Supported employment, Blended Supports, Transitional Services, Group Day, Individualized Day Supports, Individual Supported Employment and Respite

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

Outcomes and timelines for transition should be documented in the person's individual plan and reviewed at a minimum annually. Service cannot exceed three years and requires regional director review.

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

- ☐ **Participant-directed as specified in Appendix E**
- ☒ **Provider managed**
- ☐ **Remote/via Telehealth**

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	Agency Provider

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Prevocational Services

Provider Category:

Agency

Provider Type:

Agency Provider

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

The agency will ensure that employees meet the following qualifications:
Prior to Employment
-18 yrs of age
-criminal background check
-registry check
-have ability to communicate effectively with the individual/family
-have ability to complete record keeping as required by the employer
Prior to being alone with the Individual:
-demonstrate competence in knowledge of DDS policies and procedures: abuse/neglect; incident reporting; client rights and confidentiality; handling fire and other emergencies, prevention of sexual abuse, knowledge of approved and prohibited physical management techniques
-demonstrate competence/knowledge in topics required to safely support the individual as described in the Individual Plan
-demonstrate competence, skills, abilities, education and/or experience necessary to achieve the specific training outcomes as described in the Individual Plan
-ability to participate as a member of the circle if requested by the individual
-demonstrate understanding of Person Centered Planning
-Medication Administration*

Verification of Provider Qualifications

Entity Responsible for Verification:

DDS

Frequency of Verification:

Initially 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:
09 Caregiver Support	09011 respite, out-of-home

Category 2: 09 Caregiver Support

Sub-Category 2: 09012 respite, in-home

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. FFP will not be 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. Respite care will be provided in the following location(s): Individual's home or place of residence; DDS certified respite care facility; DDS operated respite care facility; DDS Qualified provider. Respite services may not be provided at the same time as Community Day Support Options, Adult Day Health, Individualized Day, or Supported Employment.

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

The Per diem rate is utilized when the respite is provided for 13 or more hours in a 24 hour period.
For parents with school age children approved to provide supports (individualized day and respite) under this waiver, all supports that can be provided by such parent have a combined cap of 800 awake hours of support annually with the ability to request a prior approval exception for hours over the cap. For parents with school age children approved to provide this support, an assessment to determine age-appropriate dependency that meets the criteria of extraordinary care is required.
For legal guardians approved to provide supports (individualized day and respite) under this waiver, all supports that can be provided by such legal guardian have a combined cap of 2100 awake hours of support annually with the ability to request a prior approval exception for hours over the cap.

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

- [x] **Participant-directed as specified in Appendix E**
- [x] **Provider managed**
- [ ] **Remote/via Telehealth**

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	DDS Respite Center or Private Respite Facility
Individual	Individuals hired by Particpants who Self Direct

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Respite

Provider Category:

Agency

Provider Type:

DDS Respite Center or Private Respite Facility

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Facilities and/or entities and individuals certified in accordance with subsection (d) of Section 17a-218 or otherwise certified as a qualified provider of respite services by DDS
The agency ensures that employees meet the following qualifications:
Prior to Employment
·18 yrs of age
·criminal background check
·registry check
·have ability to communicate effectively with the individual/family
·have ability to complete record keeping as required by the employer
Prior to being alone with the Individual:
·demonstrate competence in knowledge of DDS policies and procedures: abuse/neglect; incident reporting; client rights and confidentiality; handling fire and other emergencies, prevention of sexual abuse, knowledge of approved and prohibited physical management techniques
·demonstrate competence/knowledge in topics required to safely support the individual as described in the Individual Plan
·demonstrate competence/knowledge in positive behavioral programming, working with individuals who experience moderate to severe psychological and psychiatric behavioral health needs and ability to properly implement behavioral support plans*
·Medication Administration*
* if required by the individual supported

Verification of Provider Qualifications

Entity Responsible for Verification:

DDS or designee

Frequency of Verification:

Initial and every 2 years thereafter.

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Respite

Provider Category:

Individual

Provider Type:

Individuals hired by Particpants who Self Direct

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

The FI will verify that the respite provider meets the following qualifications prior to employment:
·18 yrs of age
·criminal background check
·registry check
·have ability to communicate effectively with the individual/family
·have ability to complete record keeping as required by the employer
Prior to being alone with the Individual:
·demonstrate competence in knowledge of DDS policies and procedures: abuse/neglect; incident reporting; client rights and confidentiality; handling fire and other emergencies, prevention of sexual abuse, knowledge of approved and prohibited physical management techniques
·demonstrate competence/knowledge in topics required to safely support the individual as described in the Individual Plan
·demonstrate competence/knowledge in positive behavioral programming, working with individuals who experience moderate to severe psychological and psychiatric behavioral health needs and ability to properly implement behavioral support plans*
·Medication Administration*
* if required by the individual supported

Verification of Provider Qualifications

Entity Responsible for Verification:

FI and DDS

Frequency of Verification:

FI Prior to employment

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:

Supports for Participant Direction

The waiver provides for participant direction of services as specified in Appendix E. Indicate whether the waiver includes the following supports or other supports for participant direction.

Support for Participant Direction:

Information and Assistance in Support of Participant Direction

Alternate Service Title (if any):

Independent Support Broker

HCBS Taxonomy:

Category 1:	Sub-Category 1:
12 Services Supporting Self-Direction	12020 information and assistance in support of self-directio

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):*

Support and Consultation provided to individuals and/or their families to assist them in directing their own plan of individual support. This service is limited to those who direct their own supports.
The services included are:
·Assistance with developing a natural community support network
·Assistance with managing the Individual Budget
·Support with and training on how to hire, manage and train staff
·Accessing community activities and services, including helping the individual and family with day to day coordination of needed services.
·Assistance with negotiating rates and reimbursements.
·Developing an emergency back up plan
·Self advocacy training and support

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**
- ☐ **Remote/via Telehealth**

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	Agency Provider
Individual	Individual Hired by Participants who Self direct

Appendix C: Participant Services

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

Service Type: Supports for Participant Direction
Service Name: Independent Support Broker

Provider Category:

Agency

Provider Type:

Agency Provider

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

The agency meets the qualifications described in DDS Procedure PR.015 Qualifying Providers. In addition, the agency ensures that employees meet the following qualifications prior to employment:
·21 yrs of age
·criminal background check
·registry check
·demonstrated ability, experience and/or education to assist the individual and/or family in the specific areas of support as described by the circle in the Individual Plan.
·Five years experience in working with people with intellectual disability involving participation in an interdisciplinary team process and the development, review and/or implementation of elements in an individuals plan of care.
·One year of the General Experience must have involved supervision of direct care staff in OR responsibility for developing, implementing and evaluating individualized supports for people with intellectual disability in the areas of behavior, education or rehabilitation.
Substitutions Allowed: College training in programs related to supporting people with disabilities (social service, education, psychology, rehabilitation etc.) may be substituted for the General Experience on the basis of fifteen (15) semester hours equaling one-half (1/2) year of experience to a maximum of four (4) years.
·demonstrate competence in knowledge of DDS policies and procedures: abuse/neglect; incident reporting; human rights and confidentiality; handling fire and other emergencies, prevention of sexual abuse, knowledge of approved and prohibited physical management techniques
·demonstrate understanding of the role of the service, of advocacy, person-centered planning, and community services
·demonstrate understanding of individual budgets and DDS fiscal management policies

Verification of Provider Qualifications

Entity Responsible for Verification:

DDS

Frequency of Verification:

Initial and every 2 years thereafter.

Appendix C: Participant Services

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

Service Type: Supports for Participant Direction
Service Name: Independent Support Broker

Provider Category:

Individual

Provider Type:

Individual Hired by Participants who Self direct

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

The FI will ensure that the individual meets the following qualifications prior to employment:
·21 yrs of age
·criminal background check
·registry check
·demonstrated ability, experience and/or education to assist the individual and/or family in the specific areas of support as described by the circle in the Individual Plan.
·Five years experience in working with people with intellectual disability involving participation in an interdisciplinary team process and the development, review and/or implementation of elements in an individuals plan of care.
·One year of the General Experience must have involved supervision of direct care staff in OR responsibility for developing, implementing and evaluating individualized supports for people with intellectual disability in the areas of behavior, education or rehabilitation.
Substitutions Allowed: College training in programs related to supporting people with disabilities (social service, education, psychology, rehabilitation etc.) may be substituted for the General Experience on the basis of fifteen (15) semester hours equaling one-half (1/2) year of experience to a maximum of four (4) years.
·demonstrate competence in knowledge of DDS policies and procedures: abuse/neglect; incident reporting; human rights and confidentiality; handling fire and other emergencies, prevention of sexual abuse, knowledge of approved and prohibited physical management techniques
·demonstrate understanding of the role of the service, of advocacy, person-centered planning, and community services
·demonstrate understanding of individual budgets and DDS fiscal management policies

Verification of Provider Qualifications

Entity Responsible for Verification:

FI and DDS

Frequency of Verification:

FI Prior to Employment
DDS Quality Management staff conduct an annual Quality Service Review on a sample of consumer directed persons. Review includes verification of training qualifications.

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:

Supports for Participant Direction

The waiver provides for participant direction of services as specified in Appendix E. Indicate whether the waiver includes the following supports or other supports for participant direction.

Support for Participant Direction:

Other Supports for Participant Direction

Alternate Service Title (if any):

Peer Support

HCBS Taxonomy:

Category 1:	Sub-Category 1:
12 Services Supporting Self-Direction	12020 information and assistance in support of self-directio
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):*

Peer support includes face-to-face interactions including Face Time or comparable technology(such as IPAD, IPHONE) in accordance with all HIPAA requirements that are designed to promote ongoing engagement of waiver participants towards the participant's personal goals. All peer support will promote the individuals strengths and abilities to continue improving socialization, self-advocacy, development of natural supports, and maintenance of community living skills. Peer support also includes communication and coordination with medical providers including behavioral health services providers and/or others in support of the participant.

Service can be provided in the participants home, at their job or community.
Example of Activities: How to manage the participants home, manage self-direction of supports, How to find a job or maintain a job, How to advance in chosen career, how to access the community and build community supports.

The Peer Support uses his/her personal experience and how to engage the participant in order to continually reinforce and maintain skills.

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

Peer Support interventions will exclude activities that are duplicative of any other waiver service.

Peer Support is limited to 2 hours per week and over a six month time period. Prior approval is needed to extend beyond the six months and should be documented in the individual plan.

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

- [x] **Participant-directed as specified in Appendix E**
- [x] **Provider managed**
- [ ] **Remote/via Telehealth**

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	Peer Support
Individual	Peer Support

Appendix C: Participant Services

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

Service Type: Supports for Participant Direction
Service Name: Peer Support

Provider Category:

Agency

Provider Type:

Peer Support

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Be at least 21 yrs old;
Possess at least a high school diploma or GED;
Minimum 2 years of personal experience,
Other qualifications as determined by the participant in their individual plan
Training programs will address abilities to:
Follow instructions given by the participant or the participant's conservator; Report changes in the participant's condition or needs; Maintain confidentiality; Meet the participant's needs as delineated in the Individual Plan; Function as a member of an interdisciplinary team; Healthy Relationships; Respond to fire and emergency situations; Accept supervision in a manner prescribed by the department or its designated agent; Maintain accurate, complete and timely records that meet Medicaid requirements; Provide services in a respectful, culturally competent manner; and Use effective Peer Support practices.

Verification of Provider Qualifications

Entity Responsible for Verification:

Provider Agency or FI

Frequency of Verification:

Initial

Appendix C: Participant Services

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

Service Type: Supports for Participant Direction
Service Name: Peer Support

Provider Category:

Individual

Provider Type:

Peer Support

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Be at least 21 yrs old;
Possess at least a high school diploma, GED or a certificate of completion;
Minimum 2 years of personal experience,
Other qualifications as determined by the participant in their individual plan
Training programs will address abilities to:
Follow instructions given by the participant or the participant's conservator; Report changes in the participant's condition or needs; Maintain confidentiality; Meet the participant's needs as delineated in the Individual Plan; Function as a member of an interdisciplinary team; Healthy Relationships; Respond to fire and emergency situations; Accept supervision in a manner prescribed by the department or its designated agent; Maintain accurate, complete and timely records that meet Medicaid requirements; Provide services in a respectful, culturally competent manner; and Use effective Peer Support practices.

Verification of Provider Qualifications

Entity Responsible for Verification:

FI

Frequency of Verification:

Initial

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, or improve functional capabilities of participants. Assistive technology service means a service that directly assists a participant in the selection, acquisition, use or continued use of an assistive technology device. Assistive technology includes:
a) the evaluation of the assistive technology needs of a participant, including a functional evaluation of the impact of the provision of appropriate assistive technology and appropriate services to the participant in the customary environment of the participant;
b) services consisting of purchasing, leasing, or otherwise providing for the acquisition of assistive technology devices for the participant;
c) services consisting of selecting, designing, fitting, customizing, adapting, applying, maintaining, repairing, or replacing assistive technology devices;
d) training or technical assistance for the participant, or, where appropriate, the family members, or authorized representatives of the participant; and
e) training or technical assistance for professionals or other individuals who provide services to, employ, or are otherwise substantially involved in the major life functions of the participant.
f) ongoing support costs of assistive technology

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

Items available under the individual's medical insurance are excluded. May use up to $25,000 for a 5 year period. Services over 25,000 require DDS Commissioner Approval.

Prior approval for these devices is required.

Under HCBS ARPA service cap temporarily increased to 30,000 through the end of the ARPA period.

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

- [x] **Participant-directed as specified in Appendix E**
- [x] **Provider managed**
- [ ] **Remote/via Telehealth**

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	Other vendor
Agency	Assistive Technology Provider

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Assistive Technology

Provider Category:

Individual

Provider Type:

Other vendor

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Commercial vendor

Verification of Provider Qualifications

Entity Responsible for Verification:

Fiscal Intermediary

Frequency of Verification:

Initially and every two years

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:

Assistive Technology Provider

Provider Qualifications

License *(specify):*

Pharmacies: CT Dept. of Consumer Protection Pharmacy Practice Act: Regulations Concerning Practice of Pharmacy Section 20-175-4-6-7.

Certificate *(specify):*

Other Standard *(specify):*

Medicaid provider status for assistive technology and supplies or agency that obtains Medicaid performing provider status Regulations of CT. State Agencies 17-134-165

Private Vendors: Conn. State Agency Reg. Section 10-102-3(e)(8)

Dept. of Admin. Services Bureau of Purchasing/Purchasing Manual 11/91

Direct Purchase Activity No. 8-F (CGS 4a-50 and 4a-52.

Participants may use their approved budgets to purchase AT items such as i-pads directly from vendors.

Verification of Provider Qualifications

Entity Responsible for Verification:

DDS or FI

Frequency of Verification:

Initial and as needed there after

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:

Behavioral Support Services

HCBS Taxonomy:

Category 1:	**Sub-Category 1:**
10 Other Mental Health and Behavioral Services	10040 behavior support
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):*

Clinical and therapeutic services which are not covered by the Medicaid State Plan, necessary to improve the individuals independence and inclusion in their community. This service is available to individuals who have intellectual disabilities and demonstrate an emotional, behavioral or mental health issue that results in the functional impairment of the individual

and substantially interferes with or limits functioning at home or in the community. Professional clinical service to include: 1) Assess and evaluate the behavioral and clinical need(s); 2) Develop a behavioral support plan that includes intervention techniques as well as teaching strategies for increasing new adaptive positive behaviors, and decreasing challenging behaviors addressing these needs in the individuals natural environments; 3) Provide training to the individuals family and the support providers in appropriate implementation of the behavioral support plan and associated documentation; and, 4) Evaluate the effectiveness of the behavioral support plan by monitoring the plan on a monthly basis, and by meeting with the team one month after the implementation of the behavior plan, and in future three month intervals. The service will include any changes to the plan when necessary and the professional(s) shall be available to the team for questions and consultation. The professional(s) shall make recommendations to the Individual Support Team and Case Manager for referrals to community physicians and other clinical professionals that support the recommendations of the assessment findings as appropriate. Use of this service requires the preparation of a formal comprehensive assessment and submission of any restrictive behavioral support program to the DDS Program Review Committee for approval prior to implementation.

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**
- ☐ **Remote/via Telehealth**

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	Master's Level Behavioral Support Provider
Individual	LCSW
Agency	DDS Qualified Agency provider
Individual	Psychologist
Individual	Board Certified Behavior Analyst

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Behavioral Support Services

Provider Category:

Individual

Provider Type:

Master's Level Behavioral Support Provider

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

· Masters degree in psychology, special education, social work or a related field.

· Two years of experience providing behavioral supports to people with developmental disabilities.
· Review of all application materials and approval by the Operations Center and its designee (DDS Supervising Psychologist 2s)
· Criminal background check, DDS Abuse/Neglect Registry check and Sex Offender Registry check required. When an individual self directs, these checks are done by the
persons Fiscal Intermediary; if the service is purchased through an agency, the provider is responsible for conducting these checks for their employees.

Verification of Provider Qualifications

Entity Responsible for Verification:

FI and DDS or designee

Frequency of Verification:

FI Prior to Employment for consumer directed services

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Behavioral Support Services

Provider Category:

Individual

Provider Type:

LCSW

Provider Qualifications

License *(specify):*

Licensure per CGS Chapter 383b (Licensed Clinical Social Worker)

Certificate *(specify):*

Other Standard *(specify):*

· Two years of experience providing behavioral supports to people with developmental disabilities.
· Review of all application materials and approval by the Operations Center and its designee (DDS Supervising Psychologist 2s)
· Criminal background check, DDS Abuse/Neglect Registry check and Sex Offender Registry check required. When an individual self directs, these checks are done by the
persons Fiscal Intermediary; if the service is purchased through an agency, the provider is responsible for conducting these checks for their employees.

Verification of Provider Qualifications

Entity Responsible for Verification:

FI and DDS or designee

Frequency of Verification:

FI Prior to Employment for consumer directed services
DDS Annual verification of ongoing licensure.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Behavioral Support Services

Provider Category:

Agency

Provider Type:

DDS Qualified Agency provider

Provider Qualifications

License *(specify):*

Agency must ensure that clinicians are licensed LCSWs, Psychologists, applied Behavioral Analysts or Masters Level Behavioral Health Provide with qualifications specified in the requirements for the individual provider

Certificate *(specify):*

Other Standard *(specify):*

The agency meets the qualifications described in DDS Procedure DDS PR.015. In addition, the agency ensures that employees meet the following qualifications:
Prior to Employment:
·21 yrs of age
·criminal background check
·registry check
·have ability to communicate effectively with the individual/family
·have ability to complete record keeping as required by the employer
Prior to being alone with the Individual:
·demonstrate competence in knowledge of DDS policies and procedures: abuse/neglect; incident reporting; client rights and confidentiality; handling fire and other emergencies, prevention of sexual abuse, knowledge of approved and prohibited physical management techniques
·demonstrate competence/knowledge in topics required to safely support the individual as described in the Individual Plan
·demonstrate competence, skills, abilities, education and/or experience necessary to achieve the specific training outcomes as described in the Individual Plan
·ability to participate as a member of the circle if requested by the individual
·demonstrate understanding of Person Centered Planning

Verification of Provider Qualifications

Entity Responsible for Verification:

DDS

Frequency of Verification:

Initially and every two years thereafter

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Behavioral Support Services

Provider Category:

Individual

Provider Type:

Psychologist

Provider Qualifications

License *(specify):*

Licensed by the American Psychological Association and meets requirements of Connecticut General Statutes Chapter 383

Certificate *(specify):*

Other Standard *(specify):*

· Two years of experience providing behavioral supports to people with developmental disabilities.
· Review of all application materials and approval by the Operations Center and its designee (DDS Supervising Psychologist 2s)
· Criminal background check, DDS Abuse/Neglect Registry check and Sex Offender Registry check required. When an individual self directs, these checks are done by the
persons Fiscal Intermediary; if the service is purchased through an agency, the provider is responsible for conducting these checks for their employees.

Verification of Provider Qualifications

Entity Responsible for Verification:

FI and DDS or designee

Frequency of Verification:

FI Prior to Employment for consumer directed services
DDS Annual verification of ongoing licensure.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Behavioral Support Services

Provider Category:

Individual

Provider Type:

Board Certified Behavior Analyst

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Current certification as a Board Certified Behavioral Analyst (BCBA)

Other Standard *(specify):*

· Two years of experience providing behavioral supports to people with developmental disabilities.
· Review of all application materials and approval by the Operations Center and its designee (DDS Supervising Psychologist 2s)
· Criminal background check, DDS Abuse/Neglect Registry check and Sex Offender Registry check required. When an individual self directs, these checks are done by the
persons Fiscal Intermediary; if the service is purchased through an agency, the provider is responsible for conducting these checks for their employees.

Verification of Provider Qualifications

Entity Responsible for Verification:

FI and DDS or designee

Frequency of Verification:

FI Prior to Employment for consumer directed services
DDS Annual verification of ongoing licensure.

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:

Customized Employment Supports

HCBS Taxonomy:

Category 1:	**Sub-Category 1:**
03 Supported Employment	03030 career planning
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):*

Customized Employment Supports is a process through which the relationship between employer and employee is negotiated and personalized in a way that meets the needs of both parties in a typical workplace environment. Wages are at least minimum wage or higher and at a rate comparable to non-disabled workers performing the same tasks. Employees with disabilities must have the same benefits and opportunities as those without disabilities in the same position to interact with other employees, customers and vendors.
Supports include: co-worker mentors who can help an employee learn a new job, develop social networks within the job, take advantage of training offered, job coaching, HR and more.
Customized employment may also include modifications to an employee's work environment, changes to certain job functions that help an employee successfully perform them, and adjustments to employment policies or practices that support the employee.
These supports fall into three main categories:
1. Environmental supports such as: equipment, physical structures, surroundings, or objects present in the business that make the job site more accessible for current or future employees.
2. Procedural supports that employers provide to assist potential or current employees with performing their jobs and job-related functions.
3. Natural informal supports typically available to any employee. These may include ride sharing to and from work with other employees, or a senior staff member helping a new co-worker get the job done when he/she needs extra assistance.
It is anticipated that the employees with IDD will have access to the same supports that are available to all employees: HR, EAP, Supervisor, training, promotional opportunities etc.

This is a distinct and separate service that is different from other employment services. This service may not be provided at the same time as Individualized Day Supports, Individual or Group Supported Employment, Adult Day Health, Transitional Services, Prevocational or Respite.

The payment rates for Customized Employment are based on the combination of the Level of Need and the specific plan that is developed for the individual.

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**

☐ **Remote/via Telehealth**

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

☐ **Legally Responsible Person**

☒ **Relative**

☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Private Provider
Individual	Individuals Hired by Participant

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Customized Employment Supports

Provider Category:

Agency

Provider Type:

Private Provider

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

The agency will ensure that employees meet the following qualifications:
Prior to Employment
21 yrs of age
criminal background check
registry check
have ability to communicate effectively with the individual/family
have ability to complete record keeping as required by the employer

Prior to being alone with the Individual:
demonstrate competence in knowledge of DDS policies and procedures: abuse/neglect; incident reporting; client rights and confidentiality; handling fire and other emergencies, prevention of sexual abuse, knowledge of approved and prohibited physical management techniques
demonstrate competence/knowledge in topics required to safely support the individual as described in the Individual Plan

demonstrate competence, skills, abilities, education and/or experience necessary to achieve the specific training outcomes as described in the Individual Plan
ability to participate as a member of the team if requested by the individual
demonstrate understanding of Person Centered Planning
demonstrate competence/knowledge in positive behavioral programming, working with individuals who experience moderate to severe psychological and psychiatric behavioral health needs and ability to properly implement behavioral support plans*
Medication Administration*

* if required by the individual supported
Training or Certification in
Discovery
Evidence Based Job Development
Systematic Instruction
Skill Enhancement

Verification of Provider Qualifications

Entity Responsible for Verification:

DDS or Designee

Frequency of Verification:

Initial

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Customized Employment Supports

Provider Category:

Individual

Provider Type:

Individuals Hired by Participant

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

The FI or DDS Designee will ensure that employees meet the following qualifications:
Prior to Employment
21 yrs of age
criminal background check
registry check
have ability to communicate effectively with the individual/family
have ability to complete record keeping as required by the employer

Prior to being alone with the Individual:
demonstrate competence in knowledge of DDS policies and procedures: abuse/neglect; incident reporting; client rights and confidentiality; handling fire and other emergencies, prevention of sexual abuse, knowledge of approved and prohibited physical management techniques
demonstrate competence/knowledge in topics required to safely support the individual as described in the Individual Plan
demonstrate competence, skills, abilities, education and/or experience necessary to achieve the specific training outcomes as described in the Individual Plan

ability to participate as a member of the team if requested by the individual
demonstrate understanding of Person Centered Planning
demonstrate competence/knowledge in positive behavioral programming, working with individuals who experience moderate to severe psychological and psychiatric behavioral health needs and ability to properly implement behavioral support plans*
Medication Administration*

* if required by the individual supported
Certification in
Discovery
Evidence Based Job Development
Systematic Instruction
Skill Enhancement

Verification of Provider Qualifications

Entity Responsible for Verification:

FI or DDS Designee

Frequency of Verification:

Prior to employment

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:

Employment Transitional Services

HCBS Taxonomy:

Category 1:	Sub-Category 1:
03 Supported Employment	03010 job development
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):*

Employment Transitional Services is a time limited, community-based, vocational service.
It focuses on:

- providing career discovery
- career exploration
- skill development
- self-advocacy

With the goal of obtaining competitive employment for which an individual is compensated at or above the minimum wage, but not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by individuals without disabilities is considered to be the optimal outcome of services.

The service offers the following opportunities to develop the necessary skills for competitive employment::

1. exploration of employment sites
2. Offers Adult Education opportunities and assistance with and Post-Secondary Schools
3. Assists with Apprenticeships/Internships
4. skills building classes leading to employment
5. financial management
6. participation in community activities to promote networking

Time limited

One 6 month extension can be granted by Regional Director or Designee in the case of someone needing short time to successfully transition out of Transition Employment services into employment.
After 3 year period individual will need to seek another Transition Employment Service provider if they are still in need of that service.

The payment rate for transitional employment is directly linked to the group supported employment payment rate.

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

Time limit 3 years

An extension can be granted by Regional Director or Designee in the case of someone needing time to successfully transition out of Transition Employment services into employment.
After 3 year period individual will need to seek another Transition Employment Service provider if they are still in need of that service.

Documentation is maintained in the file of each individual receiving this service that the service is not available under a program funded under section 110 of the Rehabilitation Act of 1973 or the IDEA (20 U.S.C. 1401 et seq.)

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

- ☐ **Participant-directed as specified in Appendix E**
- ☒ **Provider managed**
- ☐ **Remote/via Telehealth**

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	DDS Private Provider

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Employment Transitional Services

Provider Category:

Agency

Provider Type:

DDS Private Provider

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

The agency will ensure that employees meet the following qualifications:
Prior to Employment
18 yrs of age
criminal background check
registry check
have ability to communicate effectively with the individual/family
have ability to complete record keeping as required by the employer
Prior to being alone with the Individual:
demonstrate competence in knowledge of DDS policies and procedures: abuse/neglect; incident reporting; client rights and confidentiality; handling fire and other emergencies, prevention of sexual abuse, knowledge of approved and prohibited physical management techniques
demonstrate competence/knowledge in topics required to safely support the individual as described in the Individual Plan
demonstrate competence, skills, abilities, education and/or experience necessary to achieve the specific training outcomes as described in the Individual Plan
ability to participate as a member of the circle if requested by the individual
demonstrate understanding of Person Centered Planning
Medication Administration*
* if required by the individual supported

Verification of Provider Qualifications

Entity Responsible for Verification:

DDS or designee

Frequency of Verification:

Initial

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 Modifications

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):*

Those physical adaptations to the private residence of participant or the participant's family, required by the individual's plan of care, which are necessary to ensure the health, welfare and safety of the individual, or which enable the individual to function with greater independence in the home, and without which, the individual would require institutionalization. Such adaptations may include the installation of ramps and grab-bars, widening of doorways, modification of bathroom facilities, or installation of specialized electric and plumbing systems which are necessary to accommodate the medical equipment and supplies which are necessary for the welfare of the individual. Excluded are those adaptations or improvements to the home that are of general utility, and are not of direct medical or remedial benefit to the individual, such as carpeting, roof repair, central air conditioning, etc. Also excluded are those modifications which would normally be considered the responsibility of the landlord. 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. Home accessibility modifications may not be furnished to adapt living arrangements that are owned or leased by providers of waiver services.

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

Maximum benefit over the term of the waiver (5 years) are capped at $35,000. Services over $35,000 require Prior Approval.

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

- ☐ **Participant-directed as specified in Appendix E**
- ☒ **Provider managed**
- ☐ **Remote/via Telehealth**

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	Contractors

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Environmental Modifications

Provider Category:

Agency

Provider Type:

Contractors

Provider Qualifications

License *(specify):*

Licensed in State of CT for specific service to be rendered, i.e. electrical, plumbing, general contractor.

Certificate *(specify):*

Other Standard *(specify):*

NFPA Life Safety CodeState Building Code

Verification of Provider Qualifications

Entity Responsible for Verification:

FI and DDS

Frequency of Verification:

FI Initial
DDS Annual sample of consumer directed participants.

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:

Group Supported Employment

HCBS Taxonomy:

Category 1:	**Sub-Category 1:**
03 Supported Employment	03022 ongoing supported employment, group
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):*

Group Supported Employment consists of ongoing supports that enable participants in a structured work environment focused towards work. Participants for whom competitive employment at or above the minimum wage is unlikely but are on the path to competitive employment with some ongoing supports and need supports to perform in a regular work setting. Group Supported employment may include assisting the participant with assessments, career planning, locate a job or develop a job on behalf of the participant. Group Supported employment is conducted in a variety of settings, particularly work sites where persons without disabilities are employed. Group Supported Employment includes activities needed to obtain and sustain paid work by participants, including career planning, assistive technology ,job development, supervision and training. When group supported employment services are provided at a work site where persons without disabilities are employed, payment is made only for adaptations, supervision and training required by participants receiving waiver services as a result of their disabilities but does not include payment for supervisory activities rendered as a normal part of the business setting. However, Medicaid funds may not be used to defray the expenses associated with starting up or operating a business.
FFP will not be claimed for incentive payments, subsidies, or unrelated vocational training expenses such as the following:
1. Incentive payments made to an employer to encourage or subsidize the employer's participation in a supported employment program;
2. Payments that are passed through to users of supported employment programs;
3. Payments for vocational training that is not directly related to a participant's supported employment.
Group Supported employment services furnished under the waiver are not available under a program funded by either program funded by either the Rehabilitation Act of 1973 or P.L. 94-142.
May not be provided at the same time as Adult Day Health, Group Day, Prevocational services, Individual Supported employment, Respite or Individualized Day Supports

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

Group is defined as 8 or less.
Generally limited to 40 hours per week unless a prior approval has been issued and it is documented in the Individual Plan.

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

- ☐ **Participant-directed as specified in Appendix E**
- ☒ **Provider managed**
- ☐ **Remote/via Telehealth**

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	DDS Qualified Provider

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Group Supported Employment

Provider Category:

Agency

Provider Type:

DDS Qualified Provider

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

The agency will ensure that employees meet the following qualifications:
Prior to Employment
21 yrs of age
criminal background check
registry check
have ability to communicate effectively with the individual/family
have ability to complete record keeping as required by the employer
Prior to being alone with the Individual:
demonstrate competence in knowledge of DDS policies and procedures: abuse/neglect; incident reporting; client rights and confidentiality; handling fire and other emergencies, prevention of sexual abuse, knowledge of approved and prohibited physical management techniques
demonstrate competence/knowledge in topics required to safely support the individual as described in the Individual Plan
demonstrate competence, skills, abilities, education and/or experience necessary to achieve the specific training outcomes as described in the Individual Plan
ability to participate as a member of the circle if requested by the individual
demonstrate understanding of Person Centered Planning
Medication Administration*
* if required by the individual supported

Verification of Provider Qualifications

Entity Responsible for Verification:

DDS or designee

Frequency of Verification:

Initial and Certified after one year of service.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Home Delivered Meals

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):*

The preparation and home delivery of meals for individuals who are unable to prepare or obtain nourishing meals independently, or when the individual responsible for this activity is temporarily absent or unable to prepare meals. Home delivered meals, or "meals on wheels," include the preparation and delivery of one or two meals for persons who are unable to prepare or obtain nourishing meals on their own. Meals on Wheels providers include delicatessans, Family Services Agencies, Community Action Agencies, Catholic Charities, Town Social Services, visiting nurse agencies, assisted living agencies, senior centers, soup kitchens. Meals must meet a minimum of one-third for single meals and two-thirds for double meals of the daily recommended allowance and requirements as established by the Food and Nutrition Academy of Sciences National Research Council. Special diet meals are available such as diabetic, cardiac, low sodium, pureed and renal as are ethnic meals such as Hispanic and Kosher meals. The service shall not be provided in a setting that has room and board.

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

Prior Approval Required

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

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

☒ **Provider managed**

☐ **Remote/via Telehealth**

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

☐ **Legally Responsible Person**

☐ **Relative**

☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Agency Provider

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Home Delivered Meals

Provider Category:

Agency

Provider Type:

Agency Provider

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Must have an approval/contract through DSS, or a contractor of the Department of Aging and Disability Services, to provide home-delivered meals for other existing programs. Reimbursement for home delivered meals shall be available under the Waiver to providers which provide meals that meet a minimum of one-third of the current daily recommended dietary allowance and requirements as established by the Food and Nutrition Board of the National Academy of Sciences National Research Council. All meals on wheels providers shall provide their menus to the department, contracted agencies or department designee for review and approval. Service providers must be in compliance with the dietary requirements and the requirements for the preparation and storage and delivery of food based on the department policies for the elderly nutrition program and Title (III) of the Older Americans Act. Meals on Wheels providers include delicatessans, Family Services Agencies, Community Action Agencies, Catholic Charities, Town Social Services, visiting nurse agencies, assisted living agencies, senior centers, soup kitchens.

Verification of Provider Qualifications

Entity Responsible for Verification:

Fiscal Intermediary

Frequency of Verification:

At start of services and at recertification every two years.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Individual Direct Goods and Services

HCBS Taxonomy:

Category 1:	**Sub-Category 1:**
17 Other Services	17010 goods and services
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, equipment or supplies that assist an individual in directing their own supports and addressing an identified need in in the individual Plan. The service, equipment or supply must either reduce the reliance of the individual on other paid supports, be directly related to the health and/or safety of the individual in his/her home or in the community, be habilitative in nature and contribute to a therapeutic goal, enhance the individual's ability to be integrated into the community, or provide resources to expand self-advocacy skills and knowledge, and, the individual has no other funds to purchase the described goods or services. With Prior Approval this service may be used to pay a staff person to provide the IDGS service as well as train, assist and manage day to day supervision of direct support professionals as established by the Individual Plan. Paid staff person may also teach the individual how to provide supervision to other direct support professionals and assist with managing the individual budget, including negotiation of rates and reimbursements for supports provided as identified in the IP. DDS Cost Standards are a set of guidelines which are used to ensure applies consistent criteria with respect to the appropriateness of the services or items to be approved in this service definition and their cost. Experimental and prohibited treatments are excluded. This service is only available for individuals who self-direct their own supports, and must be pre-approved by DDS and follow DDS Cost Standards. DDS applies consistent guidelines in respect to the appropriateness of the services or items to be approved in this service definition. This service may not duplicate any Medicaid State Plan service. Direct supports under this service may not be provided at the same time as Individualized Day Supports, Group Day, Supported Employment, Respite, Individualized Home Supports, Adult Companion, or Personal Support, Senior Supports and Companion Supports a

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**

☐ **Remote/via Telehealth**

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	Participant directed Individual
Agency	Provider agency or Private Vendor

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Individual Direct Goods and Services

Provider Category:

Individual

Provider Type:

Participant directed Individual

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Meets any applicable state regulations for the type of supply or service as described in the Individual Plan approved by DDS.
If the participant is purchasing direct support the FI will ensure that the person hired meets the following qualifications prior to employment:
·18 yrs of age
·criminal background check
·registry check
·have ability to communicate effectively with the individual/family
·have ability to complete record keeping as required by the employer
Prior to being alone with the Individual:
·demonstrate competence in knowledge of DDS policies and procedures: abuse/neglect; incident reporting; client rights and confidentiality; handling fire and other emergencies, prevention of sexual abuse, knowledge of approved and prohibited physical management techniques
·demonstrate competence/knowledge in topics required to safely support the individual as described in the Individual Plan
·demonstrate competence, skills, abilities, education and/or experience necessary to achieve the specific training outcomes as described in the Individual Plan
·ability to participate as a member of the circle if requested by the individual
·demonstrate understanding of Person Centered Planning
·Medication Administration*

* if required by the individual supported

Verification of Provider Qualifications

Entity Responsible for Verification:

FI and DDS

Frequency of Verification:

FI Prior to employment
DDS Annual sample of consumer directed persons

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Individual Direct Goods and Services

Provider Category:

Agency

Provider Type:

Provider agency or Private Vendor

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Meets any applicable state regulations for the type of supply or service as described in the Individual Plan approved by DDS.
If the participant is purchasing direct supports the agency will ensure that employees meet the following qualifications prior to employment:
·18 yrs of age
·criminal background check
·registry check
·have ability to communicate effectively with the individual/family
·have ability to complete record keeping as required by the employer
Prior to being alone with the Individual:
·demonstrate competence in knowledge of DDS policies and procedures: abuse/neglect; incident reporting; client rights and confidentiality; handling fire and other emergencies, prevention of sexual abuse, knowledge of approved and prohibited physical management techniques
·demonstrate competence/knowledge in topics required to safely support the individual as described in the Individual Plan
·demonstrate competence, skills, abilities, education and/or experience necessary to achieve the specific training outcomes as described in the Individual Plan
·ability to participate as a member of the circle if requested by the individual
·demonstrate understanding of Person Centered Planning
·Medication Administration*
* if required by the individual supported

Verification of Provider Qualifications

Entity Responsible for Verification:

DDS

Frequency of Verification:

Initial and every 2 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:

Individualized Day Support

HCBS Taxonomy:

Category 1:	Sub-Category 1:
04 Day Services	04020 day habilitation
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 and supports provided to individuals tailored to their specific personal outcomes related to the acquisition, improvement and/or retention of skills and abilities to prepare and support an individual for work and/or community participation and/or meaningful retirement activities, or for an individual who has their own business, and could not do so without this direct support. This service may start from the participant's home and is not delivered in or from a facility-based program. The service may be provided by electronic face to face means in accordance with HIPAA requirements All transportation costs are included in the rate. May not be provided at the same time as Community Day Support Options, Supported Employment, Adult Day Health or Respite.

Direct Support staffing services may be provided in a short-term acute care hospital stay for the purposes of supporting the participant’s personal, behavioral and communication supports not otherwise provided in that setting. Services may not be duplicative of hospital or short-term institutional services.

1. The State has mechanisms in place to prevent duplicate billing for both institutional and home and community based services.
2. These necessary waiver services:

a. Must be identified in the individual’s person-centered service plan;
b. Must be provided the meet the individual’s needs and are not covered in such settings;

c. Should not substitute for services that the setting is obligated to provide through its condition of participation under federal or State law, under another applicable requirement; and
d. Should be designed to ensure smooth transitions between the setting and the home community-based setting and preserves the participant's functional abilities.

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

This service is limited to no more than 8 hours per day.
For parents with school age children approved to provide supports (individualized day and respite) under this waiver, all supports that can be provided by such parent have a combined cap of 800 awake hours of support annually with the ability to request a prior approval exception for hours over the cap. For parents with school age children approved to provide this support, an assessment to determine age-appropriate dependency that meets the criteria of extraordinary care is required.
For legal guardians approved to provide supports (individualized day and respite) under this waiver, all supports that can be provided by such legal guardian have a combined cap of 2100 awake hours of support annually with the ability to request a prior approval exception for hours over the cap.

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

☒ **Participant-directed as specified in Appendix E**
☒ **Provider managed**
☒ **Remote/via Telehealth**

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	Individuals Hired by Participants who Self Direct
Agency	Provider Agency

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Individualized Day Support

Provider Category:

Individual

Provider Type:

Individuals Hired by Participants who Self Direct

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

The FI ensures that employeew meet the following qualifications:
Prior to Employment:
·21 yrs of age
·criminal background check
·registry check
·have ability to communicate effectively with the individual/family

·have ability to complete record keeping as required by the employer
Prior to being alone with the Individual:
·demonstrate competence in knowledge of DDS policies and procedures: abuse/neglect; incident reporting; client rights and confidentiality; handling fire and other emergencies, prevention of sexual abuse, knowledge of approved and prohibited physical management techniques
·demonstrate competence/knowledge in topics required to safely support the individual as described in the Individual Plan
·demonstrate competence, skills, abilities, education and/or experience necessary to achieve the specific training outcomes as described in the Individual Plan
·ability to participate as a member of the team if requested by the individual
·demonstrate understanding of Person Centered Planning
·Medication Administration*
* if required by the individual supported

Verification of Provider Qualifications

Entity Responsible for Verification:

FI and DDS

Frequency of Verification:

FI Prior to employment
DDS Quality Management staff conduct an annual Quality Service Review on a sample of consumer directed persons. Review includes verification of training qualifications.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Individualized Day Support

Provider Category:

Agency

Provider Type:

Provider Agency

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

The agency meets the qualifications described in DDS Procedure DDS PR.015. In addition, the agency ensures that employees meet the following qualifications:
Prior to Employment:
·21 yrs of age
·criminal background check
·registry check
·have ability to communicate effectively with the individual/family
·have ability to complete record keeping as required by the employer
Prior to being alone with the Individual:
·demonstrate competence in knowledge of DDS policies and procedures: abuse/neglect; incident reporting; client rights and confidentiality; handling fire and other emergencies, prevention of sexual abuse, knowledge of approved and prohibited physical management techniques
·demonstrate competence/knowledge in topics required to safely support the individual as described in the Individual Plan
·demonstrate competence, skills, abilities, education and/or experience necessary to achieve the specific training outcomes as described in the Individual Plan
·ability to participate as a member of the circle if requested by the individual
·demonstrate understanding of Person Centered Planning

·Medication Administration*
* if required by the individual supported

Verification of Provider Qualifications

Entity Responsible for Verification:

DDS

Frequency of Verification:

Initial and every 2 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:

Interpreter

HCBS Taxonomy:

Category 1:	Sub-Category 1:
17 Other Services	17020 interpreter
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):*

Service of an interpreter to provide accurate, effective, and impartial communication where the waiver recipient or representative is deaf or hard of hearing or where the individual does not understand spoken English.

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**

☐ **Remote/via Telehealth**

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	Individuals Hired by Participants who Self Direct
Agency	Private or public translation service

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Interpreter

Provider Category:

Individual

Provider Type:

Individuals Hired by Participants who Self Direct

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Sign language interpreter: Certified by National Assn. Of the Deaf or National registry of Interpreters for the Deaf. Sign language interpreters must be registered with the Department of Rehabilitation Services.

Other Standard *(specify):*

Any other language interpreter:
Prior to Employment
·18 yrs of age
·criminal background check
·registry check
·have ability to communicate effectively with the individual/family
·be proficient in both languages
·be committed to confidentiality
·understand cultural nuances and emblems
·understands the interpreters role to provide accurate interpretation

Verification of Provider Qualifications

Entity Responsible for Verification:

FI and DDS

Frequency of Verification:

FI Prior to employment
DDS Quality Management staff conduct an annual Quality Service Review on a sample of consumer directed persons.

Review includes verification of training qualifications.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Interpreter

Provider Category:

Agency

Provider Type:

Private or public translation service

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Sign language interpreter: Certified by National Assn. Of the Deaf or National registry of Interpreters for the Deaf. Sign language interpreters must be registered with the Commission on the Deaf and Hearing Impaired.

Other Standard *(specify):*

For any other language interpreter the agency ensures that employees meet the following qualifications:
Prior to Employment:
·18 yrs of age
·criminal background check
·registry check
·have ability to communicate effectively with the individual/family
·be proficient in both languages
·be committed to confidentiality
·understand cultural nuances and emblems
·understands the interpreters role to provide accurate interpretation

Verification of Provider Qualifications

Entity Responsible for Verification:

DDS

Frequency of Verification:

Initial and every 2 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:

Personal Emergency Response System (PERS)

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 directly to the 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, a 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:

NA

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

- [ ] **Participant-directed as specified in Appendix E**
- [x] **Provider managed**
- [ ] **Remote/via Telehealth**

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	Personal Emergency Response System Provider

Appendix C: Participant Services

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

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

Provider Category:

Agency

Provider Type:

Personal Emergency Response System Provider

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Providers Shall:
·Provide trained emergency response staff on a 24-hour basis
·Have quality control of equipment
·Provide service recipient instruction and training
·Assure emergency power failure backup and other safety features
·Conduct a monthly test of each system to assure proper operation
·Recruit and train community-based responders in service provision
·Provide an electronic means of activating a response system to emergency medical and psychiatric services, police or social support systems.

Verification of Provider Qualifications

Entity Responsible for Verification:

DDS

Frequency of Verification:

Initial and every 2 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:

Remote Supports Services

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):*

"Remote supports" means the provision of supports by staff at a remote location who are engaged with the individual through technology/devices with the capability for live two-way communication. Equipment used to meet this requirement must include one or more of the following systems: motion sensing system, radio frequency identification, live video feed, live audio feed, GPS tracking, web-based monitoring system, or a device that otherwise meets the requirement for two-way communication. Individual interaction in a remote capacity with the staff person may be scheduled, on-demand, or in response to an alert from a device in the remote support equipment system. Specific to remote interactions initiated on an on-demand basis, staff may already be on-call during the need for interaction or may be in response to a need at any time initiated by the individual or in response to an alert from the device in the remote support system. Such remote interactions initiated in this manner may be billed as a passive remote support interaction.

Remote supports may include a service component, a passive service component and a technology component. May not be provided at the same time as Group Day, Individualized Day, Supported Employment, Respite, Individualized Goods and Services, and/or Assistive Technology.

As there is an electronic monitoring component to this service, the equipment/monitoring will comport with 42 CFR section 441.301(c)(4)(iii).

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

NA

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

- [x] **Participant-directed as specified in Appendix E**
- [x] **Provider managed**
- [x] **Remote/via Telehealth**

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	Individuals Hired by Participants who self-direct
Agency	Private Agency or DDS

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Remote Supports Services

Provider Category:

Individual

Provider Type:

Individuals Hired by Participants who self-direct

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

The FI will ensure that employees meet the following qualifications:
Prior to Emplyment:
·18 yrs of age
·criminal background check
·registry check
·have ability to communicate effectively with the individual/family
·have ability to complete record keeping as required by the employer
Prior to being alone with the Individual:
·demonstrate competence in knowledge of DDS policies and procedures: abuse/neglect; incident reporting; client rights and confidentiality; handling fire and other emergencies, prevention of sexual abuse, knowledge of approved and prohibited physical management techniques
·demonstrate competence/knowledge in topics required to safely support the individual as described in the Individual Plan
·demonstrate competence, skills, abilities, education and/or experience necessary to achieve the specific training outcomes as described in the Individual Plan
·ability to participate as a member of the team if requested by the individual
·demonstrate understanding of Person Centered Planning
·demonstrate competence/knowledge in positive behavioral programming, working with individuals who experience moderate to severe psychological and psychiatric behavioral health needs and ability to properly implement behavioral support plans*
·Medication Administration*
* if required by the individual supported

Verification of Provider Qualifications

Entity Responsible for Verification:

Verified by the FI and DDS

Frequency of Verification:

FI verifies prior to employment and DDS conducts an annual sample of participant directed persons

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Remote Supports Services

Provider Category:

Agency

Provider Type:

Private Agency or DDS

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

The agency ensures that employees meet the following qualifications:
Prior to Employment:
·18 yrs of age
·criminal background check
·registry check
·have ability to communicate effectively with the individual/family
·have ability to complete record keeping as required by the employer
Prior to being alone with the Individual:
·demonstrate competence in knowledge of DDS policies and procedures: abuse/neglect; incident reporting; client rights and confidentiality; handling fire and other emergencies, prevention of sexual abuse, knowledge of approved and prohibited physical management techniques
·demonstrate competence/knowledge in topics required to safely support the individual as described in the Individual Plan
·demonstrate competence, skills, abilities, education and/or experience necessary to achieve the specific training outcomes as described in the Individual Plan
·ability to participate as a member of the team if requested by the individual
·demonstrate understanding of Person Centered Planning
·Medication Administration*
* if required by the individual supported

Verification of Provider Qualifications

Entity Responsible for Verification:

DDS

Frequency of Verification:

Initial and every 2 years certification 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:

Specialized Medical Equipment and Supplies

HCBS Taxonomy:

Category 1:	Sub-Category 1:
14 Equipment, Technology, and Modifications	14031 equipment and technology
Category 2:	**Sub-Category 2:**
14 Equipment, Technology, and Modifications	14032 supplies
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):*

Devices, controls, or appliances specified in the Individual Plan, which enable individuals to increase their abilities to perform activities of daily living or to perceive, control, or communicate with the environment in which they live.

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

When recommended by a licensed professional, for items costing more than $1000 prior approval will be required with documentation. SME is limited to $5,000 over the period of the waiver per recipient. Should not duplicate what is available under the state plan or does not duplicate what is required to be provided under the EPSDT. Competitive bid process will be required depending on the item or service.

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

- [ ] **Participant-directed as specified in Appendix E**
- [x] **Provider managed**
- [ ] **Remote/via Telehealth**

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 of Specialized Medical Equipment and Supplies

Appendix C: Participant Services

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

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

Provider Category:

Agency

Provider Type:

Vendors of Specialized Medical Equipment and Supplies

Provider Qualifications

License *(specify):*

Pharmacies: CT Dept. of Consumer Protection Pharmacy Practice Act: Regulations Concerning Practice of Pharmacy Section 20-175-4-6-7.

Certificate *(specify):*

Other Standard *(specify):*

Private Vendors: Conn. State Agency Reg. Section 10-102-3(e)(8)
Dept. of Admin. Services Bureau of Purchasing/Purchasing Manual 11/91
Direct Purchase Activity No. 8-F (CGS 4a-50 and 4a-52.

Verification of Provider Qualifications

Entity Responsible for Verification:

DDS

Frequency of Verification:

Initial and as needed 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:

Training, Counseling and Support Services for Unpaid Caregivers

HCBS Taxonomy:

Category 1:	Sub-Category 1:
09 Caregiver Support	09020 caregiver counseling and/or 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):*

Training Counseling and Support services for individuals who provide unpaid support, training, companionship or supervision to waiver participants.

Service can be provided in participants own home, family home, employment/jobsite or community.

For purposes of this service, individual is defined as any person, family member, neighbor, friend, companion, or co-worker who provides uncompensated care, training, guidance, companionship or support to a person served on the waiver.

Legal Guardians compensated for such service shall be limited to participation in a formal or professional training, instruction or counseling.

This service may not be provided in order to train paid caregivers.
Training includes instruction about treatment regimens and other services included in the service plan, use of equipment specified in the service plan, and includes updates as necessary to safely maintain the participant at home. Counseling must be aimed at assisting the unpaid caregiver in meeting the needs of the participant.

Waiver participant does not need to be present for unpaid caregiver to receive this service.

All training for unpaid care giver who provide unpaid support to the participant must be included in the participant's individual plan. Individual plan will detail what support the unpaid caregiver will use to benefit the waiver participant.

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

Use FI to facilitate payment and reimbursement.

Is available for the costs of registration and training fees associated with formal instruction, accessing supports in areas relevant to participant needs identified in the individual plan and identify frequency such as monthly or bimonthly at max rate of $100 per hour.
Is not available for the costs of travel, meals and overnight lodging to attend a training event or conference.

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

- [x] **Participant-directed as specified in Appendix E**
- [ ] **Provider managed**
- [ ] **Remote/via Telehealth**

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

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

Provider Specifications:

Provider Category	Provider Type Title
Individual	Unpaid Caregiver

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Training, Counseling and Support Services for Unpaid Caregivers

Provider Category:

Individual

Provider Type:

Unpaid Caregiver

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Be at least 18 yrs old;
Other qualifications as determined by the participant

Verification of Provider Qualifications

Entity Responsible for Verification:

FI or DDS or designee

Frequency of Verification:

Initial and as needed 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):*

Service offered in order to enable individuals to get to their place of employment or their community based day supports. Can include pre-purchased bus tickets or bus passes. Payment per mile is made for a maximum of one round trip daily. Wheelchair accessible transportation is paid at a higher rate only if the individual requires the use of a wheelchair accessible vehicle.

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

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

- [x] **Participant-directed as specified in Appendix E**
- [x] **Provider managed**
- [ ] **Remote/via Telehealth**

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	Private agency or Transportation Vendor
Individual	Individuals Hired by Participants who Self Direct

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Transportation

Provider Category:

Agency

Provider Type:

Private agency or Transportation Vendor

Provider Qualifications

License *(specify):*

Transportation Vendor: Livery License or registered as a transportation network company

Certificate *(specify):*

Other Standard *(specify):*

The agency will ensure that employees meet the following qualifications:
·Valid CT Driver's License
·18 years of age
·criminal background check
·registry check
·have ability to communicate effectively with the individual/family
·have ability to complete record keeping as required by the employer
Prior to being alone with the Individual:
·demonstrate competence in knowledge of DDS policies and procedures: abuse/neglect; incident reporting; client rights and confidentiality; handling fire and other emergencies, prevention of sexual abuse, knowledge of approved and prohibited physical management techniques

Verification of Provider Qualifications

Entity Responsible for Verification:

DDS

Frequency of Verification:

Initial and every 2 years certification 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:

Individuals Hired by Participants who Self Direct

Provider Qualifications

License *(specify):*

Valid CT Driver's License

Certificate *(specify):*

Other Standard *(specify):*

The FI will ensure that employees meet the following qualifications:
Prior to Employment:
Proof of insurance
·18 yrs of age
·criminal background check
·registry check
·have ability to communicate effectively with the individual/family
·have ability to complete record keeping as required by the employer
Prior to being alone with the Individual:
·demonstrate competence in knowledge of DDS policies and procedures: abuse/neglect; incident reporting; client rights and confidentiality; handling fire and other emergencies, prevention of sexual abuse, knowledge of approved and prohibited

physical management techniques

Verification of Provider Qualifications

Entity Responsible for Verification:

FI and DDS

Frequency of Verification:

FI Prior to employment

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Vehicle Modifications

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):*

Alterations made to a vehicle which is the individuals primary means of transportation, when such modifications are necessary to improve the individuals independence and inclusion in the community, and to avoid institutionalization. The vehicle may be owned by the individual, a family member with whom the individual lives or has consistent and on-going contact, or a non-relative who provides primary long-term support to the individual.

The following are specifically excluded:
1.Adaptations or improvements to the vehicle that are of general utility, and are not of direct medical or remedial benefit to the individual;
2.Purchase or lease of a vehicle; and
3.Regularly scheduled upkeep and maintenance of a vehicle except upkeep and maintenance of the modifications.

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

The benefit package is limited to a maximum of $25,000 within the waiver period per recipient for vehicle modifications. Services over $25,000 require Prior Approval. Once this cap is reached, $750 per individual per year may be allowable for repair, replacement or additional modification with prior approval.

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

- ☒ **Participant-directed as specified in Appendix E**
- ☒ **Provider managed**
- ☐ **Remote/via Telehealth**

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 specialize in Vehicle Modifications
Individual	Individuals Hired by Participants who self-direct

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Vehicle Modifications

Provider Category:

Agency

Provider Type:

Vendors who specialize in Vehicle Modifications

Provider Qualifications

License *(specify):*

CGS 14-52 and has Dept. of Motor Vehicles Dealers Registration

Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

DDS

Frequency of Verification:

Initial

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Vehicle Modifications

Provider Category:

Individual

Provider Type:

Individuals Hired by Participants who self-direct

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

The FI will ensure that employees meet the following qualifications:
Prior to Employment:
·18 yrs of age
·criminal background check
·registry check
·have ability to communicate effectively with the individual/family
·have ability to complete record keeping as required by the employer
Prior to being alone with the Individual:
·demonstrate competence in knowledge of DDS policies and procedures: abuse/neglect; incident reporting; client rights and confidentiality; handling fire and other emergencies, prevention of sexual abuse, knowledge of approved and prohibited physical management techniques
·demonstrate competence/knowledge in topics required to safely support the individual as described in the Individual Plan
·demonstrate competence, skills, abilities, education and/or experience necessary to achieve the specific training outcomes as described in the Individual Plan
·ability to participate as a member of the team if requested by the individual
·demonstrate understanding of Person Centered Planning
·demonstrate competence/knowledge in positive behavioral programming, working with individuals who experience moderate to severe psychological and psychiatric behavioral health needs and ability to properly implement behavioral support plans*
·Medication Administration*
* if required by the individual supported

Verification of Provider Qualifications

Entity Responsible for Verification:

Verified by the FI and DDS

Frequency of Verification:

FI verifies prior to employment and DDS conducts an annual sample of participant directed persons

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:

Virtual Health Consultation

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):*

This specialized Virtual Health Consultation service is tailored to meet the unique needs of individuals with intellectual and developmental disabilities (IDD), ensuring greater access to both routine and specialized medical care that might otherwise be challenging to obtain through traditional means. The goal of Virtual Health Consultation is to provide timely specialized telehealth assessments when a participant's primary care physician is unavailable or unable to determine the most appropriate clinical course of action. This approach helps reduce unnecessary emergency room visits, promoting efficient and accessible care. This service does not duplicate services that are covered by the state plan and is not a substitute for in-person exams or primary care as required.

This service enables real time medical consultation, coordination and guidance on physical and behavioral health concerns, assisting participants, families and providers in understanding health symptoms and determining next steps. This service may be available on-demand without a previously scheduled appointment and delivers disability-specific support and consultative guidance in real time or in passive manner as follow-up. Individuals with IDD can receive specialized healthcare interventions tailored to their unique needs. It offers medical support and consultation to address health concerns, assist in symptom assessment, and determine when in-person care is necessary. Additionally, it facilitates care coordination by helping participants and caregivers manage ongoing health needs, including chronic condition management and targeted health interventions. This service may also include behavioral support by offering access to mental health evaluations, behavioral health assessments, physical therapy consultations, and assistive technology assessments, all specifically designed for individuals with IDD.

This service provides expert guidance to enhance support for individuals with IDD within their private or residential settings, and the community. It provides consultative training for both paid and unpaid caregivers, equipping them with the skills and knowledge necessary to deliver effective, disability-specific care. Support can be provided in any residential or day setting that is agreed upon by the planning and support team. Support must be provided in a private area to comply with HIPAA and PHI requirements.

Eligibility may require a current documented medical condition as identified in the Level of Need. A DDS clinical assessment may be required to determine necessity of virtual healthcare services.

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

Participants must have access to an electronic tablet or smart phone that has internet service via Wi-Fi or cellular data and is capable of audio and video transmission to utilize the service. If the individual does not have access to such technology the planning and support team shall make a referral to review the Assistive Technology need. Cellular data service and internet service cannot be covered through the waivers.

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

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

☒ **Provider managed**

☒ **Remote/via Telehealth**

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

☐ **Legally Responsible Person**

☐ **Relative**

☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Private Agency or DDS

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Virtual Health Consultation

Provider Category:

Agency

Provider Type:

Private Agency or DDS

Provider Qualifications

License *(specify):*

This service must be provided or overseen by physicians who are:
- Licensed to practice medicine in the Commonwealth of Connecticut as required by Connecticut General Statutes Chapter 370, or have appropriate reciprocity; and
- Board Certified or board eligible with the American Board of Medical Specialties (ABMS).
- Functions which are overseen by a physician with the above qualifications will be provided by a Registered Nurse, Certified Registered Nurse Practitioner, or Physician's Assistant acting within their scope of practice.

Certificate *(specify):*

Other Standard *(specify):*

Providers of this service must have a minimum of 5 years' experience working with individuals with intellectual disabilities. For children, the provider must have 3 years of experience in working with children and adolescents with intellectual disabilities.

Verification of Provider Qualifications

Entity Responsible for Verification:

DDS or designee

Frequency of Verification:

FI Prior to employment
DDS Initial and annual verification of ongoing licensure.

Appendix C: Participant Services

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

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

- ○ **Not applicable** - Case management is not furnished as a distinct activity to waiver participants.
- ◉ **Applicable** - Case management is furnished as a distinct activity to waiver participants.

Check each that applies:

- ☐ **As a waiver service defined in Appendix C-3.** *Do not complete item C-1-c.*
- ☐ **As a Medicaid state plan service under section 1915(i) of the Act (HCBS as a State Plan Option).** *Complete item C-1-c.*
- ☒ **As a Medicaid state plan service under section 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.*
- ☐ **As a Medicaid state plan service under section 1945 and/or section 1945A of the Act (Health Homes Comprehensive Care Management).** *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 and the requirements for their training on the HCBS settings regulation and person-centered planning requirements:

State of CT Department of Developmental Services

d. Remote/Telehealth Delivery of Waiver Services. Specify whether each waiver service that is specified in Appendix C-1/C-3 can be delivered remotely/via telehealth.

Service
Individual Supported Employment
Individualized Day Support
Remote Supports Services
Virtual Health Consultation

1. Will any in-person visits be required?

- ○ **Yes.**
- ◉ **No.**

2. *By checking each box below, the state assures that it will address the following when delivering the service remotely/via telehealth.*

- ☒ **The remote service will be delivered in a way that respects privacy of the individual especially in instances of toileting, dressing, etc.** ***Explain:***

The service is provided remotely in accordance with all HIPAA requirements. No such remote service shall be provided in a person's private bathroom or bedroom except when it has been determined by the planning and support team to be necessary and is justified in the IP.

☒ **How the telehealth service delivery will facilitate community integration.** ***Explain:***

The service will focus on participants specific personal outcomes related to improving skills related to work or community-based activities.

☒ **How the telehealth will ensure the successful delivery of services for individuals who need hands on assistance/physical assistance, including whether the service can be rendered without someone who is physically present or is separated from the individual.** ***Explain:***

For participants that need hands on assistance, remote options for this service may be approved temporarily for a specific amount of time due to a specific issue or event. The planning and support team will monitor to ensure needs are met during the time to temporary support is offered.

☒ **How the state will support individuals who need assistance with using the technology required for telehealth delivery of the service.** ***Explain:***

The state provides assistance with technology to ensure all parties are familiar with the mechanism in which services are provided. The planning and support team should articulate a backup plan for any technology issues or failures.

☒ **How the telehealth will ensure the health and safety of an individual.** ***Explain:***

The planning and support team oversees the health and safety of the participant. The remote support will be reviewed and agreed upon by the team to ensure it meets the needs of the individual and will be monitored ongoing to ensure there are no issues during the provision of the support.

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):

Direct Support and professional support services under the following service definitions are required to submit to state (CT) only criminal checks. This includes all staff employed under behavioral supports, community day support options, supported employment, respite, adult day health, individual goods and services, interpreters, and transportation providers. Criminal background checks for providers of the following services may be required if requested by the individual receiving the supports or their representative: clinical behavioral support. Vendors enrolled as specialized medical and adaptive equipment are not required to submit to criminal background checks.

The process for ensuring that mandatory investigations have been completed depends upon the service and the hiring entity. The Fiscal Intermediary is required to obtain a criminal background check for any service vendor hired through the consumer-directed process prior to processing any employment paperwork or permitting the employee to begin work. DDS conducts annual FI audits for consumer-directed services to ensure that the required criminal background checks are conducted. For individually enrolled vendors, criminal background checks are required to enroll in the DDS HCBS waiver program and receive a provider agreement. For services operated by larger vendor agencies, the vendor agency agrees to obtain a criminal background check for any individual who provides the specified services as part of the Medicaid Provider Agreement. When an incident involving abuse/neglect or other misconduct by an employee reveals that the employee has a criminal history DDS Policy requires that DDS conducts an inquiry into the vendor agencys compliance with conducting criminal background checks.

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; (c) the process for ensuring that mandatory screenings have been conducted; and (d) the process for ensuring continuity of care for a waiver participant whose service provider was added to the abuse registry. 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):

DDS maintains an abuse/neglect registry pursuant to CT General Statutes 17a-247a-17a-247e. All employees of DDS or agencies funded or licensed by DDS who are found guilty of abuse and terminated or separated from employment are subject to inclusion on the registry. The fiscal intermediary is required to ensure the abuse/neglect registry has been checked for all individual employees sought to be hired through consumer-direction. The DDS and private vendor is required to check the registry prior to hiring any employee who will deliver services. The DDS monitors this expectation during annual FI audits and at the vendor level through bi-annual Quality Service Reviews conducted by DDS.

Appendix C: Participant Services

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

Note: Required information from this page is contained in response to C-5.

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 or regulations to care for another person (e.g., the parent (biological or adoptive) of a minor child or the guardian of a minor child who must provide care to the child). At the option of the state and under extraordinary circumstances specified by the state, payment may be made to a legally responsible individual for the provision of personal care or similar services. *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 types of legally responsible individuals who may be paid to furnish such services and the services they may provide; (b) the method for determining that the amount of personal care or similar services provided by a legally responsible individual is ***"extraordinary care"***, exceeding the ordinary care that would be provided to a person without a disability or chronic illness of the same age, and which are necessary to assure the health and welfare of the participant and avoid institutionalization; (c) the state policies to determine that the provision of services by a legally responsible individual is in the best interest of the participant; (d) the state processes to ensure that legally responsible individuals who have decision-making authority over the selection of waiver service providers use substituted judgement on behalf of the individual; (e) any limitations on the circumstances under which payment will be authorized or the amount of personal care or similar services for which payment may be made; (f) any additional safeguards the state implements when legally responsible individuals provide personal care or similar services; and, (g) the procedures that are used to implement required state oversight, such as ensuring 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.*

For parents with school age children approved to provide individualized day and/or respite under this waiver, all supports that can be provided by such parent have a combined cap of 800 awake hours of support annually with the ability to request a prior approval exception for hours over the cap. For parents with school age children requesting to provide such support and be compensated, an assessment to determine age-appropriate dependency that meets the criteria of extraordinary care is required. This assessment will be done through a form that utilizes a rating scale that reflects support or assistance a child needs that exceeds the typical standard of care for any child. The state has finalized this form.
For legal guardians approved to individualized day and/or respite under this waiver, all supports that can be provided by such legal guardian have a combined cap of 2100 awake hours of support annually with the ability to request a prior approval exception for hours over the cap.

Details related to the necessity of a parent or legal guardian to provide such supports must be discussed and agreed upon by the planning and support team and documented in the person-centered plan.
All quality mechanisms and controls to ensure payments are made only for services rendered for all waiver services will stay intact for these arrangements. Quality mechanisms and controls in quality service reviews by the quality unit and case managers, FI reviews of timesheets and payments, electronic visit verification utilization requirements. If billing or other irregularities are reported or discovered the billing is corrected and necessary actions are taken. Employers of record are prohibited from providing any other supports outside of their role as employer of record. This includes being compensated for personal care services as a legal guardian or a parent of a school age child. The sponsoring person who may also be a legal guardian or a parent of a school age child under self-direction is also prohibited from providing any other paid supports outside of their role as a sponsoring person, unless a prior approval identifying the unique need and unsuccessful efforts to find staff is explicitly reviewed and approved.

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 types of relatives/legal guardians to whom payment may be made, the services for which payment may be made, the specific circumstances under which payment is made, and the method of determining that such circumstances apply. Also specify any limitations on the amount of services that may be furnished by a relative or legal guardian, and any additional safeguards the state implements when relatives/legal guardians provide waiver services. Specify the state policies to determine that that the provision of services by a relative/legal guardian is in the best interests of the individual. When the relative/legal guardian has decision-making authority over the selection of providers of waiver services, specify the state's process for ensuring that the relative/legal guardian uses substituted

judgement on behalf of the individual. Specify the procedures 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.*

For parents with school age children approved to provide supports (individualized day and respite) under this waiver, all supports that can be provided by such parent have a combined cap of 800 awake hours of support annually with the ability to request a prior approval exception for hours over the cap. For parents with school age children approved to provide this support, an assessment to determine age-appropriate dependency that meets the criteria of extraordinary care is required.
For legal guardians approved to provide supports (individualized day and respite) under this waiver, all supports that can be provided by such legal guardian have a combined cap of 2100 awake hours of support annually with the ability to request a prior approval exception for hours over the cap.

○ **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:

All information regarding requirements for and instructions to enroll as a qualified provider for the DDS HCBS waivers is posted to the DDS web site. DDS completes the evaluation of qualified providers and notifies DSS for final provider enrollment. Any provider of services may submit an application for enrollment to the DDS Operations Center for any service at any time.

g. State Option to Provide HCBS in Acute Care Hospitals in accordance with Section 1902(h)(1) of the Act. Specify whether the state chooses the option to provide waiver HCBS in acute care hospitals. *Select one*:

○ **No, the state does not choose the option to provide HCBS in acute care hospitals.**

◉ **Yes, the state chooses the option to provide HCBS in acute care hospitals under the following conditions.** *By checking the boxes below, the state assures:*

☒ **The HCBS are provided to meet the needs of the individual that are not met through the provision of acute care hospital services;**

☒ **The HCBS are in addition to, and may not substitute for, the services the acute care hospital is obligated to provide;**

☒ **The HCBS must be identified in the individual's person-centered service plan; and**

☒ **The HCBS will be used to ensure smooth transitions between acute care setting and community-based settings and to preserve the individual's functional abilities.**

*And specify:***(a) The 1915(c) HCBS in this waiver that can be provided by the 1915(c) HCBS provider that are not duplicative of services available in the acute care hospital setting;(b) How the 1915(c) HCBS will assist the individual in returning to the community; and(c) Whether there is any difference from the typically billed rate**

for these HCBS provided during a hospitalization. If yes, please specify the rate methodology in Appendix I-2-a.

Direct Support staffing services may be provided in a short-term acute care hospital stay for the purposes of supporting the participant's personal, behavioral and communication supports not otherwise provided in that setting. Services may not be duplicative of hospital or short-term institutional services.
1. The State has mechanisms in place to prevent duplicate billing for both institutional and home and community based services.
2. These necessary waiver services:
a. Must be identified in the individual's person-centered service plan;
b. Must be provided the meet the individual's needs and are not covered in such settings;
c. Should not substitute for services that the setting is obligated to provide through its condition of participation under federal or State law, under another applicable requirement; and
d. Should be designed to ensure smooth transitions between the setting and the home community-based setting and preserves the participant's functional abilities.

Appendix C: Participant Services

Quality Improvement: Qualified Providers

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

a. Methods for Discovery: Qualified Providers

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:
The number and percent of provider applications by provider type that meet initial provider certification and enrollment standards Numerator= Number of provider applications that meet initial certification and enrollment standards
Denominator=Number of initial provider applications

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

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

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

Data Aggregation and Analysis:

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

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

Performance Measure:
Number and percent of all provider applications, by provider type, continuing to meet certification following initial enrollment as specified in the waiver. Numerator=number of provider certifications issued following initial enrollment as specified in the waiver. Denominator=number of all providers up for recertification following initial enrollment as specified in the waiver.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Provider certifications

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

	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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

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

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

Performance Measure:
Number and percent of non-licensed/non-certified providers, by provider type, who adhere to waiver requirements. Numerator= total number of self-directed providers qualified. Denominator= total number of non-licensed/non-certified self-directed

providers.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Employment applications, Criminal History Background Checks and training 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** Confidence Interval =
☒ **Other** Specify: Fiscal Intermediaries	☐ **Annually**	☐ **Stratified** Describe Group:
	☒ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**

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

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

For each performance measure 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 participants who reported that support staff have the right training to meet their needs. Numerator=number of NCI surveys completed where people report that their support staff have the right training to meet their needs. Denominator=number of NCI surveys completed.

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

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**

☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

Performance Measure:
Number and percent of employees hired through the self direction program who complete trainings in accordance with state requirements Numerator= the number of employee hired through self direction that completed training in accordance with state requirements Denominator = Number of employees hired through self direction

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**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Number and percent of provider agencies that comply with state requirements for staff training Numerator= Number of provider agencies reviewed that comply with state requirements for staff training Denominator=Number of provider agencies reviewed

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

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☒ **Representative Sample** Confidence Interval = 95%
☐ **Other**	☐ **Annually**	☐ **Stratified**

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

Data Aggregation and Analysis:

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

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

b. Methods for Remediation/Fixing Individual Problems

i. Describe the state's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction and the state's method for analyzing information from individual problems, identifying systemic deficiencies, and implementing remediation actions. In

addition, provide information on the methods used by the state to document these items.

When issues are identified qualified providers are required to submit a plan of correction with timeframes for completion. If a provider continues to have less than acceptable performance they can be put on enhanced monitoring, can be prohibited from serving any new participants until their performance has reached an acceptable level of quality, can lose their status as a qualified provider for the service(s) with less than acceptable quality, and/or can be removed as a qualified provider altogether.
Potential providers must apply and submit organizational documentation to the Operational Center. Once the application is complete, the material is reviewed, the principal (s) of the organization is/are subjected to a background check and the executive team is interviewed by DDS staff. An organization that satisfactorily meets the expectation of all three steps above will become a qualified provider for the services approved by DDS. The provider signs an Assurance Agreement that itemizes the qualifications an organization must demonstrate in order to maintain qualified provider status.
Whenever an issue concerning the qualifications of an organization is identified through Quality Service Review or regional monitoring, the region(s) will meet with the Provider to discuss the issue(s). A plan of correction will be developed with timeframes for completion. If the provider fails to meet the items listed in the plan of correction or lacks the ability to demonstrate its capacity to maintain all the requirements listed on the Assurance Agreement, the provider will be placed on Enhanced Monitoring. A provider placed on Enhanced Monitoring will be downgraded to a conditional qualified provider status subject to additional monitoring by the region, suspension of new admissions, Program Integrity Review and prohibition from expanding services through an RFP. Continued lack of progress on the identified issue(s) may result in disqualification of a particular service or as a provider for DDS.

ii. Remediation Data Aggregation

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

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

c. Timelines

When the state does not have all elements of the quality improvement strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Qualified Providers that are currently non-operational.

◉ **No**

○ **Yes**

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

Appendix C: Participant Services

C-3: Waiver Services Specifications

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

Appendix C: Participant Services

C-4: Additional Limits on Amount of Waiver Services

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

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

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

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

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

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

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

Each individual receives a budget allocation based on the results of the participants assessed CT DDS Level of Need Assessment and Screening Tool (LON). The resulting score of 1-8 is associated with a prospective individual funding amount for vocational related services and respite services. The LON Assessment and preliminary associated funding levels were developed under the CMS Independence Plus Grant using qualitative and quantitative methodologies. The bulk of the historical financial data used to calculate these rates includes information on individuals who were served on Master Contracts prior to the conversion to the present Fee for Service model. The design, testing and development of this assessment tool was supported by a CMS Systems Change Grant under the guidance of a volunteer Steering Committee representing various DDS stakeholders, and completed by a research team from the UCONN Health Center. This assessment provides the information needed to accomplish the following objectives:

a) determine an individuals need for supports in an equitable and consistent manner for the purposes of allocating DDS resources

b) identify potential risks that could affect the health and safety of the individual, and support the development of a comprehensive Individual Plan to address potential risks

c) identify areas of support that may need to be addressed to assist the individual in actualizing personal preferences and goals

Areas assessed by the LON include: Health and Medical, PICA, Behavior, Psychiatric, Criminal/ Sexual Issues, Seizure, Mobility, Safety, Comprehension and Understanding, Social Life, Communication, Personal Care, and Daily Living. Scores in each domain are based on the amount of support the participant needs in that area. An algorithm is then applied that calculates the participants overall need for support into a Composite score from 1-8.

Individuals with scores of 8 have exceptional support needs and will receive and allocation based on their individual support needs. Applicants with a LON score of 0 will not be eligible to receive waiver services since they will not meet the Level of Care criteria. Composite LON scores, much like overall IQ scores, are comprised of information obtained from the answers on the assessment and just as no two people with the same IQ score have the exact same skills no two people with the same LON score have the same skills and risk areas. The CT LON Assessment and Manual are posted on the DDS website at http://www.ct.gov/dds/lib/dds/forms/lon/ctlon.pdf and http://www.ct.gov/dds/lib/dds/forms/lon/ct_lon_manual.pdf. People with approved support packages that exceed $75,000 are enrolled in either the IFS or the Comprehensive Waiver. During the period covered by this waiver the analysis of the data will continue and allocations will be modified according to the results of the analyses.

The DDS Regional Planning and Resource Allocation Team notifies the applicant of the funding limit via letter as described in Appendix D. The budget allocation limits apply to all services with the exception of Specialized Adaptive Equipment, which is not an annualized services. Adjustments to the budget allocation limit can be made either as a result of an assessed CT DDS Level of Need Assessment and Screening Tool which results in an increased or decreased LON score, or due to short-term circumstances necessitating an increased amount of services to address short term health and safety needs.

☒ **Other Type of Limit.** The state employs another type of limit.

Describe the limit and furnish the information specified above.

Documentation is maintained in the file of each individual receiving this service that the service is not available under a program funded under section 110 of the Rehabilitation Act of 1973 or the IDEA (20 U.S.C. 1401 et seq.)

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 in which 1915(c) HCBS are recieved. *(Specify and describe the types of settings in which waiver services are received.)*

DDS continues to work with qualified providers to ensure continued final settings compliance across all DDS Medicaid settings
including residential, day and employment settings.
At the time of submission all provider owned and controlled settings in this waiver were reviewed, assessed and determined to
meet the HCBS settings requirements in accordance 42 CFR 441.301(c)(4)-(5) and associated CMS guidance. This includes all
of the settings in the HCBS program, as offered through this waiver. DDS continues to work with qualified providers to confirm
continued compliance across all DDS Medicaid settings and to ensure awareness of the settings rule expectations through numerous communications, trainings, presentations and a webpage that is regularly updated specific to the rule. DDS provided
access to distance learning opportunities and created a section of the website where information regarding the Settings Rule can
be accessed by both internal and external users. Regular communication tools including memos and Executive Briefs are used to
share information and educate staff about the Settings Rule. Staff were trained in Regional Supervision meetings, and ongoing
education and outreach is available as needed and for new staff.
The Department has included settings rule compliance as a requirement within all signed service contracts with the department.
This means qualified providers are agreeing to abide by the terms of final settings or they are in breach of contract. Final settings
requirements have been articulated to all waiver qualified providers through the means articulated above.
DDS also continues to work with DDS staff and providers to ensure participation in a continued and ongoing person-centered
service planning process is occurring as well as appropriate documentation of any necessary modifications in the Individual Plan.
A review of the person-centered plan is done at least annually and a minimum quarterly check-ins with the individual is required.
Settings were assessed using the Quality Service Review (QSR) tool which includes all of the settings criteria consisting of over
200 questions and is organized around 6 main areas including Consumer (Individual) Interview. The QSR tool will be used at
least annually for ongoing monitoring to ensure all settings continue to meet all of the settings requirements and criteria.
Measures, such as Corrective Action Plans (CAPs), will be put into place for any settings that are identified as not compliant.
Ongoing monitoring is to ensure that all of the settings continue to meet all of the settings criteria.
Facility-Based Respite Care: DSS clarifies that facility-based respite is excluded from assessment since this service is a time
limited service capped at 30 days and therefore does not require an assessment of the settings in which it is provided. It is not the
institutional nature of the setting that excludes the settings from site-specific assessment; it is the nature of time-limited respite
service.

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 in the future as part of ongoing monitoring. *(Describe the process that the state will use to assess each setting including a detailed explanation of how the state will perform on-going monitoring across residential and non-residential settings in which waiver HCBS are received.)*

As part of the ongoing monitoring process to measure and document that a provider setting is meeting and continues to meet all
settings criteria as outlined in the HCBS final rule, DDS will look at all settings based criteria including but not limited to how
settings establish opportunities for individuals to participate in services and/or activities in the community, outside the walls of
the setting; how settings ensure that participants are made aware of these opportunities; how settings ensure that individuals can
freely choose from these services and/or activities; and how these services and/or activities are consistent with individual needs,
as noted in the person-centered service plan. Non-compliant providers will be expected to remediate identified issues in a timely
manner and document that all issues are addressed in order to continue to provide HCBS.
Individual, Privately-Owned Homes – How the State will Monitor Compliance of this Category with HCB Settings Requirements Over Time: The QSR tool is used to conduct setting surveys on an annual and ongoing basis and is conducted
through the QSR division staff and case management. The tool includes questions specific to settings criteria including privately
owned homes.
Case manager on-site touch point meetings will be used as the primary source to determine directly from members if they are
residing in privately owned settings that are institutional in nature. If identified, these providers will be non-compliant providers
will be expected to remediate identified issues in a timely manner and document that all issues are addressed in order to continue
to provide HCBS. This can may be done through a CAP or the enhanced monitoring process.
The tenets of the final settings rule; community based services, choice and integrated supports and services are also noted as part
of the National Core Indicator survey process that is done annually for a random sample of DDS waiver participants with a goal
of competing 600 surveys. Although NCI is not tied to a site-specific setting, it is a method that can identify overall systemic
issues that may need more intense review and mitigation. The requirements of the rule are also integrated into the annual quality
meeting that occurs with all qualified waiver providers every year to ensure consistent communication, reminders and discussion
on the details of the rule. This allows providers a formal opportunity to ask any clarifying questions they may have on some of
the details associated with the rule

3. *By checking each box below, the state assures that the process will ensure that each setting will meet each requirement:*

☒ **The setting is integrated in and supports full access of individuals receiving Medicaid HCBS to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community, to the same degree of access as individuals not receiving Medicaid HCBS.**

☒ **The setting is selected by the individual from among setting options including non-disability specific settings and an option for a private unit in a residential setting. The setting options are identified and documented in the person-centered service plan and are based on the individual's needs, preferences, and, for residential settings, resources available for room and board.** ***(see Appendix D-1-d-ii)***

☒ **Ensures an individual's rights of privacy, dignity and respect, and freedom from coercion and restraint.**

☒ **Optimizes, but does not regiment, individual initiative, autonomy, and independence in making life choices, including but not limited to, daily activities, physical environment, and with whom to interact.**

☒ **Facilitates individual choice regarding services and supports, and who provides them.**

☒ **Home and community-based settings do not include a nursing facility, an institution for mental diseases, an**

intermediate care facility for individuals with intellectual disabilities, a hospital; or any other locations that have qualities of an institutional setting.

Provider-owned or controlled residential settings. (*Specify whether the waiver includes provider-owned or controlled settings.*)

- ○ **No, the waiver does not include provider-owned or controlled settings.**
- ◉ **Yes, the waiver includes provider-owned or controlled settings.** (By checking each box below, the state assures that each setting, *in addition to meeting the above requirements, will meet the following additional conditions*):
  - ☐ **The unit or dwelling is a specific physical place that can be owned, rented, or occupied under a legally enforceable agreement by the individual receiving services, and the individual has, at a minimum, the same responsibilities and protections from eviction that tenants have under the landlord/tenant law of the state, county, city, or other designated entity. For settings in which landlord tenant laws do not apply, the state must ensure that a lease, residency agreement or other form of written agreement will be in place for each HCBS participant, and that the document provides protections that address eviction processes and appeals comparable to those provided under the jurisdiction's landlord tenant law.**
  - ☒ **Each individual has privacy in their sleeping or living unit:**
    - ☒ **Units have entrance doors lockable by the individual.**
    - ☒ **Only appropriate staff have keys to unit entrance doors.**
    - ☒ **Individuals sharing units have a choice of roommates in that setting.**
    - ☒ **Individuals have the freedom to furnish and decorate their sleeping or living units within the lease or other agreement.**
  - ☒ **Individuals have the freedom and support to control their own schedules and activities.**
  - ☒ **Individuals have access to food at any time.**
  - ☒ **Individuals are able to have visitors of their choosing at any time.**
  - ☒ **The setting is physically accessible to the individual.**
  - ☒ **Any modification of these additional conditions for provider-owned or controlled settings, under § 441.301(c)(4)(vi)(A) through (D), must be supported by a specific assessed need and justified in the person-centered service plan*(see Appendix D-1-d-ii of this waiver application).***

Appendix D: Participant-Centered Planning and Service Delivery

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

State Participant-Centered Service Plan Title:

Individual Plan

a. Responsibility for Service Plan Development. Per 42 CFR § 441.301(b)(2), specify who is responsible for the development of the service plan and the qualifications of these individuals. Given the importance of the role of the person-centered service plan in HCBS provision, the qualifications should include the training or competency requirements for the HCBS settings criteria and person-centered service plan development. *(Select each that applies):*

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

DDS Case Managers are state employees who meet the following qualifications: considerable understanding of nature of clinical assessments; considerable knowledge of services available to persons with intellectual disability; knowledge of residential programs for persons with intellectual disability; knowledge of interdisciplinary approach to program planning; knowledge of intellectual disability; considerable skill in facilitating positive group process; oral and written communication skills; considerable ability to translate clinical findings and recommendations into program activities and develop realistic program objectives; ability to collect and analyze large amounts of information; familiarity with automated data systems.

The General Experience is defined as one of the following:
1.
A Bachelor's degree that meets the eligibility criteria for certification/designation as a Qualified Intellectual Disabilities Professional (QIDP) as set forth in federal regulations and interpretive guidelines and two (2) years of professional experience involving responsibility for developing, implementing and evaluating individualized programs for individuals with intellectual disabilities in the areas of behavior, education and rehabilitation.
OR
2.
A Master's degree that meets the eligibility criteria for certification/designation as a Qualified Intellectual Disabilities Professional (QIDP) as set forth in federal regulations and interpretive guidelines and one (1) year of professional experience involving responsibility for developing, implementing and evaluating individualized programs for individuals with intellectual disabilities in the areas of behavior, education and rehabilitation.
NOTE:
A degree that meets the eligibility criteria for certification/designation as a Qualified Intellectual Disabilities Professional (QIDP) is a degree in the field of human services, healthcare or education including but not limited to: nursing, psychology, rehabilitation counseling, special education or sociology.
SPECIAL REQUIREMENTS:
1.
Incumbents in this class may be required to possess fluency in a foreign language or sign language for designated positions.
2.
Incumbents in this class must be eligible for certification as a Qualified Intellectual Disabilities Professional as required by Federal regulations.
3.
Incumbents in this class may be required to possess and retain a valid Motor Vehicle Operator's license.
4.
Incumbents in this class may be required to travel.
This replaces the existing specification for the class of Developmental Services Case Manager in Salary Group HC 24 approved effective May 2, 2014. (Revised Experience and Training and modify content)

☐ **Social Worker**

Specify qualifications:

☐ **Other**

Specify the individuals and their qualifications:

Appendix D: Participant-Centered Planning and Service Delivery

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

b. Service Plan Development Safeguards. Providers of HCBS for the individual, or those who have interest in or are employed by a provider of HCBS; are not permitted to have responsibility for service plan development except, at the

option of the state, when providers are given responsibility to perform assessments and plans of care because such individuals are the only willing and qualified entity in a geographic area, and the state devises conflict of interest protections. *Select one:*

- ◉ **Entities and/or individuals that have responsibility for service plan development may not provide other direct waiver services to the participant.**
- ○ **Entities and/or individuals that have responsibility for service plan development may provide other direct waiver services to the participant. *Explain how the HCBS waiver service provider is the only willing and qualified entity in a geographic area who can develop the service plan:***

(Complete only if the second option is selected) The state has established the following safeguards to mitigate the potential for conflict of interest in service plan development. *By checking each box, the state attests to having a process in place to ensure:*

- ☐ **Full disclosure to participants and assurance that participants are supported in exercising their right to free choice of providers and are provided information about the full range of waiver services, not just the services furnished by the entity that is responsible for the person-centered service plan development;**
- ☐ **An opportunity for the participant to dispute the state's assertion that there is not another entity or individual that is not that individual's provider to develop the person-centered service plan through a clear and accessible alternative dispute resolution process;**
- ☐ **Direct oversight of the process or periodic evaluation by a state agency;**
- ☐ **Restriction of the entity that develops the person-centered service plan from providing services without the direct approval of the state; and**
- ☐ **Requirement for the agency that develops the person-centered service plan to administratively separate the plan development function from the direct service provider functions.**

Appendix D: Participant-Centered Planning and Service Delivery

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

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

The DDS case manager supports the waiver participant and other team members to develop and implement a plan that addresses the individuals needs and preferences. The case manager supports the individual to be actively involved in the planning process and assists the individual to identify members of his or her planning and support team and to invite them to the meeting. The case manager supports the individual to determine the content of the meeting and decide how the meeting will be run and organized. Individuals who are interested in self-directing their supports are made aware of the opportunity to either utilize a DDS Support Broker who also provides TCM or to keep their regular DDS case Manager for TCM, and in addition, hire an Independent Support Broker to assist with planning. If selected, the Independent Support Broker would become a member of the persons planning and support team. During the planning meeting the individual and team discuss ways to enhance the individuals future participation in the planning process if needed. The DDS case manager supports the individual and family to review assessments and reports before the meeting. The DDS case manager is responsible to ensure the individual planning meeting is scheduled at a time when the person, his or her family and other team members can attend. The DDS case manager ensures the individual has a choice of supports, service options, and providers and that the plan represents the individuals preferences.

Appendix D: Participant-Centered Planning and Service Delivery

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

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

The individual planning process results in the development of a comprehensive Individual Plan, which is the document to guide all supports and services provided to the individual. Individual planning, a form of person-centered planning, is a way to discover the kind of life a person desires, map out a plan for how it may be achieved, and ensure access to needed supports and services. Individual planning is an approach to planning driven by a respect for the individual, a belief in the capacities and gifts of all people, and the conviction that everyone deserves the right to create their own future. Individual planning supports people to achieve the outcomes of the mission of the Department of Developmental Services, which states that all people should have opportunities to experience:

-Presence and participation in Connecticut town life.
-Opportunities to develop and exercise competence.
-Opportunities to make choices in the pursuit of a personal future.
-Good relationships with family members and friends.
-Respect and dignity

The individual planning process promotes and encourages the person and those people who know and care for him or her to take the lead in directing this process and in planning, choosing, and evaluating supports and services. Individual planning puts the person at the center of the plan. Individual planning offers people the opportunities to lead self-determined lifestyles and exercise greater control in their lives. With individual planning, the person is viewed holistically to develop a plan of supports and services that is meaningful to him or her. Services and supports are identified to meet the person's unique desires and needs, regardless of funding source and may include state plan services, generic resources, and natural support networks. Individuals meeting the eligibility requirements for this DDS HCBS waiver must initiate a HCBS waiver application at the time of the new resource allocation or requested service notice. To access waiver services, a current Individual Plan, and accompanying Individual Budget, if applicable, must be developed or updated to identify specific needs, preferences and individual outcomes that will be addressed by waiver services. The DDS Individual Plan serves as the Medicaid Plan of Care that supports and prescribes the need for the specific type(s), frequency, amount and/or duration of waiver services. Without a complete plan as described below, Medicaid waiver services cannot be authorized. Following are the major steps of the Individual Planning process:
· Prepare to plan.
The case manager develops strategies to assist the person and his or her family to be actively involved in the planning process. The case manager and other team members assemble as much information as possible before the meeting to assist the individual and his or her family to prepare for the meeting. This helps the meeting to be shorter, more focused on decision making, and more efficient. Before the meeting, the case manager or another team member may assist the individual and his or her family to begin to update the Information Profile and the CT Level of Need Assessment and Risk Screening Tool. The case manager may provide a copy of "My Health and Safety Screening" to the individual or his or her family so they may identify health and safety concerns they want to be sure are addressed in the plan. Providers of supports and services share current assessments, reports and evaluations with the case manager at least 14 days prior to the scheduled meeting. The case manager shares the LON and LON Summary Report with team members prior to the planning meeting. It is also helpful before the meeting to ensure that the person and his or her family has a chance to review the information in current Assessments, Reports, and Evaluations that will be discussed at the meeting. Supporting the individual to prepare for the meeting offers an opportunity to express his or her desires or concerns to the case manager or another team member with whom he or she is comfortable and who can assist the individual to share these issues with the larger group. The case manager assists the individual to understand the waiver service options and hiring options that DDS now provides to all consumers and explains the DDS portability process. There may be circumstances when the individual does not want to discuss something in a meeting. This preference should be respected when possible, however, personal information that affects supports or impacts the individual's health or safety must be addressed. In these circumstances, the topic should be acknowledged and dealt with respectfully and privately outside of the meeting with the person and with others who need to know this information to provide appropriate supports. During the planning meeting, the individual and his or her planning and support team completes a profile or assessment of the person's current life situation and future vision. The team completes an analysis of the person's preferences, desired outcomes, and support needs. They also review the information profile, personal profile, future vision, current assessments, reports, and evaluations, including the health and safety screening, to identify what is important to include in the plan and identify any additional assessments needed. The sections of the plan completed during this stage of plan development include the:
· Information Profile
· Personal Profile

· CT DDS Level of Need Assessment and Screening Tool
· Future Vision
· Assessment Review

Any dispute with the results of a completed LON may be resolved by requesting that a new LON be completed by a different DDS employee who has the requisite skills and background to coordinate the completion of the assessment. The completion of the LON must include input from the individual, family, personal representatives, friends and service providers who know the person best. If a LON ultimately affects the amount, type or duration of waiver services, the individual and personal representative will be provided Fair Hearing Rights notice. The action plan includes desired outcomes, needs or issues addressed, actions and steps, responsible person(s), and by when and should consider the individual's choices and preferences.

The section of the plan completed during this stage of plan development includes the:

· Action Plan

The Individual Plan must address each identified risk area that was identified by the LON. If new action is required then the Action Plan must include services or supports that are needed to address an identified risk. Once the individual and team have completed the action plan, they identify the type of services and supports that will address the Action Plan. Specific agencies and/or individuals who will provide service or support are further identified. The need for a waiver service that addresses specific outcomes included in the Action Plan must be clearly identified and supported by the Individual Plan. The case manager ensures that the individual and his or her family or guardian have sufficient information available to make informed selections of support providers, and information to make informed decisions regarding the degree to which the individual and his or her family or guardian may wish to self-direct services and supports.

The section of the plan completed during this stage of plan development includes the:

· Summary of Supports or Services

During the planning meeting, the individual and planning and support team discuss plans to monitor progress and to evaluate whether the supports are helping the person to reach desired outcomes. At a minimum, the case manager initiates a contact quarterly to evaluate the implementation or satisfaction with the plan, and visits the individual at each service site during the year to review progress on the plan. The team may be assembled to review the Individual Plan any time during the year if the individual experiences a life change, identifies a need to change supports, or requests a review.

The section of the plan completed during this stage of plan development includes the:

· Summary of Monitoring and Evaluation of the Plan

Once the plan is completed and the individual and planning and support team agree with the plan, the case manager ensures the plan is documented on the appropriate forms. Each waiver service specifies the experience, background and training requirements for the agency and/or individual providing the support. Services delivered in licensed settings and in facility day programs are governed by regulation and contract requirements. Individual support services require that the planning and support team designates specific training, experience or background requirements for the staff based on the specific needs of the individual.

Specific training and/or experience and the timeframe for completion of any training is recorded on the:

· Provider Qualifications and Training Form

Every effort should be made to arrange for needed supports and to implement the plan as soon as possible after the final approval is obtained as outlined above.

The role of the DDS case manager (TCM) in individual planning is to support the person and other team members to develop and implement a plan that addresses the individual's needs and preferences. Case managers support individuals to be actively involved in the planning process. They are responsible for ensuring that individual planning meetings are scheduled at times when the person, his or her family and other team members can attend. The case manager is responsible for facilitating the annual individual planning meeting unless the individual requests another team member to facilitate the meeting. The case manager ensures the meeting is facilitated in line with the individual planning process and encompasses input across services settings. The case manager ensures the plan is documented on the Individual Plan forms, though other team members or clerical staff may do the actual transcription of the plan. He or she ensures the plan is distributed to all team members, though this task may also be assumed by another team member or clerical staff. The case manager is responsible for ensuring the completion of a HCBS waiver application during the initial planning process. The case manager monitors implementation of the plan and ensures supports and services match the individual's needs and preferences. He or she ensures the plan is periodically reviewed and

updated based on individual circumstances and regulatory requirements. Under all DDS waivers, individuals who do, or are considering whether to, self-direct services and supports by hiring staff directly may choose to purchase the Independent Support Broker service with waiver funding. The DDS case manager will inform the individual that this option is available to individuals and families who may wish to pursue self-direction in advance of the Individual Planning meeting. This notice shall be provided as soon as an individual has been awarded waiver funding by the PRAT so there is sufficient time to locate and initiate the Independent Support Broker service provider of the individual's choice prior to the IP meeting. If requested by the individual, the case manager will submit a request for Independent Support Broker authorization up to 6 hours to be paid by DDS prior to the completion and approval of the Individual Plan and Budget. Payment may be state funded if the person has not yet completed enrollment in a waiver, or waiver funded if the person is already enrolled and is so noted in the IP6 for the purpose of initial individual planning. Once the Individual Plan has been completed, Independent Support Broker may continue to be a selected service if the individual self-directs services, and chooses to retain the Independent Support Broker service as part of his/her individual budget. In those cases, the DDS case manager continues to carry out TCM activities on behalf of the individual. Another option that is available to people who self-direct their services is the use of a DDS Support Broker (specialized state employee case manager) to provide both TCM and support to self-direct.

The individual and his or her family members should be comfortable with the people who help to develop the Individual Plan and should consider inviting a balance of people who can contribute to planning, including friends, family, support providers, professional staff. The individual should be supported to include people in the planning and support team who:
Care about the individual and see him or her in a positive light;
Recognize the individual's strengths and take the time to listen to him or her; and,
Can make a commitment of time and energy to help the individual to develop, carry out, review and update the plan.
At the very minimum, all planning and support teams shall include the individual who is receiving supports, his or her guardian if applicable, his or her case manager, and persons whom the individual requests to be involved in the individual planning process. Planning and support teams for individuals who receive residential, employment, or day support should include support staffs that know the individual best. Depending upon the individual's specific needs, health providers, allied health providers, and professionals who provide supports and services to the individual should be involved in the individual planning process and may be in attendance at the individual planning meeting. Every effort will be made to schedule the planning meeting at times and locations that will facilitate participation by the individual and his or her family, guardian, advocate or other legal representative, as applicable. The case manager will ensure that the individual and/or the person's family are contacted to schedule the meeting at their convenience. If the person, family, or guardian refuses to participate in the Individual Plan meeting, the case manager shall document his or her attempt(s) to invite participation and the responses to those attempts in the individual record and in the Individual Plan, Section 5 - Summary of Representation, Participation, and Plan Monitoring. In these situations, the case manager shall pursue other ways to involve the individual, family, or guardian in the planning process outside of the meeting.

ii. HCBS Settings Requirements for the Service Plan. *By checking these boxes, the state assures that the following will be included in the service plan:*

☒ **The setting options are identified and documented in the person-centered service plan and are based on the individual's needs, preferences, and, for residential settings, resources available for room and board.**

☒ **For provider owned or controlled settings, any modification of the additional conditions under 42 CFR § 441.301(c)(4)(vi)(A) through (D) must be supported by a specific assessed need and justified in the person-centered service plan and the following will be documented in the person-centered service plan:**

- ☒ **A specific and individualized assessed need for the modification.**
- ☒ **Positive interventions and supports used prior to any modifications to the person-centered service plan.**
- ☒ **Less intrusive methods of meeting the need that have been tried but did not work.**
- ☒ **A clear description of the condition that is directly proportionate to the specific assessed need.**
- ☒ **Regular collection and review of data to measure the ongoing effectiveness of the modification.**
- ☒ **Established time limits for periodic reviews to determine if the modification is still necessary or can be terminated.**
- ☒ **Informed consent of the individual.**

☒ **An assurance that interventions and supports will cause no harm to the individual.**

Appendix D: Participant-Centered Planning and Service Delivery

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

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

Each waiver participant has a CT DDS Level of Need Assessment and Screening Tool competed regarding his/her skills and circumstances, and reviewed with the Team at least on an annual basis. This tool produces a Summary report that identifies all responses that may present a risk to the participant in medical, health, safety, behavioral and natural support areas. The team is required to address how each potential risk is mitigated in the Individual Plan. Included in this response is the use of an emergency back up plan if the participant is reliant upon a paid or unpaid service to provide for basic health and welfare supports.

Appendix D: Participant-Centered Planning and Service Delivery

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

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

All waiver participants are provided with a complete listing of all waiver service providers at the time of the Individual Plan and provider selection process by the DDS case manager. This list of providers is also available on the DDS website. Provider Profiles are posted on line to assist waiver recipients in choosing service providers.

Appendix D: Participant-Centered Planning and Service Delivery

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

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

DDS authorizes the Individual Plan under the Memorandum of Understanding agreement subject to quarterly retrospective reviews of a sample of 10-15 Individual Plans each quarter by DSS. DDS also prepares quarterly reports of Individual Plan quality reviews by DDS case management supervisors, the DDS Medicaid Operations Unit and DDS Quality Service Review results for review and comment by the DSS oversight unit.

Appendix D: Participant-Centered Planning and Service Delivery

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

h. Service Plan Review and Update. The service plan is subject to at least annual periodic review and update, when the individual's circumstances or needs change significantly, or at the request of the individual, to assess the appropriateness and adequacy of the services as participant needs change. Specify the minimum schedule for the review and update of the service plan:

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

Specify the other schedule:

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

☐ **Medicaid agency**

☐ **Operating agency**

☒ **Case manager**

☐ **Other**

Specify:

Appendix D: Participant-Centered Planning and Service Delivery

D-2: Service Plan Implementation and Monitoring

a. Service Plan Implementation and Monitoring. Specify: (a) the entity (entities) responsible for monitoring the implementation of the service plan, participant health and welfare, and adherence to the HCBS settings requirements under 42 CFR §§ 441.301(c)(4)-(5); (b) the monitoring and follow-up method(s) that are used; and, (c) the frequency with which monitoring is performed.

The DDS case manager is responsible to monitor the implementation of the Individual Plan. This is accomplished by: case manager transcribes/distributes the Individual Plan, reviews vendor reports and reviews progress on the plan during regular ongoing communications and any such service site visits that may occur; review of the FI monthly and quarterly expenditure reports for individuals who choose participant-direction; and quarterly contacts through the Targeted Case Management service requirements. DDS also reviews service plan implementation through Quality Service Review process detailed in Appendix H. Quality Review staff review the implementation of a service plan during each quality service review activity to evaluate a significant sample size on an annual basis. Contact requires a response from the participant to be considered monitoring.

During the planning meeting, the individual and his or her planning and support team discuss plans to monitor progress and to evaluate whether the supports are helping the person to reach desired outcomes. The team reviews all areas of the individual plan when there are any changes in the individual's life situation, and at least annually, or more frequently, as required by state or federal regulations. The IP includes all supports and services available to the person, not just those offered through the waiver. The right to select other qualified providers or to use resources to self-direct is reviewed at least annually. The annual service plan implementation meeting and any such corresponding monitoring may be held virtually in accordance with all HIPAA requirements as long as one interaction during that year, at a minimum, between the case manager and the individual is done face to face to ensure health, safety and welfare. Health, safety and welfare standards are maintained through numerous efforts through the year including quality reviews, which include a participant interview and ongoing case management interactions. In addition, DDS conducts a participant survey to gather feedback on the quality of supports and services provided. These methods are also relevant for those individuals living in their own home or family home and may not be willing to meet in such settings for team meetings.

b. Monitoring Safeguard. Providers of HCBS for the individual, or those who have interest in or are employed by a provider of HCBS; are not permitted to have responsibility for monitoring the implementation of the service plan except, at the option of the state, when providers are given this responsibility because such individuals are the only willing and qualified entity in a geographic area, and the state devises conflict of interest protections. *Select one:*

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

the participant.

○ **Entities and/or individuals that have responsibility to monitor service plan implementation, participant health and welfare, and adherence to the HCBS settings requirements may provide other direct waiver services to the participant because they are the only the only willing and qualified entity in a geographic area who can monitor service plan implementation.** *(Explain how the HCBS waiver service provider is the only willing and qualified entity in a geographic area who can monitor service plan implementation).*

(Complete only if the second option is selected) The state has established the following safeguards to mitigate the potential for conflict of interest in monitoring of service plan implementation, participant health and welfare, and adherence to the HCBS settings requirements. *By checking each box, the state attests to having a process in place to ensure:*

☐ **Full disclosure to participants and assurance that participants are supported in exercising their right to free choice of providers and are provided information about the full range of waiver services, not just the services furnished by the entity that is responsible for the person-centered service plan development;**

☐ **An opportunity for the participant to dispute the state's assertion that there is not another entity or individual that is not that individual's provider to develop the person-centered service plan through a clear and accessible alternative dispute resolution process;**

☐ **Direct oversight of the process or periodic evaluation by a state agency;**

☐ **Restriction of the entity that develops the person-centered service plan from providing services without the direct approval of the state; and**

☐ **Requirement for the agency that develops the person-centered service plan to administratively separate the plan development function from the direct service provider functions.**

Appendix D: Participant-Centered Planning and Service Delivery

Quality Improvement: Service Plan

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

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

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

i. Sub-Assurances:

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

Performance Measures

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

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

Performance Measure:
Number and percent of IPs that meet the needs of the participant (including health and safety risk factors). Numerator=number of records that show the IP meets the needs of the participant (including health and safety risk factors). Denominator=number of records reviewed.

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

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☒ **Representative Sample** Confidence Interval = 95%
☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

Performance Measure:
Number and percent of IPs that meet the goals of the participant. Numerator= number of records reviewed that show the IP meets the goals of the participant. Denominator=number of records reviewed

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

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☒ **Representative Sample** Confidence Interval = 95%
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:

	☒ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

b. ***Sub-assurance: Service plans are updated/revised at least annually, when the individual's circumstances or needs change significantly, or at the request of the individual.***

Performance Measures

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

For each performance measure, provide information on the aggregated data that will enable the state to

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

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

Performance Measures

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

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

Performance Measure:
Number and percent of IPs that were revised as needed to address participants' changing needs Numerator=number of records reviewed that show the IP address the participants' changing needs Denominator=number of records reviewed

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

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☒ **Representative Sample** Confidence Interval = 95%
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☒ **Continuously and Ongoing**	☐ **Other** Specify:

	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

Performance Measure:
Number and percent of Individual Plans (IPs) that were revised at least annually. Numerator=number of IPs that were revised at least annually. Denominator=number of IPs requiring an annual revision.

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

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid**	☐ **Weekly**	☒ **100% Review**

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

Data Aggregation and Analysis:

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

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

d. ***Sub-assurance: Participants are afforded choice between/among waiver services and providers.***

Performance Measures

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

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

Performance Measure:
Number and percent of quality indicators rating the participant received services in the type, scope, amount, duration and frequency as specified in the IP.
Numerator=number of records reviewed that show the participant received services in the type, scope, amount, duration and frequency as specified in the IP.
Denominator=number of records reviewed.

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

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

	☒ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

Performance Measure:
Number and percent of participants who say their staff come and leave when they are supposed to. Numerator=number of NCI surveys completed where the participants affirms their staff come and leave when they are supposed to. Denominator=number of NCI surveys completed

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

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☒ **Representative Sample** Confidence Interval = 95%
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☒ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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

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

Performance Measures

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

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

Performance Measure:
Number and percent of Individual Plans (IP) that document responsiveness to the individual's request to make changes in supports and services or providers, if applicable. Numerator=number of records reviewed that document the IP was responsive to the individual's request to make changes in supports and services or providers, if applicable. Denominator=number of records reviewed.

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

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence

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

Data Aggregation and Analysis:

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

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

b. Methods for Remediation/Fixing Individual Problems

i. Describe the state's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction and the state's method for analyzing information from individual problems, identifying systemic deficiencies, and implementing remediation actions. In addition, provide information on the methods used by the state to document these items.

All participant specific findings are entered into the QSR database and communicated to the service provider or case manager as appropriate for corrective action on an individual basis. The CM Supervisor monitors case management follow-up. Regional Quality Review staff monitor individual provider follow-up at the next service location visit.

Provider systemic findings are presented and monitored for corrective action by the Regional Resource Management Unit during annual performance review meetings.

DDS system wide data is presented to the statewide Systems Design Committee on a quarterly basis. QI plans may be developed that address case management, service providers and system issues depending on the findings.

ii. Remediation Data Aggregation

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

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

c. Timelines

When the state does not have all elements of the quality improvement strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Service Plans that are currently non-operational.

◉ **No**

○ **Yes**

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

Appendix E: Participant Direction of Services

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

- (●) **Yes. This waiver provides participant direction opportunities.** Complete the remainder of the Appendix.
- ( ) **No. This waiver does not provide participant direction opportunities.** Do not complete the remainder of the Appendix.

CMS urges states to afford all waiver participants the opportunity to direct their services. Participant direction of services includes the participant exercising decision-making authority over workers who provide services, a participant-managed budget or both.

Appendix E: Participant Direction of Services

E-1: Overview (1 of 13)

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

The CT Department of Developmental Services (DDS) will provide consumer-directed options for participants who choose to direct the development of their Individual Plans and to have choice and control over the selection and management of waiver services. Individuals may choose to have either employer authority, budget authority or both. The Individual Planning process is designed to promote and encourage the individual and those people who know and care about him or her to take the lead in directing the process and in planning, choosing, and managing supports and services to the extent they desire. The development of the Individual Plan is participant led. During the planning process services and supports are identified to meet the persons unique desires and needs, regardless of funding source and may include state plan services, generic resources, and natural support networks. At the time of the planning process, the individuals case manager ensures the person and his or her family or personal representative have sufficient information available to make informed choices about the degree to which they wish to self-direct supports and services. The case manager also ensures the individual and his or her family or personal representative have information to make informed selections of qualified waiver providers. This information is presented in three Consumer Guidebooks: Understanding the HCBS waivers; Your Hiring Choices; and Making Good choices about your DDS Supports and Services. Case managers also notify individuals about their ability to change providers when they are not satisfied with a providers performance. Self-direction is included in the Employment and Day Supports Waiver to the extent the individual and/or family wishes to directly manage services and supports. Individuals may self-direct some or all of their waiver services identified in the Individual Plan. They may choose to have both Employer Authority and Budget Authority for the following services: Individualized Day Support, Respite care, Individual Supported Employment Services, Transportation, Behavioral Support, Individual Goods and Services, Independent Support Broker, Blended Supports, Peer Support, Assistive Technology, Customized Employment Support, Remote Supports, Training, Counseling and Support for Unpaid Caregivers, Vehicle Modifications and Interpreter Services. Individuals who self-direct may choose to be the direct employer of the workers who provide waiver services, or may select an Agency with Choice. The Agency with Choice is the employer of record for employees hired to provide waiver services for the individual, however, the individual maintains the ability to select and supervise those workers. The individual may refer staff to the Agency with Choice for employment. In both arrangements, the individual and/or family have responsibility for managing the services they choose to direct. Individuals who self-direct and hire their own workers have the authority to recruit and hire staff, verify staff qualifications, obtain and review criminal background checks, determine staff duties, set staff wages and benefits within established guidelines, schedule staff, provide training and supervision, approve time sheets, evaluate staff performance, and terminate staff employment. Individuals who self direct by hiring their own staff will have a DDS case manager or, a specialized case manager (Support Broker), to assist them to direct their plan of individual support. In addition to case management activities, the Support Brokers assist individuals to access community and natural supports and advocate for the development of new community supports as needed. They assist individuals to monitor and manage the Individual Budgets. Brokers may provide support and training on how to hire, manage and train staff and to negotiate with service providers. They assist individuals to develop an emergency back up plan and may assist individuals to access self-advocacy training and support. Another option for those who self-direct is to have a DDS case manager and an Independent Support Broker through the waiver service. This waiver service provides support and consultation to individuals and/or their families to assist them in directing their own plan of individual support. This service may be self-directed or provided by a qualified agency and is available to those who direct their own supports and hire their own staff.

The services included in Independent Support Broker service are:
·Assistance with developing a natural community support network
·Assistance with managing the Individual Budget
·Support with and training on how to hire, manage and train staff
·Accessing community activities and services, including helping the individual and family with day-to-day coordination of needed services.
·Developing an emergency back up plan
·Self advocacy training and support
The services of a Fiscal Intermediary also known as Vendor Fiscal Employer Agent (VFEA) are required for individuals who self-direct their services and supports. The VFEA assists the individual and/or family or personal representative to manage and distribute funds contained in the individual budget including, but not limited to, the facilitation of employment of service workers by the individual or family, including federal, state and local tax withholding/payments, processing payroll or making payments for goods and services and unemployment compensation fees, wage settlements, fiscal accounting and expenditure reports, support to enter into provider agreements on behalf of the Medicaid agency, and providing information and training materials to assist in employment and training of workers. This service is required to be utilized by individuals and families who choose to hire their own staff and self-direct some or all of the waiver services in their Individual Plan. The service will be delivered as an administrative cost and is not included in individual budgets.

Appendix E: Participant Direction of Services

E-1: Overview (2 of 13)

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

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

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

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

Specify these living arrangements:

Appendix E: Participant Direction of Services

E-1: Overview (3 of 13)

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

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

Specify the criteria

Appendix E: Participant Direction of Services

E-1: Overview (4 of 13)

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

An important part of pre-meeting planning is helping the individual understand the choices that are available. The case manager helps the individual to understand the waiver service options and hiring options that DDS provides to all consumers and explains the DDS portability process. A review of support options is especially important during periods of transition, such as during the transition from school-to-work, when funding resources become available to the individual, when major life changes occur, or when aging issues become apparent. An individual can begin planning to self direct at anytime by contacting his/her case manager.
The case manager provides information about options to self-direct to the participants and their families at the time of the Individual Planning meeting and at any time the individual expresses an interest in self-direction. (This includes a Family Manual on Self-Direction and Your Hiring Choices https://portal.ct.gov/DDS/SelfAdvocacySelfDetermination/Self-Determination/Self-Determination , and informational fact sheets). The Fiscal Intermediary (FI) has responsibility to provide fact sheets to individuals who are referred to them who choose to self-direct. Fact sheets include information about criminal background checks, abuse/neglect registry checks, employer responsibilities, hiring and managing your own supports, employee safety: workers compensation and liability insurance. The FI ensures that individual provider qualifications and training requirements are met prior to employment and the appropriate forms to document that training are completed.

Appendix E: Participant Direction of Services

E-1: Overview (5 of 13)

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

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

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

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

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

☒ **Waiver services may be directed by a non-legal representative freely chosen by an adult participant.**
Specify the policies that apply regarding the direction of waiver services by participant-appointed representatives, including safeguards to ensure that the representative functions in the best interest of the participant:

The states practice is to allow participants the opportunity to self direct their waiver services independently, if they are able to do so, or with assistance, if needed, from family members, advocates, or a representative of the participants choosing, to help with the responsibilities of self-direction. A representative does not have to be a legal representative. The representative assumes responsibilities for the Agreement For Self Directed Supports, which is reviewed with the representative and the participant, and signs the Agreement. The Agreement for Self Directed Supports includes the identification of areas of responsibility where the participant will require assistance. Any assistance needed as indicated in the agreement must be addressed in the participants Individual Plan.

Appendix E: Participant Direction of Services

E-1: Overview (6 of 13)

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

Waiver Service	Employer Authority	Budget Authority
Individual Supported Employment	☒	☒
Training, Counseling and Support Services for Unpaid Caregivers	☒	☒
Remote Supports Services	☒	☒
Assistive Technology	☒	☒
Customized Employment Supports	☒	☒
Individualized Day Support	☒	☒
Transportation	☒	☒
Behavioral Support Services	☒	☒
Interpreter	☒	☒
Peer Support	☒	☒
Respite	☒	☒
Vehicle Modifications	☐	☒
Independent Support Broker	☐	☒
Individual Direct Goods and Services	☐	☒
Blended Supports	☒	☒

Appendix E: Participant Direction of Services

E-1: Overview (7 of 13)

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

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

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

☐ **Governmental entities**

☒ **Private entities**

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

Appendix E: Participant Direction of Services

E-1: Overview (8 of 13)

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

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

The waiver service entitled:

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

Provide the following information

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

Fiscal Intermediaries (FIs) are procured through a competitive RFP process. Private not for profit and for profit corporations and LLCs furnish these services. CT DDS pays the FIs directly per the contract. Participants who self direct must use a FI under contract with the state. CT requires the re-bidding of FI contracts every three years.

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

Payment through a contract with the DDS as a result of an awarded RFP.

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

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

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

Specify:

Verify training requirements of direct support workers are completed.

Supports furnished when the participant exercises budget authority:

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

Specify:

Additional functions/activities:

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

Specify:

FIs provide an enrollment packet to each individual to whom it provides fiscal intermediary services under their state contract. The enrollment packet includes the States forms and information (employee application, fact sheet on employer liability and safety, Criminal Background and Abuse/Neglect Registry checks, Individual Provider Medicaid agreement, employee and Vendor Agreement forms, Individual Provider Training Verification Record and training materials).

FIs meet with each participant who is hiring individual providers to review all of the State and Federal employer requirements. FIs secure Workers Compensation Policies for each participant employer with employees who work 26 or more hours per week and for employers and employees who choose to have Workers Compensation Insurance for employees who work fewer than 26 hours per week. The Contractor is responsible for filing Criminal History Background Check, Abuse/Neglect Registry Check, drivers license checks, Workers Compensation Policies, and training verification records along with all state and federal employee and employer forms.

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

The state conducts an annual performance review of FIs. FIs are responsible for providing the state with an independent annual audit of its organization and the state funds and expenditures under the agents control according to procedures dictated by the CT DDS audit unit (FI contract template Part 3). In addition, quarterly statements of expenditures against individual budgets are sent to the individual and the regional office. These statements are reviewed on a periodic basis by regional administration staff and the individuals DDS case manager, DDS Support Broker or the Independent Support Broker. In addition to the quarterly statements an annual expenditure report is submitted for each participant that is reviewed by the state and either accepted or sent back for clarification or changes.

Appendix E: Participant Direction of Services

E-1: Overview (9 of 13)

j. Information and Assistance in Support of Participant Direction. In addition to financial management services, participant direction is facilitated when information and assistance are available to support participants in managing their services. These supports may be furnished by one or more entities, provided that there is no duplication. Specify the payment authority (or authorities) under which these supports are furnished and, where required, provide the additional information requested *(check each that applies)*:

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

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

The role of the DDS case manager (state employee who provides Targeted Case Management) in individual planning is to support the person and other team members to develop and implement a plan that addresses the individuals needs and preferences. Case managers support individuals to be actively involved in the planning process. DDS case managers share information about choice of qualified providers and self-directed options at the time of the planning meeting and upon request. DDS case managers assist the person to develop an individual budget and assist with arranging supports and services as described in the plan. They also assist the individual to monitor services and make changes as needed. DDS case managers share information regarding the ability to change providers when individuals are dissatisfied with performance.
As described in Section E.1.a, individuals who self direct by hiring their own staff will have DDS case manager or a specialized DDS case manager, called a DDS Support Broker, to assist them to direct their plan of individual support. In addition to providing case management (TCM) activities, the DDS Support Brokers assist individuals to hire, train and manage the support staff, negotiate provider rates, develop and manage the individual budget, develop emergency back up plans, and provide support and training to access and develop self-advocacy skills. These additional duties are considered outside the scope of the TCM service so the DDS Support Broker has a smaller caseload than other DDS case Managers and the time/costs associated with the additional duties are not included in the rate setting methodology for TCM.

☒ **Waiver Service Coverage.**

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

Participant-Directed Waiver Service	Information and Assistance Provided through this Waiver Service Coverage
Group Supported Employment	☐
Individual Supported Employment	☐
Training, Counseling and Support Services for Unpaid Caregivers	☐
Virtual Health Consultation	☐
Remote Supports Services	☐
Assistive Technology	☐
Environmental Modifications	☐
Employment Transitional Services	☐
Customized Employment Supports	☐
Personal Emergency Response System (PERS)	☐
Individualized Day Support	☐
Transportation	☐
Specialized Medical Equipment and Supplies	☐
Behavioral Support Services	☐
Interpreter	☐
Peer Support	☐
Prevocational Services	☐
Home Delivered	☐

Participant-Directed Waiver Service	Information and Assistance Provided through this Waiver Service Coverage
Meals	
Respite	☐
Vehicle Modifications	☐
Independent Support Broker	☐
Adult Day Health	☐
Group Day Supports aka Community Based Day Support Options	☐
Individual Direct Goods and Services	☐
Blended Supports	☐

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

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

Appendix E: Participant Direction of Services

E-1: Overview (10 of 13)

k. Independent Advocacy *(select one).*

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

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

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

Independent Advocacy is available to participants through the Office of the Ombudsperson for Developmental Services. The Independent Office of the Ombudsperson for Developmental Services works on behalf of consumers and their families to address complaints or problems regarding access to services or equity in treatment. The results and nature of complaints and concerns are communicated to the Governor's Council on Developmental Disabilities, the State Legislature and the Department of Developmental Services (DDS) Commissioner in order to better direct the resources of the department and to improve service to DDS consumers and/or their families. One of the important functions of the Ombudsperson's Office is to help individuals and their families seek information to help them solve particular problems. Often consumers or their families are unclear about DDS policies and procedures (including appeals). The Ombudsperson can help individuals become familiar with such policies and procedures as part of the options provided to help people solve particular problems or deal with specific concerns.

In addition, independent advocacy can be obtained through the use of an Independent Support Broker (not DDS Support Broker).

Appendix E: Participant Direction of Services

E-1: Overview (11 of 13)

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

Individuals may through the Individual Plan process request the termination of self-direction and his or her Self Directed Support Agreement. An individual/family may decide to terminate the Self Directed Support Agreement and choose an alternative support service. The case manager, support broker or regional designee discusses with the individual/family all the available options and resources available, updates the Individual Plan, and begins the process of referral to the selected options. Once the new option has been identified and secured, the case manager, support broker or regional designee will fill out the form for termination of the individual budget. The form is sent within 10 business days to the VFEA, Resource Administrator, or regional designee, and the regional fiscal office representative. The individual and the support team meet to develop a transition plan and modify the Individual Plan. The DDS case manager ensures that the participants health and safety needs are met during the transition, coordinates the transition of services and assists the individual to choose a qualified provider to replace the directly hired staff.

Appendix E: Participant Direction of Services

E-1: Overview (12 of 13)

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

Each individual who self-directs by hiring his or her own workers has an Agreement for Self Directed Supports describing the expectations of participation. Termination of the participants self-direction opportunity may be made when a participant or representative cannot adhere to the terms of the Agreement for Self Directed Supports:
Key requirements are:
1)To participate in the development and implementation of the Individual Planning Process.
2)Funds received under this agreement can only be used for items, goods, supports, or services identified in the service recipients individual plan and authorized individual budget.
3)To actively participate in the selection and ongoing monitoring of supports and services
4)To understand that no one can be both a paid employee and the employer of record.
5)To authorize payments for services provided only to the recipient according to the individual plan and budget.
6)To enter into an agreement with the provider agency/agencies or individual support worker(s) hired. The agreement is outlined in the Individual Family Agreements with Vendors and Employees and identifies the type and amount of supports and services that will be provided.
7)To submit timesheets, receipts, invoices, expenditure reports, or other documentation on the required forms to the fiscal intermediary on a monthly basis or within the agreed upon timeframe.
8)To review the VFEA expenditures reports on a quarterly basis and notify the case manager, broker and VFEA of any questions or changes.
9)To follow the DDS Cost Standards and Costs Guidelines for all services and supports purchased with the DDS allocation.
10)To get prior authorization from the DDS to purchase supports, services, or goods from a party that is related to the individual through family, marriage, or business association.
11)To seek and negotiate reasonable fees for services and reasonable costs for items, goods, or equipment, and to obtain three bids for purchases of items, equipment costing over $2500
12)Any special equipment, furnishings, or items purchased under the agreement are the property of the service recipient and will be transferred to the individuals new place of residence or day program or be returned to the state when the item is no longer needed.
13)To participate in the departments quality review process.
14)To use qualified vendors enrolled by DDS.
15)To ensure that each employee has read the required training materials and completed any individual specific training in the Individual Plan prior to working with the person.
16)To offer employment to any new employee on a conditional basis until the Criminal History Background Check, Drivers License Check, and DDS Abuse Registry Check has been completed. Anyone on the DDS Abuse Registry cannot be employed to provide support to the individual.
17)To notify the case manager/broker when the individual is no longer able to meet the responsibilities for self directed services.

The individual acknowledges that the authorization and payment for services that are not rendered could subject him/her to Medicaid fraud charges under state and federal law. Breach of any of the above requirements with or without intent may disqualify the individual from self-directing-services. An Agreement for Self-Directed Supports can be terminated if the participant does not comply with the agreed upon requirements. The individual and the support team meet to develop a transition plan and modify the Individual Plan. The DDS case manager ensures that the participants health and safety needs are met during the transition, coordinates the transition of services and assists the individual to choose a qualified provider to replace the directly hired staff.

Appendix E: Participant Direction of Services

E-1: Overview (13 of 13)

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

Table E-1-n

	Employer Authority Only	Budget Authority Only or Budget Authority in Combination with Employer Authority
Waiver Year	**Number of Participants**	**Number of Participants**

Table E-1-n

	Employer Authority Only	Budget Authority Only or Budget Authority in Combination with Employer Authority
Waiver Year	**Number of Participants**	**Number of Participants**
Year 1		70
Year 2		80
Year 3		90
Year 4		100
Year 5		110

Appendix E: Participant Direction of Services

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

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

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

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

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

Agencies with Choice are permitted and encouraged. Any DDS Qualified Provider may apply to be categorized as an "Agency with Choice". DDS requires specific assurances to enroll and be designated as an Agency with Choice organization through the submission of policies and procedures that support the control and oversight by the participants over the employees, and requires periodic participation in DDS sponsored training and events in consumer-direction.

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

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

☒ **Recruit staff**

☒ **Refer staff to agency for hiring (co-employer)**

☒ **Select staff from worker registry**

☒ **Hire staff common law employer**

☒ **Verify staff qualifications**

☒ **Obtain criminal history and/or background investigation of staff**

Specify how the costs of such investigations are compensated:

Costs are covered in the individual budget provided for the participant by DDS.

☒ **Specify additional staff qualifications based on participant needs and preferences so long as such qualifications are consistent with the qualifications specified in Appendix C-1/C-3.**

Specify the state's method to conduct background checks if it varies from Appendix C-2-a:

Fiscal intermediary completes background checks on participant's behalf

☒ **Determine staff duties consistent with the service specifications in Appendix C-1/C-3.**

☒ **Determine staff wages and benefits subject to state limits**

☒ **Schedule staff**

☒ **Orient and instruct staff in duties**

☒ **Supervise staff**

☒ **Evaluate staff performance**

☒ **Verify time worked by staff and approve time sheets**

☒ **Discharge staff (common law employer)**

☒ **Discharge staff from providing services (co-employer)**

☐ **Other**

Specify:

Appendix E: Participant Direction of Services

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

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

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

☒ **Reallocate funds among services included in the budget**

☒ **Determine the amount paid for services within the state's established limits**

☒ **Substitute service providers**

☒ **Schedule the provision of services**

☒ **Specify additional service provider qualifications consistent with the qualifications specified in Appendix C-1/C-3**

☒ **Specify how services are provided, consistent with the service specifications contained in Appendix C-1/C-3**

☒ **Identify service providers and refer for provider enrollment**

☒ **Authorize payment for waiver goods and services**

☒ **Review and approve provider invoices for services rendered**

☐ **Other**

Specify:

Appendix E: Participant Direction of Services

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

b. Participant - Budget Authority

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

Initial funding range is provided by the Regional Planning and Resource Allocation Team based on CT DDS Level of Need Assessment and Screening Tool. Within that allocation individuals design an Individual Budget to support the outcomes identified in the Individual Plan. The resource allocation ranges have been derived from analysis of past utilization and costs for services used by like individuals based on assessed level of need as described in Appendix C4 of this application. The participant can direct the entire budget for waiver services as the participant chooses. Information regarding this process is available to the public on the DDS website and in the Guide for Consumers and their Families.

Appendix E: Participant Direction of Services

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

b. Participant - Budget Authority

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

The Regional Planning and Resource Allocation Team (PRAT) provides the individual with the resource allocation based on their assessed Level of Need in writing. Following the development of the Individual Plan, the individual may request additional funding based on identified needs. The request is reviewed by the regional PRAT, and may go to a regional utilization review process depending upon the amount of funding requested beyond the initial funding range. Any denial of service/funding levels is communicated in writing by the Central Office Waiver Policy Unit and includes the formal notice and requests for a Fair Hearing. This same process applies any time an individual requests an increase in approved funding levels.

Appendix E: Participant Direction of Services

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

b. Participant - Budget Authority

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

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

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

Adjustments are changes to existing Individual Budgets in amount or type of waiver service without a change in funding. The individual/family and case manager or support broker discuss the need for a change in the type or amount of a particular support or service that does not increase the total budget. When this change is within existing line items or results in a new line item without a change in the authorized allocation, a revision to the individual budget is required to effect the change. Individuals who are self-directing and have an Individual Budget may shift funds among waiver services authorized in their budgets up to the designated amount identified in policy without a change in the Individual Plan. When changes exceed the designated amount found in policy, or, include a new waiver service, a change in the Individual Plan is required. The case manager reviews the proposed changes with the Planning and Service Team. When the Planning and Service Team is in agreement with the changes, the case manager has the option of updating the IP and all relative sections, completing an IP 12, Periodic Review Form, or developing a new plan. An IP 6 and a Waiver Form 223 are required and the case manager supervisor is required to authorize the change.

Appendix E: Participant Direction of Services

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

b. Participant - Budget Authority

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

The FI monitors expenditures and alerts the waiver participant and Departments support broker/case manger of any variance in line items that exceed the quarterly budgeted amount for the specific line item where the variance occurred prior to making the payment.

The FI has a system to verify that the service or support or product billed is in the authorized Individual Budget prior to making payment. The FI is responsible to cover out of its own funds any payments that exceed what the state has authorized in the Individual Budget.

Monthly and Quarterly Utilization Reports: Each region has a regional contact person to whom the FI sends the Quarterly Utilization Reports. Each region has an internal system for distribution and review of these reports. In addition to the quarterly expenditure report the participant and the case manager also receive a monthly expenditure report. The FI must provide the reports to the participant and the Case Manager by the 25th day of the month following the reporting period. The DDS case manager/broker monitors the monthly expenditure reports, and is responsible to review the expenditure reports against the approved individual plan and budget on at least a quarterly basis to monitor for under/over utilization. The region administrator reviews the quarterly reports for utilization and follows up with the case manager/broker when there are significant variances in service utilization caused by things such as, delay in hiring staff, participant illness.

Appendix F: Participant Rights

Appendix F-1: Opportunity to Request a Fair Hearing

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

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

Participants are informed of the Fair Hearing process at the Individual Plan meeting, in the Consumer and Family Guide to the HCBS Waivers, and in all correspondence related to the HCBS waiver program related to resource allocation and access to the HCBS waiver program by DDS. Any time access to a HCBS waiver or services are denied, reduced or terminated, the participant and legal representative are notified in writing by the DDS Case Manager or Waiver Unit. Each notice includes a Department of Social Services (DSS) Request for an Administrative Hearing for the DDS HCBS Waiver Program form.

Appendix F: Participant-Rights

Appendix F-2: Additional Dispute Resolution Process

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

- ○ **No. This Appendix does not apply**
- ◉ **Yes. The state operates an additional dispute resolution process**

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

Individual Plans and budgets that exceed the resources allocated to the individual by PRAT or Individual Budget limits based on the Level of Need Assessment and additional information as presented by the support team proceed through utilization review (UR). Each waiver specifies circumstances where services can exceed established Level of Need limits.

Review Process and Timelines--Individual Plans and budgets are reviewed to evaluate the amount, type, frequency, and intensity of services directly related to health and safety needs of the individual, and desired outcomes based on the individuals preferences and needs as described below:

Requests for resource allocations exceeding original allocation or Individual Budget limit provided by the Regional PRAT are made to the PRAT. PRAT has up to 10 business days to issue a decision on the request. The Regional Director or designee is required to review and approve PRAT decisions that exceed PRAT approval limits and will do so within 5 business days. Regional Directors may provide immediate temporary approval for requests to address immediate threats to the individuals health and/or safety. The PRAT notifies the case manager of the UR decision within 12 business days of the submission. The case manager will contact the individual and personal representative by phone to inform them of the decision within 3 business days. If the request has been denied by UR, the individual and personal representative will be offered the following options: 1)revise the service plan to fall within the original resource allocation; 2)request an informal negotiation with DDS to determine if a compromise can be reached; or, 3)request that the decision be forwarded to the Central Office Waiver Policy and Enrollment Unit for formal action and Medicaid Fair Hearing rights if the UR denial is upheld.

The individual and his or her personal/legal representative may request a review of any decision to which he/she/they claim to be aggrieved by the next level review authority (Regional Director, Utilization Review Committee). Such reviews will be completed within the timelines described above.

The telephone contact and outcome of the discussion will be documented in the case managers running case notes in the individuals master record. If the individual requests an opportunity to further discuss and negotiate the regions decision, the case manager will notify his/her supervisor and the region will designate an administrator from a different regional Division to meet with the individual and family or other support persons within 10 business days. The outcome of this meeting will either be an agreement on a service package, or continued disagreement and submission of the proposed plan to the DDS CO Waiver Unit for a final determination. The outcome of the meeting will be documented by the regional administrator in a letter to the individual and family immediately following the meeting, with a copy to the case manager and the PRAT. If the individual and personal representative request that the decision be reviewed by the Central Office Waiver Unit, the complete packet will be forwarded to the Unit within 3 business days of that decision by the PRAT.

For determinations of the CO Waiver Unit that constitute a denial of or reduction in a waiver service, the CO Waiver Policy and Enrollment Unit will provide information and forms to initiate an administrative hearing through the Department of Social Services.

DDS maintains an additional informal dispute resolution process, the Programmatic Administrative Review (PAR). This informal dispute resolution is available to individuals supported by DDS for any service oriented decision regardless of HCBS waiver status. A request for a PAR does not preclude the participant from requesting a Fair Hearing at any time and does not delay a Fair Hearing should one be requested. DDS also operates an Administrative Hearing process for decisions regarding placement on the DDS Waiting List for services that may affect potential waiver participants.

DDS sends a letter to the individual/legal representative informing them of the denial services/funding. The letter includes information about their right to appeal and the form for requesting an appeal and a statement that if an appeal is filed services will continue until the outcome of the Hearing Officers decision is known.
Paper and electronic records of Service and Enrollment denials are kept in DDS Central Office. Notice of adverse actions, such as termination of Medicaid, which implicate continued waiver eligibility, are issued and maintained by DSS. The formal administrative hearing process is managed by DSS. Documentation of informal dispute resolution processes, the PAR, etc., are maintained electronically and in hard copy in the Regions and at the Central Office, to the extent a matter is subject to review at the CO level.
DDS aggregates the PARs annually for review and trending by the Executive Team. Strategies for improvements are identified and implemented as needed.

Appendix F: Participant-Rights

Appendix F-3: State Grievance/Complaint System

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

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

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

Individuals can file a Fair Hearing with DSS without utilizing the State Grievance and Complaint Sysyem.
DDS and the Office of the Ombudsperson for Developmental Services are avenues to file complaints.

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

Participants or their parent, legal guardian or legal representative my file a grievances or complaints by phone, letter, fax or in person to the DDS Commissioner or Regional Director. The complaint or grievance is entered into a data tracking system and assigned by the Commissioner or Regional Director for follow-up and resolution. The Independent Office if the Ombudsperson may also receive grievances or complaints and investigates accordingly. The Independent Office of the Ombudsperson reports to the Governor's Council on Developmental Services at each meeting, and prepares an Annual Report.

Programmatic Administrative Review(PAR)
A PAR is an informal dispute resolution process offered to participant,family member, guardian or advocate, if not satisfied with any decision related to:
• eligibility, admission, placement evaluation, and assignment of programs and services;
• care and treatment, or a change in a service you receive;
• A change in, termination of, or discharge from, a service you are involved in;
• Disagreements regarding any element of your Individual Plan.
Your case manager shall inform the participant, or family member, guardian or advocate of the availability of the PAR process.
A PAR can be requested any time you are not satisfied with a decision made about your services. The "Request for Programmatic Administrative Review" form, which can be obtained from your Case Manager.

This must be completed by the participant, family member, guardian or advocate. On the form, it is helpful to clearly state the decision you are not satisfied with, and your reason for requesting the review by the Regional Director. After you submit your request, you will be given the opportunity to meet with the Regional Director to further discuss your concerns.
Once a PAR is requested, within fifteen (15) working days the Regional Director will review all pertinent information related to the subject of the request, and render a written decision. If a decision cannot be made within the noted time frame, you will be informed of that in writing.
If you are not satisfied with the decision of the Regional Director, you may request reconsideration of that decision by the Commissioner.
You can request that a PAR decision be reconsidered by the Commissioner by completing the "Request for Commissioner's Review/Programmatic Administrative Review" form, which will be attached to the Director's decision. Again, it is important to clearly state why you are not satisfied with the decision of the Regional Director. You should attach copies of his or her written decision, and any supporting information you think is important to be reviewed by the Commissioner or his designee. The Commissioner or his designee shall issue a written decision to you within thirty (30) working days of receiving your request for reconsideration. The decision of the Commissioner or his designee is final except in situations involving denial of waiver enrollment or waiver services. While the PAR is pending, there shall be no change in your status, except in the event of an emergency.

Appendix G: Participant Safeguards

Appendix G-1: Response to Critical Events or Incidents

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

◉ **Yes. The state operates a Critical Event or Incident Reporting and Management Process** *(complete Items b through e)*

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

b. State Critical Event or Incident Reporting Requirements. Specify the types of critical events or incidents (including

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

Abuse/Neglect Reporting (Who Reports, Timeframe for Reporting)
Who Reports (Policy No. I.F.PO.001: Policy Statement)
Any employee of DDS or a Provider Agency must immediately intervene on the individuals behalf in any abuse/neglect situation and shall immediately report the incident.

Timeframe for reporting (Procedure Nos. I.F.PR.001 D.; I.F.PR.002)
A verbal report must be made immediately to the appropriate agency including the Abuse Investigation Division, Department of Children and Family or Department of Social Service and a subsequent written report by the individual witnessing the abuse/neglect incident. The verbal report is transcribed by the receiving agency and is forwarded to DDS Division of Investigations via fax or secure electronic transmission.

Any report of alleged abuse or neglect where those actions rise to the level of a crime or a serious threat to the individual shall be reported, as soon as possible, to an appropriate law enforcement agency. Section 5 of I.F. PR 001 details this process.

Critical Incident Types (Who Reports, Timeframe for Reporting)

Critical Incident Types (Procedure No. I.D.PR.009 C. Definitions) in DDS or Private Agency Operated Settings.
1. Deaths
2. Severe Injury
3. Vehicle accident involving moderate or severe injury
4. Missing Person
5. Fire requiring emergency response and/or involving a severe injury
6. Police Arrest
7. Victim of Aggravated Assault or Forcible Rape
Who Reports (Procedure No. I.D.PR.009 B.: Applicability)
Staff of all DDS operated, funded or licensed facilities and programs.

Timeframe for Reporting (Procedure No. I.D.PR.009 D.1.a-b Implementation)
During Normal Business Hours: Immediately report the incident to the individuals family and/or guardian and appropriate DDS regional director or designee via telephone. An Incident Report form shall be faxed to the DDS Regional Directors Office. The form should be forwarded to the appropriate DDS Region in the usual process within five business days.
After Normal Business Hours: Immediately report the incident to the individuals family and/or guardian and appropriate DDS on-call manager. An Incident Report form shall be faxed to the DDS on-call manager the next business day. The form should be forwarded to the appropriate DDS Region in the usual process within five business days.

Critical Incident Types (Procedure No. I.D.PR.009a C. Definitions) in Own/Family Home and Receive DDS Funded Services) if service is located in individuals own or family home.
1. Deaths
2. Use of restraint
3. Severe Injury
4. Fire requiring emergency response and/or involving a severe injury
5. Hospital admission
6. Missing Person
7. Police Arrest
8. Victim of theft or larceny
9. Victim of Aggravated Assault or Forcible Rape
10. Vehicle accident involving moderate or severe injury.

Who Reports ((Procedure No. I.D.PR.009a B: Applicability)
Applies to all staff employed directly by the individual, individuals family or provider agency to provide services and supports to the applicable individuals.

Time Frames for Reporting (Procedure No. I.D.PR.009a D. Implementation)
Immediately notify the individuals family and the individuals DDS case manager or broker. If not available, leave a voice mail message regarding the incident. Complete an Incident Report form. Send or bring the completed form to the

employer (individual, family or private agency) who shall keep the original and send the remaining copies to the DDS Regional Director or designees office immediately or the next working day following the incident.

Non-critical incidents are recorded on the DDS Form 255 and submitted to DDS within five (5) business days for entry into CAMRIS. Non-critical incidents include restraint, injury, unusual behavioral incidents and medication errors.

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

Abuse/Neglect Training (Policy No. I.F.PO.001 D.1 Abuse and Neglect; Procedure No. I.F.PR004 Abuse and Neglect/Investigations Recommendations, Protective Services and Prevention Activities

The department has produced and made available on its website family fact sheets on abuse/neglect reporting

https://portal.ct.gov/dds/searchable-archive/investigations/investigations/regional-abuse-and-neglect-reporting-protocol

Such information is provided during the annual plan meeting. During the Individual Plan meeting a review of a participants individual needs is conducted to identify methods of prevention if appropriate. People who direct their own supports receive additional materials to train his/her staff on abuse and neglect policies and reporting

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

The following agencies receive reports of abuse/neglect (Procedure No. I.F.PR.001 D.2 Reporting and Notification and PR.005 D. Implementation):

- The Abuse Investigation Division if the individual is between 18-59 years of age
- Dept. of Children and Families (DCF) if the individual is under 18 years of age
- Dept. of Social Services (DSS) if the individual is 60 years of age or over
- Dept. of Public Health (DPH) if a medical facility or provider is licensed by DPH. In this case the appropriate agency above would also be notified.
- The Abuse Investigations Division (AID) within DDS is the unit that generates all intakes of allegations of abuse and neglect against individuals with intellectual disability. Methods for evaluating reports (Procedure No. I.F.PR.005 D.2 Investigation Assignment and D.3. Investigations)

The Abuse Investigations Division (AID) within DDS is the designated unit to generate all intakes of allegations of abuse and neglect. The AID assigns which agency will conduct the primary investigation. The AID investigates all incidents of abuse and neglect that are alleged to have occurred in a private home. The AID may direct DDS staff to implement an Immediate Protective Services Plan when an allegation is made. This plan is developed, implemented and monitored by the Case Manager, the Abuse and Neglect Liaison and AID for participants while the investigation is conducted. DCF, DSS and DPH conduct investigations per statutory charge. DDS and private agencies are also responsible for investigating reports involving the individuals they are responsible for serving.

The DDS Division of Investigations (DOI) provides technical support, as needed, to private agencies conducting investigations. The DOI reviews the completion of all private agency investigations and may select cases to directly investigate in private agencies after consultation with AID. The DDS or private agency investigation into any allegation of abuse or neglect that is determined to have the potential to lead to a recommendation to place an employee on the DDS Abuse Neglect Registry will be monitored by the DDS DOI.

All investigations completed by DDS and private agencies are to be submitted to the DDS regional Abuse/Neglect Liaison or designee within sixty (60) days from the date of intake, however, investigations are not considered overdue until after ninety (90) days. AID investigations must also be submitted to the AID Lead Investigator for review and approval within the sixty (60) day time frame. The sixty (60) day deadline allows for additional information to be obtained as needed if the investigation is reviewed and not considered complete. AID investigations are reviewed and approved by the AID Lead Investigator and the Director of Investigations. DDS investigations are reviewed and approved by the DOI Lead Investigator. DDS investigations completed by a regional DOI Lead Investigator are reviewed and approved by the Director of Investigations. The Director of Investigations conducts the final review and approval of all investigations pertaining to the death of an individual. The regional DOI Lead Investigator or designee review and approve all private agency investigations. However, the Director of Investigations also has the discretion to review and be the final approver of any investigation conducted by DDS or a private agency investigator.

Based upon the investigation, the allegation (s) are either substantiated or not substantiated. Recommendations for follow up actions are generated (for substantiated cases, and in some cases, unsubstantiated cases) by the investigator or during the review process by the Agency executive director, DDS or DOI. Within seven (7) days of the review of the recommendations of the completed abuse or neglect investigation, a written response shall be requested by the regional abuse neglect liaison, of the provider. A written response is due from the provider within thirty (30) days of the request date.

Procedures are in place to address situations in which the written response is not submitted within the required timeframe. A standard tracking system is used to track responses to the recommendations and will be monitored by the Regional Director or designee. Ongoing reports on recommendations will be generated and reviewed by the regions, and shared with the appropriate central office divisions.

Critical Incidents

The following agencies receive reports of critical incidents (Procedure No. I.D.PR.009 D.1. Implementation):
DDS receives all reports of Critical Incidents. Deaths are also reported to the OCME if considered sudden and/or unexpected. DDS Nurse Investigators conduct a review of all deaths occurring in funded service settings to determine if a more detailed review or investigation is indicated. If no further review is indicated the case is referred to mortality review. If further review is indicated the case is referred to expedited mortality review if systemic issues are identified or suspected. If abuse or neglect is suspected to contribute to the death, the allegation is reported to AID and is processed through the Abuse/Neglect reporting and investigation system.

Incidents are determined to be critical based on meeting the definitional requirements stated on section a under Critical Incident Types. The participant's team is responsible for assessing and documenting all follow-up regarding the critical incident on the DDS Incident Follow-up Form and submit the document to the DDS Regional Director or designee within 5 business days. Appropriate staff ensure that action has been taken on all follow up activities.
All incidents are reviewed for trends and discussion by the team every six months. A program nurse reviews all medication errors on a quarterly basis.

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

The Abuse Investigation Division is the charged with the responsibility of oversight for Abuse/Neglect for individuals between the ages of 18 and 59, DCF has responsibility for children under the age of 18 and DSS (the State Medicaid Agency) has responsibility for people age 60 and over. DDS has joint responsibility for Abuse/Neglect reporting as well as Critical Incident Reporting, Investigation and Follow-up. The Abuse Investigations Division also monitors the submission of abuse and neglect reporting, investigations and reports. Critical Incidents are reported using the DDS Incident Reporting Procedure and are stored in the DDS Incident Reporting data system. Critical incident oversight is managed at many different levels. Critical incident reporting is tracked in a database. Each specific incident has to have a follow-up plan that should start with the participants support team. Data is reviewed quarterly by each Region. Central office quality management staff follow-up on critical incidents during the course of their quality reviews. Regional staff meet every six months with qualified providers and critical incident data and follow-up is reviewed.

Appendix G: Participant Safeguards

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

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

○ **The state does not permit or prohibits the use of restraints**

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

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

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

Reference Incident Reporting Procedure I.D.PR.009 and Procedure No. I.D.PR.011 (own and family home) and PRC Procedure I.E. PR.004, Regional Human Rights Procedure I. F.PR.006, DMR Policy 1 Client Rights, Behavior Support Plans Procedure I. E.PR.002 Behavior Modifying Medications Policy I.E.PO.003 and Procedure I.E.PR.003,

When submitting the proposed use of a physical restraint, seclusion, or the use of a mechanical restraint, documentation must exist that less aversive procedures have been found to be ineffective in addressing the target behavior. If the Interdisciplinary team identifies the need for restraint and/or seclusion the proposed use of the procedure must be reviewed and approved by the regional Program Review Committee, the Human Rights Committee and the Regional Director prior to its implementation. The use of the procedure must be presented within the context of an overall behavior support plan designed to teach adaptive skills and reduce the identified target behavior. There must also be documentation that: 1)The proposed procedure is not medically contraindicated by the individuals physician 2)Methods for increasing positive behaviors and decreasing undesirable behaviors 3)Criteria for ensuring the least restrictive level of aversive intervention is employed 4)Required documentation concerning use of restraints or seclusion 5)The individual and the individuals family, guardian or advocate are informed of the target behavior, goal of the plan, the adaptive behavior to be taught, the aversive procedure under consideration, the possible side effects of using the procedure, the consequences of not administering the procedure, documentation that less restrictive procedures have been found to be ineffective, expected duration of the plan, the PRC and Human Rights Review Committee processes, and the procedures for appeal as required by Connecticut General Statutes 17a-210. Note that the Department has recently issued a procedure which states that the use of prone (face-down) restraint is not allowed by the Department.

Procedure No. I.E.PR.004 and Procedure No. I.D.PR.011 (own and family home) Incident Reporting
All use of restraint or seclusion (physical isolation), both planned and emergency, are required to be reported using the DDS Incident Reporting procedures. Incident reports require the date and time of the incident, the length of time of the restraint or seclusion, the specific restraint type(s) used in the incident, behaviors necessitating the restraint and whether an injury occurred as a result of the restraint or if abuse/neglect was suspected in the restraint application. Some selected restraints may be reported on a monthly basis but individuals are still required to report the total number of restraint applications and the total time in restraint. The only restraints which can be reported in this way are: Helmets; Bed Rails; Specialized Clothing; Mitts; Vehicle/Transport; Waist Restraint/chest/vest; Safety Cuffs; Arm Splints; and Held By Arms only for the purpose of completing ADL Activities. This data is collected in the DDS Incident Reporting data system and is kept historically.

During quality review visits, waiver participants are interviewed by DDS Quality Review staff. Questions include those that would lead a reviewer to further investigate the possible use of an unauthorized restraint. Case managers and other team staff are also involved in the monitoring of services and are instructed to closely monitor participants records who may be at high risk of unauthorized restraint. Within 24 hours of the use of an emergency application of a physical restraint, supervisory or professional staff must examine the participant and report any evidence of trauma to a nurse or physician and report to the Regional DDS Director. Within 3 working days of the incident the team, including a physician, shall review the participant and his/her environment to determine if changes in the plan including the continued use of an emergency restraint or seclusion procedure are required. If the team plans to continue the use of a restraint or seclusion procedure, a behavior support plan must be designed and the approval process be initiated within five days of the team meeting.

Use of planned restraint by paid staff: use of a restraint that has been reviewed by the department's Program Review and Human Right Committees (PRC/HRC)

a. The responsible staff shall record each use of restraint on a restraint log that contains the following information:

1.)Date of restraint

2.)Time in and time out

3.)Type of restraint
4.)Behavior type that resulted in use of restraint
5.)Whether an injury occurred as a direct result of the restraint
b.Staff shall document and report an injury resulting from the use of restraint as detailed above.
c.At the end of each month, staff shall send the completed restraint log to the employer. The employer shall maintain the
original in the individuals record and send copies to the DDS Director of Autism services or designee who shall forward copies
to the participants case manager, and identified staff for data entry.

Within 24 hours of the use of an emergency application of a physical restraint, supervisory or professional staff must examine the participant and report any evidence of trauma to a nurse or physician and report to the Regional Director Within 3 working days of the incident the team, including a physician, shall review the participant and his/her environment to determine if changes in the plan including the continued use of an emergency restraint or seclusion procedure are required. If the team plans to continue the use of a restraint or seclusion procedure, a behavior support plan must be designed and the approval process be initiated within five days of the team meeting.

Education and training requirements personnel must meet who are involved with the administration of restraints or seclusion.

Only staff with the appropriate training/in-service and experience can be assigned to implement use of restraints or other restrictive procedures. DDS only allows training on use of restraints to be done via a specific approved training curricula (ID PR.009, Attachment G) which specify particular physical and mechanical restraint techniques and allows only DDS approved mechanical restraints to be used for mechanical restraint procedures (ID PR.009, Attachment I).

Use of behavior modifying medications, defined as any chemical agent used for the direct effect it exerts upon the central nervous system to modify thoughts, feelings, mental activities, mood or performance, require the use in conjunction with a comprehensive behavioral support plan. The behavior modifying medication may only be prescribed for a condition that is diagnosed according to the most current edition of the DSM. Use of the medication may be initiated upon consent of the individual, guardian or conservator, or if the individual does not have the capacity to consent and has no guardian or conservator, with the approval by an emergency Program Review Committee review, pending full review by the DDS PRC and HRC as described above. If the individual, guardian, or conservator does not consent, a physician may order the start of such medication if the physician determines the individual is a danger to him/herself or others. The individual/guardian/conservator is informed of their right to a hearing if this occurs.

Use of a medication on a STAT or at once basis may be used with approval by the DDS PRC and HRC Committees for time-limited purposes and in extraordinary circumstances. Standing orders for the use of chemical restraint are prohibited by DDS policy. The team must review the use of behavior modifying medications on a quarterly basis and be reported to the physician. Medications must be reviewed and re-ordered no more than every 6 months by the physician.

The completion and annual review of the Level of Need and Risk Screening Assessment Tool identifies if an individual has experienced issues in a number of categorical areas relevant to the need for safeguards (critical/serious incidents, medication, risk to self or others, physical control risks or personal safety). If an issue is identified, an assessment or review must be done as part of the individual planning process. All assessments or reviews must contain specific recommendations for supports or procedures to minimize the risk to the person. All recommended supports and procedures must be referenced in the persons plan. The persons team ensures that recommended supports or procedures are in place, required training is completed and documented and ongoing supervision provided.

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

DDS policy and procedure on incident reporting identifies the type of incidents that are reported and the follow up actions related to an incident. Hard copies of the incidents are sent to the Regional Offices and Case Managers. Designated staffs enter the incidents into e-CAMRIS (database) and aggregate and/or individual reports can be produced for review at will. During the annual provider performance reviews these incidents are reviewed with the provider staffs and needed improvement activities are identified for their quality improvement plans. Case Managers utilize incident reports during the revisions of Individual Plans and PST meetings.

All providers are required to report emergency use (use that has not been pre-approved by the Program Review Committee) of restraint and other aversive procedures using the DDS incident reporting procedures. Use of emergency restraints and other aversive procedures must be reviewed by the interdisciplinary team and, if the use of these procedures are planned to continue or if there is an ongoing pattern of use (once per month for three months or three times within a 30 day period) a behavior support plan must be designed including this procedure and the approval process begun. Information and findings are communicated to the Medicaid agency upon request.

If the Interdisciplinary team identifies the need for and restrictive intervention, restraint and/or seclusion the proposed use of the procedure must be reviewed and approved by the regional Program Review Committee, the Human Rights Committee and the Regional Director prior to its implementation. Behavioral Support Plans must be written, then approved by the team, and staff trained in all interventions to increase adaptive skills and decrease challenging behaviors. Data must be collected, charted, and reviewed by the team on both the increase of adaptive skills and the decrease of challenging behaviors. Behavioral Support Plans are then modified as needed to decrease the occurrence of challenging behaviors and the need for restrictive intervention, restraint and/or seclusion.

During quality review visits, waiver participants are interviewed by DDS Quality Review staff. Questions include those that would lead a reviewer to further investigate the possible use of an unauthorized restraint. Case managers are also involved in the monitoring of services and are instructed to closely monitor participants records who may be at high risk of unauthorized restraint.

The DDS Central Office monitors the use of restraint on an emergency and planned basis, and can initiate an investigation of agency practice or of an individual based on a quarterly analysis of restraint data. Additionally, the DDS Central Office monitors the Regional Operations of the Program Review and Human Rights Review Committees to ensure policies and procedures as described herein are carried out.

Appendix G: Participant Safeguards

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

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

○ **The state does not permit or prohibits the use of restrictive interventions**

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

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

i. Safeguards Concerning the Use of Restrictive Interventions. Specify the safeguards that the state has in effect concerning the use of interventions that restrict participant movement, participant access to other

individuals, locations or activities, restrict participant rights or employ aversive methods (not including restraints or seclusion) to modify behavior. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency.

All procedures described above are in place for any restrictive intervention. Use of an intrusive device that signals the whereabouts or movements of an individual to ensure the safety of the individual or safety of the community, or a restriction that prevents an individual from having access to specific categories of objects likely to be dangerous for the individual or others, such as knives, lighter fluid, weapons, matches or lighters, must always be reviewed and approved by the DDS Human Rights Committee. The Human Rights Committee is comprised of individuals who are not employees of DDS and provide oversight and advice regarding the rights of DDS service participants. Following the HRC review the Regional Director must also approve the restrictive procedure. The HRC determines the frequency of its review of the procedure and supporting behavior plans. Data are entered and maintained in the department's eCAMRIS data system and are analyzed periodically by the Directors of Clinical Services who make recommendations for quality improvement. Information and findings are communicated to the Medicaid agency upon request.

During quality review visits, waiver participants are interviewed by DDS Quality Review staff. Questions include those that would lead a reviewer to further investigate the possible use of an unauthorized restraint. Case managers and other team staff are also involved in the monitoring of services and are instructed to closely monitor participants records who may be at high risk of unauthorized restraint.

All Behavioral Support Plans that have Restrictive Interventions in them must be reviewed by the Program Review Committee (PRC) and Human Rights Committee (HRC) and approved by the Director of Waiver services. For restrictive interventions utilized with a participant living in their own home or their family home a log system was put in place in order to preserve the home environment. In the home this allows for less paperwork while maintaining overview of the safety of the individual, and allowing the Individual Support Team (IST) to review the effectiveness of the Behavioral Support Plan. All interventions utilized by paid staff must have been approved by PRC, HRC and the Director of waiver services. All interventions are logged for review by the IST and the Psychologist/Behaviorist.

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

As indicated above the individual/aggregate incident reports are reviewed at the service level, and more formally at the provider perfomance reviews and the individual planning and support team meetings. At the statewide level and at the Business Plan's quarterly reviews DDS tracks incidents related to health and safety. The Teams and Case Managers are required to evaluate and revise prevention strategies for each individual to prevent re-occurance.

All providers are required to report emergency use (use that has not been pre-approved by the Program Review Committee) of restrictive interventions and other aversive procedures using the DDS incident reporting procedures. Use of emergency restrictive interventions and other aversive procedures must be reviewed by the interdisciplinary team and, if the use of these procedures are planned to continue or if there is an ongoing pattern of use (once per month for three months or three times within a 30 day period) a behavior support plan must be designed including this procedure and the approval process begun.

If the Interdisciplinary team identifies the need for and restrictive intervention, restraint and/or seclusion the proposed use of the procedure must be reviewed and approved by the regional Program Review Committee, the Human Rights Committee and the Regional Director prior to its implementation. Behavioral Support Plans must be written, then approved by the team, and staff trained in all interventions to increase adaptive skills and decrease challenging behaviors. Data must be collected, charted, and reviewed by the team on both the increase of adaptive skills and the decrease of challenging behaviors. Behavioral Support Plans are then modified as needed to decrease the occurrence of challenging behaviors and the need for restrictive intervention, restraint and/or seclusion.

Information and findings are communicated to the Medicaid agency upon request.

During quality review visits, waiver participants are interviewed by DDS Quality Review staff. Questions include those that would lead a reviewer to further investigate the possible use of an unauthorized restrictive interventions. Case managers are also involved in the monitoring of services and are instructed to closely monitor participants records who may be at high risk of unauthorized restrictive interventions .

The DDS Central Office monitors the use of restrictive interventions on an emergency and planned basis, and can initiate an investigation of agency practice or of an individual based on a quarterly analysis of data. Additionally, the DDS Central Office monitors the Regional Operations of the Program Review and Human Rights Review Committees to ensure policies and procedures as described herein are carried out.

Appendix G: Participant Safeguards

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

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

○ **The state does not permit or prohibits the use of seclusion**

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

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

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

These policies define restraint and seclusion and establish requirements for documenting and/or reporting these activities. As the agency with oversight responsibility for the waiver, DSS will review regular reports that summarize investigations or problems that arose from any use of restraint or seclusion for waiver participants
DDS Policies and procedures referenced
1.I.D.PR.009Incident Reporting Procedure and Procedure No. I.D.PR.011 (own and family home) and
2. I.E. PR.004 PRC Procedure
3. I. F.PR.006,Regional Human Rights Procedure
4. I. E.PR.002, Client Rights, Behavior Support Plans Procedure
5. I. E.PR.003, Behavior Modifying Medications Policy

Agencies seeking to use seclusion must submit a proposed individual behavior support plan to DDS. When submitting the proposed use of a phy seclusion practice, documentation must be presented shows that less aversive procedures have been found to be ineffective in addressing the target behavior. If the planning team identifies the need for seclusion, the proposed use of the procedure must be reviewed and approved by DDS Waiver Coordinator or their designee prior to its implementation. The use of the procedure must be presented within the context of an overall behavior support plan designed to teach adaptive skills and reduce the identified target behavior. There must also be documentation that:

The proposed procedure is not medically contraindicated by the individuals physician
Methods for increasing positive behaviors and decreasing undesirable behaviors.
Criteria for ensuring the least restrictive level of aversive intervention is employed
Required documentation concerning use of seclusion
The individual and the individuals family, or legal representative, are informed of the target behavior, goal of the plan, the adaptive behavior to be taught, the aversive procedure under consideration, the possible side effects of using the procedure, the consequences of not administering the procedure, documentation that less restrictive procedures have been found to be ineffective, expected duration of the plan, the Program Review Committee (PRC) and Human Rights Review Committee (HRC) processes, and the procedures for appeal as required by Connecticut General Statutes 17a-210.

All Behavioral Support Plans that have Restrictive Interventions in them must be reviewed by the Program Review Committee (PRC) and Human Rights Committee (HRC) and approved by the Director of Waiver services. For restrictive interventions utilized with a participant living in their own home or their family home a log system was put in place in order to preserve the home environment. In the home this allows for less paperwork while maintaining overview of the safety of the individual, and allowing the Individual Support Team (IST) to review the effectiveness of the Behavioral Support Plan. All interventions utilized by paid staff must have been approved by PRC, HRC and the Director of waiver services. All interventions are logged for review by the IST and the Psychologist/Behaviorist.

Education and training requirements

The completion and at a minimum annual review of the Level of Need and Risk Screening Assessment Tool identifies if an individual has experienced issues in a number of categorical areas relevant to the need for safeguards (critical/serious incidents, medication, risk to self or others, physical control risks or personal safety). If an issue is identified, an assessment or review must be done as part of the individual planning process. All assessments or reviews must contain specific recommendations for supports or procedures to minimize the risk to the person. All recommended supports and procedures must be referenced in the persons plan. The persons team ensures that recommended supports or procedures are in place, required training is completed and documented and ongoing supervision provided.

These items would be subject to PRC review and may at times replace staffing but with the objective to enhance independence. Treatment Consent would be required and the team would review at least every six

months unless the team delineated a more frequent review. If the person refuses consent we would use the Probate Court system to resolve issues.

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

All providers are required to report emergency use (use that has not been pre-approved by the Program Review Committee) of seclusion or other aversive procedures using the DDS incident reporting procedures. Use of seclusion and other aversive procedures must be reviewed by the interdisciplinary team and, if the use of these procedures are planned to continue or if there is an ongoing pattern of use (once per month for three months or three times within a 30 day period) a behavior support plan must be designed including this procedure and the approval process begun.

During quality review visits, waiver participants are interviewed by DDS Quality Review staff. Questions include those that would lead a reviewer to further investigate the possible use of an unauthorized restraint. Case managers are also involved in the monitoring of services and are instructed to closely monitor participants records who may be at high risk of unauthorized restraint.

The DDS Central Office monitors the use of restraint or seclusion on an emergency and planned basis, and can initiate an investigation of agency practice or of an individual based on a quarterly analysis of restraint data. Additionally, the DDS Central Office monitors the Regional Operations of the Program Review and Human Rights Review Committees to ensure policies and procedures as described herein are carried out.

Appendix G: Participant Safeguards

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

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

a. Applicability. Select one:

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

- **Medication Management and Follow-Up**

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

The individual's team will review the medication regimen when developing the Individual Plan and quarterly thereafter. The Registered Nurse on the team is responsible for reviewing all current medications as well as past history of medication use and consults with the prescriber and pharmacist for any questions on safety of drug choice, dosage, side effects or interactions On a quarterly basis the Registered Nurse completes a report on the health status of the individual that includes changes in medications and the individuals response to these changes, pertinent laboratory values related to medication usage, and communication and follow up with prescriber or pharmacist on medication administration issues. The individual's Primary Care Physician will review their current plan of care at their annual physical exam and any subsequent visits.

For individuals whose regimen includes two or more behavior modifying medications or at least one anti-psychotic medication there must be an initial review by the Program Review Committee with follow up reviews as determined by the Committee. This committee is comprised of a group of professionals, including a psychiatrist, assembled to review individual behavior treatment plans and behavior modifying medications to ensure that they are clinically sound, supported by proper documentation and rationale, and are being proposed for use in conformance with department policies.

DDS Policy No. I.E.PO.003 and DDS Procedure No. I.E.003 addresses the use of behavior modifying medications and programmatic support. DDS Policy No. I.E.PO.004 and DDS Procedure No. I.E.004 addresses the Program Review Committee. These procedures apply to all individuals placed or treated under the direction of the Commissioner. This includes individuals receiving services in or from DDS operated, funded and/or licensed facilities, including CLA, CCH, Day Services and DDS Individualized Home Supports provided in any setting and/or any DDS funded service regardless of where the individual lives. It applies to individuals receiving any HCBS Waiver Services where paid staff are required to carry out a behavioral intervention that utilizes an aversive, physical, or other restraint procedure and/or staff funded by the DDS who are required to pass/give a behavior modifying medication, regardless of where the individual lives. It also applies to any individuals who receive ongoing, planned psychiatric supports where behavior modifying medication is prescribed by the Psychiatrist regardless of where the individuals live. Additionally there are several DDS Medical Advisories including; 91-2 Unlabeled use of Medication for their Behavior Modifying effects for DDS Participants, 92-2 Monitoring the Use of Psychotropic Medications for DDS Participants, 98-5 Standards for Multiple Psychotropic drug Use, and 2000-2 Monitoring for Abnormal Involuntary Movements (Tardive Dyskinesia Screening). The individual's planning team has the responsibility to ensure that these policies, procedures and advisories are followed. The individuals Primary Care Physician will also see the individual annually to evaluate their current treatment plan.

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

The supervising Registered Nurse is responsible for observing certified non-licensed personnel administering medication annually and documenting these observations. The supervising Registered Nurse monitors and documents on an ongoing basis and not less than quarterly the prescribers orders; medication labels and medications listed on the medication records; and medication record and receipt forms. The supervising Registered Nurse tracks and monitors medication errors and prohibited practices and imposes the sanction process which includes retraining of staff and notification and follow up with the prescriber and individuals family or guardian. The supervising Registered Nurse suspends the medication administration responsibilities of non-licensed certified personnel at any time the health and safety if an individual is in jeopardy. If the medication error is significant or habitual the supervising Registered Nurse makes a request to the Commissioner to revoke the certification of the non-licensed certified employee. The supervising Registered Nurse completes a quarterly medication audit of medication errors and prohibited medication administration practices by residential setting and submits this report to the DDS regional Nurse Consultant who analyzes the data and works with providers on corrective actions if indicated.

The Administration of Medications: Residential Facilities, Respite Centers, Day Programs, Community Training Homes(CCH), and Individual and Family Supports regulations are sections 17a-210-1-10 of the Regulations of Connecticut State Agencies. The interpretive guidelines for these regulations are in 14-1 Interpretive Guidelines for the DDS Regulations Concerning the Administration of Medication by Certified Unlicensed Personnel. and 14-1 replaces 89-1, 93-1, 97-1 and 99-3. Any Medical Advisory or Health Standard that has an active link on the webpage is currently in force.

DDS Policy No. I.E.PO.003 and DDS Procedure No. I.E.003 addresses the use of behavior modifying medications and programmatic support. DDS Policy No. I.E.PO.004 and DDS Procedure No. I.E.004 addresses the Program Review Committee. The Program Review Committee (PRC) is a group of professionals, including a psychiatrist,assembled to review individual behavior treatment plans and behavior modifying medications to ensure that they are clinically sound, supported by proper documentation and rationale, and are being proposed for use in conformance with department policies. The PRC acts as an advisory group to the Regional or Training School director. These procedures apply to all individuals placed or treated under the direction of the Commissioner. This includes individuals receiving services in or from DDS operated, funded and/or licensed facilities, including CLA, CTH, Day Services and DDS Individualized Home Supports provided in any setting and/or any DDS funded service regardless of where the individual lives. It applies to individuals receiving any HCBS Waiver Services where paid staff are required to carry out a behavioral intervention that utilizes an aversive, physical, or other restraint procedure and/or staff funded by the DDS who are required to pass/give a behavior modifying medication, regardless of where the individual lives. It also applies to any individuals who receive ongoing, planned psychiatric supports where behavior modifying medication is prescribed by the Psychiatrist regardless of where the individuals live.

The individual's planning team has the responsibility to ensure that these policies, procedures and advisories are followed. The individuals Primary Care Physician will also see the individual annually to evaluate their current treatment plan. The team, with representation from DDS, will also review the behavior plan when the Individual Plan is being reviewed.

Appendix G: Participant Safeguards

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

c. Medication Administration by Waiver Providers

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

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

• **State Policy.** Summarize the state policies that apply to the administration of medications by waiver providers or waiver provider responsibilities when participants self-administer medications, including (if applicable) policies concerning medication administration by non-medical waiver provider personnel. State laws, regulations, and

policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

No employee of a residential facility, respite center or day program may administer medications without successful completing a department approved certification training program that includes the following areas: theory; medical terminology; drug classifications; intended purpose and effects of medication; identification of medication reactions; correct and safe techniques of medication administration; prohibited and dangerous techniques of medication administration; documentation of medication administration; report of medication errors; responsibilities associated with control and storage of medications; available medication information sources; communication and reporting responsibilities; state and federal statutes and regulations pertaining to medication; laboratory practicum; written examination. In addition to the classroom training the employee must complete a worksite practicum administered by a Registered Nurse. Each person who successfully complete the certification training is issued a certificate with an expiration date of two years. The employee is recertified after successfully completing the worksite practicum under the supervision of the Registered Nurse and passing the departments recertification examination.

The Administration of Medications: Residential Facilities, Respite Centers, Day Programs, Community Training Homes, and Individual and Family Supports regulations are sections 17a-210-1-10 of the Regulations of Connecticut State Agencies. The interpretive guidelines for these regulations are in 14-1 Interpretive Guidelines for the DDS Regulations Concerning the Administration of Medication by Certified Unlicensed Personnel. and 14-1 replaces 89-1, 93-1, 97-1 and 99-3. Any Medical Advisory or Health Standard that has an active link on the webpage is currently in force.
There are two procedures for Medication Administration in addition to 14-1. I.D.PR.014 Medication Administration Sanctions Process for Certified Non-licensed Personnel and I.D.PR.015 Medication Administration Sanctions Process for Licensed Nurses.

This set of regulations identifies the process for the training and certification of non-licensed staff and governs the safe and correct handling, storage, and administration of prescription medications, controlled substances, and over the counter preparations. The expectations for the identification, reporting and remediation of medication administration errors including revocation is also specified. This set of regulations also addresses the expectations for participants who self-administer medications identifying the criteria to assume this responsibility, the authorization required, and the oversight provided.

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

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

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

Per DDS policy, all medication errors are reported by providers using an incident report form specially designed to report medication errors. All reports are sent to DDS and reported internally per the provider's policy. When a medication error relates to a controlled drug it is also reported to the CT Department of Consumer Protection.

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

Medication omission, errors involving wrong: client, medication, route, dose, or time, and any medication error resulting in the need for medical care.

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

All medication errors required to be recorded must be reported to DDS. DDS Procedure No. I.D.PR.009 outlines the procedure for incident reporting including medication errors.

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

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

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

DDS will be responsible for the monitoring of the administration of medication. The team, including DDS representation, implementing the Individual Plan will seek information from the provider concerning the administration of medications. This will include a review of the current medications, compliance of the individual in taking medications, and any identified supports needed. This review will happen with the review of the Individual Plan. In settings where there is nursing oversight of administation of medication by licensed or certified non-licensed personnel, a nurse is identified to be responsible for the on-going review of medication administration, identification of medication errors, and immediate remediation. In these settings, a quarterly review of the administration of medication by the RN is conducted and reported to a designated DDS regional nurse. Any issues of significant concern regarding safe management or administration of medication identified in the review of the individual plan,or reported as a special concern or incident, will be brought to the attention of the regional health services director for appropriate remediation and follow-up. This follow-up includes consideration of the need for revocation of certification/authorization to administer medications.

Appendix G: Participant Safeguards

Quality Improvement: Health and Welfare

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

a. Methods for Discovery: Health and Welfare

The state demonstrates it has designed and implemented an effective system for assuring waiver participant health and welfare.

i. Sub-Assurances:

a. ***Sub-assurance: The state demonstrates on an ongoing basis that it identifies, addresses and seeks to prevent instances of abuse, neglect, exploitation and unexplained death.***

Performance Measures

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

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

Performance Measure:
Number and percent of mortality reviews conducted annually on deaths that meet the

DDS policy for mortality reviews. Numerator=number of mortality reviews conducted annually on deaths that meet the DDS policy for mortality reviews. Denominator=number of deaths that meet the DDS policy for mortality reviews.

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

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

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**

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

Performance Measure:
Number and percent of allegations of abuse, neglect, and exploitation that were investigated within required timeframes. Numerator=number of allegations of abuse, neglect, and exploitation that were investigated within required timeframes. Denominator=number of allegations of abuse, neglect and exploitation that were investigated.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Abuse and Neglect data in e-Camris

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

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

Data Aggregation and Analysis:

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

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

Performance Measures

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

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

Performance Measure:
The number and percent of service providers that have documented training regarding reporting and preventing neglect and abuse. Numerator= Number of records reviewed that indicate the provider has documented training regarding reportingand preventing neglect and abuse Denominator= Total number of records reviewed

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

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

Data Aggregation and Analysis:

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

Performance Measure:
The number and percent of persons surveyed who report they have someone they can talk to if they are scared Numerator=Number of surveys that indicate a person has someone they can talk to if they are scared Denominator= Number of NCI surveys completed

Data Source (Select one):
Analyzed collected data (including surveys, focus group, interviews, etc)
If 'Other' is selected, specify:
NCI survey

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

☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☒ **Continuously and Ongoing**	☒ **Other** Specify: NCI uses a pre-screening requirement for the survey participant to pass in order to be asked this question. This pre-screening requirement reduces the universe and sample size of the data set.
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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

Performance Measure:
Number and percent of Critical Incidents where there was follow-up by the region per DDS policy. Numerator=number of critical incidents where there was follow-up by the region per DDS policy. Denominator=total number of critical incidents.

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:
Incident data in e-Camris

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

Data Aggregation and Analysis:

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

c. ***Sub-assurance: The state policies and procedures for the use or prohibition of restrictive interventions (including restraints and seclusion) are followed.***

Performance Measures

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

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

Performance Measure:
Number and percent of restrictive interventions(including restraint and seclusion) that were used in accordance of state policies and procedures. Numerator=number of restrictive interventions(including restraint and seclusion) that were used in accordance of state policies and procedures. Denominator=number of restrictive interventions.

Data Source (Select one):
Record reviews, on-site

If 'Other' is selected, specify:
Incident data in e-Camris

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

Data Aggregation and Analysis:

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

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

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

Performance Measures

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

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

Performance Measure:
Number and percent of providers that confirm that medications were administered to waiver participants by only licensed or certified personnel. Numerator=Records reviewed that demonstrates meds were administered only by licensed or certified personnel Denominator= Number of records reviewed in which participants received medication administration

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:
QSR subset of records in which participants received med admin as part of their IP

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**

☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☒ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

Performance Measure:
The number and percent of records reviewed that indicate the participant has received the necessary oral and dental care Numerator= Number of records reviewed that indicate the participant has received the necessary oral an dental care Denominator= The number of records reviewed

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

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

Data Aggregation and Analysis:

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

Performance Measure:
The number and percent of waiver participants surveyed who report having a primary care practitioner Numerator= Number of persons surveyed in which the person reports they have a primary care practitioner Denominator=Number of people surveyed

Data Source (Select one):
Analyzed collected data (including surveys, focus group, interviews, etc)
If 'Other' is selected, specify:

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

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

Data Aggregation and Analysis:

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

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.

Health and Safety issues are monitored by the PSTs and support staff on an ongoing basis. Safety risk assessments are conducted and are part of the individual plans. Data is collected by the Teams, is aggregated and examined by the PST, at the annual provider performance reviews, and by the Program/Human Rights committees. Individual focused or systemic remedies can be implemented by any of these review entities. Abuse and neglect allegations are reported, investigated and resulting recommendations are followed up until resolution at the regional and provider levels. State wide aggregate incident reports are reported quarterly in the Management Information Report (MIR) and reviewed by DDS Executive

Teams to identify trends and resulting, potential system changes via the establishment and tracking of annual Business Plan goals.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the state's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction and the state's method for analyzing information from individual problems, identifying systemic deficiencies, and implementing remediation actions. In addition, provide information on the methods used by the state to document these items.

All findings related to participant safeguards are entered into quality databases and communicated to the service provider or case manager as appropriate for corrective action. Quality Review staff monitor individual provider follow-up at the next service location visit.

Provider systemic findings are presented and monitored for corrective action by the Regional Resource Management Unit during annual performance review meetings.

ii. Remediation Data Aggregation

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

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

c. Timelines

When the state does not have all elements of the quality improvement strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of health and welfare that are currently non-operational.

◉ **No**

○ **Yes**

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

Appendix H: Quality Improvement Strategy (1 of 3)

Under Section 1915(c) of the Social Security Act and 42 CFR § 441.302, the approval of an HCBS waiver requires that CMS determine that the state has made satisfactory assurances concerning the protection of participant health and welfare, financial accountability and other elements of waiver operations. Renewal of an existing waiver is contingent upon review by CMS and a

finding by CMS that the assurances have been met. By completing the HCBS waiver application, the state specifies how it has designed the waiver's critical processes, structures and operational features in order to meet these assurances.

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

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

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

Quality Improvement Strategy: Minimum Components

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

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

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

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

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

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

Appendix H: Quality Improvement Strategy (2 of 3)

H-1: Systems Improvement

a. System Improvements

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

The Department of Developmental Services (DDS) has structured its quality improvement system (QIS) to systemically address all requirements of the six HCBS assurances both thorough its organizational structures and the establishment of its standing committees related to the HCBS Waivers. Regional offices assume responsibility for implementation of overall service access, planning and delivery (Level of Care and Service Planning) and for substantial elements of the quality system through provision of TCM, quality review activities, system safeguards and the maintenance of administrative functions. DDS central office maintains responsibility for the Division of Investigations, oversight of TCM, provider licensure and certification activities, quality review activities and for systemic oversight, evaluation and analysis of data related to provider performance, system safeguards, fiscal accountability, administrative authority and quality improvement.

The department developed a web-based data application to support quality assurance/improvement functions through a CMS Systems Change Grant awarded in 2003. The Quality Service Review (QSR) data application, is used to automate information from quality monitoring conducted by case management and quality review staff. The application records findings resulting from ongoing provider performance reviews, notifies providers and key DDS staff of needed corrective actions, and tracks follow-up on corrective action plans created automatically or by the reviewer. The application data is used to produce administrative and analytic reports to track quality monitoring activities and identify data trends for remediation. In addition to the QSR data application, the department tracks and trends data such as but not limited to abuse and neglect and critical incidents, individual specific risk factors and level of need, program review and human rights committee actions and decisions, and compliance with waiver administration, service planning, and financial accountability expectations.

Currently DDS aggregates this information into Waiver Evidence Reports and submits to CMS via our State Operating Agency (DSS) on the required combined Waiver Evidence submission schedule for the 3 Intellectual and Developmental Disability Waivers. DDS was approved to consolidate reporting across 3 Waivers (The Employment and Day Services Waiver Control #0881, the Individual and Family Support Waiver Control #0426, and the Comprehensive Supports Waiver Control #0437) due to meeting criteria as outlined in the CMS Bulletin “Modifications to Quality Measures and Reporting in the 1915 (c) Home and Community-Based Waivers” dated March 14, 2014. DDS uses a Random Sampling approach combining participants from each of the 3 I/DD Waiver groups to make up the combined sample group. DDS maintains the integrity of the data to allow for separation by Waiver for analysis if needed, however has implemented a system-wide sampling, analysis, reporting, and improvement approach enabling DDS to most effectively manage and coordinate Quality Improvement Activities across these 3 Waivers.

Adopting the standards laid out by CMS for the requirement for formalized Quality Improvement based on performance at or above 86%, the DDS Waiver Assurance Committee will manage and maintain the overall Quality Improvement Plan. DDS develops improvement plans, implements and tracks specific improvement activities, and assess the effectiveness of specific activities against desired performance improvement benchmarks. Provider-level improvement requirements are managed at the Regional Level through the Quality Review oversight process and the use of the Annual Provider Quality Review-Continuous Quality Improvement Planning Process, and larger system-wide improvement activities are be managed centrally by the Waiver Assurance Committee, who reports findings and outcomes to the System Design Team. A DDS Management Information Report (MIR) is prepared quarterly by the Division of Business Intelligence. It includes information on the following: DDS participant demographics; DDS referral and eligibility; services utilization; placement/access to services; waiting list data; waiver enrollment; incident data; abuse/neglect data; worker’s compensation data; federal revenue; referrals to the Abuse/Neglect Registry; and psychiatric hospitalization utilization. Ad hoc reports are prepared and included as available or requested. This quarterly report is submitted to the Legislature’s Office of Fiscal Analysis, disseminated to all DDS staff, and is available on the DDS website.

The department prepares a mortality review report in which mortality data and analysis is compiled on an annual basis to report causes of death, trends regarding mortality of individuals supported by DDS, and recommendations for systemic DDS and health care system improvement. In addition to DDS’s internal mortality review process, DDS responds to recommendations from the state’s Independent Fatality Review Board annual report about system improvements needed based on their findings of mortality reviews of selected individuals served by the DDS.

The information from the above sources is used in the development of quality improvement initiatives. Data is shared with a variety of department functional units as well as standing DDS committees and interest groups associated with the department. The need for improvement strategies is identified through the analysis of qualitative and quantitative data and are developed, assigned to and implemented by the appropriate organizational entity at either the regional or central office level.

Key DDS committees (DDS System Design Team, DDS Waiver Assurance Committee, DDS Regional Advisory Councils, and the DDS Private Provider Trades) meet periodically throughout the year to review data, make recommendations and follow up on status of improvement projects. More about these committees is described below.

ii. System Improvement Activities

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

b. System Design Changes

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

The DDS Central Office tracks and monitors overall system improvement strategies and related design changes resulting from analysis of discovery and remediation information generated by various DDS functional units. Identified improvement strategies are reviewed periodically by the key committees described below.
DSS/DDS Waiver Implementation Committee
Membership: DSS Managers and DDS Audit, Billing and Rate Setting and Waiver Service Managers
The purpose of this joint committee is for DSS, the Connecticut SSMA, to assure that DDS meets federal quality requirements and expectations for the operation of HCBS Waivers. DSS monitors DDSs activities and performance according to the Memorandum of Understanding between the two agencies and associated requirements found in the Administrative Authority assurance. Recommends priorities for quality improvement activities.

DDS System Design Team
Membership: DDS Central Office and Regional Executive Managers
The purpose of this committee is to monitor compliance with the six HCBS Waiver assurances and other federal, state, and agency requirements. Their responsibilities include a routine administrative review of key organizational and programmatic issues and data trends associated with the departments quality management system in order to determine and/or recommend changes in agency policy, program, infrastructure, and funding levels. The System Design Team ensures that all changes in program and practice are appropriately reflected in the agency policy, procedure, and operations manuals and communicated to stakeholders. This group works in conjunction with regional and central office Executive Management Teams to make final decisions on improvement and implementation strategies and new systems design development to advance the HCBS Waivers. They are informed by the following department functional units: Medicaid Operations (waiver enrollment and policy, rates and billing), Quality Improvement, Quality Management, Provider Operations, Business Intelligence, Provider Administration and Resource Management, Legal Services, Health Services and Audit.
Regional Advisory Councils
Membership: Individuals and families receiving DDS services and supports and DDS regional management team members
The purpose of the three regional advisory councils is to provide opportunity for individual and family input and to review key quality findings and data trends in order to make recommendations for regional and state level systems improvement that will have a positive impact on individuals and families receiving DDS supports and services. With the support of the Regional Quality Improvement divisions, Regional Advisory Council recommendations are shared with regional management teams, and the and Systems Design Team.
Provider Council
Membership: DDS Leadership and Provider Trades

The purpose of this committee is to review proposed changes in DDS policy, program, and practice in order to assess the impact that the changes will have on the DDS provider community. This includes a routine administrative review of key organizational and programmatic issues and data trends associated with the department quality management system and business intelligence. Provider Trades recommendations are shared with the DDS QSI Committee and Systems Design Team.

ii. Describe the process to periodically evaluate, as appropriate, the quality improvement strategy.

The department HCBS related committee structures as well as its functional units address compliance with the six waiver assurances. This allows for ongoing opportunities to modify the department QIS. System Design periodically reviews the QIS to determine if modifications are needed.

Appendix H: Quality Improvement Strategy (3 of 3)

H-2: Use of a Patient Experience of Care/Quality of Life Survey

a. Specify whether the state has deployed a patient experience of care or quality of life survey for its HCBS population in the last 12 months *(Select one):*

- ○ **No**
- ◉ **Yes** *(Complete item H.2b)*

b. Specify the type of survey tool the state uses:

- ○ **HCBS CAHPS Survey :**
- ◉ **NCI Survey :**
- ○ **NCI AD Survey :**
- ○ **Other** *(Please provide a description of the survey tool used):*

Appendix I: Financial Accountability

I-1: Financial Integrity and Accountability

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

All DDS Contracted Providers of residential and day services under contract with DDS are required to file annually an Operational Plan and Annual Report of Day and Residential Service. The Annual Report is in conformance with generally accepted accounting standards. Contracted providers and Fiscal Intermediaries submit audited financial statements on an annual basis.

The Annual Report documents are the basis for field audits either by the Department of Social Services or the Department of Developmental Services. DDS Resource Managers review contract compliance on at least an annual basis. The Department of Social Services (DSS), the Department of Developmental Services, and the State Auditor of Public Accounts are responsible for conducting State financial audits per CT Gen Statute 17a-226 and 17a-246. The DSS Office of Quality Assurance, Medical Audit Unit audits Medicaid payments on a continuous basis. The audit is based on an analysis of a random sample of claim information maintained by DSS and a review of appropriate medical and administrative records maintained by the Provider. The audit of paid claims was directed to a determination that: the services were rendered to an eligible recipient; the billings properly reflected the type and amount of services rendered; the services were medically necessary; original documentation was maintained to accurately evidence the services provided and the medical necessity of such services; the provider adhered to all applicable State statutes and regulations promulgated by DSS; all available third party insurance was properly billed; the provider adhered to all standards for licensure governing the type of service rendered; and the provider adhered to all terms and conditions of its Provider Agreement with DSS. Audit findings identifying non-compliance with the stated requirements may result in financial disallowances being assessed against the provider.

Both DSS and DDS oversee different aspects of the Fiscal Contractor. a)Currently it's a 3 step process, the Providers use an independent CPA firm that audits and issues an opinion on the financial statements, and they're then submitted to the DSS contractor currently (Myers & Stauffer) and the DDS Operations unit for analysis. The operations unit has a check list used to analyze the reports, if questions arise they ask for details from the provider, if the response is insufficient to answer the question the Operations Unit will request a field audit. b)Currently the management team of the DDS operations unit may request a desk/field audit of a provider. DDS will conduct all initial audits resulting from the DDS Providers annual reports based on the finding of the Audit unit. The matter may be referred to DSS's Audit unit if the audit indicates that there is potential Medicaid fraud, systematic failures to record and document the utilization of Medicaid reimbursed services or material departure from the State of CT Cost Standards that providers offering Medicaid reimbursable services must adhere to when allocating operational cost to DDS funded Medicaid services.

c)That Audit unit may at the discretion of the DDS Director of Audit perform either a desk or field audit based on the nature of the concern voiced by the Operations Unit, the materiality of the matter and availability of the underlying documents needed to conduct the audit. An example of the availability of the documents would be concerns about service utilization, DDS maintains the database's (eCAMRIS: placement/waiver data; WebResDay – attendance data) used to submit attendance by our contracted vendors. DDS also has access to the DSS Medicaid billing information that can be cross referenced. This allows the Audit unit to conduct extensive desk audit reviews.

d) DDS and DSS has their own process for assessing and executing disallowances for cost and or provider billings that don't comply with the cost standards and or Medicaid billing rules. Factors affecting the decision to enforce a disallowance include:

a. Materiality of the disallowance and the impact to the individuals served if the Provider was effectively forced out of business.

b. Establishing if there was a willful intent to defraud or mislead the State or was it an error in applying the States cost standards.

c. Past practices that were known to the State but no action was taken.

d. Did the disallowed cost affect Medicaid Reimbursement rates or State Funded Only services?

e) Audits with findings that demonstrate a Provider is not in compliance with CT State Cost Standards and or cost billed to Medicare that are not appropriate will result in the States requirement that a corrective plan of action is submitted by the Provider. In the case of DDS audits of Medicaid services funded by or through the agency will result in a Corrective plan of action monitored by either the Operations or Quality Assurance units with follow-up compliance audits or quality reviews being performed to ensure the plan is being implemented by the Provider. If the Provider operates other Medicaid Programs for Agencies besides DDS it is likely that DSS would be the agency charged with evaluating and monitoring a Providers plan of corrective action.

f) The state ensures that a provider has executed its plan of correction via several methods:

a. Require the restatement of their annual cost reports.

b. Review and authorization of the cost allocation plan

c. Follow-up audit or quality assurance review to ensure the provider has implemented the changes including:

i. Revision of Providers policies and procedures

ii. Relevant staff retraining has occurred

iii. New processes are in place and being used to ensure compliance and guard against a repeat finding.

d. Signed audit response letter agreeing with the audit findings and acknowledging that they need to come into compliance with the relevant State Cost Standards and or Medicaid Billing rules.

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

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

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

Providers are selected on a rotating basis for the various waiver types. The selection of a provider is based on total dollar payments and claim activity.

The objective of the audit is to review medical assistance payments made to a provider to determine whether the provider:
1. rendered services to an eligible recipient;
2. submitted claims that properly reflected the type and amount of services rendered;
3. rendered services that were medically necessary;
4. maintained documentation that accurately accounts for services rendered and the medical necessity of such services;
5. complied with all applicable federal and state laws, regulations and policies;
6. properly billed all available third party insurance;
7. met all standards for licensure governing the type of service rendered; and
8. adhered to all terms and conditions of its Provider Agreement with the Department.

The Department assesses financial errors against the provider if the Department identifies non-compliance with the above requirements.

The scope of the audit of a provider is based on a review of claims paid normally during a three year period. The audit includes an analysis of claim information maintained by the Department and a review of medical and administrative records maintained by the provider. Third party sources are contacted if the Department deemed such contacts to be necessary. The audit verifies whether the services billed complied with state laws, which requires the services to be billed in accordance with an approved plan and for approved state rates. The Auditor of Public Accounts is responsible for a periodic independent audit of the waiver program.
There are four types of audits:

1.DDS Internal Audit-Performed by the DDS Audit Unit-Sample Size, Time Period and Sample Selection are determined by

the internal auditors with direction from the Commissioner, Deputy Commissioner or other DDS official. Many audits happen annually while others are used to address tips given to the auditors by DDS employees or private providers
2.DSS Audit-Performed by the DSS Audit Unit-DSS uses a statistician to select the sample for their audits. DSS pulls claims from the MMIS system for DDS providers and have the statistician select a sample from those claims.
3.Quality Audit-Performed by the DDS Quality Unit-DSS uses a statistician to select the sample for their audits. DSS pulls claims from the MMIS system for DDS providers and have the statistician select a sample from those claims. Typically DSS is looking back at three years of claims
4.Audit of Financial Statements-Performed by independent CPAs that issue an opinion on the financial statements-DSS uses a statistician to select the sample for their audits. DSS pulls claims from the MMIS system for DDS providers and have the statistician select a sample from those claims. Typically DSS is looking back at three years of claims
When an audit identifies an inappropriate payment and results in a CAP required from the provider, the State ensures these claims are removed from its FFP calculation and the inappropriate payment is recouped.
The state voids the claim in our internal utilization system. This leads to two separate processes, 1. The next payment to the provider is subtracted by the amount of the voided claim. 2. DDS sends a correction record to the Department of Administrative Services that allows them to void the claim in the MMIS, which takes it out of the FFP calculation

Appendix I: Financial Accountability

Quality Improvement: Financial Accountability

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

a. Methods for Discovery: Financial Accountability Assurance:
The state must demonstrate that it has designed and implemented an adequate system for ensuring financial accountability of the waiver program.

i. Sub-Assurances:

a. Sub-assurance: The state provides evidence that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver and only for services rendered.

Performance Measures

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

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

Performance Measure:
Number and percent of claims coded and paid for in accordance with reimbursement methodology specified in approved waiver. Numerator= number of claims coded and paid for in accordance with reimbursement methodology specified in approved waiver. Denominator=total number of claim.

Data Source *(Select one):*
Financial records (including expenditures)
If 'Other' is selected, specify:
MMIS

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***	☐ ***Weekly***	☒ ***100% Review***

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

Data Aggregation and Analysis:

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

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

Performance Measure:
Number and percent of claims that were denied appropriately due to system edits and audits Numerator=Number of claims denied appropriately due to system edits and audits Denominator= Number of claims denied

Data Source *(Select one):*
Financial records (including expenditures)
If 'Other' is selected, specify:
MMIS

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

Data Aggregation and Analysis:

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

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

Performance Measures

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

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

Performance Measure:
The number and percent of the rates that remain consistent with the rate methodology in the approved waiver throughout the entire waiver cycle. Numerator=number of rates that stay consistent in rate methodology. Denominator=total number of rates.

Data Source *(Select one):*
Financial records (including expenditures)
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	***Frequency of data collection/generation*** *(check each that applies):*	***Sampling Approach****(check each that applies):*
☒ ***State Medicaid Agency***	☐ ***Weekly***	☒ ***100% Review***

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

Data Aggregation and Analysis:

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

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

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

b. Methods for Remediation/Fixing Individual Problems

i. *Describe the state's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction and the state's method for analyzing information from individual problems, identifying systemic deficiencies, and implementing remediation actions. In addition, provide information on the methods used by the state to document these items.*

All day providers have moved to utilization based payments based on an approved service authorization. In the Fee for Service system, the provider invoices a Fiscal Intermediary for each unit of service provided. A provider with a Purchase of Service contract records all units of services provided in a month on a web based attendance application. The information is uploaded on the 10th of the following month and DDS reimburses providers based on the inputted data on the web based application and the approved unit rate of the service authorization.
Once an overpayment/incorrect payment has been identified pertaining to the recorded billable units, the provider will be instructed to correct the problem based on the service system.
A provider in the Fee for Service system will be instructed to resubmit a corrected invoice to the fiscal intermediary. The fiscal intermediary will adjust the payment for the individual in the next billing cycle.
A provider with a Purchase of Service contract will be instructed to make the correction to the attendance in the web based application. The payment will be adjusted accordingly after the next upload.

DDS Medicaid Operations staff typically take the lead role in the review and correction of irregularities. The contracting and Investigation Units provide assistance when requested. When appropriate, retraining occurs. When errors are discovered DDS corrects past HCBS waiver billing and pursues recoupment of funds.

DAS and DDS both review and note billing irregularities. Isolated instances are corrected or deleted from the waiver billing.

ii. Remediation Data Aggregation

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

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

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

c. Timelines

When the state does not have all elements of the quality improvement strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Financial Accountability that are currently non-operational.

- ◉ ***No***
- ○ ***Yes***

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

Appendix I: Financial Accountability

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

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

DDS services are claimed based on documented attendance in DDS web based attendance system or through FI billing system utilizing interim rates. Interim rates are developed based on a prior fiscal year rate. The Interim rate may include an inflation factor up to the Medical Care CPI and other requirements as approved by the Connecticut General Assembly or state bargaining agreements that mandate changes that affect rates. Final cost based replacement rates are computed by the DDS Rate Setting Unit and approved by DSS Reimbursement and CON Unit. DDS public programs are analyzed after the close of the fiscal year in an agreed-upon rate setting methodology. Contracted providers submit their Annual Reports to document the cost of providing the contracted services and the DDS Rate Setting Unit analyzes these reports minus any cost settlement of unexpended funds or unallowable costs in accordance with the State's established cost standards to develop provider level reimbursement rates. The Fiscal Intermediaries submit cost reports for the services of the Self-directed participants to the DDS Rates Setting Unit and those cost specifics are analyzed for the "FI" rates. All rates, interim and final cost-based replacement rates are approved by DSS Reimbursement and CON.

Below is a guide as to which services are claimed based on the documented attendance in the DDS web-based attendance system and which services are claimed based on the Fiscal Intermediaries (FI) billing system utilizing interim rates.
-DDS Exclusively: Any service that is Per Diem
-FI Exclusively: Independent support broker, Peer Support, Assistive Technology, Individual Direct Goods and Services, Interpreter, Specialized Medical Equipment and Supplies and Training, Counseling and Support Services for Unpaid Caregivers. For Individual Directed Goods and Services and Specialized Medical Equipment and Supplies, these billed rates, DDS pays the actual cost of the goods/services and equipment
-Every other service happens both through DDS' attendance system and through the FI's system.
DDS administrative costs will not be claimed as waiver services as of July 1, 2014. As of July 1, 2014, the waiver services will include a de minimis rate pursuant to 2 CFR 200.414 until an HHS approved indirect cost rate is obtained. Payment rates paid to contracted providers and self-directed providers and staff are developed by the DDS Operations Center. The payment rates are based on a direct wage baseline with adjustments for indirect, supervision and (providers) administrative costs at the private provider level and reported on their Annual Report of Day and Residential Services. These costs are not included in the State's Cost Allocation Plan, as they are not direct state costs, but provider costs. However, these costs are included in the service costs in the DDS Waiver Rates as they are the provider's costs to operate the programs. These expenses are based on information drawn from Connecticut Department of Labor wage statistics, salary surveys, and audited findings from annual provider fiscal reports. Any and all provider costs of doing business that are attributable to room and board are excluded from waiver service rates, including maintenance and upkeep, and physical plant alterations. The service rates for Group Day Supports, Supported Employment, Respite, Individualized Day Support, Independent Support Broker, and Transportation were developed based on the direct support hourly wage and the additional components of supervision, employee benefits, indirect costs, administrative and general costs at the provider level, and the number of clients per the direct care staffing ratio. There is an additional component of hours of supports for those rates calculated on a per diem basis. Payment adjustments are made to providers who experience unanticipated low attendance rates or extraordinary costs due to extreme weather conditions such as blizzards, hurricanes floods, etc., Acts of God or other unforeseen circumstance such as arson or vandalism. DDS reviews the total revenue and expenses reported on the provider's Annual Report of Day and Residential Services and cost settles any unexpended funds or unallowable costs in accordance with the State's established cost standards. Individualized Day Supports is paid two separate ways. 1) On contract - in which we developed rates based on the direct support hourly wage and the additional components of supervision, employee benefits, indirect costs, administrative and general costs at the provider level, and the number of individuals per the direct care staffing ratio
2) Self-Directed – The employer of record negotiates the payment rate, but it must comply with the collective bargaining agreement. As rates are negotiated in self-direction, the rates must comply with the collective bargaining agreement. The rates for, Behavioral Support Services and Interpreter were developed based on the contracts of similar supports with other DDS and State of Connecticut departments. The rate is to reimburse the provider for the wage and benefits of the behaviorist and interpreter along with any associated overhead (ie. office space, insurance, etc.). As noted above, the waiver services will include a de minimis rate pursuant to 2 CFR 200.414 until an HHS approved indirect cost rate is obtained.
Assistive Technology is individually priced and capped at $15,000 year and is paid at "up to max" rates because the services require manual pricing.
Peer Support rate is based on a review of direct and indirect costs and is paid off the department's fee schedule.
Adult Day Health is paid according to the Department of Social Services fee schedule. This service was included in Phase 1 of the rate study.

Waiver service rates are based on direct and indirect costs of providing Waiver services. Individuals, provider organizations and DDS staff have had the opportunity to review the Waiver application and rates pursuant to the public

notice. The Waiver application has been reviewed and approved by the committees of cognizance of the Connecticut state legislature
DDS has worked to connect the rates to the support needs of each person using the CT Level of Need Assessment and Risk Screening Tool (LON). The LON uses an algorithm that takes all of the assessed information on an individual to create a composite score ranging from 0-8. DDS has associated a staffing level to each of the scores from 1 through 8 to produce "need based" rates. The system also contains a separate review of extraordinary support needs that are outside the eight levels.
Data developed by DDS is formatted and sent to DSS (the single state Medicaid agency) for review and Medicaid rate approval.
Updated rates are posted by Fiscal Year on the DDS website and an email is sent out notifying all stakeholders of the rate changes.
In 2018 CT General Assembly passed SA 18-5 a minimum wage bill for private provider employees that provide supports to CT DDS individuals. This legislation prompted a review of the rates for each waiver in 2019 so the rates could be revised to align with the new requirement. The Special Act implemented two major provisions: 1) All private employees who work in DDS funded programs would make $14.75 minimum wage; and 2) Any employee being paid above $14.75 prior to the effective date of the Act, is entitled to an increase in pay up to 5%. Rates are reviewed during each bi-annual budget period based on the amount of funds we are allocated from the Gov's budget. Most recent updates were due to the Minimum Wage Act (SA 18-5). All rates were revised based on special act 18-5 in 2018.
Rates are reviewed during each bi-annual budget period based on the amount of funds we are allocated from the Governor's budget. Most recent updates were due to the Minimum Wage Act (SA 18-5)in 2018.
DDS has a cost settlement process where we review costs by provider of each service category. The review is completed each year and that data is used to both assist providers with issues in their programs and review our rates.

Individual Day support rates for self directed providers are now determined by a collective bargaining agreement between the state and SEIU 1199 for the time period of 4/1/18 through 6/30/21. A renegotiation of the terms of the contract will take place prior to the termination of the agreement absent mutual agreement to a different time period. All applicable employer taxes are added to the pay rate to determine the Medicaid rate.
Payment rates for Blended Supports are directly linked to the Individualized Day Support rate.

The payment rates for Customized Employment are based on the combination of the Level of Need and the specific plan that is developed for the individual.

The payment rate for transitional employment is directly linked to the group supported employment payment rate.

The payment rate for Counseling and Support Services is approved on a case by case basis, based on the cost of the service.

Currently, the rate for Prevoc services is the same as the Supported Employment rate.

Group Day Supports Medical- The rate was adjusted based on a lower level of utilization. We needed to increase the rate as there will be far more days when the entire group does not meet as opposed to regular Group Day Supports. This service is for an individual participating in the regular group day support service but has complex medical needs that may interrupt their ability to attend day program on a full-time basis. Approval of this service requires that the individual meets a medically based subcategory of the Level of Need Assessment and that the service request has been reviewed and approved by the DDS Utilization Resource Review Committee.
This service is for an individual participating in the regular group day support service but has complex medical needs that require them to need certain additional medical care that is more costly. Examples include an individual in the group that changes the ratio of supervision, or there needs to be availability of medical staff during certain times in the group.
Remote Supports Service rate is based on the monitoring agency's fee plus the amount of coverage needed for the backup agency. There will be an enhanced rate paid to providers for individuals that use Remote Supports when they previously utilized a more intensive services (Such as IHS) for up to two years.

Remote Supports Technology Rate will be paid based on the actual cost of the technology being used. The backup agency is always on call with per diem staff available while the monitoring agency is providing the remote service.

Environmental Mods- Only a self-hired service. There is a cap on what they can use (depending on the modification),

must obtain 3 quotes.

Vehicle Mods- $25k cap for the modification and must obtain three bids. This service is for families not providers.

PERS (install and monitoring) are at max fee, being that all provider costs and utilization computes the per unit cost used in the cost-based final replacement rates: PERS (install and monitoring)

Public Transportation is cost based (cost of Ticket, Fare and/or Pass)
Remote Supports Services Passive Per Diem and Per 15 min. – Is based on the expected cost of monitoring alerts for DDS persons. As this is a new service we will continually assess costs associated.
Home Delivered Meals rates are based on current CT rates in other programs. We will need to continue to assess this service to ensure the rates support the unique population DDS serves.
Virtual Health Consultation- Negotiated based on the unique needs of the individual served.

CT agreed to a phased approach for the Medicaid rate study. Currently, DSS as the single state Medicaid agency, is completing their rate study, which is considered phase 1. Once complete our understanding is the phase 2 of rate study will include DDS.

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

DDS funds all providers of services and supports from State General Funds directly appropriated to the DDS. Payment is made to providers of service through contract payments, or through an approved Fiscal Intermediary per delegated authority from the Medicaid Agency. For HCBS waiver services, DDS serves as the Medicaid Billing Provider and holds Performing Provider Agreements with private providers of service through delegation by the Medicaid Agency (DSS).

For individuals who self-direct services and supports, the Medicaid Agency (DSS) delegates the authority to hold the Performing Provider Agreement(s) and to make provider payments for those services and supports to the Fiscal Management Agency (FI). The DDS private providers bill DDS and DDS provides payment for services in the fee for service system. The DDS providers may choose to bill directly through the MMIS if requested. Fiscal Intermediaries awarded through a RFP process are Allied Resources and Sunset Shores.

Appendix I: Financial Accountability

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

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

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

Select at least one:

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

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

The Department of Developmental Services is the state agency which operates the waiver and all expenditures come from DDS annual appropriation. Private Providers of residential and day services under contract with DDS are required to file annually an Operational Plan and Audited Consolidated Operational Report (ACOR). The audited report is in conformance with generally accepted accounting standards. DDS public expenditures are subject to audit by the State Auditor of Public Accounts. All funding for the waiver is reflected in the CPE. Service bills must be submitted within one year of the date of service and DSS claims in the quarter in which the bill was processed.
On an annual basis, DDS service costs are compiled and allocated within a DDS cost report. DDS calculates waiver replacement rates based on an agreed-upon rate setting methodology. Proposed replacement rates are then submitted to DSS for their review and approval. DDS certifies public expenditures on an annual basis after the fiscal year closes.
42 CFR 433.51 notes that public funds are certified by the contributing public agency as expenditures eligible for FFP and that public funds are not Federal funds. Both of these assertions are correct. The Medicaid Agency (DSS) reviews the DDS cost reports used to determine the Medicaid rates and DSS approves all replacement rates. Cost data is compiled at the end of the fiscal year and submitted to DSS by February 1, following the June 30 fiscal year end. Rates are adjusted typically by March/April following the close of the fiscal year and any rate increases or decreases are processed at that time. Service billing is done on a monthly basis after services are rendered. Interim rates are set by DSS based on costs from a previous fiscal year. Reconciliation of expenditures to cost data is done at the end of the fiscal year, once the costs are finalized. All DDS expenditures are reconciled at the start of the cost review process. It is DDS goal to have completed Cost Profiles to DSS for their review and approval by February 1st following the June 30th close of the fiscal year, and to have replacement rates developed and approved by March 1st. However, at times that timeframe is difficult to meet, with the various priorities in process. Annually rates are replaced with actual cost based replacement rates. DSS does the draw down and funds and the review of payments is conducted in the DSS rate setting unit.
All service units are entered and attested to by the providers. DDS verifies units are authorized through an individual plan covering the services and are Medicaid eligible. As Providers have implemented Electronic Visit Verification, effective 1/1/2021, DDS is able to also verify that services are being delivered.

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

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

Appendix I: Financial Accountability

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

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

(a) Eligibility for waiver services is annotated in the DDS ECAMRIS computer system. This system generates the attendance documents for Medicaid billing and annotates who is eligible for waiver services on the attendance form. The Department of Administrative Services which completes the data entry for billing is also informed of those eligible for waiver services and has access to the CAMRIS system for verification if necessary.
(b) The DDS Audit, Billing and Rate Setting Unit conducts audits of consumer files and compares individual plans with Medicaid billing.
(c) DDS Quality Monitors review billing records during program reviews selected through a random waiver sample. Identified concerns or issues are reported back to the audit unit and region as applicable.
(d) The billing agent (the Department of Administrative Services) and the Medicaid Management Information System performs eligibility matching to ensure that the individual was eligible for the Medicaid waiver on the date of the service billing.

Through the Individual Plan process participants or their guardians are given information on the choices including providers and self direction. DDS maintains a provider list on the website that is updated frequently. The choice is also documented in the Individual Plan and reviewed through the Quality review system.

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

Appendix I: Financial Accountability

I-3: Payment (1 of 7)

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

- (●) ***Payments for all waiver services are made through an approved Medicaid Management Information System (MMIS).***
- ( ) ***Payments for some, but not all, waiver services are made through an approved MMIS.***

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

- ( ) ***Payments for waiver services are not made through an approved MMIS.***

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

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

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

Appendix I: Financial Accountability

I-3: Payment (2 of 7)

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

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

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

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

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

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

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

Appendix I: Financial Accountability

I-3: Payment (3 of 7)

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

○ ***No. The state does not make supplemental or enhanced payments for waiver services.***

◉ ***Yes. The state makes supplemental or enhanced payments for waiver services.***

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

Payment rates and details associated with the ARPA incentives are posted on the DDS website for public access at any time. Due to character count limitations details on supplemental or enhanced payments can be found in Main 8 B- Optional section

Appendix I: Financial Accountability

I-3: Payment (4 of 7)

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

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

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

DDS provides respite services in publicly operated facilities and the state receives FFP for these services.

Appendix I: Financial Accountability

I-3: Payment (5 of 7)

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

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

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

Describe the recoupment process:

Appendix I: Financial Accountability

I-3: Payment (6 of 7)

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

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

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

Appendix I: Financial Accountability

I-3: Payment (7 of 7)

g. Additional Payment Arrangements

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

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

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

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

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

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

iii. Contracts with MCOs, PIHPs or PAHPs.

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

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

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

○ ***This waiver is a part of a concurrent section 1115/section 1915(c) waiver. Participants are required to obtain waiver and other services through a MCO and/or prepaid inpatient health plan (PIHP) or a prepaid ambulatory health plan (PAHP). The section 1115 waiver specifies the types of health plans that are used and how payments to these plans are made.***

○ ***If the state uses more than one of the above contract authorities for the delivery of waiver services, please select this option.***

In the text box below, indicate the contract authorities. In addition, if the state contracts with MCOs, PIHPs, or PAHPs under the provisions of section 1915(a)(1) of the Act to furnish waiver services: Participants may voluntarily elect to receive waiver and other services through such MCOs or prepaid health plans. Contracts with these health plans are on file at the state Medicaid agency. Describe: (a) the MCOs and/or health plans that furnish services under the provisions of section 1915(a)(1); (b) the geographic areas served by these plans; (c) the waiver and other services furnished by these plans; and, (d) how payments are made to the health plans.

Appendix I: Financial Accountability

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

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

☐ ***Appropriation of State Tax Revenues to the State Medicaid Agency***

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

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

(a) The Department of Developmental Services receives a State appropriation and directly expends funds for services provided under this waiver.
(b) The Department of Developmental Services expends funds directly as noted in I-2-c. DDS receives a direct appropriation for services provided under this waiver. DDS provides the services directly, by contracting for services or paying for self directed services through a fiscal intermediary.

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

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

Appendix I: Financial Accountability

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

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

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

Check each that applies:

☐ ***Appropriation of Local Government Revenues.***

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

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

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

Appendix I: Financial Accountability

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

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

- ◉ ***None of the specified sources of funds contribute to the non-federal share of computable waiver costs***
- ○ ***The following source(s) are used***

Check each that applies:

☐ ***Health care-related taxes or fees***

☐ ***Provider-related donations***

☐ ***Federal funds***

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

Appendix I: Financial Accountability

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

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

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

b. Method for Excluding the Cost of Room and Board Furnished in Residential Settings. *The following describes the methodology that the state uses to exclude Medicaid payment for room and board in residential settings:*

The state has several mechanisms to ensure that room and board costs are not included in the request for federal reimbursement for residential supports in the HCBS Waiver.
1. Cost standards have been established for individual support agreements that specifically exclude room and board as allowed costs. These agreements are used to fund services which are self directed and provided in the recipients home. In residential settings the qualified provider has a contract with DDS that requires them to provide DDS with an Annual report that contains a cost report that specifically breaks out room and board costs that are disallowed under the waiver.

2. Each region has a program resource allocation team which reviews applications for the HCBS waiver. These teams ensure that appropriate resources are allocated and through the individual plan and LON(level of need review) ensures that the waiver assurances are met. DDS also uses an extensive Quality Review System to review and remediate.
3. A costing methodology has been established which specifically excludes room and board expenses from the established rates used to request federal reimbursement. As part of the cost reconciliation process, public costs are reviewed to remove all room and board items from the wavier rates. Private costs are also reviewed to ensure that the service costs in the waiver rates do not include room and board. When DDS is allocating funds room and board costs are not included. Vendor authorizations clearly separate out support funding and room and board funding.
4. The DDS Central Office Waiver Unit reviews the waiver application to ensure that all the assurances and waiver enrollment requirements have been met. The waiver unit also verifies the allocation of funding does not include room and board. For Contracted services the Contract system and the vendor authorization is reviewed and for individual budgets each budget is reviewed prior to enrollment to ensure room and board are not included.
5. Room and board is an audit item for DDS auditors conducts onsite and paper reviews are conducted when they review regional program costs. The Audit, Rate Setting and Billing Unit reviews all DDS costs included in the waiver rates. This review includes determining the Other Expense account details to ensure that the room and board costs identified by DSS are not included in the DDS waiver rates.

Appendix I: Financial Accountability

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

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

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

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

Appendix I: Financial Accountability

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

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

- ◉ ***No. The state does not impose a co-payment or similar charge upon participants for waiver services.***
- ○ ***Yes. The state imposes a co-payment or similar charge upon participants for one or more waiver services.***

i. Co-Pay Arrangement.

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

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

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

Specify:

Appendix I: Financial Accountability

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

a. Co-Payment Requirements.

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

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

Appendix I: Financial Accountability

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

a. Co-Payment Requirements.

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

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

Appendix I: Financial Accountability

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

a. Co-Payment Requirements.

iv. Cumulative Maximum Charges.

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

Appendix I: Financial Accountability

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

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

- (●) ***No. The state does not impose a premium, enrollment fee, or similar cost-sharing arrangement on waiver participants.***
- ( ) ***Yes. The state imposes a premium, enrollment fee or similar cost-sharing arrangement.***

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

Appendix J: Cost Neutrality Demonstration

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

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

Level(s) of Care: ICF/IID

Col. 1	Col. 2	Col. 3	Col. 4	Col. 5	Col. 6	Col. 7	Col. 8
Year	Factor D	Factor D'	Total: D+D'	Factor G	Factor G'	Total: G+G'	Difference (Col 7 less Column4)
1	42590.38	10129.88	52720.26	297878.80	3649.14	301527.94	248807.68
2	41022.96	10666.76	51689.72	306815.16	3842.55	310657.71	258967.99
3	39898.99	11232.10	51131.09	316019.62	4046.20	320065.82	268934.73
4	38859.91	11827.40	50687.31	325500.21	4260.65	329760.86	279073.55
5	38006.50	12454.25	50460.75	335265.21	4486.46	339751.67	289290.92

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:
		ICF/IID

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:
		ICF/IID
Year 1	*2491*	*2491*
Year 2	*2703*	*2703*
Year 3	*2915*	*2915*
Year 4	*3127*	*3127*
Year 5	*3339*	*3339*

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 average length of stay is based on the CMS Form 372 for CT.0881 (EDS Waiver) for the most current available waiver year (i.e., 4/1/2018 to 3/31/2019)

Appendix J: Cost Neutrality Demonstration

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

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

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

The estimates of Factor D are based on past utilization of services in the EDS waiver (CT.0881), which were then prorated for estimates of increased enrollment.

Data is based on the latest run 372 report at the time and used to trend the rates for Factors D. Alternative growth rates were used for newer or modified services. Utilization was based on the most recent 372 report, which we believe is the best representation of utilization pattern across services that is available. For the most part, the mix of utilization across services has remained stable. The base utilization was then trended based on the projected trend in overall users, which is expected to remain stable for the next 5 years.

Updates to Environmental Modifications, Vehicle Modifications, PERS and Assistive Technology were based on trends from the Comprehensive and IFS waivers.

The Remote Supports Service Users and Units were based on trends CT is seeing in our population (The demand for supports that do not directly have staff inside a home is rising). The cost is based on the rates we plan to use on Jan 1st if this waiver is approved.

Remote Supports Technology costs is an estimate based on the combination of buying and leasing equipment. Systems can range depending on needs and technological complexity and most systems will have a monthly lease fee.

The inflation factor is based on 2.8% medical inflation.
Source: https://www.hrsa.gov/get-health-care/affordable/hill-burton/cpi.html#:~:text=or%20deficit%20amounts-,The%20change%20in%20the%20CPI%20for%20medical,2018%20and%202019%20is%202.8%25.

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

Factor D' was based on the CMS 372 report for 2019 (i.e., 4/1/2018 to 3/31/2019) and trended forwarded by 5.3% per year. The trend factor was based on the August 2020 Medical Care CPI.

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

Factor D' was based on the CMS 372 report for 2019 (i.e., 4/1/2018 to 3/31/2019) and trended forwarded by 3.00% per year. The trend factor was based on the August 2020 Nursing Home CPI.

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

Factor G' was based on the CMS 372 report for 2019 (i.e., 4/1/2018 to 3/31/2019) and trended forwarded by 5.3% per year. The trend factor was based on the August 2020 Medical Care CPI.

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	
Blended Supports	
Group Day Supports aka Community Based Day Support Options	
Individual Supported Employment	
Prevocational Services	
Respite	
Independent Support Broker	
Peer Support	
Assistive Technology	
Behavioral Support Services	
Customized Employment Supports	
Employment Transitional Services	
Environmental Modifications	
Group Supported Employment	
Home Delivered Meals	
Individual Direct Goods and Services	
Individualized Day Support	
Interpreter	
Personal Emergency Response System (PERS)	
Remote Supports Services	
Specialized Medical Equipment and Supplies	
Training, Counseling and Support Services for Unpaid Caregivers	
Transportation	
Vehicle Modifications	
Virtual Health Consultation	

Appendix J: Cost Neutrality Demonstration

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

d. Estimate of Factor D.

i. Non-Concurrent Waiver.*Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.*

Waiver Year: Year 1

Waiver Service/ Component	*Unit*	*# Users*	*Avg. Units Per User*	*Avg. Cost/ Unit*	*Component Cost*	*Total Cost*
Adult Day Health Total:						***31560.41***
Adult Day Health--Half Day	*Per Half Day*	*1*	*311.66*	*44.04*	***13725.51***	
Adult Day Health	*Per diem*	*2*	*545.41*	*16.35*	***17834.91***	
Blended Supports Total:						***18882.08***
Per 15 Minutes	*Per 15 minutes*	*4*	*366.50*	*12.88*	***18882.08***	
Group Day Supports aka Community Based Day Support Options Total:						***51655460.36***
Per Diem	*Per diem*	*911*	*156.91*	*136.60*	***19526288.37***	
Per half day	*Per half day*	*1*	*313.82*	*68.31*	***21437.04***	
Per 15 minutes	*Per 15 minutes*	*911*	*3614.82*	*9.75*	***32107734.94***	
Individual Supported Employment Total:						***780038.72***
Individual Supported Employment	*Per 15 minutes*	*356*	*359.20*	*6.10*	***780038.72***	
Prevocational Services Total:						***1360434.12***
Per 15 minutes	*Per 15 minutes*	*35*	*3532.60*	*10.81*	***1336559.21***	
Per diem	*Per diem*	*1*	*199.19*	*119.86*	***23874.91***	
Respite Total:						***5666898.53***
Less than 24 hours	*Per 15 minutes*	*81*	*1200.23*	*8.07*	***784554.34***	
Overnight respite	*Per Diem*	*274*	*11.68*	*1525.58*	***4882344.19***	
Independent Support						***75.35***

GRAND TOTAL: 106092627.11

Total Estimated Unduplicated Participants: 2491

Factor D (Divide total by number of participants): 42590.38

Average Length of Stay on the Waiver: *340*

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Broker Total:						
Independent Support Broker	Per 15 minutes	2	2.50	15.07	75.35	
Peer Support Total:						2223.52
Per 15 Minutes	Per 15 minutes	1	208.00	10.69	2223.52	
Assistive Technology Total:						6652.19
Assistive Technology	Per Service	1	1.00	6652.19	6652.19	
Behavioral Support Services Total:						56097.60
Behavioral Support Services	Per 15 minutes	31	56.55	32.00	56097.60	
Customized Employment Supports Total:						56175.83
Per Diem	Per Diem	1	199.19	249.46	49689.94	
Per 15 minutes	Per 15 minutes	1	1294.59	5.01	6485.90	
Employment Transitional Services Total:						3427214.05
Per Diem	Per Diem	1	199.19	119.86	23874.91	
Per 15 minutes	Per 15 minutes	182	3035.66	6.16	3403339.14	
Environmental Modifications Total:						12721.71
Environmental Modifications	Per Service	1	1.00	12721.71	12721.71	
Group Supported Employment Total:						32313373.73
per half day	per half day	1	398.38	59.96	23886.86	
per 15 minutes	Per 15 minutes	590	3794.07	8.56	19161571.13	
per diem	per diem	550	199.19	119.83	13127915.74	
Home Delivered Meals Total:						0.00
Home Delivered Meals	Per Service	100	0.00	8.93	0.00	
Individual Direct Goods and Services Total:						28277.38
Individual Direct Goods and Services					28277.38	

GRAND TOTAL: 106092627.11

Total Estimated Unduplicated Participants: 2491

Factor D (Divide total by number of participants): 42590.38

Average Length of Stay on the Waiver: 340

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
	Per Service	32	12.66	69.80		
Individualized Day Support Total:						**9100280.10**
Per 15 Minutes	Per 15 minutes	601	1926.45	7.86	**9100280.10**	
Interpreter Total:						**149.12**
Interpreter	Per 15 minutes	1	8.00	18.64	**149.12**	
Personal Emergency Response System (PERS) Total:						**509.16**
Personal Emergency Response System (PERS)	Per Month	1	12.00	42.43	**509.16**	
Remote Supports Services Total:						**48234.48**
Passive Per Diem	Per Diem	1	0.00	55.81	**0.00**	
Technology Cost	Per Service	1	3120.00	14.98	**46737.60**	
Per 15 Minute Unit	Per 15 minutes	2	6.00	124.74	**1496.88**	
Specialized Medical Equipment and Supplies Total:						**7663.19**
Specialized Medical Equipment and Supplies	Per Service	15	5.82	87.78	**7663.19**	
Training, Counseling and Support Services for Unpaid Caregivers Total:						**1901.04**
Training, Counseling and Support Services for Unpaid Caregivers	Per Month	1	12.00	158.42	**1901.04**	
Transportation Total:						**1482248.46**
Per trip	Per Trip	916	273.17	1.99	**497945.20**	
Per mile	Per mile	154	1776.29	0.46	**125832.38**	
Per Ticket (Public Transportation)	Per Ticket	334	307.92	8.28	**851558.92**	
Per Pass (Public Transportation)	Per Pass	33	7.24	28.93	**6911.96**	
Vehicle Modifications Total:						**1371.98**
Vehicle					**1371.98**	

GRAND TOTAL: 106092627.11

Total Estimated Unduplicated Participants: 2491

Factor D (Divide total by number of participants): 42590.38

Average Length of Stay on the Waiver: 340

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Modifications	Per Service	1	1.00	1371.98		
Virtual Health Consultation Total:						**34184.00**
Per Service	Per Service	50	4.00	69.61	**13922.00**	
Per Month	Per Month	50	12.00	33.77	**20262.00**	

GRAND TOTAL: 106092627.11

Total Estimated Unduplicated Participants: 2491

Factor D (Divide total by number of participants): 42590.38

Average Length of Stay on the Waiver: 340

Appendix J: Cost Neutrality Demonstration

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

d. Estimate of Factor D.

i. Non-Concurrent Waiver.*Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.*

Waiver Year: Year 2

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Day Health Total:						**32641.88**
Adult Day Health--Half Day	Per Half Day	1	311.66	45.27	**14108.85**	
Adult Day Health	Per diem	2	545.41	16.99	**18533.03**	
Blended Supports Total:						**19615.08**
Per 15 Minutes	Per 15 minutes	4	366.50	13.38	**19615.08**	
Group Day Supports aka Community Based Day Support Options Total:						**53669335.04**
Per Diem	Per diem	911	156.91	141.93	**20288185.27**	
Per half day	Per half day	1	313.82	70.22	**22036.44**	
Per 15 minutes	Per 15 minutes	911	3614.82	10.13	**33359113.33**	
Individual Supported Employment Total:						**810728.77**

GRAND TOTAL: 110885072.41

Total Estimated Unduplicated Participants: 2703

Factor D (Divide total by number of participants): 41022.96

Average Length of Stay on the Waiver: 340

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Individual Supported Employment	Per 15 minutes	356	359.20	6.34	810728.77	
Prevocational Services Total:						1413030.63
Per 15 minutes	Per 15 minutes	35	3532.60	11.23	1388488.43	
Per diem	Per diem	1	199.19	123.21	24542.20	
Respite Total:						5887455.34
Less than 24 hours	Per 15 minutes	81	1200.23	8.38	814692.12	
Overnight respite	Per Diem	274	11.68	1585.08	5072763.23	
Independent Support Broker Total:						78.25
Independent Support Broker	Per 15 minutes	2	2.50	15.65	78.25	
Peer Support Total:						2283.84
Per 15 Minutes	Per 15 min	1	208.00	10.98	2283.84	
Assistive Technology Total:						6838.45
Assistive Technology	Per service	1	1.00	6838.45	6838.45	
Behavioral Support Services Total:						58271.38
Behavioral Support Services	Per 15 minutes	31	56.55	33.24	58271.38	
Customized Employment Supports Total:						57747.42
Per Diem	Per Diem	1	199.19	256.44	51080.28	
Per 15 minutes	Per 15 minutes	1	1294.59	5.15	6667.14	
Employment Transitional Services Total:						3560478.97
Per Diem	Per Diem	1	199.19	123.21	24542.20	
Per 15 minutes	Per 15 minutes	182	3035.66	6.40	3535936.77	
Environmental Modifications Total:						13077.91
Environmental Modifications	Per Service	1	1.00	13077.91	13077.91	

GRAND TOTAL: 110885072.41

Total Estimated Unduplicated Participants: 2703

Factor D (Divide total by number of participants): 41022.96

Average Length of Stay on the Waiver: 340

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Group Supported Employment Total:						**34229447.42**
per half day	per half day	1	398.38	61.63	**24552.16**	
per 15 minutes	Per 15 minutes	590	3794.07	8.89	**19900276.56**	
per diem	per diem	583	199.19	123.18	**14304618.71**	
Home Delivered Meals Total:						**0.00**
Home Delivered Meals	Per Service	100	0.00	9.18	**0.00**	
Individual Direct Goods and Services Total:						**29379.30**
Individual Direct Goods and Services	Per Service	32	12.66	72.52	**29379.30**	
Individualized Day Support Total:						**9459197.00**
Per 15 Minutes	Per 15 minutes	601	1926.45	8.17	**9459197.00**	
Interpreter Total:						**153.28**
Interpreter	Per 15 minutes	1	8.00	19.16	**153.28**	
Personal Emergency Response System (PERS) Total:						**523.32**
Personal Emergency Response System (PERS)	Per Month	1	12.00	43.61	**523.32**	
Remote Supports Services Total:						**49572.00**
Passive Per Diem	Per Diem	1	0.00	57.37	**0.00**	
Technology Cost	Per Service	1	3120.00	15.39	**48016.80**	
Per 15 Minute Unit	Per 15 minutes	2	6.00	129.60	**1555.20**	
Specialized Medical Equipment and Supplies Total:						**8402.22**
Specialized Medical Equipment and Supplies	Per Service	16	5.82	90.23	**8402.22**	
Training, Counseling and Support Services for Unpaid Caregivers Total:						**1954.20**
Training, Counseling and	Per Month		12.00	162.85	**1954.20**	

GRAND TOTAL: 110885072.41

Total Estimated Unduplicated Participants: 2703

Factor D (Divide total by number of participants): 41022.96

Average Length of Stay on the Waiver: 340

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Support Services for Unpaid Caregivers		1				
Transportation Total:						**1538182.31**
Per trip	Per Trip	916	273.17	2.07	**517963.10**	
Per mile	Per mile	154	1776.29	0.47	**128567.87**	
Per Ticket (Public Transportation)	Per Ticket	334	307.92	8.60	**884469.41**	
Per Pass (Public Transportation)	Per Pass	33	7.24	30.06	**7181.94**	
Vehicle Modifications Total:						**1410.39**
Vehicle Modifications	Per Service	1	1.00	1410.39	**1410.39**	
Virtual Health Consultation Total:						**35268.00**
Per Service	Per Service	50	4.00	72.00	**14400.00**	
Per Month	Per Month	50	12.00	34.78	**20868.00**	

GRAND TOTAL: 110885072.41
Total Estimated Unduplicated Participants: 2703
Factor D (Divide total by number of participants): 41022.96
Average Length of Stay on the Waiver: 340

Appendix J: Cost Neutrality Demonstration

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

d. Estimate of Factor D.

i. Non-Concurrent Waiver. *Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.*

Waiver Year: Year 3

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Day Health Total:						**33754.51**
Adult Day Health--Half Day	Per Half Day	1	311.66	46.53	**14501.54**	
Adult Day Health	Per diem	2	545.41	17.65	**19252.97**	

GRAND TOTAL: 116305562.25
Total Estimated Unduplicated Participants: 2915
Factor D (Divide total by number of participants): 39898.99
Average Length of Stay on the Waiver: 340

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Blended Supports Total:						**20392.06**
Per 15 Minutes	Per 15 minutes	4	366.50	13.91	**20392.06**	
Group Day Supports aka Community Based Day Support Options Total:						**55779105.89**
Per Diem	Per diem	911	156.91	147.47	**21080100.62**	
Per half day	Per half day	1	313.82	72.18	**22651.53**	
Per 15 minutes	Per 15 minutes	911	3614.82	10.53	**34676353.74**	
Individual Supported Employment Total:						**841418.82**
Individual Supported Employment	Per 15 minutes	356	359.20	6.58	**841418.82**	
Prevocational Services Total:						**1468117.88**
Per 15 minutes	Per 15 minutes	35	3532.60	11.67	**1442890.47**	
Per diem	Per diem	1	199.19	126.65	**25227.41**	
Respite Total:						**6117381.28**
Less than 24 hours	Per 15 minutes	81	1200.23	8.71	**846774.27**	
Overnight respite	Per Diem	274	11.68	1646.90	**5270607.01**	
Independent Support Broker Total:						**81.30**
Independent Support Broker	Per 15 minutes	2	2.50	16.26	**81.30**	
Peer Support Total:						**2346.24**
Per 15 Minutes	Per 15 minutes	1	208.00	11.28	**2346.24**	
Assistive Technology Total:						**7029.92**
Assistive Technology	Per service	1	1.00	7029.92	**7029.92**	
Behavioral Support Services Total:						**60550.35**
Behavioral Support Services	Per 15 minutes	31	56.55	34.54	**60550.35**	
Customized Employment Supports Total:						**59358.85**

GRAND TOTAL: 116305562.25

Total Estimated Unduplicated Participants: 2915

Factor D (Divide total by number of participants): 39898.99

Average Length of Stay on the Waiver: 340

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Per Diem	Per Diem	1	199.19	263.62	52510.47	
Per 15 minutes	Per 15 minutes	1	1294.59	5.29	6848.38	
Employment Transitional Services Total:						3699286.71
Per Diem	Per Diem	1	199.19	126.65	25227.41	
Per 15 minutes	Per 15 minutes	182	3035.66	6.65	3674059.30	
Environmental Modifications Total:						13444.09
Environmental Modifications	Per Service	1	1.00	13444.09	13444.09	
Group Supported Employment Total:						36245395.07
per half day	per half day	1	398.38	63.35	25237.37	
per 15 minutes	Per 15 minutes	590	3794.07	9.24	20683752.01	
per diem	per diem	616	199.19	126.62	15536405.68	
Home Delivered Meals Total:						377200.00
Home Delivered Meals	Per Service	100	400.00	9.43	377200.00	
Individual Direct Goods and Services Total:						30525.79
Individual Direct Goods and Services	Per Service	32	12.66	75.35	30525.79	
Individualized Day Support Total:						9829691.86
Per 15 Minutes	Per 15 minutes	601	1926.45	8.49	9829691.86	
Interpreter Total:						157.52
Interpreter	Per 15 minutes	1	8.00	19.69	157.52	
Personal Emergency Response System (PERS) Total:						537.96
Personal Emergency Response System (PERS)	Per Month	1	12.00	44.83	537.96	
Remote Supports Services Total:						71908.67
Passive Per Diem					20934.35	

GRAND TOTAL: 116305562.25

Total Estimated Unduplicated Participants: 2915

Factor D (Divide total by number of participants): 39898.99

Average Length of Stay on the Waiver: 340

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
	Per Diem	1	355.00	58.97		
Technology Cost	Per Service	1	3120.00	15.82	49358.40	
Per 15 Minute Unit	Per 15 minutes	2	6.00	134.66	1615.92	
Specialized Medical Equipment and Supplies Total:						9176.68
Specialized Medical Equipment and Supplies	Per Service	17	5.82	92.75	9176.68	
Training, Counseling and Support Services for Unpaid Caregivers Total:						2008.80
Training, Counseling and Support Services for Unpaid Caregivers	Per Month	1	12.00	167.40	2008.80	
Transportation Total:						1598918.12
Per trip	Per Trip	916	273.17	2.15	537981.00	
Per mile	Per mile	154	1776.29	0.49	134038.84	
Per Ticket (Public Transportation)	Per Ticket	334	307.92	8.94	919436.80	
Per Pass (Public Transportation)	Per Pass	33	7.24	31.23	7461.47	
Vehicle Modifications Total:						1449.88
Vehicle Modifications	Per Service	1	1.00	1449.88	1449.88	
Virtual Health Consultation Total:						36324.00
Per Service	Per Service	50	4.00	74.16	14832.00	
Per Month	Per Month	50	12.00	35.82	21492.00	

GRAND TOTAL: 116305562.25

Total Estimated Unduplicated Participants: 2915

Factor D (Divide total by number of participants): 39898.99

Average Length of Stay on the Waiver: 340

Appendix J: Cost Neutrality Demonstration

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

d. Estimate of Factor D.

i. Non-Concurrent Waiver. *Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.*

Waiver Year: Year 4

Waiver Service/ Component	*Unit*	*# Users*	*Avg. Units Per User*	*Avg. Cost/ Unit*	*Component Cost*	*Total Cost*
Adult Day Health Total:						***34912.34***
Adult Day Health--Half Day	*Per Half Day*	*1*	*311.66*	*47.83*	***14906.70***	
Adult Day Health	*Per diem*	*2*	*545.41*	*18.34*	***20005.64***	
Blended Supports Total:						***21183.70***
Per 15 Minutes	*Per 15 minutes*	*4*	*366.50*	*14.45*	***21183.70***	
Group Day Supports aka Community Based Day Support Options Total:						***57951845.03***
Per Diem	*Per diem*	*911*	*156.91*	*153.22*	***21902034.43***	
Per half day	*Per half day*	*1*	*313.82*	*74.20*	***23285.44***	
Per 15 minutes	*Per 15 minutes*	*911*	*3614.82*	*10.94*	***36026525.16***	
Individual Supported Employment Total:						***874666.37***
Individual Supported Employment	*Per 15 minutes*	*356*	*359.20*	*6.84*	***874666.37***	
Prevocational Services Total:						***1524461.47***
Per 15 minutes	*Per 15 minutes*	*35*	*3532.60*	*12.12*	***1498528.92***	
Per diem	*Per diem*	*1*	*199.19*	*130.19*	***25932.55***	
Respite Total:						***6355992.16***
Less than 24 hours	*Per 15 minutes*	*81*	*1200.23*	*9.05*	***879828.60***	
Overnight respite	*Per Diem*	*274*	*11.68*	*1711.13*	***5476163.56***	
Independent Support Broker Total:						***84.50***
Independent Support Broker	*Per 15 minutes*	*2*	*2.50*	*16.90*	***84.50***	
Peer Support Total:						***2410.72***
Per 15 Minutes	*Per 15 minutes*	*1*	*208.00*	*11.59*	***2410.72***	
Assistive Technology Total:						***7226.75***
Assistive					***7226.75***	

GRAND TOTAL: 121514925.07

Total Estimated Unduplicated Participants: 3127

Factor D (Divide total by number of participants): 38859.91

Average Length of Stay on the Waiver: *340*

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Technology	Per service	1	1.00	7226.75		
Behavioral Support Services Total:						**62916.96**
Behavioral Support Services	Per 15 minutes	31	56.55	35.89	**62916.96**	
Customized Employment Supports Total:						**61010.11**
Per Diem	Per Diem	1	199.19	271.00	**53980.49**	
Per 15 minutes	Per 15 minutes	1	1294.59	5.43	**7029.62**	
Employment Transitional Services Total:						**3843639.28**
Per Diem	Per Diem	1	199.19	130.19	**25932.55**	
Per 15 minutes	Per 15 minutes	182	3035.66	6.91	**3817706.73**	
Environmental Modifications Total:						**13820.52**
Environmental Modifications	Per Service	1	1.00	13820.52	**13820.52**	
Group Supported Employment Total:						**38341899.18**
per half day	per half day	1	398.38	65.12	**25942.51**	
per 15 minutes	Per 15 minutes	590	3794.07	9.60	**21489612.48**	
per diem	per diem	649	199.19	130.16	**16826344.19**	
Home Delivered Meals Total:						**387600.00**
Home Delivered Meals	Per Service	100	400.00	9.69	**387600.00**	
Individual Direct Goods and Services Total:						**31716.84**
Individual Direct Goods and Services	Per Service	32	12.66	78.29	**31716.84**	
Individualized Day Support Total:						**10211764.69**
Per 15 Minutes	Per 15 minutes	601	1926.45	8.82	**10211764.69**	
Interpreter Total:						**161.92**
Interpreter	Per 15 minutes	1	8.00	20.24	**161.92**	

GRAND TOTAL: 121514925.07

Total Estimated Unduplicated Participants: 3127

Factor D (Divide total by number of participants): 38859.91

Average Length of Stay on the Waiver: 340

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Personal Emergency Response System (PERS) Total:						**552.96**
Personal Emergency Response System (PERS)	Per Month	1	12.00	46.08	**552.96**	
Remote Supports Services Total:						**73930.22**
Passive Per Diem	Per Diem	1	355.00	60.62	**21520.10**	
Technology Cost	Per Service	1	3120.00	16.26	**50731.20**	
Per 15 Minute Unit	Per 15 minutes	2	6.00	139.91	**1678.92**	
Specialized Medical Equipment and Supplies Total:						**9987.82**
Specialized Medical Equipment and Supplies	Per Service	18	5.82	95.34	**9987.82**	
Training, Counseling and Support Services for Unpaid Caregivers Total:						**2064.96**
Training, Counseling and Support Services for Unpaid Caregivers	Per Month	1	12.00	172.08	**2064.96**	
Transportation Total:						**1662168.10**
Per trip	Per Trip	916	273.17	2.24	**560501.13**	
Per mile	Per mile	154	1776.29	0.51	**139509.82**	
Per Ticket (Public Transportation)	Per Ticket	334	307.92	9.28	**954404.20**	
Per Pass (Public Transportation)	Per Pass	33	7.24	32.45	**7752.95**	
Vehicle Modifications Total:						**1490.47**
Vehicle Modifications	Per Service	1	1.00	1490.47	**1490.47**	
Virtual Health Consultation Total:						**37418.00**
Per Service	Per Service	50	4.00	76.39	**15278.00**	
Per Month	Per Month	50	12.00	36.90	**22140.00**	

GRAND TOTAL: 121514925.07

Total Estimated Unduplicated Participants: 3127

Factor D (Divide total by number of participants): 38859.91

Average Length of Stay on the Waiver: 340

Appendix J: Cost Neutrality Demonstration

d. Estimate of Factor D.

i. Non-Concurrent Waiver. *Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.*

Waiver Year: Year 5

Waiver Service/ Component	*Unit*	*# Users*	*Avg. Units Per User*	*Avg. Cost/ Unit*	*Component Cost*	*Total Cost*
Adult Day Health Total:						***36112.23***
Adult Day Health--Half Day	*Per Half Day*	*1*	*311.66*	*49.16*	***15321.21***	
Adult Day Health	*Per diem*	*2*	*545.41*	*19.06*	***20791.03***	
Blended Supports Total:						***22004.66***
Per 15 Minutes	*Per 15 minutes*	*4*	*366.50*	*15.01*	***22004.66***	
Group Day Supports aka Community Based Day Support Options Total:						***60188978.78***
Per Diem	*Per diem*	*911*	*156.91*	*159.19*	***22755416.14***	
Per half day	*Per half day*	*1*	*313.82*	*76.27*	***23935.05***	
Per 15 minutes	*Per 15 minutes*	*911*	*3614.82*	*11.36*	***37409627.59***	
Individual Supported Employment Total:						***909192.67***
Individual Supported Employment	*Per 15 minutes*	*356*	*359.20*	*7.11*	***909192.67***	
Prevocational Services Total:						***1584534.20***
Per 15 minutes	*Per 15 minutes*	*35*	*3532.60*	*12.60*	***1557876.60***	
Per diem	*Per diem*	*1*	*199.19*	*133.83*	***26657.60***	
Respite Total:						***6603576.04***
Less than 24 hours	*Per 15 minutes*	*81*	*1200.23*	*9.40*	***913855.12***	
Overnight respite	*Per Diem*	*274*	*11.68*	*1777.86*	***5689720.92***	
Independent Support Broker Total:						***87.80***

GRAND TOTAL: ***126903697.37***

Total Estimated Unduplicated Participants: ***3339***

Factor D (Divide total by number of participants): ***38006.50***

Average Length of Stay on the Waiver: *340*

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Independent Support Broker	Per 15 minutes	2	2.50	17.56	87.80	
Peer Support Total:						2477.28
Per 15 Minutes	Per 15 minutes	1	208.00	11.91	2477.28	
Assistive Technology Total:						7429.09
Assistive Technology	Per service	1	1.00	7429.09	7429.09	
Behavioral Support Services Total:						65371.23
Behavioral Support Services	Per 15 minutes	31	56.55	37.29	65371.23	
Customized Employment Supports Total:						62714.16
Per Diem	Per Diem	1	199.19	278.58	55490.35	
Per 15 minutes	Per 15 minutes	1	1294.59	5.58	7223.81	
Employment Transitional Services Total:						3993536.66
Per Diem	Per Diem	1	199.19	133.83	26657.60	
Per 15 minutes	Per 15 minutes	182	3035.66	7.18	3966879.06	
Environmental Modifications Total:						14207.49
Environmental Modifications	Per Service	1	1.00	14207.49	14207.49	
Group Supported Employment Total:						40520931.72
per half day	per half day	1	398.38	66.94	26667.56	
per 15 minutes	Per 15 minutes	590	3794.07	9.97	22317857.96	
per diem	per diem	682	199.19	133.80	18176406.20	
Home Delivered Meals Total:						398400.00
Home Delivered Meals	Per Service	100	400.00	9.96	398400.00	
Individual Direct Goods and Services Total:						32952.46
Individual Direct Goods and Services	Per Service	32	12.66	81.34	32952.46	

GRAND TOTAL: 126903697.37

Total Estimated Unduplicated Participants: 3339

Factor D (Divide total by number of participants): 38006.50

Average Length of Stay on the Waiver: 340

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Individualized Day Support Total:						**10605415.48**
Per 15 Minutes	Per 15 minutes	601	1926.45	9.16	**10605415.48**	
Interpreter Total:						**166.40**
Interpreter	Per 15 minutes	1	8.00	20.80	**166.40**	
Personal Emergency Response System (PERS) Total:						**568.44**
Personal Emergency Response System (PERS)	Per Month	1	12.00	47.37	**568.44**	
Remote Supports Services Total:						**75999.69**
Passive Per Diem	Per Diem	1	355.00	62.31	**22120.05**	
Technology Cost	Per Service	1	3120.00	16.71	**52135.20**	
Per 15 Minute Unit	Per 15 minutes	2	6.00	145.37	**1744.44**	
Specialized Medical Equipment and Supplies Total:						**10836.84**
Specialized Medical Equipment and Supplies	Per Service	19	5.82	98.00	**10836.84**	
Training, Counseling and Support Services for Unpaid Caregivers Total:						**2122.68**
Training, Counseling and Support Services for Unpaid Caregivers	Per Month	1	12.00	176.89	**2122.68**	
Transportation Total:						**1726013.15**
Per trip	Per Trip	916	273.17	2.32	**580519.03**	
Per mile	Per mile	154	1776.29	0.53	**144980.79**	
Per Ticket (Public Transportation)	Per Ticket	334	307.92	9.65	**992456.95**	
Per Pass (Public Transportation)	Per Pass	33	7.24	33.72	**8056.38**	
Vehicle Modifications Total:						**1532.20**
Vehicle Modifications	Per Service	1	1.00	1532.20	**1532.20**	

GRAND TOTAL: 126903697.37

Total Estimated Unduplicated Participants: 3339

Factor D (Divide total by number of participants): 38006.50

Average Length of Stay on the Waiver: 340

Waiver Service/ Component	*Unit*	*# Users*	*Avg. Units Per User*	*Avg. Cost/ Unit*	*Component Cost*	*Total Cost*
Virtual Health Consultation Total:						***38536.00***
Per Service	*Per Service*	*50*	*4.00*	*78.68*	***15736.00***	
Per Month	*Per Month*	*50*	*12.00*	*38.00*	***22800.00***	

GRAND TOTAL: ***126903697.37***

Total Estimated Unduplicated Participants: ***3339***

Factor D (Divide total by number of participants): ***38006.50***

Average Length of Stay on the Waiver: *340*