Application for a §1915 (c) HCBS Waiver

HCBS Waiver Application Version 3.3

Submitted by:

Connecticut Department of Social Services Patricia A. Wilson Coker, JD, MSW Commissioner

Submission Date:	October 6, 2006

CMS Receipt Date *(CMS Use)*	October 6, 2006

Provide a brief one-two sentence description of the request (e.g., renewal of waiver, request for new waiver, amendment):

Brief Description:
This is a request to renew Connecticut's Acquired Brain Injury Waiver. The intent of the waiver is to provide an alternative to institutional care for persons with brain injuries who are at least 18 years of age.

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

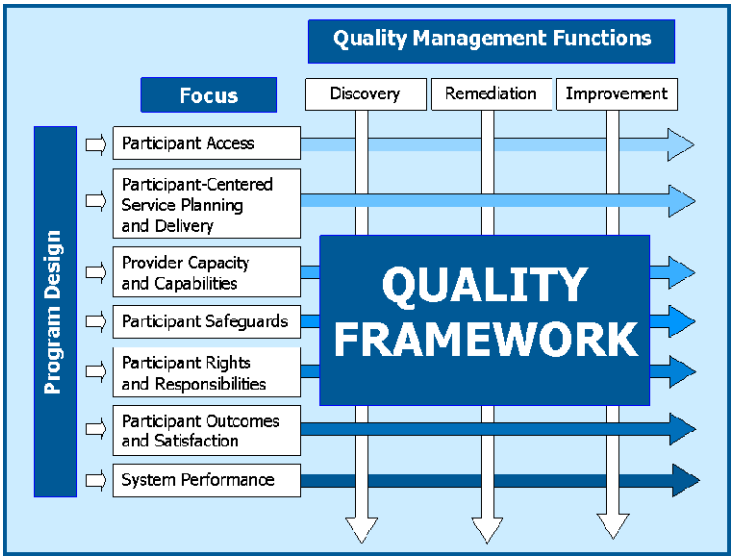
PURPOSE OF THE HCBS WAIVER PROGRAM

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

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

The waiver application is based on the HCBS Quality Framework. The Framework focuses on seven broad, participant-centered desired outcomes for the delivery of waiver services, including assuring participant health and welfare:

- **Participant Access**: *Individuals have access to home and community-based services and supports in their communities.*
- **Participant-Centered Service Planning and Delivery**: *Services and supports are planned and effectively implemented in accordance with each participant's unique needs, expressed preferences and decisions concerning his/her life in the community.*
- **Provider Capacity and Capabilities**: *There are sufficient HCBS providers and they possess and demonstrate the capability to effectively serve participants.*
- **Participant Safeguards**: *Participants are safe and secure in their homes and communities, taking into account their informed and expressed choices.*
- **Participant Rights and Responsibilities**: *Participants receive support to exercise their rights and in accepting personal responsibilities.*
- **Participant Outcomes and Satisfaction**: *Participants are satisfied with their services and achieve desired outcomes.*
- **System Performance**: *The system supports participants efficiently and effectively and constantly strives to improve quality.*



The Framework also stresses the importance of respecting the preferences and autonomy of waiver participants.

The Framework embodies the essential elements for assuring and improving the quality of waiver services: design, discovery, remediation and improvement. The State has flexibility in developing and implementing a Quality Management Strategy to promote the achievement of the desired outcomes expressed in the Quality Framework.

1. Request Information

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

B. Waiver Title (*optional*): CT ABI Waiver

C. Type of Request *(select only one)*:

○	**New Waiver (3 Years)**	CMS-Assigned Waiver Number (*CMS Use*):	
○	**New Waiver (3 Years) to Replace Waiver #** CMS-Assigned Waiver Number (*CMS Use*): *Attachment #1 contains the transition plan to the new waiver.*		
◉	**Renewal (5 Years) of Waiver #**	0302.90	
○	**Amendment to Waiver #**		

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

○	**Model Waiver**. In accordance with 42 CFR §441.305(b), the State assures that no more than 200 individuals will be served in this waiver at any one time.
◉	**Regular Waiver**, as provided in 42 CFR §441.305(a)

E.1 Proposed Effective Date: January 1, 2007

E.2 Approved Effective Date *(CMS Use):* January 1, 2007

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 under age 21 as provided in 42 CFR § 440.160
☒	Nursing Facility *(select applicable level of care)*	
	◉	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:
	◉	Acquired Brain Injury Nursing Facility (ABI/NF) - A type of nursing facility that provides specialized programs for persons with acquired brain injury.
	○	Institution for Mental Disease for persons with mental illnesses aged 65 and older as provided in 42 CFR §440.140
☒	Intermediate Care Facility for the Mentally Retarded (ICF/MR) (as defined in 42 CFR §440.150). If applicable, specify whether the State additionally limits the waiver to subcategories of the ICF/MR facility level of care:	

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

<table>
<tr><td>☐</td><td colspan="4">Services furnished under the provisions of §1915(a) of the Act and described in Appendix I</td></tr>
<tr><td rowspan="2">☐</td><td colspan="4">Waiver(s) authorized under §1915(b) of the Act. Specify the §1915(b) waiver program and indicate whether a §1915(b) waiver application has been submitted or previously approved:</td></tr>
<tr><td colspan="4"></td></tr>
<tr><td rowspan="4"></td><td colspan="4">Specify the §1915(b) authorities under which this program operates (check each that applies):</td></tr>
<tr><td>☐</td><td>§1915(b)(1) (mandated enrollment to managed care)</td><td>☐</td><td>§1915(b)(3) (employ cost savings to furnish additional services)</td></tr>
<tr><td>☐</td><td>§1915(b)(2) (central broker)</td><td>☐</td><td>§1915(b)(4) (selective contracting/limit number of providers)</td></tr>
<tr><td colspan="4"></td></tr>
<tr><td>☐</td><td colspan="4">A program authorized under §1115 of the Act. Specify the program:</td></tr>
<tr><td></td><td colspan="4"></td></tr>
<tr><td>☒</td><td colspan="4">Not applicable</td></tr>
</table>

2. Brief Waiver Description

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

Goals and Objectives

Connecticut's Acquired Brain Injury Waiver (ABI) serves persons who are at least 18 years of age with acquired brain injury who, without such services, would otherwise require placement in one of four types of institutional settings. It is designed to assist participants to relearn, improve or retain the skills needed to support community living. The waiver employs the principles of person-centered planning to develop an adequate, appropriate and cost-effective plan of care from a menu of nineteen home and community-based services to achieve personal outcomes that support the individual's ability to live in his/her community of choice.

Organizational Structure:

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

DSS social workers, in consultation with the consumer, their family and care providers (e.g., skilled nursing/ABI facility staff, primary care physicians, and neuropsychologists) develop plans of care to meet an individual's cognitive, physical, and behavioral support needs. Regional social work supervisors review completed Plans of Care (POC) and forward them to the DSS Central Office manager for further review of eligibility, service adequacy and responsiveness to the waiver participant's needs.

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

Service Delivery

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

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

3. Components of the Waiver Request

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

A. Waiver Administration and Operation. **Appendix A** specifies the administrative and operational structure of this waiver.

B. Participant Access and Eligibility. **Appendix B** specifies the target group(s) of individuals who are served in this waiver, the number of participants that the State expects to serve during each year that the waiver is in effect, applicable Medicaid eligibility and post-eligibility (if applicable) requirements, and procedures for the evaluation and reevaluation of level of care.

C. Participant Services. **Appendix C** specifies the home and community-based waiver services that are furnished through the waiver, including applicable limitations on such services.

D. Participant-Centered Service Planning and Delivery. **Appendix D** specifies the procedures and methods that the State uses to develop, implement and monitor the participant-centered service plan (of care).

E. Participant-Direction of Services. When the State provides for participant direction of services, **Appendix E** specifies the participant direction opportunities that are offered in the waiver and the supports that are available to participants who direct their services. *(Select one)*:

⊙	The waiver provides for participant direction of services. *Appendix E is required*.
○	Not applicable. The waiver does not provide for participant direction of services. *Appendix E is not completed*.

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 Management Strategy. **Appendix H** contains the Quality Management Strategy for this waiver.

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

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

4. Waiver(s) Requested

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

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

○	Yes
○	No
⊙	Not applicable

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

○	**Yes** *(complete remainder of item)*
⊙	**No**

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

5. Assurances

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

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

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

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

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

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

1. Informed of any feasible alternatives under the waiver; and,
2. Given the choice of either institutional or home and community-based waiver services.

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

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

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

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

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

I. Habilitation Services. The State assures that prevocational, educational, or supported employment services, or a combination of these services, if provided as habilitation services under the waiver are: (1) not otherwise available to the individual through a local educational agency under the Individuals with Disabilities Education Improvement Act of 2004 (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) under age 21 when 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 amount, frequency and duration and the type of provider that furnishes each service and (b) the other services (regardless of funding source, including State plan services) and informal supports that complement waiver services in meeting the needs of the participant. The service plan is subject to the approval of the Medicaid agency. Federal financial

participation (FFP) is not claimed for waiver services furnished prior to the development of the service plan or for services that are not included in the service plan.

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

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

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

E. Free Choice of Provider. In accordance with 42 CFR §431.51, a participant may select any willing and qualified provider to furnish waiver services included in the service plan unless the State has received approval to limit the number of providers under the provisions of §1915(b) or another provision of the Act.

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

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

H. Quality Management. 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 Management Strategy specified in **Appendix H**.

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

The development of this waiver renewal included input from the ABI Waiver consumers, family members, non-waiver participants with brain injury, the Independent Living Centers, brain injury providers, DSS social work staff and the Brain Injury Association of Connecticut (BIAC).

- BIAC Provider Council: Provider Comments 03/31/06
- BIAC Council: Advocacy Comments 03/31/06
- DSS Social Work Focus Group: 04/20/2006
- BIAC Consumer Focus Groups: 05/11/2006 and 05/30/2006

- Disabilities Council: 03/08/06

Pursuant to Connecticut General Statutes Section 17b-260a the Commissioner of the Connecticut Department of Social Services was mandated to seek a waiver from federal law to establish a Medicaid-financed, home and community-based program for individuals with acquired brain injury.

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 as 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:

First Name:	Pamela
Last Name	Giannini
Title:	Director, Aging, Community, and Social Work Services
Agency:	Connectiut Department of Social Services
Address 1:	25 Sigourney Street
Address 2:	
City	Hartford
State	CT
Zip Code	06106
Telephone:	860-424-5277
E-mail	Pamela.Giannini@po.state.ct.us
Fax Number	860-424-4957

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

First Name:	n/a
Last Name	
Title:	
Agency:	
Address 1:	
Address 2	
City	

State	
Zip Code	
Telephone:	
E-mail	
Fax Number	

8. Authorizing Signature

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

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

Signature: _____ **Date:**

State Medicaid Director or Designee

First Name:	Patricia
Last Name	Wilson-Coker
Title:	Commissioner
Agency:	Connecticut Department of Social Services
Address 1:	25 Sigourney Street
Address 2:	
City	Hartford
State	CT
Zip Code	06106
Telephone:	860-424-5008
E-mail	Pat.Wilson-Coker@ct.gov
Fax Number	860-424-5129

Attachment #1: Transition Plan

Specify the transition plan for the waiver:

n/a

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; do not complete Item A-2*):
	○ The Medical Assistance Unit *(name of unit)*:
	⊙ Another division/unit within the State Medicaid agency that is separate from the Medical Assistance Unit (name of division/unit) Bureau of Aging, Community and Social Work Services
○	The waiver is operated by a separate agency of the State that is not a division/unit of the Medicaid agency. 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.*

2. Medicaid Agency Oversight of Operating Agency Performance. When the waiver is not operated by the Medicaid agency, 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:

n/a

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

⊙	**Yes.** Contracted entities perform waiver operational and administrative functions on behalf of the Medicaid agency and/or the 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.*
	Provides fiduciary, training, and credentialing services. (See Items A-5 and A-6).
○	**No**. Contracted entities do not perform waiver operational and administrative functions on behalf of the Medicaid agency and/or the operating agency (if applicable).

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 *(check each that applies)*:

☐	**Local/Regional non-state public agencies** conduct waiver operational and administrative functions at the local or regional level. There is an **interagency agreement or memorandum of understanding** between the Medicaid agency and/or the operating agency (when authorized by the Medicaid agency) and each local/regional non-state agency that sets forth the responsibilities and performance requirements of the local/regional agency. The interagency agreement or memorandum of understanding is available through the Medicaid agency or the operating agency (if applicable). *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*:
☒	**Not applicable** – Local/regional non-state agencies do not perform waiver operational and administrative functions.

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

The Department of Social Services (i.e., Bureau of Aging Community and Social Work Service, Medical Operations and Quality Assurance) is responsible for assessing the performance of fiscal intermediary which, performs operational and administrative duties for the ABI Waiver.

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

DSS has a contract with a fiscal intermediary to perform operational/administrative duties. The Department assesses this entity's performance of Waiver functions, which they are responsible for, in an ongoing regular basis, using diverse methods. These methods and frequency of their use are specified below:

1. Quarterly and ad hoc reports from the fiscal intermediary
2. Annual on-site visits to review operational and administrative functions

3. DSS staff attend trainings administered/approved by the fiscal intermediary to assess quality and consistency (2 times annually)
4. DSS staff attend a number of forums to gather information in each area of the state about how the Waiver is functioning. These include but are not limited to the following:
    a. Brain Injury Association of Connecticut support group meetings (1 in each of the Connecticut's 3 geographic regions). Participants: persons with brain injuries (Waiver and non-waiver) and their family members.
    b. Connecticut Council on Persons with Disabilities (bi-monthly). Participants: consumers across the spectrum of disabilities, disability advocates and other state agencies. *Note: last year DSS made a concerted and successful effort to support the recruitment of ABI Waiver participants/families to serve on this legislatively mandated group*.
    c. Provider Council Meetings facilitated by the Brain Injury Association of Connecticut ("BIAC") (bi-monthly). Participants: ABI Waiver Providers
5. Ongoing correspondence between the fiscal intermediary and DSS staff regarding progress on deliverables (e.g., claims processing, training schedules, numbers of credential providers, etc.)
6. A bi-annual survey of waiver participants is issued to consumers, advocates and providers to gauge the functioning of the Waiver, including its fiscal intermediary
7. Participate with DSS on an expected to be established Quality Advisory Board comprised of participants, DSS staff, waiver providers, advocates, family/representatives of persons with brain injury.

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.

Function	Medicaid Agency	Other State Operating Agency	Contracted Entity	Local Non-State Entity
Disseminate information concerning the waiver to potential enrollees	☒	☐	☒	☐
Assist individuals in waiver enrollment	☒	☐	☐	☐
Manage waiver enrollment against approved limits	☒	☐	☐	☐
Monitor waiver expenditures against approved levels	☒	☐	☒	☐
Conduct level of care evaluation activities	☒	☐	☐	☐
Review participant service plans to ensure that waiver requirements are met	☒	☐	☐	☐
Perform prior authorization of waiver services	☒	☐	☒	☐
Conduct utilization management functions	☒	☐	☒	☐
Recruit providers	☒	☐	☒	☐
Execute the Medicaid provider agreement	☒	☐	☒	☐
Determine waiver payment amounts or rates	☒	☐	☐	☐
Conduct training and technical assistance concerning waiver requirements	☒	☐	☒	☐

Appendix B: Participant Access and Eligibility

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

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

Included	Target Group/Subgroup	Minimum Age	Maximum Age	
			Maximum Age Limit: Through age –	No Maximum Age Limit
○	**Aged or Disabled, or Both**			
☐	Aged (age 65 and older)			☐
☒	Disabled (Physical) (under age 65)	18	None*	
☒	Disabled (Other) (under age 65)	18	None*	
	Specific Aged/Disabled Subgroup			
☒	Brain Injury	18	None*	☐
☐	HIV/AIDS			☐
☐	Medically Fragile			☐
☐	Technology Dependent			☐
○	**Mental Retardation or Developmental Disability, or Both**			
☐	Autism			☐
☐	Developmental Disability			☐
☐	Mental Retardation			☐
○	**Mental Illness**			
☐	Mental Illness (age 18 and older)			☐
☐	Serious Emotional Disturbance (under age 18)			

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

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

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

1. The individual must have an Acquired Brain Injury, which is defined as any combination of focal and diffuse central nervous system dysfunctions, both immediate and/or delayed, at the brain stem level or above. These dysfunctions may be acquired through the interaction of any external forces and the body, as well as through oxygen deprivation, infection, toxicity, surgery and vascular disorders not associated with aging. These disorders are not developmental or degenerative.
2. The individual must meet the level of care criteria;
3. The individual must be able to participate in the development of a service plan that offers an

alternative to institutionalization. Note: This provision allows for this role to be fulfilled by a conservator for applicants who have been deemed incapable of managing their own affairs; and

4. The total cost of the individual's service plan, does not exceed 200% of the state's projected expenditure if the individual had been placed in or remained in institutional care.

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—for Waiver Participants
○	**The following transition planning procedures are employed for participants who will reach the waiver's maximum age limit (*specify*):**

Appendix B-2: Individual Cost Limit

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)*:

○	**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)*:
◉	**200** %, a level higher than 100% of the institutional average * This limit is used for waiver entrance as well as ongoing participation.
○	Other *(specify)*:
○	**Institutional Cost Limit**. Pursuant to 42 CFR 441.301(a)(3), the State refuses entrance to the waiver to any otherwise eligible individual when the State reasonably expects that the cost of the home and community-based services furnished to that individual would exceed 100% of the cost of the level of care specified for the waiver. *Complete Items B-2-b and B-2-c.*
○	**Cost Limit Lower Than Institutional Costs**. The State refuses entrance to the waiver to any otherwise qualified individual when the State reasonably expects that the cost of home and community-based services furnished to that individual would exceed the following amount specified by the State that is less than the cost of a level of care specified for the waiver. *Specify the basis of the limit, including evidence that the limit is sufficient to assure the health and welfare of waiver participants. Complete Items B-2-b and B-2-c.*
	The cost limit specified by the State is *(select one)*:
○	The following dollar amount: $
	The dollar amount *(select one)*:
○	Is adjusted each year that the waiver is in effect by applying the following 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: %
○	Other – *Specify:*

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

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

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

☐	The participant is referred to another waiver that can accommodate the individual's needs.
☒	Additional services in excess of the individual cost limit may be authorized. Specify the procedures for authorizing additional services, including the amount that may be authorized:
	When a consumer's Level Of Care (LOC) is thought to be inappropriate, DSS social work staff reassesses that individual, with oversight by the Department's ABI Waiver Manager and a neuropsychologist to ensure that all necessary factors have been considered in assigning the care level. If a situation arises where a consumer has been assigned to a LOC that is too low, but within waiver standards, that consumer is assigned to a higher level and their care plan is appropriately adapted. If the services cannot be accommodated within an appropriate LOC it is determined that a client does not qualify for services under the ABI waiver. If a subsequent service reduction or termination is indicated, the client receives, as noted above, a NOA that sets forth the proposed denial/change. Clients are afforded the opportunity for a Fair Hearing in accordance with Departmental Medicaid Policy. Service cannot be reduced until the hearing decision is issued if a client requests a hearing within 10 days of the date of the NOA.
☐	Other safeguard(s) *(specify)*:

Appendix B-3: Number of Individuals Served

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	369
Year 2	369
Year 3	369
Year 4 (renewal only)	369
Year 5 (renewal only)	369

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

⊙	The State does not limit the number of participants that it serves at any point in time during a waiver year.
○	The State limits the number of participants that it serves at any point in time during a waiver year. The limit that applies to each year of the waiver period is specified in the following table:

Table B-3-b	
Waiver Year	Maximum Number of Participants Served At Any Point During the Year
Year 1	
Year 2	
Year 3	
Year 4 (renewal only)	
Year 5 (renewal only)	

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). For each purpose, describe how the amount of reserved capacity was determined:
	The capacity that the State reserves in each waiver year is specified in the following table:

Table B-3-c

Waiver Year	Purpose:	Purpose:
	Capacity Reserved	Capacity Reserved
Year 1		
Year 2		
Year 3		
Year 4 (renewal only)		
Year 5 (renewal only)		

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

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

e. Allocation of Waiver Capacity. *Select one:*

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

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

A recipient of medical assistance benefits who applies for coverage of acquired brain injury services and applicants for acquired brain injury services shall meet all requirements for eligibility in the

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

Waiting List:

If an individual applies for ABI waiver services at a time when the participant cap has been reached, his or her application shall be reviewed and processed for financial eligibility and fulfillment of the level of care criteria. An otherwise eligible individual who is denied solely because of the program quota shall be placed on the Department's waiting list for the ABI program.

1. Individuals who are eligible to be placed on the waiting list include:
    a) those whose service plans have been reviewed but exceed the aggregate cap;
    b) those whose service plans would cause the Department to exceed the funding limit; and
    c) those who are denied solely due to program quotas.

2. Individuals on the waiting list shall be considered in the order of the completion of their service plans. In the event that there are limited program funds, individuals shall be prioritized based on their date of request for waiver services (i.e., first come first serve), which shall be the date the Department receives the individual's Waiver Request Form. An individual may be passed over on the waiting list if the plan exceeds the aggregate cap, or causes the program to exceed funding limitations; however, the individual shall retain his/her place on the waiting list and shall be reconsidered every time there is a program vacancy.

3. An individual shall be removed from the waiting list if:
    a) the applicant asks to be removed; or
    b) the applicant moves out of state; or
    c) the applicant reaches age 65; or
    d) he or she dies; or
    e) his or her condition has changed and they no longer meet the financial or clinical criteria for the program.

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

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

Attachment #1 to Appendix B-3

Waiver Phase-In/Phase Out Schedule

a. The waiver is being *(select one)*:

○	Phased-in
○	Phased-out

b. **Waiver Years Subject to Phase-In/Phase-Out Schedule** *(check each that applies)*:

Year One	Year Two	Year Three	Year Four	Your Five
☐	☐	☐	☐	☐

c. **Phase-In/Phase-Out Time Period**. *Complete the following table:*

	Month	Waiver Year
Waiver Year: First Calendar Month		
Phase-in/Phase out begins		
Phase-in/Phase out ends		

d. **Phase-In or Phase-Out Schedule**. *Complete the following table:*

Phase-In or Phase-Out Schedule			
	Waiver Year:		
Month	Base Number of Participants	Change in Number of Participants	Participant Limit

Appendix B-4: Medicaid Eligibility Groups Served in the Waiver

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

○	§1634 State
○	SSI Criteria State
X	209(b) State

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

Eligibility Groups Served in the Waiver (excluding the special home and community-based waiver group under 42 CFR §435.217)			
☐	Low income families with children as provided in §1931 of the Act		
☐	SSI recipients		
X	Aged, blind or disabled in 209(b) states who are eligible under 42 CFR §435.121		
X	Optional State supplement recipients		
☐	Optional categorically needy aged and/or disabled individuals who have income at: *(select one)*		
	○	100% of the Federal poverty level (FPL)	
	○	%	of FPL, which is lower than 100% of FPL
X	Working individuals with disabilities who buy into Medicaid (BBA working disabled group as provided in §1902(a)(10)(A)(ii)(XIII)) of the Act)		
X	Working individuals with disabilities who buy into Medicaid (TWWIIA Basic Coverage Group as provided in §1902(a)(10)(A)(ii)(XV) of the Act)		
☐	Working individuals with disabilities who buy into Medicaid (TWWIIA Medical Improvement Coverage Group as provided in §1902(a)(10)(A)(ii)(XVI) of the Act)		
☐	Disabled individuals age 18 or younger who would require an institutional level of care (TEFRA 134 eligibility group as provided in §1902(e)(3) of the Act)		
☐	Medically needy		
X	Other specified groups (include only the statutory/regulatory reference to reflect the additional groups in the State plan that may receive services under this waiver) *specify*: Persons defined as qualified severely impaired individuals in section 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				
X	Only the following groups of individuals in the special home and community-based waiver group under 42 CFR §435.217 *(check each that applies)*:				
	X	A special income level equal to (select one):			
		X	300% of the SSI Federal Benefit Rate (FBR)		
		○	%	of FBR, which is lower than 300% (42 CFR §435.236)	
		○	$	which is lower than 300%	
	☐	Aged, blind and disabled individuals who meet requirements that are more restrictive than the SSI program (42 CFR §435.121)			
	☐	Medically needy without spenddown in States which also provide Medicaid to recipients of SSI (42 CFR §435.320, §435.322 and §435.324)			
	☐	Medically needy without spend down in 209(b) States (42 CFR §435.330)			
	☐	Aged and disabled individuals who have income at: *(select one)*			
		○	100% of FPL		
		○	%	of FPL, which is lower than 100%	
	☐	Other specified groups (include only the statutory/regulatory reference to reflect the additional groups in the State plan that may receive services under this waiver) *specify*:			

Appendix B-5: Post-Eligibility Treatment of Income

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

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

⊙	Spousal impoverishment rules under §1924 of the Act are used to determine the eligibility of individuals with a community spouse for the special home and community-based waiver group. In the case of a participant with a community spouse, the State elects to (*select one*):
⊙	Use *spousal* post-eligibility rules under §1924 of the Act. *Complete ItemsB-5-b-2 (SSI State) or B-5-c-2 (209b State) and Item B-5-d.*
○	Use *regular* post-eligibility rules under 42 CFR §435.726 (SSI State) (*Complete Item B-5-b-1*) or under §435.735 (209b State) (*Complete Item B-5-c-1). Do not complete Item B-5-d.*
○	Spousal impoverishment rules under §1924 of the Act are not used to determine eligibility of individuals with a community spouse for the special home and community-based waiver group. The State uses regular post-eligibility rules for individuals with a community spouse. *Complete Item B-5-c-1 (SSI State) or Item B-5-d-1 (209b State). Do not complete Item B-5-d.*

NOTE: Items B-5-b-1 and B-5-c-1 are for use by states that do not use spousal eligibility rules or use spousal impoverishment eligibility rules but elect to use regular post-eligibility rules.

b-1. Regular Post-Eligibility Treatment of Income: SSI State. The State uses the post-eligibility rules at 42 CFR §435.726. Payment for home and community-based waiver services is reduced by the amount remaining after deducting the following allowances 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)*			
○	SSI standard			
○	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)			
○	%	of the FBR, which is less than 300%		
○	$	which is less than 300%.		
○	%	of the Federal poverty level		
○	Other (specify):			
○	The following dollar amount:	$	If this amount changes, this item will be revised.	

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

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

○	SSI standard		
○	Optional State supplement standard		
○	Medically needy income standard		
○	The following dollar amount:	$	If this amount changes, this item will be revised.
○	The amount is determined using the following formula:		
○	Not applicable *(see instructions)*		

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

○	AFDC need standard		
○	Medically needy income standard		
○	The following 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:		
○	Other (specify):		
○	Not applicable (see instructions)		

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

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

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

○	The State does not establish reasonable limits.
○	The State establishes the following reasonable limits *(specify)*:

c-1. Regular Post-Eligibility: 209(b) State. The State uses more restrictive eligibility requirements than SSI and uses the post-eligibility rules at 42 CFR §435.735. 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:
    - ○ 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)
      - ○ % of the FBR, which is less than 300%
      - ○ $ which is less than 300% of the FBR
    - ○ % of the Federal poverty level
    - ○ Other (specify):
- ○ The following dollar amount: $ If this amount changes, this item will be revised.
- ○ The following formula is used to determine the needs allowance:

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

- ○ The following standard under 42 CFR §435.121
- ○ Optional State supplement standard
- ○ Medically needy income standard
- ○ The following dollar amount: $ If this amount changes, this item will be revised.
- ○ The amount is determined using the following formula:
- ○ Not applicable *(see instructions)*

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

- ○ AFDC need standard
- ○ Medically needy income standard

○	The following 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:
○	Other (specify):
○	Not applicable (see instructions)

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:*

○	The State does not establish reasonable limits.
○	The State establishes the following reasonable limits *(specify)*:

NOTE: Items B-5-c-2 and B-5-d-2 are for use by states that use spousal impoverishment eligibility rules *and* elect to apply the spousal post eligibility rules.

b-2. Regular Post-Eligibility Treatment of Income: SSI State. The State uses the post-eligibility rules at 42 CFR §435.726 for individuals who do not have a spouse or have a spouse who is not a community spouse as specified in §1924 of the Act. Payment for home and community-based waiver services is reduced by the amount remaining after deducting the following allowances 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)*
  - ○ SSI standard
  - ○ 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)
    - ○ ____ % of the FBR, which is less than 300%
    - ○ $ ____ which is less than 300%.
  - ○ ____ % of the Federal poverty level
  - ○ Other (specify):
- ○ The following dollar amount: $ ____ If this amount changes, this item will be revised.
- ○ The following formula is used to determine the needs allowance:

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

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

  Specify the amount of the allowance:
  - ○ SSI standard
  - ○ Optional State supplement standard
  - ○ Medically needy income standard
  - ○ The following dollar amount: $ ____ If this amount changes, this item will be revised.
  - ○ The amount is determined using the following formula:
- ○ Not applicable

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

○	AFDC need standard
○	Medically needy income standard
○	The following 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:
○	Other (specify):
○	Not applicable (see instructions)

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

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

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

○	The State does not establish reasonable limits.
○	The State establishes the following reasonable limits *(specify)*:

c-2. Regular Post-Eligibility: 209(b) State. The State uses more restrictive eligibility requirements than SSI and uses the post-eligibility rules at 42 CFR §435.735 for individuals who do not have a spouse or have a spouse who is not a community spouse as specified in §1924 of the Act. Payment for home and community-based waiver services is reduced by the amount remaining after deducting the following amounts and expenses from the waiver participant's income:

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

⊙	The following standard included under the State plan *(select one)*			
	○	The following standard under 42 CFR §435.121:		
	○	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)	
		○	%	of the FBR, which is less than 300%
		○	$	which is less than 300% of the FBR
	○			of the Federal poverty level

	○	Other (specify):	
○	The following dollar amount:	$	If this amount changes, this item will be revised.
⊙	The following formula is used to determine the needs allowance:		
	200 percent of the Federal Poverty Level		

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

○	The state provides an allowance for a spouse who does not meet the definition of a community spouse in §1924 of the Act. Describe the circumstances under which this allowance is provided:		
	Specify the amount of the allowance:		
	○	The following standard under 42 CFR §435.121:	
	○	Optional State supplement standard	
	○	Medically needy income standard	
	○	The following dollar amount:	$ If this amount changes, this item will be revised.
	○	The amount is determined using the following formula:	
⊙	Not applicable		

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

○	AFDC need standard		
⊙	Medically needy income standard		
○	The following 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:		
○	Other (specify):		
○	Not applicable (see instructions)		

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:*

⊙	The State does not establish reasonable limits.
○	The State establishes the following reasonable limits *(specify)*:

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

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

i. <u>Allowance for the personal needs of the waiver participant</u> *(select one)***:**			
○	SSI Standard		
○	Optional State Supplement standard		
○	Medically Needy Income Standard		
○	The special income level for institutionalized persons		
⊙	200 %	of the Federal Poverty Level	
○	The following dollar amount:	$	If this amount changes, this item will be revised
○	The following formula is used to determine the needs allowance:		
○	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 section 1902(r)(1) of the Act:
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:*

⊙	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-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 waiver 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 *(insert number):*	
	2	
ii.	**Frequency of services**. The State requires *(select one)*:	
	⊙	The provision of waiver services at least monthly
	○	Monthly monitoring of the individual when services are furnished on a less than monthly basis. If the State also requires a minimum frequency for the provision of waiver services other than monthly (e.g., quarterly), specify the frequency:

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

⊙	Directly by the Medicaid agency
○	By the operating agency specified in Appendix A
○	By an entity under contract with the Medicaid agency. *Specify the entity*:
○	Other (*specify*):

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

The Connecticut Department of Social Services' social workers will provide for an evaluation of the need or level(s) of care in collaboration with a neuropsychologist who is familiar with the participant. Other qualified individuals will join the interdisciplinary team as appropriate.

Social Worker Qualifications: A Master's degree in social work or a closely related field or a Bachelor's degree in social work or a closely related field and two (2) years of experience in the self directed use of case management techniques and counseling to sustain or restore client functioning or a Bachelor's degree and three (3) years of experience in the self directed use of case management techniques and counseling to sustain or restore client functioning. Substitution Allowed: For state employees successful completion of the Social Worker Trainee

program may be substituted for the General Experience.

Neuropsychologist Qualifications: Licensure by the Connecticut Department of Public Health pursuant to Connecticut General Statutes Sections. 20-186 to 20-195

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

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

As a means to guide this level of care assessment, Connecticut Department of Social Services utilizes form W-1034 "Level of Care Determination: PCA and ABI Waiver Programs" in accordance with, Connecticut General Statutes17b-260a-1, Connecticut Department of Social Services pending regulations and the Connecticut Department of Social Services Acquired Brain Injury Desk Guide.

Level of Care Criteria:

1. Category I (NF) - The individual is considered to require care in a nursing facility (NF) if he or she resides in such a facility, or has impaired cognition and, due to physical or cognitive deficits, requires physical assistance, supervision or cueing with two or more activities of daily living. Activities of daily living (ADLs) include eating, bathing, dressing, toileting and transfers.

2. Category II (ABI/NF) - The individual is considered to require care in an acquired brain injury nursing facility (ABI/NF) if he or she resides in such a facility, or has impaired cognition, impaired behavior requiring daily supervision or cueing, and a mental illness which manifested itself before the brain injury occurred.

3. Category III (ICF/MR) - The individual is considered to require care in an intermediate care facility for mentally retarded or developmentally disabled persons (ICF/MR) if he or she resides in such a facility, or has impaired cognition, an acquired brain injury that occurred before the age of 22 and, due to physical deficits, requires physical assistance, with two or more ADLs.

4. Category IV (CDH) - The individual is considered to require care in a chronic disease hospital (CDH) if he or she resides in such a facility, or has impaired cognition, impaired behavior and, due to physical or cognitive deficits, requires physical assistance, supervision or cueing with two or more ADLs.

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

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

○	The same instrument is used in determining the level of care for the waiver and for institutional care under the State Plan.

⊙	A different instrument is used to determine the level of care for the waiver than for institutional care under the State plan. Describe how and why this instrument differs from the form used to evaluate institutional level of care and explain how the outcome of the determination is reliable, valid, and fully comparable.

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

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

The Assessment for ABI Waiver utilizes a more structured assessment tool because it is administered by social workers. The instrument utilized for the Acquired Brain Injury Waiver differs from the standard form used for institutional care but yields reliable results as it is based on the outcome of the DSS Assessment for Adult Community Based Services, PCA or ABI Waiver Services (Form W-953). This document provides the framework to assesses the following;

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

Workers then use the Level of Care Determination Form (Form W-1034) to assign a level of care. This form addresses Activities of Daily Living (ADL's) and the data gathered for the assessment, and the results of a neuropsychological to select a level of care that are defined on the assessment form for easy reference. The social worker supervisor and then the ABI Program manager then review these results for final approval.

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

For the purposes of determining level of care, a Department of Social Services Social Worker makes an evaluation of each applicant. Information gathered for the evaluation/revaluation of care is derived from face to face interviews and includes a thorough evaluation of the client's individual circumstances. The level of care determination form (W-1034) is used to summarize this information and confirm level of care. The reevaluation process is the same as the evaluation process.

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*):

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. The qualifications of individuals who perform reevaluations are *(specify)*:

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

Reevaluations are an administrative component performed by DSS social workers. DSS utilizes an electronic case management system in which care plan review dates are logged. The system has a tickler feature that allows it to prompt workers when care plans are due. Through this case management system, queries can be conducted to ensure that reviews are happening in a timely manner. Also, in meetings with social work supervisory staff (typically in November/December meetings) review date projection reports are distributed to track for the upcoming waiver year, as a back-up to the case management database. In monthly supervision with social workers, supervisors are required to track progress on plan of care reviews.

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 §74.53. Specify the location(s) where records of evaluations and reevaluations of level of care are maintained:

Written copies of the care plan evaluations and reevaluation documents are maintained by the Department of Social Services' Social Worker at the regional office in conformance with 42 CFR §441.303(c)(3) and 45 CFR §74.53. The DSS case management database also retains an electronic record of the performance of evaluations and reevaluations. As a back-up the fiscal intermediary maintains copies of approved care plans.

Appendix B-7: Freedom of Choice

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

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

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

At the time of screening for eligibility to participate in this waiver, the social worker informs the potential participant of his or her option of receiving services in a long-term care institution or through this waiver. The individual is also advised of his/her right to a Fair Hearing. This is documented on the (form W-1035) "Freedom of Choice/Fair Hearing Notification". This form is maintained by the social worker in the participant's case file.

b. Maintenance of Forms. Per 45 CFR §74.53, written copies or electronically retrievable facsimiles of Freedom of Choice forms are maintained for a minimum of three years. Specify the locations where copies of these forms are maintained.

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

Appendix B-8: Access to Services by Limited English Proficient Persons

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

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

Appendix C: Participant Services

Appendix C-1: Summary of Services Covered

a. Waiver Services Summary. Appendix C-3 sets forth the specifications for each service that is offered under this waiver. *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:*

Statutory Services *(check each that applies)*		
Service	Included	Alternate Service Title (if any)
Case Management	☒	
Homemaker	☒	
Home Health Aide	☐	
Personal Care	☒	
Adult Day Health	☐	
Habilitation	☐	
Residential Habilitation	☐	
Day Habilitation	☐	
Expanded Habilitation Services as provided in 42 CFR §440.180(c):		
Prevocational Services	☒	
Supported Employment	☒	
Education	☐	
Respite	☒	
Day Treatment	☐	
Partial Hospitalization	☐	
Psychosocial Rehabilitation	☐	
Clinic Services	☐	
Live-in Caregiver (42 CFR §441.303(f)(8))	☐	

Other Services *(select one)*	
○	Not applicable
⊙	As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional services not specified in statute *(list each service by title)*:
a.	Community Living Support Services
b.	Home Delivered Meals

c.	Independent Living Skill Training
d.	Cognitive Behavioral Programs
e.	Substance Abuse Programs
f.	Transitional Living Services
g.	Vehicle Modifications
h.	Chore Services
i.	Environmental Accessibility Adaptations
j.	Transportation
k.	Personal Emergency Response System (PERS)
l.	Companion Services
m.	Specialized Medical Equipment And Supplies

Extended State Plan Services *(select one)*

⊙	Not applicable
○	The following extended State plan services are provided *(list each extended State plan service by service title)*:
a.	
b.	
c.	

Supports for Participant Direction *(select one)*

⊙	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.
○	Not applicable

Support	Included	Alternate Service Title (if any)
Information and Assistance in Support of Participant Direction	☐	
Financial Management Services	☐	

Other Supports for Participant Direction *(list each support by service title)*:

a.	
b.	
c.	

b. Alternate Provision of Case Management Services to Waiver Participants. When case management is not a covered waiver service, indicate how case management is furnished to waiver participants *(check each that applies)*:

☐	As a Medicaid State plan service under §1915(g)(1) of the Act (Targeted Case Management). *Complete item C-1-c.*
☒	As an administrative activity. *Complete item C-1-c.*
☐	Not applicable – Case management is not furnished as a distinct activity to waiver participants. *Do not 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:

Case Management/Service Coordination

DSS Administrative Function

** All Waiver participants receive this service through their DSS Social Worker*

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

Department of Social Service's Social Worker Responsibilities/Administrative Functions

The Department of Social Service's Social Worker will also be responsible for:

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

Case Management Waiver Service

**This is a Waiver Service delivered by private providers for participants who need it.*

The key to individual choice and satisfaction is person-centered service coordination. Programmatic service coordinator is a Waiver service. Waiver participants will receive this service only if they are unable to coordinate their own plans or do not have family or natural supports to act in this role, under circumstances which may include one or more of the following: crisis intervention and monitoring; after-hours availability; when the conservator, family member(s) or other natural supports are out-of-state or are not available to fulfill this function; if assistance is required to identify, locate and coordinate the hiring and scheduling of multiple individual and/or private waiver service providers; when it is clinically unsound for the conservator and/or family or other natural supports to provide such service.

The service coordinator:

1. responds to the individual by helping the participant to identify his or her unique wishes and needs;
2. promotes activities which will increase the individual's independence and life satisfaction through

participation in meaningful activities;
3. assists in the inclusion of the individual in the community of his/her choice;
4. arranges for daily living supports and services to meet the individual's needs, including assistance in accessing entitlements and other funding sources;
5. provides advocacy for participant to receive needed services, and
6. convenes crisis intervention, service planning in collaboration with the DSS social worker.

Throughout his/her involvement with the waiver participant, the service coordinator will support and encourage the waiver participant to increase his/her ability to problem solve, be in control of life situations, and be as independent as possible. This is balanced by the need to assure the waiver participant's health, safety, well-being and inclusion in the community. The waiver participant must be included in the decision-making process leading to the plan of care development. The DSS social worker, acting as administrative coordinator, will complete an initial assessment, evaluate the level of care and, with the waiver participant, develop the service plan. If service coordination is identified in the plan as a needed service, the service coordinator will oversee the plan implementation. Individuals for whom service coordination is not a needed service will have family, natural supports or themselves to oversee plan implementation. The DSS social worker will not act as programmatic service coordinator.

Appendix C-2: General Service Specifications

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)*:

⊙	**Yes**. Criminal history and/or background investigations are required. Specify: (a) the types of positions (e.g., personal assistants, attendants) for which such investigations must be conducted; (b) the scope of such investigations (e.g., state, national); and, (c) the process for ensuring that mandatory investigations have been conducted. State laws, regulations and policies referenced in this description are available to CMS upon request through the Medicaid or the operating agency (if applicable):
	DSS requires any persons serving as household employees* providing personal care assistance services to a consumer submit to a State of Connecticut criminal background check. DSS has the discretion to refuse payments for household employees performing services who have been convicted of a felony, as defined in section 53a-25 of the Connecticut General Statutes, involving forgery under section 53a-137 of the Connecticut General Statutes; robbery under section 53a-133 of the Connecticut General Statutes; larceny under sections 53a-119, 53a-122, 53a-123 and 53a-124 of the Connecticut General Statutes; or of a violation of section 53a-290 to 53a-296, inclusive of the Connecticut General Statutes; involving vendor fraud, section 53-20 of the Connecticut General Statutes involving cruelty to persons; sections 53a-70, 53a-70a, 53a-70b, 53a-71, 53a-72a, 53a-72b, or 53a-73a of the Connecticut General Statutes involving sexual assault; section 53a-59 of the Connecticut General Statutes involving assault; section 53a-59a of the Connecticut General Statutes involving assault of an elderly, blind, disabled, pregnant or mentally retarded person; and sections 53a-320 to 53a-323, inclusive, of the Connecticut General Statutes involving abuse of elderly, blind, disabled or mentally retarded persons. This review is carried out by the fiduciary intermediary in which the contract requires that as part of consideration for employment by any ABI Waiver participant, they process background checks for Household Employee Provider Registry applicants upon submission of the Provider Registry application.. The nature of the criminal activity revealed by the background check, including but not limited to check fraud, theft, abuse, or assault may result in disqualification from continued enrollment in the Provider Registry, and consideration for employment by any ABI Waiver participant. *Household Employees: providers who perform chore, companion, homemaker, personal care assistance, and respite services and who are not employed by an agency.
○	**No**. Criminal history and/or background investigations are not required.

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

○	**Yes**. The State maintains an abuse registry and requires the screening of individuals through this registry. Specify: (a) the entity (entities) responsible for maintaining the abuse registry; (b) the types of positions for which abuse registry screenings must be conducted; and, (c) the process for ensuring that mandatory screenings have been conducted. State laws, regulations and policies referenced in this description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable):
⊙	**No**. The State does not conduct abuse registry screening.

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

○	**No**. Home and community-based services under this waiver are not provided in facilities subject to §1616(e) of the Act. *Do not complete Items C-2-c.i – c.iii.*
⊙	**Yes**. Home and community-based services are provided in facilities subject to §1616(e) of the Act. The standards that apply to each type of facility where waiver services are provided are available to CMS upon request through the Medicaid agency or the operating agency (if applicable). *Complete Items C-2-c.i –c.iii.*

i. Types of Facilities Subject to §1616(e). Complete the following table for *each type* of facility subject to §1616(e) of the Act:

Type of Facility	Waiver Service(s) Provided in Facility	Facility Capacity Limit
ABI Provider Housing (Home or Apartment)	All Waiver and State Plan Services	3 Participants

ii. Larger Facilities: In the case of residential facilities subject to §1616(e) that serve four or more individuals unrelated to the proprietor, describe how a home and community character is maintained in these settings.

N/A

iii. Scope of Facility Standards. By type of facility listed in Item C-2-c-i, specify whether the State's standards address the following *(check each that applies)*:

Standard	Facility Type ABI Provider Housing (Home or Apartment)	Facility Type	Facility Type	Facility Type
Admission policies	☒	☐	☐	☐
Physical environment	☒	☐	☐	☐
Sanitation	☒	☐	☐	☐
Safety	☒	☐	☐	☐
Staff : resident ratios	☒	☐	☐	☐
Staff training and qualifications	☒	☐	☐	☐
Staff supervision	☒	☐	☐	☐
Resident rights	☒	☐	☐	☐
Medication administration	☒	☐	☐	☐
Use of restrictive interventions	☒ (no restrictive	☐	☐	☐

	interventions)			
Incident reporting	☒	☐	☐	☐
Provision of or arrangement for necessary health services	☒	☐	☐	☐

When facility standards do not address one or more of the topics listed, explain why the standard is not included or is not relevant to the facility type or population. Explain how the health and welfare of participants is assured in the standard area(s) not addressed:

N/A

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

⊙	**No**. The State does not make payment to legally responsible individuals for furnishing personal care or similar services.
○	**Yes**. The State makes payment to legally responsible individuals for furnishing personal care or similar services when they are qualified to provide the services. Specify: (a) the legally responsible individuals who may be paid to furnish such services and the services they may provide; (b) State policies that specify the circumstances when payment may be authorized for the provision of ***extraordinary care*** by a legally responsible individual and how the State ensures that the provision of services by a legally responsible individual is in the best interest of the participant; and, (c) the controls that are employed to ensure that payments are made only for services rendered. *Also, specify in Appendix C-3 the personal care or similar services for which payment may be made to legally responsible individuals under the State policies specified here.*

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

○	The State does not make payment to relatives/legal guardians for furnishing waiver services.
⊙	The State makes payment to relatives/legal guardians under ***specific circumstances*** and only when the relative/guardian is qualified to furnish services. Specify the specific circumstances under which payment is made, the types of relatives/legal guardians to whom payment may be made, and the services for which payment may be made. Specify the controls that are employed to ensure that payments are made only for services rendered. *Also, specify in Appendix C-3 each waiver service for which payment may be made to relatives/legal guardians.*

	The Department does not pay the family members of participants to perform any waiver services except for Personal Care Assistance, Independent Living Skills Training, and Transportation. The Department does not pay legally liable relatives or relatives of Conservators of Person nor Conservators of Estate to provide care any Waiver service. ABI Waiver participants are able to select qualified providers for Personal Care Assistance. In some circumstances, this may be a non-legally liable relative, who is not related to the consumer's Conservator of Person or Conservator of Estate. The participant or their conservator must sign timesheets to confirm the date(s) and time(s) services were performed. The fiscal intermediary reviews timesheets for accuracy and whether they match the allocation in the service plan. Any discrepancy results in a notification to DSS, prior to the issuance of payment. Family members must meet the same qualifications as unrelated providers. Any reported concerns regarding fraudulent billing is addressed as it would be with other service providers (e.g., investigation, provider termination, etc.).
○	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-3. Specify any limitations on the types of relatives/legal guardians who may furnish services. Specify the controls that are employed to ensure that payments are made only for services rendered. *Also, specify in Appendix C-3 each waiver service for which payment may be made to relatives/legal guardians.*
○	Other policy. *Specify*:

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

The Connecticut Department of Social Services contracts with a fiscal intermediary to conduct outreach activities in order to increase awareness of the ABI Waiver Program within the provider community and to recruit qualified providers to serve the ABI population. The Department establishes qualifications for each provider type, and publishes the qualifications in the Department's ABI Waiver Program Provider Manual. Outreach activities include:

1. Identifying those areas of the state in which service deficits exist;

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

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

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

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

6. Maintaining a log of potential providers who attend each activity or who are contacted through the outreach effort, including the date and place of each activity, the number of individuals who attend or are contacted, the number of individuals who subsequently participate in training, and the number of

individuals, by specialty type, subsequently enrolled as Qualified Providers.

Appendix C-3: Waiver Services Specifications

For each service listed in Appendix C-1, provide the information specified below. 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 Specification	
Service Title:	Case-Management

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

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

Service Definition (Scope)**:**

This service is to assist the waiver participant in implementing their service plan, and on-going assurance of effective coordination, communication and cooperation among all sources of support and services to the waiver participant. The consumer and the case-management provider regularly review the effectiveness of the plan, focusing on the consumer's satisfaction as the primary measure of quality.

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

Case-management services will be purchased only if the waiver participant is unable to coordinate and/or oversee their own plan, does not have a conservator, family or other natural supports to act in this role.

Provider Specifications

Provider Category(s) *(check one or both)***:**	☑	Individual. List types:	☑	Agency. List the types of agencies:
	Social Worker		Accredited Rehabilitative Facilities	
	Certified Rehabilitation Counselor		Accredited Behavioral Health Care	
	Certified Case Manager		Accredited Health Organizations	
	Individual Provider			

Specify whether the service may be provided by *(check each that applies):*	☐	Legally Responsible Person	☐	Relative/Legal Guardian

Provider Qualifications (*provide the following information for each type of provider)*:

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Agency Provider		Commission on Accreditation of Rehabilitative Facilities (CARF), or JCAHO Accreditation for Behavioral Health Care, or	Employed licensed Social Workers, Certified Rehabilitation Counselors and/or Certified Case Managers, or The agency employee providing ABI case-management services must have a Master's Degree in Psychology, Rehabilitation or Social Work and one year's experience providing service coordination to persons with disabilities and knowledge of community resources, or a Bachelor's Degree and two years of the above experience.

Rehabilitation Hospital Outpatient Department (providers on staff)		Joint Commission on Accreditation of Health Organizations (JCAHO)	
*****Social Worker	State of CT Department of Social Services (CGS Chap. 383b, 20-195m)		One year's experience in providing service coordination to persons with disabilities and knowledge of community resources.
*****Certified Rehabilitation Counselor		Commission on Rehabilitation Counselor Certificate	Same as above
*****Certified Case-Manager		Commission for Case-Manager Certification	Same as above
*****Individual Provider			Person with a Master's Degree in Psychology, Rehabilitation or Social Work and one year's experience in providing service coordination to persons with disabilities and knowledge of community resources, or a person with s Bachelor's Degree and two years of the above experience.
*****Self Employed Private Providers			

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
All Providers	Allied Community Resources, Inc	At start of services and at recertification.

Service Delivery Method				
Service Delivery Method *(check each that applies)*:	☐	Participant-directed as specified in Appendix E	☑	Provider managed

Appendix C-3: Waiver Services Specifications

For each service listed in Appendix C-1, provide the information specified below. 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 Specification	
Service Title:	Chore Service

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

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

Service Definition (Scope)**:**

Services needed to maintain the consumer's home in a clean, sanitary and safe condition. This service includes heavy household chores, such as washing floors, windows, walls, and moving heavy items of furniture in order to provide safe access and egress.

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

Chore services are provided only when neither the individual, nor anyone else in the household, is capable of performing or financially providing for them, or where no other third party is capable for their provision. ABI Waiver funds shall not be used if the service may be provided free of charge through friends, relatives, caregiver or community agencies. In the case of rental property, any service that is the responsibility of the landlord or his or her designee shall not be paid from ABI waiver funds; a copy of the lease agreement shall be reviewed before this service is authorized.

Provider Specifications

Provider Category(s) *(check one or both)***:**	☑	Individual. List types:	☑	Agency. List the types of agencies:
		Self employed private provider		Private or non-profit agencies

Specify whether the service may be provided by *(check each that applies):*	☐	Legally Responsible Person	☐	Relative/Legal Guardian

Provider Qualifications (*provide the following information for each type of provider)*:

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Agency Provider			Chore service providers are not licensed or regulated. Services shall not be provided by any person who is a relative of the participant, is the participant's conservator, or is a member of the conservator's family. A chore service provider shall: Be at least 18 years of age and be able to physically perform the service required. Be able to follow instructions given by the consumer or the consumer's conservator.

			Be able to report changes in the consumer's condition or needs. Maintain confidentiality. Have the ability or skills necessary to meet the consumer's needs as delineated in the service plan.
Private provider			Same as above.

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
All Providers	Allied Community Resources, Inc	At start of services

Service Delivery Method				
Service Delivery Method *(check each that applies)*:	☑	Participant-directed as specified in Appendix E	☑	Provider managed

Appendix C-3: Waiver Services Specifications

For each service listed in Appendix C-1, provide the information specified below. 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 Specification	
Service Title:	Cognitive Behavioral Programs

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 interventions designed to decrease the consumer's severe maladaptive behaviors, which jeopardize their ability to remain in the community.

Services include:

- comprehensive assessment of deficient cognition and maladaptive behavior(s);
- development of a structured cognitive/behavioral intervention plan, which has as its primary focus the teaching of socially appropriate behaviors;
- the elimination of maladaptive behaviors through the development and implementation of cognitive compensatory strategies;
- implementation of the plan;
- on-going or periodic supervision of the waiver participant, family members and caregivers concerning treatment regiments, cognitive and behavioral strategies and interventions and use of equipment specified in the plan of care;
- periodic reassessment of the plan;
- assistance to providers in implementing participant-specific interventions.

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

Provider Specifications				
Provider Category(s) *(check one or both)***:**	☑	Individual. List types:	☑	Agency. List the types of agencies:
	Neuro-Psychologist		Agency Provider	
	Educational Psychologist		Rehabilitation Hospital Outpatient Department (providers on staff)	
	Occupational Therapist			
	Psychologists			
	Speech Therapist			
	Physical Therapist			
Specify whether the service may be	☐	Legally Responsible Person	☐	Relative/Legal Guardian

provided by *(check each that applies):*				

Provider Qualifications (*provide the following information for each type of provider)*:

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Agency		CARF certification in Brain Injury, or JCAHO, or Accreditation for Behavioral Health Care, or	Employ neuro-psychologists, educational psychologists, psychologists, occupational therapists, speech therapists or physical therapists that meet the standards of individual providers.
Rehabilitation Hospital Outpatient Department (providers on staff)		JCAHO	
*****Neuro-Psychologist	State of CT Dept. of Health Services (DHS) Chap. 383B, Section 20-188-1		Post-doctoral study or clinical supervision in neuropsychology.
*****Educational Psychologist		Certification in Special Education	Ph.D. in Education with concentration in cognitive strategy development and remediation and/or post-doctoral experience in providing such services.
*****Occupational Therapist	State of CT DHS, Chap. 376, Section 20-74i-1		At least three year's experience in cognitive/behavioral programming for people with a brain injury, delivered in community settings.
*****Psychologists	State of CT DHS Chap.383B, Section 20-188-1		Same as above
*****Speech Therapist	State of CT DHS, Chap. 399, Section 20-408		Same as above
*****Physical Therapist	State of CT DHS, Chap. 376, Section 20-66		Same as above

*****Self Employed Private Provider

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
All Providers	Allied Community Resources, Inc	At beginning of services and recertification.

Service Delivery Method

Service Delivery Method *(check each that applies)*:	☐	Participant-directed as specified in Appendix E	☑	Provider managed

Appendix C-3: Waiver Services Specifications

For each service listed in Appendix C-1, provide the information specified below. 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 Specification	
Service Title:	Community Living Support Services (CLSS)
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 supervised living in the consumer's residence that provides up to 24-hour support services, for up to three individuals with acquired brain injury. Services are provided in the residence or in the community and include supervision of and assistance with: self-care; medication management; communication and interpersonal skills; socialization; sensory/motor skills; mobility; community transportation skills; problem-solving skills; money management and ability to maintain a household. Assessment and training services are not provided under this component.

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

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

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

This service is purchased by the day or half (12-hour) day.

Provider Specifications				
Provider Category(s) *(check one or both)***:**	☐	Individual. List types:	☑	Agency. List the types of agencies:
				Agency
				Rehabilitation Hospital Outpatient Department (providers on staff)

Specify whether the service may be provided by *(check each that applies):*	☐	Legally Responsible Person	☐	Relative/Legal Guardian

Provider Qualifications (*provide the following information for each type of provider)*:

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*

Agency		Commission on Accreditation of Rehabilitative Facilities (CARF), Community Support Services, or JCAHO Accreditation for Behavioral Health Care, or	Meet the State of Connecticut Standard to provide rehabilitation services for the Bureau of Rehabilitation Services (BRS), Department of Mental Retardation (DMR) or the Department of Mental Health and Addiction Services (DMHAS). Residence must meet all provisions of CT State Building Code, fire prevention, safety and construction standards. Employ staff who: • are at least 18 years of age • demonstrate the ability to maintain a safe and healthy living environment • demonstrate knowledge of basic first aid • demonstrate knowledge of response to fire and emergency situations • demonstrate ability to implement cognitive and behavioral strategies • demonstrate ability to function as a member of an interdisciplinary team. Training requirement Must have completed an approved training program(s) concerning acquired brain injury and person-centered planning, given by the a state agency, state's fiduciary, community providers, Brain Injury Association of CT, or an Independent Living Center.
Rehabilitation Hospitals Outpatient Department (providers on staff)		JCAHO/CARF certification in community support service and/or brain injury community integrated services, and	Residence must meet all provisions of CT State Building Code, Fire prevention, safety and construction standards.

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
All providers	Allied Community Resources, Inc.	At start of services and at recertification.

Service Delivery Method				
Service Delivery Method	☐	Participant-directed as specified in Appendix E	☑	Provider managed

(check each that applies):				

Appendix C-3: Waiver Services Specifications

For each service listed in Appendix C-1, provide the information specified below. 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 Specification	
Service Title:	Companion Services
Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:	
☑	Service is included in approved waiver. There is no change in service specifications.
○	Service is included in approved waiver. The service specifications have been modified.
○	Service is not included in the approved waiver.
Service Definition (Scope)**:**	
Non-medical care, supervision and socialization that are provided in accordance with a therapeutic goal included in the service plan. May assist in or supervise such tasks as meal preparation, laundry, or light housekeeping tasks that are incidental to the care and supervision of the individual.	
Specify applicable (if any) limits on the amount, frequency, or duration of this service:	
The provision of this service does not entail hands-on nursing care.	

Provider Specifications				
Provider Category(s) *(check one or both)***:**	☑	Individual. List types:	☑	Agency. List the types of agencies:
	Private Household Employee		Private Agency	

Specify whether the service may be provided by *(check each that applies):*	☐	Legally Responsible Person	☐	Relative/Legal Guardian

Provider Qualifications (*provide the following information for each type of provider)*:

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Private Agency			Provider staff shall: • be at least 18 years of age • be physically able to perform the services required • follow instructions given by the consumer or the consumer's conservator • be able to report changes in the consumer's condition or needs • maintain confidentiality • have the ability or skills necessary to meet the consumer's needs as delineated in the service plan

			• demonstrate ability to implement cognitive and behavioral strategies • be able to function as a member of an interdisciplinary team Training requirement: Has completed an approve training program(s) concerning acquired brain injury and person-centered planning, given by a state agency, the fiduciary, community providers, Brain Injury Association of CT, or an Independent Living Center.
Private household employee			Same as above or meet the qualifications for Independent Living Skills Training

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
All providers	Allied Community Resources, Inc	At start of services

Service Delivery Method				
Service Delivery Method *(check each that applies)*:	☑	Participant-directed as specified in Appendix E	☑	Provider managed

Appendix C-3: Waiver Services Specifications

For each service listed in Appendix C-1, provide the information specified below. 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 Specification	
Service Title:	Home-Delivered Meals

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

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

Service Definition (Scope)**:**

The preparation and home delivery of meals for consumers who are unable to prepare or obtain nourishing meals independently, or when the individual responsible for this activity is temporarily absent or unable to prepare meals.

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

Meals provided shall not include a full nutrition regime (three meals per day).

Provider Specifications

Provider Category(s) *(check one or both)***:**	☐	Individual. List types:	☑	Agency. List the types of agencies:
				Private agency

Specify whether the service may be provided by *(check each that applies):*	☐	Legally Responsible Person	☐	Relative/Legal Guardian

Provider Qualifications (*provide the following information for each type of provider)*:

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Private agency			Must meet that State of Connecticut standard for of home delivered meals and make application to the ABI Registry.

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
All providers	Allied Community Resources, Inc.	At start of services

Service Delivery Method

Service Delivery Method *(check each that applies)*:	☐	Participant-directed as specified in Appendix E	☑	Provider managed

Appendix C-3: Waiver Services Specifications

For each service listed in Appendix C-1, provide the information specified below. 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 Specification	
Service Title:	Homemaker Services

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

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

Service Definition (Scope)**:**

Homemaker services consist of general household activities, including meal preparation and routine household chores. Homemaker services are provided by the Department only when the individual regularly responsible for these activities is temporarily absent from the home or unable to manage the home and care for him/herself or others in the home; or, when the waiver participant is unable to (re)learn such skills or does not choose to perform these tasks.

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

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

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

Provider Specifications

Provider Category(s) *(check one or both)***:**	☑	Individual. List types:	☑	Agency. List the types of agencies:
	Private Household Employee		Agency provider	

Specify whether the service may be provided by *(check each that applies):*	☐	Legally Responsible Person	☐	Relative/Legal Guardian

Provider Qualifications (*provide the following information for each type of provider)*:

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Agency provider			Homemaker service providers are not licensed or regulated. A homemaker provider shall: • be at least 18 years of age • follow instructions given by the consumer or the consumer's conservator • be able to report changes in the consumer's condition or needs • maintain confidentiality

			• have the ability or skills necessary to meet the consumer's needs as delineated in the service plan • demonstrate ability to implement cognitive and behavioral strategies
Private provider			Same as above

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
All providers	Allied Community Resources, Inc.	At start of services

Service Delivery Method				
Service Delivery Method *(check each that applies)*:	☑	Participant-directed as specified in Appendix E	☑	Provider managed

Appendix C-3: Waiver Services Specifications

For each service listed in Appendix C-1, provide the information specified below. 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 Specification	
Service Title:	Independent Living Skill Training

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

Services are purchased on an hourly basis and provided in the "real world," i.e., in the individual's home, community, environment or specific life situation that calls for intensive assessment and training. Services are provided under this component when the individual has particular difficulty with transferring and generalizing knowledge and skills from one situation to another, as well as to carry-out strategies developed in Cognitive/Behavioral programs by the clinician.

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

Assistance and supervision are not provided under this component.

Provider Specifications

Provider Category(s) *(check one or both)***:**	☑	Individual. List types:	☑	Agency. List the types of agencies:
	Private self employed		Agency provider	
			Rehabilitation Hospital Outpatient Department (providers on staff)	

Specify whether the service may be provided by *(check each that applies):*	☐	Legally Responsible Person	☒	Relative/Legal Guardian **Relative Only**

Provider Qualifications (*provide the following information for each type of provider)*:

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Agency		CARF certification in brain injury and/or Community Support, or	Employee staff who: • are at least 18 years old • have a minimum of a Bachelor's

		JCAHO accreditation for Behavioral Health Care, or	Degree and one year's experience providing services to individuals with brain injuries in the community, **and** complete training program(s) concerning acquired brain injury and person-centered planning, given by a state agency, the fiduciary, community providers, Brain Injury Association of CT, or Independent Living Center, **or** have a high school diploma and two years experience providing services to individuals with brain injuries in the community **and** completed training program(s) concerning acquired brain injury and person-centered planning, given by a state agency, broker agency, community providers, Brain Injury Association of CT, or Independent Living Center • demonstrate ability to function as a member of an interdisciplinary team • have documented experience implementing cognitive/Behavioral interventions developed by a clinician and utilized in community settings • **or**, meet qualifications for Cognitive/Behavioral Programs
Rehabilitation Hospital Outpatient Department (providers on staff)		JCAHO	
Private provider			Same as agency provider above

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
All providers	Allied Community Resources, Inc	At start of services and at recertification/re-accreditation

Service Delivery Method

Service Delivery Method *(check each that applies)*:	☐	Participant-directed as specified in Appendix E	☑	Provider managed

Appendix C-3: Waiver Services Specifications

For each service listed in Appendix C-1, provide the information specified below. 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 Specification	
Service Title:	Personal Care Assistance (PCA)

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

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

Service Definition (Scope)**:**

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

Personal care providers may be members of the individual's family who meet the training requirements specified by the Department, except that the personal care provider may not be the participant's spouse, the participant's conservator, or a relative of the participant's conservator.

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

Provider Specifications				
Provider Category(s) *(check one or both)***:**	☑	Individual. List types:	☐	Agency. List the types of agencies:
	Private household Employee			

Specify whether the service may be provided by *(check each that applies):*	☐	Legally Responsible Person	☑	Relative/Legal Guardian

Provider Qualifications (*provide the following information for each type of provider)*:

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Private provider			A personal care provider shall: • be at least 18 years of age • have experience doing personal care • be able to follow written or verbal instructions given by the consumer or the consumer's conservator • be physically able to perform the

			services required • follow instructions given by the consumer or the consumer's conservator • receive instruction/training from consumer or their designee concerning all personal care services delineated in the service plan • be able to handle emergencies • demonstrate the ability to implement cognitive behavioral interventions/take direction to carry out plan • be able to function as a member of an interdisciplinary team Training requirement: Has completed an approve training program(s) concerning acquired brain injury and person-centered planning, given by a state agency, the fiduciary, community providers, Brain Injury Association of CT, or an Independent Living Center.

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
All providers	Allied Community Resources, Inc	At start of services

Service Delivery Method				
Service Delivery Method *(check each that applies)*:	☑	Participant-directed as specified in Appendix E	☐	Provider managed

Appendix C-3: Waiver Services Specifications

For each service listed in Appendix C-1, provide the information specified below. 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 Specification	
Service Title:	Personal Emergency Response Systems (PERS)

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 electronic device that enables certain consumers at high risk of institutionalization to secure help in an emergency; the system may include a portable "help" button to allow for mobility. The system is connected to the person's telephone and programmed to signal a response center once "help" button is activated. Trained professionals shall staff the response center.

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

The availability of this service under the ABI waiver is limited to individuals who live alone, or are alone for significant parts of the day, and who have no regular caregiver and who would otherwise require extensive routine supervision.

Provider Specifications

Provider Category(s) *(check one or both)***:**	☐	Individual. List types:	☑	Agency. List the types of agencies:
				Vendors Who Sell and Install Appropriate Equipment

Specify whether the service may be provided by *(check each that applies):*	☐	Legally Responsible Person	☐	Relative/Legal Guardian

Provider Qualifications (*provide the following information for each type of provider*):

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Vendors Who Sell and Install Appropriate Equipment			Has approved/contract through DSS, or a contractor of the department to provide PERS for other existing DSS programs.

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification

All providers	Allied Community Resources, Inc.	At start of service

Service Delivery Method				
Service Delivery Method *(check each that applies)*:	☐	Participant-directed as specified in Appendix E	☑	Provider managed

Appendix C-3: Waiver Services Specifications

For each service listed in Appendix C-1, provide the information specified below. 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 Specification	
Service Title:	Pre-Vocational Service

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)**:**

Pre-vocational services are designed to prepare an individual for paid or unpaid employment, when the person is not expected to be able to join the work force or participate in a transitional work program within one year (excluding supported employment programs).

Pre-vocational services do not include skill-building or job tasks for specific employment goals, but instead focus on teaching the concepts of compliance, attendance, task completion, problem-solving and safety, with the goal of enhancing attention span and motor skills. Pre-vocational services may include participants who perform volunteer work with pre-vocational supports.

When waiver participants are paid for pre-vocational services, they are paid at less than 50% of the minimum wage.

Pre-vocational services may not otherwise be available under a program funded under the Rehabilitation Act of 1973. Pre-vocational services are not provided under the waiver when participants are eligible for such services through special education.

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

Provider Specifications				
Provider Category(s) *(check one or both)***:**	☐	Individual. List types:	☑	Agency. List the types of agencies:
				Agency provider

Specify whether the service may be provided by *(check each that applies):*	☐	Legally Responsible Person	☐	Relative/Legal Guardian

Provider Qualifications (*provide the following information for each type of provider)*:

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Agency		Commission on	Meet the State of Connecticut Standard to

		Accreditation of Rehabilitation Facilities (CARF)-Employment Services, or	provide vocational services for the Bureau of Rehabilitation Services (BRS), Department of Mental Retardation (DMR) or the Department of Mental Health and Addiction Services (DMHAS)

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
All Providers	Allied Community Resources, Inc.	At start of services or re-accreditation.

Service Delivery Method				
Service Delivery Method *(check each that applies)*:	☐	Participant-directed as specified in Appendix E	☑	Provider managed

Appendix C-3: Waiver Services Specifications

For each service listed in Appendix C-1, provide the information specified below. 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 Specification	
Service Title:	Respite Care Services
Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:	
☑	Service is included in approved waiver. There is no change in service specifications.
○	Service is included in approved waiver. The service specifications have been modified.
○	Service is not included in the approved waiver.
Service Definition (Scope)**:**	
Services provided to persons unable to care for themselves, and furnished on a short-term basis only in the individual's home or place of residence, when person performing such services (e.g., natural supports such as family) is absent or in need of relief.	
Specify applicable (if any) limits on the amount, frequency, or duration of this service:	

Provider Specifications				
Provider Category(s) *(check one or both)***:**	☑	Individual. List types:	☑	Agency. List the types of agencies:
	Private Household employee		Agency provider	

Specify whether the service may be provided by *(check each that applies):*	☐	Legally Responsible Person	☐	Relative/Legal Guardian

Provider Qualifications (*provide the following information for each type of provider*):

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Agency		Commission on Accreditation of Rehabilitation Facilities (CARF) – Community Support Services, or	Employ staff who: • are at least 18 years of age • demonstrate the ability to maintain a safe and healthy living environment • demonstrate knowledge of basic first aid • demonstrate knowledge of response to fire and emergency situations • demonstrate ability to implement cognitive and behavioral strategies • demonstrate ability to function as a member of an interdisciplinary team.

			• Must be capable of performing all functions of the primary caregiver in their absence. Training requirement Must have completed an approved training program(s) concerning acquired brain injury and person-centered planning, given by a state agency, the state's fiduciary, community providers, Brain Injury Association of CT, or an Independent Living Center.
Private provider			Same as above or meet the qualifications for Independent Living Skills Training and Development.

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
All providers	Allied Community Resources, Inc.	At start of services or at re-accreditation for CARF Providers

Service Delivery Method

Service Delivery Method *(check each that applies)*:	☑	Participant-directed as specified in Appendix E	☑	Provider managed

Appendix C-3: Waiver Services Specifications

For each service listed in Appendix C-1, provide the information specified below. 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 Specification	
Service Title:	Specialized Medical Equipment and Supplies

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)**:**

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

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

Total Annual Individual Cost Limit $10,350.00

Provider Specifications

Provider Category(s) *(check one or both)***:**	☐	Individual. List types:	☑	Agency. List the types of agencies:
				Medical Equipment Vendors
				DME
				Pharmacies

Specify whether the service may be provided by *(check each that applies):*	☐	Legally Responsible Person	☐	Relative/Legal Guardian

Provider Qualifications (*provide the following information for each type of provider*):

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Vendor and/or DME			Meet the State of Connecticut Standard to provide medical equipment or supplies for the Bureau of Rehabilitation Services (BRS), Department of Mental Retardation (DMR) or Bureau of Education Services (BESB) to the Blind or Medicaid provider status for specialized medical equipment and supplies.
Pharmacies	State of CT Dept. of Consumer Protection Pharmacy Practice Act : Regulations Concerning Practice of Pharmacy Section 20-175-4-6-		

	7		

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
All providers	Allied Community Resources, Inc.	At start of services

Service Delivery Method

Service Delivery Method *(check each that applies)*:	☐	Participant-directed as specified in Appendix E	☑	Provider managed

Appendix C-3: Waiver Services Specifications

For each service listed in Appendix C-1, provide the information specified below. 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 Specification	
Service Title:	Substance Abuse Programs
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)**:**	
Individually designed interventions to reduce or eliminate the use of alcohol and/or drugs by the individual, when such behaviors may interfere with their ability to remain in the community.	
Specify applicable (if any) limits on the amount, frequency, or duration of this service:	

Provider Specifications				
Provider Category(s) *(check one or both)***:**	☒	Individual. List types:	☑	Agency. List the types of agencies:
	Self-Employed Private Providers (i.e., Licensed Psychologists, Certified Alcohol and Drug Counselors)		Agency provider that meet the qualifications below.	
			Rehabilitation Hospital Outpatient Department (providers on staff) that meet the qualifications below.	
			Substance abuse diagnostic and treatment centers that meet the qualifications below.	
Specify whether the service may be provided by *(check each that applies):*	☐	Legally Responsible Person	☐	Relative/Legal Guardian

Provider Qualifications (*provide the following information for each type of provider)*:

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Agency		CARF certificate in brain injury, or JCAHO accreditation for Behavioral Health Care, and	Staff with at least one year's experience in providing services to individuals with substance abuse issues, or employ certified alcohol and drug counselors or psychologists meeting standards below.
Rehabilitation Hospital Outpatient		JCAHO, and	Staff with at least one year's experience in providing services to individuals with brain injury and substance abuse issues.

Department (providers on staff)			
Substance abuse diagnostic and treatment centers	State of CT Health Services (if private facility) and	JCAHO (if public facility) and	Complete training concerning acquired brain injury given be a state agency, the fiduciary, community provider, Brain Injury Association of CT or Independent Living Centers.
Certified Alcohol and Drug Counselor		State of CT Health Services (if private facility)	At least 1 year experience in assessment and treatment of individuals with brain injury and substance abuse Ability to develop linkages with community support programs Ability to work as a member of an interdisciplinary team.
Licensed Psychologist	State of CT Health Services (if private facility)	State of CT Health Services (if private facility)	

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
All providers	Allied Community Resources, Inc.	At start of services and recertification

Service Delivery Method				
Service Delivery Method *(check each that applies)*:	☐	Participant-directed as specified in Appendix E	☑	Provider managed

Appendix C-3: Waiver Services Specifications

For each service listed in Appendix C-1, provide the information specified below. 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 Specification	
Service Title:	Supported Employment Services

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

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

Service Definition (Scope)**:**

Supported employment consists of paid employment for persons who, due to their disabilities, are unlikely to secure competitive employment at or above the minimum wage and who need on-going, intensive support to perform in a work setting.

Supported employment also includes activities needed to sustain paid work by individuals receiving waiver services, including supervision and training.

Supported employment is conducted in a variety of settings, including work sites where persons without disabilities are employed. When supported employment services are provided in such integrated settings, payments will be made only for adaptations, supervision and training needed by the individual and shall not include payment for any such modifications or activities rendered within the normal business setting.

Supported employment services may not otherwise be available under a program funded under the Rehabilitation Act of 1973. Supported Employment services may not be provided under the waiver when waiver participants are eligible for them through Special Education.

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

Provider Specifications				
Provider Category(s) *(check one or both)***:**	☐	Individual. List types:	☑	Agency. List the types of agencies:
				Agency providers that meet the provider qualifications listed below.

Specify whether the service may be provided by *(check each that applies):*	☐	Legally Responsible Person	☐	Relative/Legal Guardian

Provider Qualifications (*provide the following information for each type of provider)*:

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Agency		Commission on	Meet the State of Connecticut Standard to

		Accreditation of Rehabilitation Facilities (CARF) – Employment Services, or	provide rehabilitation services for the Bureau of Rehabilitation Services (BRS), Department of Mental Retardation (DMR) or the Department of Mental Health and Addiction Services (DMHAS).

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
All providers	Allied Community Resources, Inc.	At start of services or at recertification.

Service Delivery Method

Service Delivery Method *(check each that applies)*:	☐	Participant-directed as specified in Appendix E	☑	Provider managed

Appendix C-3: Waiver Services Specifications

For each service listed in Appendix C-1, provide the information specified below. 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 Specification	
Service Title:	Transitional Living Services
Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:	
☑	Service is included in approved waiver. There is no change in service specifications.
○	Service is included in approved waiver. The service specifications have been modified.
○	Service is not included in the approved waiver.
Service Definition (Scope)**:**	
Individualized, short-term, residential services providing up to 24-hour support and designed to improve the individual's skills and ability to live in the community. Services include assessment, training, supervision and assistance to an individual in the areas of: self care; medication management; communication and interpersonal skills; socialization; sensory/motor skills; mobility and community transportation skills; problem solving skills; money management and ability to maintain a household. Transitional living services shall be provided only when the individual is unable to be supported in a permanent residence and is in need of intensive clinical interventions provided by this service. Prior to discharge from transitional living, the provider shall work with the individual and the DSS Social Worker to develop a community living plan of care. Upon discharge, other ABI Waiver service shall become available to the individual in accordance with the revised service plan. Applicable Accompanying Services: Case Management, Environmental Modifications, Specialized Medical Equipment and Vehicle Modifications	
Specify applicable (if any) limits on the amount, frequency, or duration of this service:	
Services are limited to consumers who are unable to be supported in a permanent residence, and who is in need of intensive clinical interventions provided by this service. These services may be provided to persons who are being deinstitutionalized as a step-down community-based service to shift toward less intensive staff supports.	

Provider Specifications				
Provider Category(s) *(check one or both)***:**	☐	Individual. List types:	☑	Agency. List the types of agencies:
				Agency provider
				Rehabilitation Hospital Outpatient Department (providers on staff)

Specify whether the service may be provided by *(check each that applies):*	☐	Legally Responsible Person	☐	Relative/Legal Guardian
Provider Qualifications (*provide the following information for each type of provider)*:				

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Agency Provider	State of CT Dept. of Health Services	CARF certification in brain injury, or JCAHO and Accreditation for Behavioral Health Care, or	Residence must meet all provisions of CT State Building Code, fire prevention, safety and construction standards.
Rehabilitation Hospital Outpatient Department (providers on staff)	State of CT Dept. of Health Services	JCAHO, and	Same as above.

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
All providers	Allied Community Resources, Inc	At start of services and at re-certification/accreditation

Service Delivery Method				
Service Delivery Method *(check each that applies)*:	☐	Participant-directed as specified in Appendix E	☑	Provider managed

Appendix C-3: Waiver Services Specifications

For each service listed in Appendix C-1, provide the information specified below. 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 Specification	
Service Title:	Transportation

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

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

Service Definition (Scope)**:**

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

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

When authorized, this service is in addition to medical transportation services required under 42CFR 440.170(a), if applicable, and shall not replace them.

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

ABI funds may not be used for this purpose when public transportation is available or when friends, family, and/or community agencies are able to provide transportation free of charge.

Provider Specifications

Provider Category(s) *(check one or both)***:**	☑	Individual. List types:	☑	Agency. List the types of agencies:
	Individual provider		Private transportation service	

Specify whether the service may be provided by *(check each that applies):*	☐	Legally Responsible Person	☑	Relative/Legal Guardian

Provider Qualifications (*provide the following information for each type of provider)*:

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Transportation Service	DOT livery license or		Subcontractor for Medicaid Transportation Brokers
Individual provider	Valid driver's license		Proof of current vehicle insurance

Verification of Provider Qualifications		
Provider Type:	Entity Responsible for Verification:	Frequency of Verification
All providers	Allied Community Resources	At approval
		When license and insurance are due for renewal or expiration.

Service Delivery Method				
Service Delivery Method *(check each that applies)*:	☐	Participant-directed as specified in Appendix E	☑	Provider managed

Appendix C-3: Waiver Services Specifications

For each service listed in Appendix C-1, provide the information specified below. 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 Specification	
Service Title:	Vehicle Modification Services

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

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

Service Definition (Scope)**:**

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

Note: Vehicle Modification Services do not include the purchase or lease, regular maintenance or upkeep of the vehicle.

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

Total Annual Individual Cost Limit $10,350.00

Provider Specifications

Provider Category(s) *(check one or both)***:**	☐	Individual. List types:	☑	Agency. List the types of agencies:
				Private contractor/businesses that meet the qualifications listed below.

Specify whether the service may be provided by *(check each that applies):*	☐	Legally Responsible Person	☐	Relative/Legal Guardian

Provider Qualifications (*provide the following information for each type of provider*):

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Contractor/Business	DMV dealer's and/or repairer's license		Must be an approved State of Connecticut Bureau of Rehabilitation Services' vendor.

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification

All providers	Allied Community Resources, Inc.	At time of service

Service Delivery Method				
Service Delivery Method *(check each that applies)*:	☐	Participant-directed as specified in Appendix E	☑	Provider managed

Appendix C-3: Waiver Services Specifications

For each service listed in Appendix C-1, provide the information specified below. 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 Specification	
Service Title:	Environmental Accessibility Adaptations

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

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

Service Definition (Scope)**:**

Environmental Accessibility Adaptations are physical adaptations to the consumer's private home that ensure the health, welfare and safety of the consumer, that enhance and promote greater independence, and without which the individual would require institutionalization. Adaptations may include but are not limited to the installation of ramps, widening of doorways, modification of bathroom facilities and specialized electrical and plumbing installations. The service is provided in a rental setting only when the owner is not required by law to make adaptations.

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

Note: Environmental Accessibility Adaptations are not allowed for provider owned residential settings.

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

Service is not provided to agency settings.

Provider Specifications				
Provider Category(s) *(check one or both)***:**	☐	Individual. List types:	☑	Agency. List the types of agencies:
				Private contractor/business

Specify whether the service may be provided by *(check each that applies):*	☐	Legally Responsible Person	☐	Relative/Legal Guardian

Provider Qualifications (*provide the following information for each type of provider*):

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Contractor/business			Meet the State of Connecticut Standard to provide Environmental Accessibility Adaptations through BRS and Home Improvement Registration by the Dept. of Consumer Protection Adheres to State/Local Building Codes.

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
All providers	Allied Community Resources, Inc.	At time of services

Service Delivery Method

Service Delivery Method *(check each that applies)*:	☐	Participant-directed as specified in Appendix E	☑	Provider managed

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

Additional Limits on Amount of Waiver Services. Indicate whether the waiver employs any of the following additional limits on the amount of waiver services *(check each that applies).*

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; and, (f) how participants are notified of the amount of the limit.

☐	**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*.
	▪ The budget limit applies to the total waiver plan budget. The limit for the levels of care was based on actual case histories of individuals institutionalized with acquired brain injury at each level of care. It is also based on trends shown in the 372 Report, which reflects costs for an institutionalized population at this level of care. The budget limit will be adjusted for 2.5% increases each Waiver year. There are occasions when it may be necessary to provide emergency assistance for an interim period. Emergency assistance may be provided in one of the following situations: ▪ Involuntary loss of present residence for any reason, including legal action; ▪ Loss of present caregiver for any reason, including death of a caregiver or ▪ Changes in the caregiver's mental or physical status resulting in the caregiver's inability to perform effectively for the participant; ▪ Abuse, neglect, or exploitation of the participant; ▪ Health and welfare conditions that pose a serious risk to the participant of immediate harm or death; or ▪ Significant changes in the emotional or physical condition of the participant that necessitate substantial, expanded accommodations that cannot be reasonably provided by the participant's existing caregiver. ▪ Participants are notified of budget limits during service planning/plan revision team meetings. ▪ Note: Connecticut utilizes 200% of institutional care as a budgetary limit on the ABI Waiver program, yet maintains an aggregate cost cap. As a result of the flexibility of 200% limits on individual care plans, ABI Waiver participants have not encountered challenges with budget limits.
☐	**Other Type of Limit.** The State employs another type of limit. *Describe the limit and furnish the information specified above.*

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

Appendix D: Participant-Centered Planning and Service Delivery

Appendix D-1: Service Plan Development

State Participant-Centered Service Plan Title:	ABI Waiver Service 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 *(check 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-3)
☐	Case Manager (qualifications not specified in Appendix C-3). *Specify qualifications*:
☒	Social Worker. *Specify qualifications:*
	A Master's degree in social work or a closely related field or a Bachelor's degree in social work or a closely related field and two (2) years of experience in the self directed use of case management techniques and counseling to sustain or restore client functioning or a Bachelor's degree and three (3) years of experience in the self directed use of case management techniques and counseling to sustain or restore client functioning. Substitution Allowed: For state employees successful completion of the Social Worker Trainee program may be substituted for the General Experience.
☐	Other (*specify the individuals and their qualifications):*

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

⊙	Entities and/or individuals that have responsibility for service plan development *may not provide* other direct waiver services to the participant.
○	Entities and/or individuals that have responsibility for service plan development *may provide* other direct waiver services to the participant. The State has established the following safeguards to ensure that service plan development is conducted in the best interests of the participant. *Specify*:

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

Department Social Work Division staff are required to assist every ABI Waiver participant (participant) in

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

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

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

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

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

In order to be eligible for ABI Waiver Services, consumers are required to exhibit a verifiable need for cueing or physical assistance in two or more activities of daily living (ADL's). DSS social workers, in consultation with the consumer, their family and care providers (e.g., skilled nursing/ABI facility staff, primary care physicians, and neuropsychologists) develop plans of care to meet an individual's cognitive, physical, and behavioral support needs. Regional social work supervisors review completed Plans of Care (POC) and forward them to the DSS Central Office manager for further review of eligibility, service adequacy and responsiveness to the waiver participant's needs.

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

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

The DSS social workers share the description of service information with consumers so that they are informed about the array of supports available. The specific, proposed services for each client, followed by the reason for selecting the service(s), the goal(s) expected to be achieved, and the timeframe for which the service is needed are also elements of the POC.

The DSS social worker, consumers, and the consumers' circle of support (family, caregivers, service providers, natural supports, and other relevant parties of the consumer's choosing) meet monthly, in most instances, to assess and monitor, through an interdisciplinary team process, service implementation, care efficacy, client progress, and safety. At such meetings, care plans are adjusted congruent with a client's current identified needs. Proposed changes to a client's person centered POC, as determined by the aforementioned team process, are signed by the consumer, submitted to a local social work supervisor, followed by review and approval by the Central Office administrator for the waiver program. The Central Office manager will return the care plan to the social worker for modification if service level/type, mix and length inadequacies are identified, as supported by the individual consumer's LOC assessment, applicable program procedures and DSS Home and Community-Based Services Provider Manual.

The ABI waiver program is person-centered, reflective of an approach to ensure that individual consumer presentations and needs are supported congruent with the eligible population standards. This service

operates under ongoing oversight checks and balances built in through Regional and Central Office DSS staff monitoring, fiscal agent[1] coordination and reporting, and system service documentation. All client specific actions are documented in the consumer's case record. All records are computer based and subject to periodic reviews by centralized managers in the DSS Division of Social Work.

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

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

The responsibility to assure health and welfare is balanced with the waiver participant's right to select their services and providers. It is imperative to accurately identify the services and supports that are needed to ensure the health and welfare of the waiver participant. During the service plan development process, the DSS social worker, the consumer/conservator and the team members (e.g., providers and other stake holders) collaborate to assess the consumer's level of skill, and identify risk factors including: inadequate supervision, social isolation, inability to summon assistance, emotional and behavioral issues, and communication capabilities. This information is used to provide the background necessary to identify areas of potential risk to the waiver participant. When risk issues are identified, members of the service planning team (e.g., DSS social worker, conservator, cognitive behaviorist, medical provider), provide feedback to the waiver participant regarding the area(s) of concern (e.g., ADL and IADL management) and members exchange ideas on how to mitigate risk. The waiver participant has the right to accept, reject or modify, recommendations that address risk.

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

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.

Social workers share with waiver consumers the provider listing, which is developed by a DSS contracted fiduciary. This listing identifies providers by service type and geographic coverage area who meet the qualifications as set forth by DSS to service waiver participants. The social workers facilitate opportunities for participants to speak with and/or interview prospective providers prior to selection. For household employees,

[1] The Department contracts with Allied Community Resources (ACR), for provider recruitment, enrollment and training under the ABI waiver. ACR also serves as the fiscal intermediary for this program, issuing claims payment to service providers and billing Medicaid for ABI waiver approved services.

a background check is conducted by the fiscal intermediary and the results are shared with the consumer to aid in their selection.

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

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

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

○	Every three months or more frequently when necessary
○	Every six months or more frequently when necessary
⊙	Every twelve months or more frequently when necessary
○	Other schedule (*specify*):

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 §74.53. Service plans are maintained by the following *(check each that applies)*:

☒	Medicaid agency
☐	Operating agency
☐	Case manager
☐	Other (*specify):*

Appendix D-2: Service Plan Implementation and Monitoring

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

DSS social workers are responsible for the development, management, administration, and monitoring of the HCBS waiver on the regional level. The social worker promotes participant choice, ensures the delivery of high quality services, assists in the development of needed services and oversees waiver cost-effectiveness, with the support of regional supervisors and central office managers. Collaboration with local and state government service providers and advocacy groups to develop a network of services and supports in the community is primarily facilitated through DSS' supervisory and management staff in the Social Work Services Division. DSS, through Social Work Services, Medical Operations, Quality Assurance, and the Bureau of Rehabilitative Services, is the central component in managing and delivering the program objectives of deinstitutionalization, diversion, waiver administration and resource development. DSS is responsible for implementing the HCBS waiver and facilitating access to waiver program supports for eligible individuals.

Monitoring Methods & Frequency: DSS social worker, consumers, and the consumers' circle of support (family, caregivers, service providers, natural supports, and other relevant parties of the consumer's choosing) meet monthly, in most instances, to assess, through an interdisciplinary team process, care efficacy, client progress, and safety. At such meetings, care plans are adjusted congruent with the client's current identified needs. Proposed changes to a client's person centered plan of care, as determined by the aforementioned team process, are submitted to a local social work supervisor, followed by review and approval by the Central Office administrator for the waiver program. The DSS social workers will report any problems that affect a waiver participant's health and welfare in their monthly meetings with their social work supervisor. The social worker/social work supervisor must contact the DSS Central Office waiver manager for technical assistance to address problems related to health and safety..

b. Monitoring Safeguards. *Select one:*

⊙	Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare *may not provide* other direct waiver services to the participant.
○	Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare *may provide* other direct waiver services to the participant. The State has established the following safeguards to ensure that monitoring is conducted in the best interests of the participant. *Specify*:

Appendix E: Participant Direction of Services

[NOTE: *Complete Appendix E only when the waiver provides for one or both of the participant direction opportunities specified below.*]

Applicability *(select one)*:

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

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

○	**Yes.** The State requests that this waiver be considered for Independence Plus designation.
⊙	**No.** Independence Plus designation is not requested.

Appendix E-1: Overview

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

Participants have the authority to and are supported to direct and manage their own services to the extent they wish and are able. The DSS social worker and other waiver providers partner with the waiver participant, and anyone he/she chooses, in the development of the participant Service Plan (SP). During SP development process the waiver participant is supported and encouraged to lead and fully participate in the process. The waiver participant attends team meetings and contributes to service plan revision decisions. Additional relevant information about DSS' participant direction is as follows:

- Service Plans are signed by the waiver participant and are maintained in each participant's file.
- Participants are the employer of record for household employees and are responsible for hiring, firing, assignment of duties and signing of timesheets. Supports in these activities are provided to those who need it. Case managing services are included in the service plans of participants who need assistance with these activities.
- Participants are afforded the opportunity to speak with and/or interview prospective agency providers prior to selection.

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

⊙	**Participant – Employer Authority**. As specified in ***Appendix E-2, Item a,*** the participant (or

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

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

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

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

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

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

DSS Social Workers and contracted providers (e.g., Brain Injury Association of Connecticut (BIAC), and Allied Community Resources (ACR) provide information to waiver consumers regarding participant direction. After completing an assessment of the applicant's needs, the DSS social worker assembles a person-centered team to help participants develop an appropriate Service Plan and provide a continuing source of support to participants after the plan has been implemented. The members of monthly service planning teams always include participant, conservator, if applicable, DSS social worker, a cognitive behaviorist, other clinical staff as necessary

and any other persons chosen by the participant. At these meetings the DSS social worker supports the waiver participant's role in directing their services.

The ABI waiver supports participant direction through its contracts with ACR and BIAC. These contracts require that the providers offer monthly ABI provider training. This training must address person-centered planning that include elements that address client choice, networking, and team building. The Brain Injury Association is required to provide services that include advocacy supports; this includes providing consultation and resource facilitation to persons who have sustained a brain injury, their families, caregivers and service providers. BIAC's work includes the following:

- Disseminating information to the community related to brain injury.
- Facilitating monthly support groups throughout Connecticut to provide information and networking opportunities to clients and client families affected by brain injury
- Fielding calls from persons who have sustained a brain injury, their families, caregivers and service providers
- Facilitating a Providers' Council with meetings 5 to 6 times per year to promote networking and information exchange between providers.
- Serving as an advocate who informs participants of their rights and supports them at team meetings, as needed.

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.	
X	The State provides for the direction of waiver services by a representative. Specify the representatives who may direct waiver services: *(check each that applies)*:	
	X	Waiver services may be directed by a legal representative of the participant.
	☐	Waiver services may be directed by a non-legal representative freely chosen by an adult participant. Specify the policies that apply regarding the direction of waiver services by participant-appointed representatives, including safeguards to ensure that the representative functions in the best interest of the participant:

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

Participant-Directed Waiver Service	Employer Authority	Budget Authority
Personal Care Assistance	**X**	☐
Companion	**X**	☐
Homemaker	**X**	☐
Chore	**X**	☐
Respite	**X**	☐

	☐	☐

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:*

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

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

○	FMS are covered as the waiver service entitled	
	As specified in Appendix C-3.	
X	FMS are provided as an administrative activity. *Provide the following information:*	
	i.	**Types of Entities**: Specify the types of entities that furnish FMS and the method of procuring these services:
		Fiscal intermediary. Services were procured through a competitive bid process.
	ii.	**Payment for FMS**. Specify how FMS entities are compensated for the administrative activities that they perform:
		Contract payment.
	iii.	**Scope of FMS**. Specify the scope of the supports that FMS entities provide *(check each that applies):*
		Supports furnished when the participant is the employer of direct support workers:
		X Assist participant in verifying support worker citizenship status
		X Collect and process timesheets of support workers
		X Process payroll, withholding, filing and payment of applicable federal, state and local employment-related taxes and insurance
		X Other *(specify):*
		Provide Consumer training that includes but is not limited to advertising/recruiting, interviewing techniques, PCA training, ongoing performance evaluations of PCA's and problem solving or termination of PCA's. The training shall also include monitoring the quality of the PCA plan implementation.

		Supports furnished when the participant exercises budget authority:
	☐	Maintain a separate account for each participant's participant-directed budget
	☐	Track and report participant funds, disbursements and the balance of participant funds
	☐	Process and pay invoices for goods and services approved in the service plan
	☐	Provide participant with periodic reports of expenditures and the status of the participant-directed budget
	☐	Other services and supports *(specify)*:
		Additional functions/activities:
	X	Execute and hold Medicaid provider agreements as authorized under a written agreement with the Medicaid agency
	X	Receive and disburse funds for the payment of participant-directed services under an agreement with the Medicaid agency or operating agency
	☐	Provide other entities specified by the State with periodic reports of expenditures and the status of the participant-directed budget
	☐	Other *(specify):*
iv.		**Oversight of FMS Entities.** Specify the methods that are employed to: (a) monitor and assess the performance of FMS entities, including ensuring the integrity of the financial transactions that they perform; (b) the entity (or entities) responsible for this monitoring; and, (c) how frequently performance is assessed.
		DSS is responsible for the monitoring an assessment of performance for the FMS. The following activities support this effort: ▪ Review of quarterly and ad hoc reports from the fiscal intermediary ▪ Annual on-site visits to review operational and administrative functions ▪ Ongoing correspondence between the fiscal intermediary and DSS staff regarding progress on deliverables (e.g., claims processing, training schedules, numbers of credential providers, etc.) ▪ A bi-annual survey administered to waiver participants regarding the FMS' performance ▪ Random audits of Medicaid Providers by DSS Quality Assurance Division

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:*
☒	**Waiver Service Coverage**. Information and assistance in support of participant direction are provided through the waiver service coverage (s) specified in Appendix C-3 entitled: **Case Managment**
	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:*

k. Indep**endent Advocacy** *(select one)*.

X	**Yes.** Independent advocacy is available to participants who direct their services. *Describe the nature of this independent advocacy and how participants may access this advocacy*:
	DSS contracts with the Brain Injury Association of Connecticut, Inc. (BIAC) for the purpose of providing consultation, advocacy, resource facilitation, support, information, training and outreach to persons with brain injury and their families. BIAC's services through this contract are intended to enable participants to advocate for themselves for access to brain injury programs and community-based supports. In addition to direct advocacy, telephonic support (statewide toll-free number), newsletter and web-based information dissemination, BIAC is funded to conduct numerous trainings and community education programs. BIAC is accessible by telephone, internet, and a community support groups held statewide. Connecticut's Office of Protection and Advocacy (P & A) provides supports and advocacy for persons with disabilities. P & A also has a HRSA grant to provide supports to persons with traumatic brain injury. They have served as advocates for persons on the ABI waiver. P & A also has a statewide toll-free number and a website.
○	**No.** Arrangements have not been made for independent advocacy.

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

Participant direction of self directed Waiver services (e.g., PCA, private homemaker, private companion) may be voluntarily terminated. All Waiver services, except for Personal Care Assistance (PCA) are available through Waiver agency providers. Home Health Services, through the Medicaid program replaces PCA for clients who do not wish to self-direct. If a participant chooses to terminate self-direction, the DSS social worker aids in the identification of agency provider and informal supports to support the consumer's need. The planning team

process supports continuity of care by ensuring linkage to the appropriate service in a timely manner.

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

Participant direction of self-directed waiver services can be involuntarily terminated, when a consumer does not demonstrate the ability to manage their household employees. In this circumstance, a Notice of Action is issued and the consumer has a right to a fair hearing, pursuant to Medicaid rules. As noted above, all services, except for Personal Care Assistance (PCA) are available through Waiver agency providers. Home Health Services, through the Medicaid program only replaces PCA for clients who do not wish to self-direct. If a participant self-direction is terminated, the DSS social worker aids in the identification of agency provider and informal supports to support the consumer's need. The planning team process supports continuity of care by ensuring linkage to the appropriate service in a timely manner.

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

Table E-1-n

	Employer Authority Only	**Budget Authority Only or Budget Authority in Combination with Employer Authority**
Waiver Year	**Number of Participants**	**Number of Participants**
Year 1	65	0
Year 2	65	0
Year 3	65	0
Year 4 (renewal only)	65	0
Year 5 (renewal only)	65	0

Appendix E-2: Opportunities for Participant-Direction

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. *Check each that applies:*

☐	**Participant/Co-Employer**. The participant (or the participant's representative) functions as the co-employer (managing employer) of workers who provide waiver services. An agency is the common law employer of participant-selected/recruited staff and performs necessary payroll and human resources functions. Supports are available to assist the participant in conducting employer-related functions. *Specify the types of agencies (a.k.a., "agencies with choice") that serve as co-employers of participant-selected staff:*
☒	**Participant/Common Law Employer**. The participant (or the participant's representative) is the common law employer of workers who provide waiver services. An IRS-approved Fiscal/Employer Agent functions as the participant's agent in performing payroll and other employer responsibilities that are required by federal and state law. Supports are available to assist the participant in conducting employer-related functions.

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

☒	Recruit staff
☐	Refer staff to agency for hiring (co-employer)
☒	Select staff from worker registry
☒	Hire staff (common law employer)
☐	Verify staff qualifications
☒	Obtain criminal history and/or background investigation of staff. Specify how the costs of such investigations are compensated:
	The fiscal intermediary, at no cost to the participant, performs this function. The results are forwarded to the waiver participant.
☐	Specify additional staff qualifications based on participant needs and preferences so long as such qualifications are consistent with the qualifications specified in Appendix C-3.
☒	Determine staff duties consistent with the service specifications in Appendix C-3.
☒	Determine staff wages and benefits subject to applicable 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)*:

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. *Check all that apply***:**

☐	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-3
☐	Specify how services are provided, consistent with the service specifications contained in Appendix 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):*

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.

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.

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

○	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:
○	Modifications to the participant-directed budget must be preceded by a change in the service plan.

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

Appendix F: Participant Rights

Appendix F-1: Opportunity to Request a Fair Hearing

The State provides an opportunity to request a Fair Hearing under42 CFR Part 431, Subpart E to individuals: (a) who are not given the choice of home and community-based services as an alternative to the institutional care specified in Item 1-F of the request; (b) are denied the service(s) of their choice or the provider(s) of their choice; or, (c) whose services are denied, suspended, reduced or terminated. The State provides notice of action as required in 42 CFR §431.210.

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

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

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

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

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*:

○	**Yes**. The State operates an additional dispute resolution process *(complete Item b)*
⊙	**No**. This Appendix does not apply (*do not complete Item b)*

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

Appendix F-3: State Grievance/Complaint System

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

⊙	**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 *(complete the remaining items)*.
○	**No.** This Appendix does not apply (*do not complete the remaining items*)

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

The Department of Social Services is responsible for the operation of the grievance/complaint system.

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

Although ABI Waiver does not have a formal complaint process, DSS receives and acts upon complaints in a number of ways. DSS may receive consumer complaints through their being reported to DSS Social Workers, Brain Injury Association Advocates, fiduciary vendor, Office of Protection and Advocacy, and community providers.
DSS regional and central office staff follow up on any complaints regarding waiver providers and direct them to appropriate authorities when needed (e.g., law enforcement, Department of Public Health, etc).

Strategy for Improvement A: Implement a more formal mechanism by which participants are informed of how to register grievances and complaints and are supported in seeking resolution. Use established disability service toll-free number as the central site for fielding complaints. Timeline to accomplishment April 2007.

Strategy for Improvement B: Within available resource to DSS, to develop a more comprehensive complaint management and follow-up tracking "add-on" to the existing ABI Waiver database. Deployment of this mechanism is intended for completion by December 2007.

Note: The aforementioned activities do not impact neither the participant's right nor the timeframe for a hearings and appeal process.

Appendix G: Participant Safeguards

Appendix G-1: Response to Critical Events or Incidents

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

A. Under the Connecticut ABI Waiver, the quality of services provided is assured in several ways: maintaining established credentials for standards for prospective providers (including background checks for household employees) by a fiscal intermediary, which maintains the provider registry; an ongoing clinical review of the plan of care by a cognitive behavioral specialist working with the consumer's team; monitoring by the DSS social worker at team meetings and through monthly provider reports; and a process for follow-up of reported incidents.

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

The Contractor shall submit to the Department's Program Manager an incident report detailing situations that have compromised the health and/or safety of clients served in the program. The incident report shall be submitted within five business days of the occurrence and shall include but not be limited to: client name, staff involved, date, time, details of the incident, an explanation of corrective action taken, and standard operating procedure established to prevent future incidences.

It is the Department's intent to modify this language to be included in all service agreements for ABI Waiver Program providers by January 2007.

The Department has developed a "Serious Reportable Incident" form specific to the ABI Waiver. This form has been piloted with an ABI Waiver vendor for the past six months. This incident reporting form will be fully deployed with the implementation of the ABI Waiver renewal.

A Serious Reportable Incident is defined as any situation in which the waiver participant experiences a perceived or actual threat to his/her health and welfare or to their ability to remain in the community. These incidents include:

- Allegations of physical, sexual and psychological abuse, seclusion, violation of civil rights, mistreatment, neglect and exploitation
- Missing person
- Death of a waiver participant

- Unplanned hospitalization
- Possible criminal action
- Medication refusal
- Medical treatment due to accident or injury

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

B. All members of the Waiver participant's care planning team and service agency staff members are required to report critical incidents. Recipients of Critical Incident reporters include:
   - Participant's DSS Worker
   - Cognitive Behaviorist
   - Participant and/or Conservator
   - DSS Central Office (ABI Program Manager/Social Work Supervisor)

Reporting Methods and Timeframes:

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

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

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

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

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

The Department contracts with the Brain Injury Association to provide services that include advocacy

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

Strategy for Improvement: As part of its quality management strategy, DSS will develop a brochure that clearly articulates the appropriate parties to contact regarding potential abuse, neglect or exploitation of waiver participants. This brochure will be developed and deployed during the March 2007. Provider and consumer/representative training beginning in March 2007 with training held throughout 2007. Consumers/representative will be informed of the necessity to report events at their annual service plan review meetings, or anytime during the waiver year that it seems necessary to reiterate this information. Documentation regarding the receipt of information about reporting actual or perceived matters that impact participants' safety and well-being will be obtained. All participants will sign the Right and Responsibilities form to evidence that such information has been imparted. Providers will be required to confirm receipt of information upon application or renewal of ABI Waiver provider enrollment.

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

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

The Department is developing an improved data system to manage incident reporting and related follow-up and analysis. In the interim, the current case management database has the capability to track safety issues and can be queried and prompted with a tickler feature to ensure timely resolution.

When a waiver participant is age sixty or older and it is deemed appropriate to contact Protective

Services for the Elderly (PSE) as part of the investigation, the social worker will assure this is done. In addition, police are notified if any criminal action occurs. Any party involved in the investigation process may initiate contact with PSE or the police. All contacts with PSE and/or the police must be documented as part of the investigation process. PSE Statute 17b-450 – 461 provides the framework for the investigation of abuse or neglect.

Strategy for Improvement: The Department is developing improved data system to manage incident reporting and related follow-up and analysis. The internal capability to develop a more comprehensive Critical Incident "add-on" to the existing database exists within the Department's resources. Deployment of this mechanism is intended for completion by the December 2007.

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

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

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

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

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions

This Appendix must be completed when the use of restraints and/or restrictive interventions is permitted during the course of the provision of waiver services regardless of setting. When a state prohibits the use of restraints and/or restrictive interventions during the provision of waiver services, this Appendix does not need to be completed.

a. Applicability. *Select one:*

⊙	This Appendix is not applicable. The State does not permit or prohibits the use of restraints or restrictive interventions *(do not complete the remaining items)*	
○	This Appendix applies. Check each that applies:	
	☐	The use of personal restraints, drugs used as restraints, mechanical restraints and/or seclusion is permitted subject to State safeguards concerning their use. *Complete item G-2-b.*
	☐	Services furnished to waiver participants may include the use of restrictive interventions subject to State safeguards concerning their use. *Complete items G-2-c.*

b. Safeguards Concerning Use of Restraints or Seclusion

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

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

c. Safeguards Concerning the Use of Restrictive Interventions

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

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

Appendix G-3: Medication Management and Administration

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:

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

b. Medication Management and Follow-Up

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

Waiver participants must be monitored regarding their ability to self-administer medication. Upon admission to the ABI Waiver, every six (6) months and as necessary, the DSS social worker, in consultation with the prescribing licensed medical provider (e.g., physician, psychiatrist, Advanced Practice Nurse), the cognitive behaviorist, and other team members, gathers information regarding the participant's ability to self-administer medication., When a client does not demonstrate the ability to self-administer medication or problems are identified, supports a put in place to facilitate safe administration or medication, methods are described below.

The prescribing licensed medical provider, conservators (if applicable), and nurses, through the State Plan Home Health service, are responsible for monitoring participant medication regimens. The prescribing medical provider determines the frequency, but monitoring is conducted daily through monthly basis, depending on the need of the participant. Methods include but are not limited to, pre-pouring medication, bubble packed medication, electronic reminders (e.g., timed pill boxes), nursing visits, and laboratory tests for blood levels.

All ABI Waiver service providers are responsible for reporting any cognitive, physical and/or behavioral changes, which may require intervention, to their supervisor or to the DSS Social Worker for follow-up.

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.

DSS is the State agency responsible for identifying potentially harmful practices DSS social workers, through team meetings and home visits with the waiver participant, he/she will assure communication occurs with Waiver provider staff and team members about waiver participant's status. This communication will allow for discussion regarding any potentially harmful practices or findings brought to the attention of the DSS and support the resolution of identified problems in collaboration the licensed prescribing provider and relevant entities (e.g., Nursing staff, participant, conservator, waiver providers). As necessary, DSS social workers will forward Service Plan revisions to support quality medication administration practices.

The State of Connecticut Department of Public Health (DPH) oversees the licensed prescribing providers, pharmacists and the Medicaid State Plan Home Health Nursing services. Any Public Health Code issues would be followed-up by DPH.

c. Medication Administration by Waiver Providers

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

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

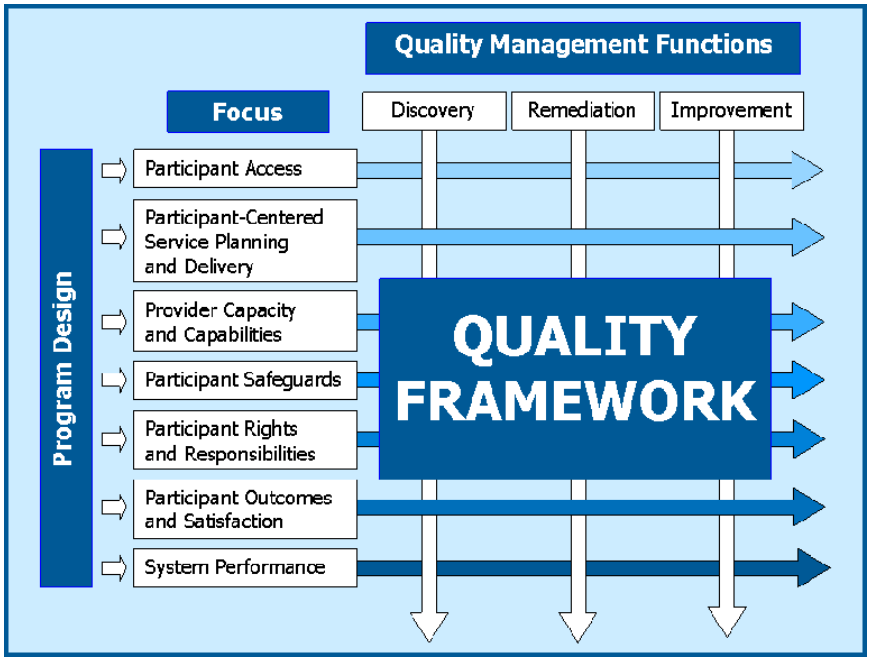
ii. State Policy. Summarize the State policies that apply to the administration of medications by waiver providers or waiver provider responsibilities when participants self-administer medications, including (if applicable) policies concerning medication administration by non-medical waiver provider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

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

○	Providers that are responsible for medication administration are required to *both* record and report medication errors to a State agency (or agencies). *Complete the following three items:*
	(a) Specify State agency (or agencies) to which errors are reported:
	(b) Specify the types of medication errors that providers are required to *record:*
	(c) Specify the types of medication errors that providers must *report* to the State:
○	Providers responsible for medication administration are required to *record* medication errors but make information about medication errors available only when requested by the State. Specify the types of medication errors that providers are required to record:

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

Appendix H: Quality Management Strategy



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

Quality Management 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. A Quality Management Strategy is explicitly describes the processes of discovery, remediation and improvement; the frequency of those processes; the source and types of information gathered, analyzed and utilized to measure performance; and key roles and responsibilities for managing quality.

CMS recognizes that a state's waiver Quality Management 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 Management 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 Management Strategy.

Quality management is dynamic and the Quality Management Strategy may, and probably will, change over time. Modifications or updates to the Quality Management Strategy shall be submitted to CMS in conjunction with the annual report required under the provisions of 42 CFR §441.302(h) and at the time of waiver renewal.

Quality Management Strategy: Minimum Components

The Quality Management Strategy that will be in effect during the period of the waiver is included as Attachment #1 to Appendix H. The Quality Management Strategy should be no more than ten-pages in length. It may reference other documents that provide additional supporting information about specific elements of the Quality Management Strategy. Other documents that are cited must be available to CMS upon request through the Medicaid agency or the operating agency (if appropriate).

1. **The Quality Management Strategy must describe how the state will determine that each waiver assurance and requirement is met.** The applicable assurances and requirements are: (a) level of care determination; (b) service plan; (c) qualified providers; (d) health and welfare; (e) administrative authority; and, (f) financial accountability. For each waiver assurance, this description must include:
   - Activities or processes related to discovery, i.e. monitoring and recording the findings. Descriptions of monitoring/oversight activities that occur at the individual and provider level of service delivery are provided in the application in Appendices A, B, C, D, G, and I. These monitoring activities provide a foundation for Quality Management by generating information that can be aggregated and analyzed to measure the overall system performance. The description of the Quality Management Strategy should not repeat the descriptions that are addressed in other parts of the waiver application;
   - The entities or individuals responsible for conducting the discovery/monitoring processes;
   - The types of information used to measure performance; and,
   - The frequency with which performance is measured.
2. **The Quality Management Strategy must describe roles and responsibilities of the parties involved in measuring performance and making improvements. Such parties include (but are not limited to) the waiver administrative entities identified in Appendix A, waiver participants, advocates, and service providers.**

   Roles and responsibilities may be described comprehensively; it is not necessary to describe roles and responsibilities assurance by assurance. This description of roles and responsibilities may be combined with the description of the processes employed to review findings, establish priorities and develop strategies for remediation and improvement as specified in #3 below.
3. **Quality Management Strategy must describe the processes employed to review findings from its discovery activities, to establish priorities and to develop strategies for remediation and improvement.** *The description of these process(es) employed to review findings, establish priorities and develop strategies for remediation and improvement may be combined with the description of roles and responsibilities as specified in # 2 above.*
4. **The Quality Management Strategy must describe how the State compiles quality management information and the frequency with which the State communicates this information (in report or other forms) to waiver participants, families, waiver service providers, other interested parties, and the public.** *Quality management reports may be designed to focus on specific areas of concern; may be related to a specific location, type of service or subgroup of participants; may be designed as administrative management reports; and/or may be developed to inform stakeholders and the public.*
5. **The Quality Management Strategy must include periodic evaluation of and revision to the Quality Management Strategy. Include a description of the process and frequency for evaluating and updating the Quality Management Strategy**.

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

When the Quality Management Strategy spans more than one waiver and/or other types of long-term care services under the Medicaid State plan, specify the control numbers for the other waiver programs and identify the other long-term services that are addressed in the Quality Management Strategy.

Attachment #1 to Appendix H

Please find below an overview of quality management strategies for each of the
The Quality Management Strategy for the waiver is as follows:

ASSURANCE: LEVEL OF CARE (LOC)

- Waiver applicants for whom there is reasonable indication that services may be needed in the future are provided an individual LOC evaluation
- The LOC of enrolled participants is reevaluated at least annually or as specified in the approved waiver
- The processes and instruments described in the approved waiver are applied to LOC determinations

Level of Care (LOC) is determined at least annually and more frequently, as needed. Social workers use a standardized "Level of Care Determination" instrument to assess need for services under the ABI waiver. This tool allows the Department to better evaluate whether there is reasonable indication that the consumer will require services in the future.

Assessments are made based upon determination of impairment and/or need within daily living, behavioral, and cognitive categories. Client determinations are reviewed by regional level social work a supervisor, which is followed by a final review and service level determination by a master's prepared Central Office social worker who is also the ABI Waiver program manager. All LOC determinations are required to be documented in the waiver consumers' case record and the Social Work Services Database.

If it is thought that a consumer's level of care (LOC) is inappropriate, that individual is reassessed by DSS social work staff with oversight by the Department's ABI Waiver Manager, to ensure that all necessary factors have been considered in assigning the care level. For example, if a situation arises where a consumer has been assigned to a LOC that is too low, but within waiver standards that consumer is assigned to a higher level and their care plan is appropriately adapted. If, on the other hand, the level assigned is too high, the consumer is issued a Notice of Action (NOA) that their care will be reduced or terminated. The consumer is afforded full access to the Medicaid appeals process, which is administered by the DSS Office of Legal Counsel, Regulations and Fair Hearings.

If it is determined that a client does not qualify for services under the ABI waiver or that subsequent service reduction or termination is indicated, the client receives, as noted above, a NOA that sets forth the proposed denial/change. Clients are afforded the opportunity for a Fair Hearing in accordance with Departmental Medicaid Policy. Service cannot be reduced until the hearing decision is issued, if a client requests a hearing within 10 days of the date of the NOA.

Furthermore, as a means to support the implementation of this program, weekly management team meetings and monthly social work supervisor meetings include waiver agenda items, with a focus on challenging cases or macro issues related to the waiver program's management. Supervisors are required to meet with social work staff at least monthly to review case issues and ensure timely assessment and reviews. Training targeted to enhance social work staffs' competencies as it pertains to assessment and care management is also provided. Timely ness of level of care determination and re-determinations has been further communicated to staff in an Informational Bulletin (#2005-01) regarding annual review dates. Also, in meetings with social work supervisory staff (typically in November/December meetings) review date projection reports are distributed to track for the upcoming waiver year, as a back-up to the case management database. In monthly supervision with social workers, supervisors are required to track progress on plan of care reviews.

ASSURANCE: SERVICE PLANS

- Individual service plan (SP) addresses all participant's assessed needs (including health and safety risk factors) and personal goals, either by the provision of waiver services or through other means
- The State monitors SP development in accordance with its policies and procedures and takes appropriate action when it identifies inadequacies in SP development
- SPs are updated/revised at least annually or when warranted by changes in the waiver participant's needs
- Services are delivered in accordance with the SP, including in the type, scope, amount, duration, and frequency specified in the SP.
- Participants are afforded choice between/among waiver services and providers

In order to be eligible for ABI Waiver Services, consumers are required to exhibit a verifiable need for cueing or physical assistance in two or more activities of daily living (ADL's). DSS social workers, in consultation with the consumer, their family and care providers (e.g., skilled nursing/ABI facility staff, primary care physicians, and *neuropsychologists*) develop plans of care to meet an individual's cognitive, physical, and behavioral support needs. Regional social work supervisors review completed Plans of Care (POC) and forward them to the DSS Central Office manager for further review of eligibility, service adequacy and responsiveness to the waiver participant's needs.

Initial care plans are developed using a standardized form. This form requires plan development informed by the following constellations:

- Health
- Risk Indicators
- Life Planning
- Functional Assessment
- Behavioral Issues
- Community-Based Supports
- Communication
- Proposed services
- Rational for Service(s),
- Goal(s)
- Timeframes

The DSS social worker, consumers, and the consumers' circle of support (family, caregivers, service providers, natural supports, and other relevant parties of the consumer's choosing) meet monthly, in most instances, to assess, through an interdisciplinary team process, care efficacy, client progress, and safety. At such meetings, care plans are adjusted congruent with the client's current identified needs. Proposed changes to a client's person centered POC, as determined by the aforementioned team process, are submitted to a local social work supervisor, followed by review and approval by the Central Office administrator for the waiver program. The Central Office manager will return the care plan to the social worker for modification if service level/type, mix and length inadequacies are identified, as supported by the individual consumer's LOC assessment, applicable program procedures and the Department's Home and Community-Based Services Provider Manual.

The ABI waiver program is managed on a case-by-case basis, reflective of an approach to ensure that individual consumer presentations and needs are supported congruent with the eligible population standards. This service operates under ongoing oversight checks and balances built in through Regional and Central Office DSS staff monitoring, fiscal agent coordination and reporting, and system service documentation. All client specific actions are documented in the consumer's case record. All records, paper and electronic, are subject to periodic reviews by centralized managers in the DSS Division of Social Work.

The State's requirement for documented client choice regarding institutional versus community-based services is evidenced through consumer attestation and signature as part of the waiver application process. A process is also in place to ensure that consumers can affect individualized provider choice. Social workers share with waiver consumers

the provider listing, which is developed by a DSS contracted fiduciary. This listing identifies providers by service type and geographic coverage area. Clients are afforded the opportunity to speak with and/or interview prospective providers prior to selection. Clients are the employer of record for household employees, therefore, they have the right and responsibility to hire, manage, oversee and fire their own providers.

ASSURANCE: QUALIFIED PROVIDERS

- The State verifies on a periodic basis that providers meet required licensing and/or certification standards and adhere to other standards prior to their furnishing waiver services.
- The State verifies on a periodic basis that providers continue to meet required licensure and/or certification standards and/or adhere to other State standards.
- The State monitors non-licensed/non-certified providers to assure adherence to waiver requirements
- The State implements its policies and procedures for verifying that training is provided in accordance with State requirements and the approved waiver.

Information from the Department's Services Data System, as of September 1, 2006, indicates that there are currently 288 active ABI waiver consumers receiving services from 218 providers. As noted above, consumer choice is supported through participant's or their conservators' selection of credentialed providers from a registry that is administered and maintained by a DSS contracted fiscal intermediary.

Use of a fiscal intermediary ensures that only qualified providers deliver services under the waiver. The fiscal intermediary is responsible for ensuring that all providers maintained on the registry undergo required and approved training in accordance with DSS stipulations, and comport to qualification standards articulated in the Home and Community-Based Services Provider Manual. These standards include providers' documentation of licensure; accreditation; staff resumes; training certifications; and/or staff job descriptions. Each service type details the specific provider qualifications required in order to be included on the registry and to be authorized for payment under the ABI waiver program. For example, under the Personal Care Assistance service, consumers are able to select from qualified individuals or chose persons that they or their representative have identified. Persons listed under the PCA category within the Provider Registry must undergo approved training through the fiscal intermediary .

In addition, the fiscal intermediary for Connecticut's ABI Waiver program documents and reports to DSS, at no less than a quarterly interval, a listing of all registered provider participation and/or disenrollment. Next, a review of waiver issues occurs at the Social Work Services Division Management Team and social work supervisor meetings. Department staff and the fiduciary agency also monitor and follow-up on discrepancies pertaining to provider qualification presentations (e.g., conflicts of interest, relationship to client issues, misrepresentations, etc.), with DSS Central Office managers taking necessary and appropriate actions to resolve the identified issue. In instances in which providers have submitted insufficient documentation to support credentialing by the fiscal intermediary, DSS Central Office managers will meet with such providers to engage them in an interview to better elicit the requisite information to allow for a proper qualification determination. Matters of fraudulent qualification presentations would, at a minimum, result in the removal of the provider from the registry and other sanctions and penalties (e.g., financial penalties, withdrawal of Medicaid provider eligibility, etc.) as available to the Department.

ASSURANCE: HEALTH AND WELFARE

- There is continuous monitoring of the health and welfare of waiver participants and remediation actions are initiated when appropriate.
- On an ongoing basis the State identifies, addresses and seeks to prevent instances of abuse, neglect and exploitation.

As noted, DSS administers and manages the ABI waiver using a person centered, social services model. Using Department social workers who engage in client assessment and case management, fiduciary agent administered provider training, credentialing, reporting and provider registry maintenance, and ongoing interdisciplinary care plan review and management, measures are in place to promote and protect the health and welfare of ABI waiver consumers. DSS also requires a clear written emergency back-up plan for each consumer to better ensure service continuity and uninterrupted care and support.

In addition, Department social work staff periodically visit consumers in their homes or other care setting. This assessment allows the staff to review consumers' ADL's, behavioral challenges, strengths, and deficits within the setting. As part of the person-centered planning process, team meetings are held, typically monthly, to assess progress on goals and objectives identified in the consumer's individualized POC. These meetings are held in the client's home, regional offices, provider agencies, or other sites agreeable to the client/conservator. In addition to input from the consumers and other key stakeholders, the plan is modified to take into consideration monthly reports submitted by ABI waiver funded providers, detailing participant's progress towards meeting the goals and objectives that have been identified. Furthermore, to support that services and level of care are congruent with client's functioning and needs, an annual assessment is required to be conducted by regional social workers. This review of care must be checked by regional social work supervisors and forwarded to the Central Office manager for approval.

Finally, DSS' general agency quality assurance, and improvement initiatives and activities apply to all programs it operates. Quality assurance activities within the Department include referral to its Fraud and Recovery unit if an incident report is of a fiscal nature. The Department also maintains the Office of Skill Development (OSD), which provides training to DSS staff about core functions of the Department and expected competencies. The training staff within OSD are employed through the University of Connecticut's School of Social Work. In addition, consumer quality of care is monitored through social worker supervision and established processes in which provider/consumer incidents are documented in the client record and reported to DSS Central Office Managers to inform ongoing program management and individual case follow-up.

ASSURANCE: ADMINISTRATIVE AUTHORITY

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

The Department of Social Services (DSS), as the state Medicaid Agency pursuant to Connecticut General Statutes (CGS) §17b-1, directly administers the ABI Waiver according to CGS §17b-260a. DSS assures that all individuals receiving waiver services meet the categorically and medically needy eligibility and income/asset requirements. DSS is responsible for calculating the consumer's share of liability that can be applied to the cost of waiver services. DSS also informs individuals determined eligible to receive waiver services of their due process rights and gives them the choice of institutional or home and community based services. As noted above, DSS contracts with a fiscal agent to conduct provider recruitment; training; engage in fiscal monitoring; claims processing and reporting; and provider credentialing. Quarterly reports, at a minimum, are submitted by the fiscal intermediary to the Department to facilitate State oversight of the waiver program. In addition, routine quality assurance activities through staff meetings, training, case conferences, consumer

record maintenance, and staff supervision are components of the Department's oversight of the ABI waiver program.

ASSURANCE: Financial Accountability

- Claims for federal financial participation in the costs of waiver services are based on state payments for waiver services that have been rendered to waiver participants, authorized in the SP, and properly billed by qualified waiver providers in accordance with the approved waiver.

DSS has contracted with a fiscal intermediary to maintain the payment records for services received and billed under the ABI Waiver. The fiscal intermediary, Allied Community Resource, Inc. (ACR) ensures that all billed services emanate from an approved consumer plan of care and submits appropriate claims to Electronic Data Systems (EDS), who is a claims payment subcontractor of the Department. EDS reviews the claim for Medicaid eligibility and other elements (i.e., spend-down requirements) before reimbursing the fiscal agent. ACR ensures that all services and corresponding claim payments are coded and properly documented. Reporting to DSS from ACR occurs, set forth by service category the payments made during the quarter and year to date. Systems are in place to require investigation into and resolution by DSS Central Office of any identified discrepancy before a disputed service may be paid. Also, the computerized service documentation system allows for the tracking of expenditures for each client (approved cost of the plan), as well as the total waiver program.

Appendix I: Financial Accountability

APPENDIX I-1: Financial Integrity and Accountability

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

The Department of Social Services has contracted with a fiscal intermediary to maintain the payment records for services received and billed under the ABI Waiver. The fiscal intermediary, Allied Community Resource, Inc. (ACR) ensures that all billed services emanate from an approved consumer plan of care and submits appropriate claims to Electronic Data Systems (EDS), who is a claims payment subcontractor of the Department. EDS reviews the claim for Medicaid eligibility and other elements (i.e., spend-down requirements) before reimbursing the fiscal agent. ACR ensures that all services and corresponding claim payments are coded and properly documented.

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

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

APPENDIX I-2: Rates, Billing and Claims

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

Pursuant to Connecticut Department of Social Services Provider manual. All schedules of payment for coverable Medical Assistance Program goods and services shall be established by the Commissioner and paid by the department in accordance with all applicable federal and state statutes and regulations. Waiver service rates are based on a trended 2.5% increase on rates established in the initial ABI waiver. Input on the waiver, including rates were afforded to all parties who commented on the ABI Waiver to support the application. This includes consumers, family, DSS social workers, and providers.

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:

Payments are made by the Medicaid agency directly to the providers of waiver and State plan services. There are provider agreements between the DSS and each provider of services under the waiver. Payments for all waiver and other State plan services are be made through an approved Connecticut's Medicaid Management Information System (MMIS). DSS pays providers through the same fiscal agent used in the rest of the Medicaid program. DSS also uses a limited fiscal agent who functions only to validate payment of waiver claims, as supported by the participant's service plan.

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

Yes. Public agencies directly expend funds for part or all of the cost of waiver services and certify their public expenditures (CPE) in lieu of billing that amount to Medicaid (*check each that applies*):

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

☐	**Certified Public Expenditures (CPE) of Non-State Public Agencies**. Specify: (a) the non-State public 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.*)
No. Public agencies do not certify expenditures for waiver services.	

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:

Payments are made by the Medicaid agency directly to the providers of waiver and State plan services. There are provider agreements between the DSS and each provider of services under the waiver. Payments for all waiver and other State plan services are be made through an approved Connecticut's Medicaid Management Information System (MMIS). DSS pays providers through the same fiscal agent used in the rest of the Medicaid program. DSS also uses a limited fiscal agent (ACR) who functions only to validate payment of waiver claims, as supported by the participant's service plan, and submits appropriate claims to Electronic Data Systems (EDS), who is a claims payment subcontractor of the Department.

For household employee services (e.g., Personal Care Assistance, private homemaker services), claims are paid when timesheets signed by the consumer or their representive are signed and the claims comport with the plan of care. Agency Waiver service providers are subject to DSS Office of Quality Assurance (QA) financial audits which, issues exceptions when appropriate for issues of non-compliance with the State's policy requirements.

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 §74.53.

APPENDIX I-3: Payment

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:

b. Direct payment. Payments for waiver services are made utilizing one or more of the following arrangements (*check each that applies*):

☒	The Medicaid agency makes payments directly to providers of waiver services.
☒	The Medicaid agency pays providers through the same fiscal agent used for the rest of the Medicaid program. ** DSS has contracts with ACR to maintain the payment records on services received and billed under the ABI Waiver. ACR ensures that all ABI waiver services billed emanate from an approved consumer POC and submits appropriate claims to Electronic Data Systems (EDS), who is a claims payment subcontractor of the Department. EDS reviews the claim for Medicaid eligibility and other elements (i.e., spend-down requirements) before reimbursing the fiscal agent.
☐	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.

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:*

X	**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 and (b) the types of providers to which such payments are made. 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.

d. Payments to Public Providers. *Specify whether public providers receive payment for the provision of waiver services.*

○	**Yes.** Public providers receive payment for waiver services. Specify the types of public providers that receive payment for waiver services and the services that the public providers furnish. *Complete item I-3-e.*
X	**No**. Public providers do not receive payment for waiver services. *Do not complete Item I-3-e.*

e. **Amount of Payment to Public Providers**. Specify whether any public provider receives payments (including regular and any supplemental payments) that in the aggregate *exceed* its reasonable costs of providing waiver services and, if so, 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 public providers is the same as the amount paid to private providers of the same service.
○	The amount paid to public 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 public providers differs from the amount paid to private providers of the same service. When a public 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:

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 do not receive and retain 100 percent of the amount claimed to CMS for waiver services. Provide a full description of the billing, claims, or payment processes that result in less than 100% reimbursement of providers. Include: (a) the methodology for reduced or returned payments; (b) a complete listing of types of providers, the amount or percentage of payments that are reduced or returned; and, (c) the disposition and use of the funds retained or returned to the State (i.e., general fund, medical services account, etc.):
○	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.

g. Additional Payment Arrangements

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

○	**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.
X	**No**. The State does not provide that providers may voluntarily reassign their right to direct payments to a governmental agency.

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

○	**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:
X	**No**. The State does not employ Organized Health Care Delivery System (OHCDS) arrangements under the provisions of 42 CFR §447.10.

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

○	The State contracts with a Managed Care Organization(s) (MCOs) and/or prepaid inpatient health plan(s) (PIHP) or prepaid ambulatory health plan(s) (PAHP) under the provisions of §1915(a)(1) of the Act for the delivery of waiver and other services. Participants may *voluntarily* elect to receive *waiver* and other services through such MCOs or prepaid health plans. Contracts with these health plans are on file at the State Medicaid agency. Describe: (a) the MCOs and/or health plans that furnish services under the provisions of §1915(a)(1); (b) the geographic areas served by these plans; (c) the waiver and other services furnished by these plans; and, (d) how payments are made to the health plans.
○	This waiver is a part of a concurrent §1915(b)/§1915(c) waiver. Participants are required to obtain *waiver* and other services through a MCO and/or prepaid inpatient health plan (PIHP) or a prepaid ambulatory health plan (PAHP). The §1915(b) waiver specifies the types of health plans that are used and how payments to these plans are made.
X	The State does not contract with MCOs, PIHPs or PAHPs for the provision of waiver services.

APPENDIX I-4: Non-Federal Matching Funds

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. *Check each that applies:*

X	**Appropriation of State Tax Revenues to the State Medicaid agency**
☐	**Appropriation of State Tax Revenues to a State Agency other than the Medicaid Agency.** If the source of the non-federal share is appropriations to another state agency (or agencies), specify: (a) the 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 public agencies as CPEs, as indicated in Item I-2-c:
☐	**Other State Level Source(s) of Funds.** Specify: (a) the source and nature of funds; (b) the entity or agency that receives the funds; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by public agencies as CPEs, as indicated in Item I-2- c:

b. Local 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. *Check each that applies:*

☐	**Appropriation of Local Revenues.** Specify: (a) the local 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 public agencies as CPEs, as specified in Item I-2- c:
☐	**Other non-State Level Source(s) of Funds.** Specify: (a) the source of funds; (b) the 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 public agencies as CPEs, as specified in Item I-2- c:
X	**Not Applicable**. There are no non-State level sources of funds for the non-federal share.

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. *Check each that applies.*

☐	Provider taxes or fees
☐	Provider donations
☐	Federal funds (other than FFP)
[redacted]	For each source of funds indicated above, describe the source of the funds in detail:
[redacted]	
X	None of the foregoing sources of funds contribute to the non-federal share of computable waiver costs.

APPENDIX 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. (*Do not complete Item I-5-b*).
⊙	As specified in Appendix C, the State furnishes waiver services in residential settings other than the personal home of the individual. (*Complete Item I-5-b*)

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:

Waiver services will be provided in accordance with an individual plan of care. Costs of care will be based on units of service provided at a set rate per unit. No component of this rate will include room and board. Entitlements such as SSI, State Supplement and Food Stamps for which program participants are eligible may be utilized for rental and food costs.

APPENDIX 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:

○	**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:*
⊙	**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.

APPENDIX I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing

a. Co-Payment Requirements. Specify whether the State imposes a co-payment or similar charge upon waiver participants for waiver services as provided in 42 CFR §447.50. 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. (*Do not complete the remaining items; proceed to Item I-7-b*).
○	**Yes**. The State imposes a co-payment or similar charge upon participants for one or more waiver services. (*Complete the remaining items*)

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)*:

ii Participants Subject to Co-pay Charges for Waiver Services. Specify the groups of waiver participants who are subject to charges for the waiver services specified in Item I-7-a-iii and the groups for whom such charges are excluded. The groups of participants who are excluded must comply with 42 CFR §447.53.

iii. Amount of Co-Pay Charges for Waiver Services. In the following table, list the waiver services for which a charge is made, the amount of the charge, and the basis for determining the charge. The amount of the charge must comply with the maximum amounts set forth in 42 CFR §447.54.

Waiver Service	Amount of Charge	Basis of the Charge

iv. Cumulative Maximum Charges. Indicate whether there is a cumulative maximum amount for all co-payment charges to a waiver participant *(select one)*:

○	There is no cumulative maximum for all deductible, coinsurance or co-payment charges to a waiver participant.

○	There is a cumulative maximum for all deductible, coinsurance or co-payment charges to a waiver participant. Specify the cumulative maximum and the time period to which the maximum applies:

v. Assurance. In accordance with 42 CFR §447.53(e), the State assures that no provider may deny waiver services to an individual who is eligible for the services on account of the individual's inability to pay a cost-sharing charge for a waiver service.

b. Other State Requirement for Cost Sharing. Specify whether the State imposes a premium, enrollment fee or similar cost sharing on waiver participants as provided in 42 CFR §447.50. *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 as set forth in 42 CFR §447.52; (c) the groups of participants subject to cost-sharing and the groups who are excluded (groups of participants who are excluded must comply with 42 CFR §447.53); and, (d) the mechanisms for the collection of cost-sharing and reporting the amount collected on the CMS 64:

Appendix J: Cost Neutrality Demonstration

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

Composite Overview. Complete the following table for each year of the waiver.

Level(s) of Care *(specify)*:							
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 (Column 7 less Column 4)**
1	80,784	6,182	86,967	96,243	6,065	102,308	15,341
2	84,447	6,398	90,847	99,611	6,278	105,889	15,042
3	88,275	6,622	94,900	103,098	6,498	109,595	14,695
4	92,277	6,854	99,135	106,706	6,725	113,431	14,296
5	96,460	7,094	103,559	110,441	6,960	117,401	13,842

Appendix J-2 - Derivation of Estimates

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

Table J-2-a: Unduplicated Participants

Waiver Year	Total Number Unduplicated Number of Participants (From Item B-3-a)	Distribution of Unduplicated Participants by Level of Care (if applicable)	
		Level of Care:	Level of Care:
		ICF/MR	NF
Year 1	369	22	195
Year 2	369	22	195
Year 3	369	22	195
Year 4 (renewal only)	369	22	195
Year 5 (renewal only)	369	22	195

Table J-2-a: Unduplicated Participants

Waiver Year	Total Number Unduplicated Number of Participants (From Item B-3-a)	Distribution of Unduplicated Participants by Level of Care (if applicable)	
		Level of Care:	Level of Care:
		ABI/NF	CDH
Year 1	369	41	111
Year 2	369	41	111
Year 3	369	41	111
Year 4 (renewal only)	369	41	111
Year 5 (renewal only)	369	41	111

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-d.

Average Length of Stay (LOS) was derived by the following method:
Multiplying LOS% increase during past 4 years (2002 – 2005) by the average annual increase of waiver participants.

- Factor D' and Factor G' Base Year-Pharmacy component was adjusted for -Medicare recipients(less) and Medicare Part D co-pay(plus)

Source: CMS 372S Data (2002-2005)

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

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

Estimates based on HCFA 372T & 372S -- ABI Waiver Lag Reports: CY 2002, CY 2003, CY 2004 and Initial Report 1/01/2005 through 12/31/2005

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:

Estimates based on HCFA 372T & 372S -- ABI Waiver Lag Reports: CY 2002, CY 2003, CY 2004 and Initial Report 1/01/2005 through 12/31/2005

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:

Estimates based on HCFA 372T & 372S -- ABI Waiver Lag Reports: CY 2002, CY 2003, CY 2004 and Initial Report 1/01/2005 through 12/31/2005

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:

Source: HCFA 372T & 372S -- ABI Waiver Lag Reports: CY 2002, CY 2003, CY 2004 and Initial Report 1/01/2005 through 12/31/2005

d. Estimate of Factor D. *Select one:* Note: Selection below is new.

X	The waiver does not operate concurrently with a §1915(b) waiver. Complete Item J-2-d-i
○	The waiver operates concurrently with a §1915(b) waiver. Complete Item J-2-d-ii

i. Estimate of Factor D – Non-Concurrent Waiver. Complete the following table for each waiver year

Waiver Year: Year 1					
	Col. 1	Col. 2	Col. 3	Col. 4	Col. 5
Waiver Service	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Total Cost
1. Case Management Individual	Hour	37.53	153.45	17.95	$103,356
2. Chore	Qtr Hour	13.39	172.45	4.10	$9,464
3. Community Living	12 hours	113.53	300.80	65.21	$2,226,739
4. Companion	Qtr Hour	273.26	5054.89	3.64	$5,032,349
5. Environmental Mods.	Item	26.73	0.66	10,350.00	$182,593
6. Homemaker	Qtr Hour	49.76	596.35	4.10	$121,623
7. Ind. Living Indiv.	Hour	342.33	985.45	36.23	$12,220,471
8. Cognitive Behavioral	Hour	356.83	27.78	82.80	$820,775
9. Home Delivered Meals	Meal	6.01	102.69	8.80	$5,430
10. Personal Care Svcs.	Qtr Hour	65.42	7267.87	3.47	$1,648,553
11. Pers. Emer. Response	Month	39.82	12.95	35.17	$18,136
12. Prevocational	Hour	193.15	716.58	36.48	$5,049,622
13. Respite Care	Hour	4.89	40.82	11.64	$2,324
14. Special Med Equip	Item	53.40	0.23	10,350.00	$127,119
15. Substance Abuse Day	Day	4.00	56.56	51.75	$11,708
15.1 Substance Abuse Hrly	Hour	4.00	32.12	43.94	$5,645
16. Supp. Employment	Hour	74.02	816.38	36.53	$2,207,158
17. Transportation	Mile	19.47	2144.46	0.26	$10,803
18. Vehicle Mods.	Item	1.23	0.25	10,350.00	$3,183
19. Transitional Living	Day	1.00	10.25	203.90	$2,090
GRAND TOTAL:					$29,809,141
TOTAL ESTIMATED UNDUPLICATED PARTICIPANTS (from Table J-2-a)					369
FACTOR D (Divide grand total by number of participants)					$80,784
AVERAGE LENGTH OF STAY ON THE WAIVER					306

Waiver Year: Year 2					
	Col. 1	Col. 2	Col. 3	Col. 4	Col. 5
Waiver Service	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Total Cost
1. Case Management Individual	Hour	37.53	154.99	$18.58	$108,047
2. Chore	Qtr Hour	13.39	174.17	$4.24	$9,893
3. Community Living	12 hours	113.53	303.81	$67.49	$2,327,737
4. Companion	Qtr Hour	273.26	5105.44	$3.77	$5,260,568
5. Environmental Mods.	Item	26.73	0.67	$10,712.25	$191,847
6. Homemaker	Qtr Hour	49.76	602.31	$4.24	$127,138
7. Ind. Living Indiv.	Hour	342.33	995.31	$37.49	$12,774,740
8. Cognitive Behavioral	Hour	356.83	28.06	$85.70	$858,064
9. Home Delivered Meals	Meal	6.01	103.72	$9.11	$5,676
10. Personal Care Svcs.	Qtr Hour	65.42	7340.55	$3.59	$1,723,315
11. Pers. Emer. Response	Month	39.82	13.08	$36.40	$18,959
12. Prevocational	Hour	193.15	723.74	$37.76	$5,278,580
13. Respite Care	Hour	4.89	41.23	$12.05	$2,430
14. Special Med Equip	Item	53.40	0.23	$10,712.25	$131,568
15. Substance Abuse Day	Day	4.00	57.13	$53.56	$12,240
15.1 Substance Abuse Hrly	Hour	4.00	32.44	$45.47	$5,901
16. Supp. Employment	Hour	74.02	824.54	$37.80	$2,307,242
17. Transportation	Mile	19.47	2165.90	$0.27	$11,293
18. Vehicle Mods.	Item	1.23	0.26	$10,712.25	$3,426
19. Transitional Living	Day	1.00	10.25	$211.03	$2,163
GRAND TOTAL:					$31,160,827
TOTAL ESTIMATED UNDUPLICATED PARTICIPANTS (from Table J-2-a)					369
FACTOR D (Divide grand total by number of participants)					84,447
AVERAGE LENGTH OF STAY ON THE WAIVER					306

Waiver Year: Year 3					
	Col. 1	Col. 2	Col. 3	Col. 4	Col. 5
Waiver Service	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Total Cost
1. Case Management Individual	Hour	37.53	156.54	$19.23	$112,947
2. Chore	Qtr Hour	13.39	175.91	$4.39	$10,342
3. Community Living	12 hours	113.53	306.84	$69.85	$2,433,236
4. Companion	Qtr Hour	273.26	5156.50	$3.90	$5,499,140
5. Environmental Mods.	Item	26.73	0.68	$11,087.18	$201,525
6. Homemaker	Qtr Hour	49.76	608.34	$4.39	$132,906
7. Ind. Living Indiv.	Hour	342.33	1005.26	$38.81	$13,354,033
8. Cognitive Behavioral	Hour	356.83	28.34	$88.70	$896,958
9. Home Delivered Meals	Meal	6.01	104.75	$9.42	$5,933
10. Personal Care Svcs.	Qtr Hour	65.42	7413.95	$3.71	$1,801,466
11. Pers. Emer. Response	Month	39.82	13.22	$37.67	$19,832
12. Prevocational	Hour	193.15	730.98	$39.08	$5,517,983
13. Respite Care	Hour	4.89	41.65	$12.47	$2,540
14. Special Med Equip	Item	53.40	0.23	$11,087.18	$136,173
15. Substance Abuse Day	Day	4.00	57.70	$55.44	$12,795
15.1 Substance Abuse Hrly	Hour	4.00	32.76	$47.07	$6,167
16. Supp. Employment	Hour	74.02	832.79	$39.13	$2,411,889
17. Transportation	Mile	19.47	2187.56	$0.28	$11,806
18. Vehicle Mods.	Item	1.23	0.26	$11,087.18	$3,546
19. Transitional Living	Day	1.00	10.25	$218.42	$2,239
GRAND TOTAL:					$32,573,456
TOTAL ESTIMATED UNDUPLICATED PARTICIPANTS (from Table J-2-a)					369
FACTOR D (Divide grand total by number of participants)					88,275
AVERAGE LENGTH OF STAY ON THE WAIVER					306

Waiver Year: Year 4					
	Col. 1	Col. 2	Col. 3	Col. 4	Col. 5
Waiver Service	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Total Cost
1. Case Management Individual	Hour	37.53	158.10	$19.90	$118,065
2. Chore	Qtr Hour	13.39	177.67	$4.54	$10,811
3. Community Living	12 hours	113.53	309.91	$72.29	$2,543,596
4. Companion	Qtr Hour	273.26	5208.06	$4.04	$5,748,521
5. Environmental Mods.	Item	26.73	0.69	$11,475.23	$211,646
6. Homemaker	Qtr Hour	49.76	614.42	$4.54	$138,932
7. Ind. Living Indiv.	Hour	342.33	1015.31	$40.16	$13,959,603
8. Cognitive Behavioral	Hour	356.83	28.62	$91.80	$937,524
9. Home Delivered Meals	Meal	6.01	105.80	$9.75	$6,202
10. Personal Care Svcs.	Qtr Hour	65.42	7488.09	$3.84	$1,883,163
11. Pers. Emer. Response	Month	39.82	13.35	$38.99	$20,728
12. Prevocational	Hour	193.15	738.29	$40.45	$5,768,225
13. Respite Care	Hour	4.89	42.06	$12.91	$2,655
14. Special Med Equip	Item	53.40	0.23	$11,475.23	$140,939
15. Substance Abuse Day	Day	4.00	58.28	$57.38	$13,376
15.1 Substance Abuse Hrly	Hour	4.00	33.09	$48.71	$6,448
16. Supp. Employment	Hour	74.02	841.12	$40.50	$2,521,274
17. Transportation	Mile	19.47	2209.44	$0.29	$12,341
18. Vehicle Mods.	Item	1.23	0.26	$11,475.23	$3,670
19. Transitional Living	Day	1.00	10.25	$226.06	$2,317
GRAND TOTAL:					$34,050,036
TOTAL ESTIMATED UNDUPLICATED PARTICIPANTS (from Table J-2-a)					369
FACTOR D (Divide grand total by number of participants)					92,277
AVERAGE LENGTH OF STAY ON THE WAIVER					306

Waiver Year: Year 5					
	Col. 1	Col. 2	Col. 3	Col. 4	Col. 5
Waiver Service	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Total Cost
1. Case Management Individual	Hour	37.53	159.68	$20.59	$123,418
2. Chore	Qtr Hour	13.39	179.45	$4.70	$11,301
3. Community Living	12 hours	113.53	313.01	$74.82	$2,658,956
4. Companion	Qtr Hour	273.26	5260.14	$4.18	$6,009,216
5. Environmental Mods.	Item	26.73	0.70	$11,876.86	$222,228
6. Homemaker	Qtr Hour	49.76	620.56	$4.70	$145,232
7. Ind. Living Indiv.	Hour	342.33	1025.46	$41.57	$14,592,627
8. Cognitive Behavioral	Hour	356.83	28.91	$95.01	$980,170
9. Home Delivered Meals	Meal	6.01	106.86	$10.10	$6,484
10. Personal Care Svcs.	Qtr Hour	65.42	7562.97	$3.98	$1,968,564
11. Pers. Emer. Response	Month	39.82	13.48	$40.36	$21,663
12. Prevocational	Hour	193.15	745.67	$41.87	$6,029,791
13. Respite Care	Hour	4.89	42.48	$13.36	$2,776
14. Special Med Equip	Item	53.40	0.23	$11,876.86	$145,872
15. Substance Abuse Day	Day	4.00	58.86	$59.38	$13,981
15.1 Substance Abuse Hrly	Hour	4.00	33.42	$50.42	$6,740
16. Supp. Employment	Hour	74.02	849.53	$41.91	$2,635,610
17. Transportation	Mile	19.47	2231.53	$0.30	$12,901
18. Vehicle Mods.	Item	1.23	0.26	$11,876.86	$3,798
19. Transitional Living	Day	1.00	10.25	$233.97	$2,398
GRAND TOTAL:					35,593,726
TOTAL ESTIMATED UNDUPLICATED PARTICIPANTS (from Table J-2-a)					369
FACTOR D (Divide grand total by number of participants)					96,460
AVERAGE LENGTH OF STAY ON THE WAIVER					306