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State/Territory Name: CT

State Plan Amendment (SPA) #: 22-0001

This file contains the following documents in the order listed:

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
601 E. 12th St., Room 355
Kansas City, Missouri 64106

Medicaid and CHIP Operations Group

January 19, 2022

William Halsey, Acting Medicaid Director
Connecticut Department of Social Services
Division of Health Services
55 Farmington Avenue
Hartford, CT 06105

RE: TN 22-0001 Connecticut Home Care Program for Elders (CHCPE) §1915(i) home and community-based services (HCBS) state plan benefit renewal

Dear Mr. Halsey:

The Centers for Medicare & Medicaid Services (CMS) is approving the state's §1915(i) state plan home and community-based services (HCBS) state plan amendment (SPA), transmittal number TN 22-0001. The purpose of this amendment is to renew Connecticut's 1915(i) state plan HCBS benefit. The effective date for this renewal is February 1, 2022. Enclosed is a copy of the approved SPA.

Since the state has elected to target the population who can receive §1915(i) state plan HCBS, CMS approves this SPA for a five-year period, expiring January 31, 2026, in accordance with §1915(i)(7) of the Social Security Act. To renew the §1915(i) state plan HCBS benefit for an additional five-year period, the state must submit a renewal application to CMS at least 180 days prior to the end of the approval period. CMS approval of a renewal request is contingent upon state adherence to federal requirements and the state meeting its objectives with respect to quality improvement and beneficiary outcomes.

Per 42 CFR §441.745(a)(i), the state will annually provide CMS with the projected number of individuals to be enrolled in the benefit and the actual number of unduplicated individuals enrolled in the §1915(i) state plan HCBS in the previous year. Additionally, at least 21 months prior to the end of the five-year approval period, the state must submit evidence of the state's quality monitoring in accordance with the Quality Improvement Strategy in their approved SPA. The evidence must include data analysis, findings, remediation, and describe any system improvement for each of the §1915(i) requirements.

The state has identified its intent to use money realized from section 9817 of the American Rescue Plan (ARP). Approval of this action does not constitute approval of the state's spending

plan. The state must have an approved spending plan to use the money realized from section 9817 of the ARP.

It is important to note that CMS approval of this 1915(i) HCBS state plan benefit renewal solely addresses the state's compliance with the applicable Medicaid authorities. CMS approval does not address the state's independent and separate obligations under federal laws including, but not limited to, the Americans with Disabilities Act, Section 504 of the Rehabilitation Act, or the Supreme Court's Olmstead decision. Guidance from the Department of Justice concerning compliance with the Americans with Disabilities Act and the Olmstead decision is available at http://www.ada.gov/olmstead/q&a_olmstead.htm.

If you have any questions concerning this information, please contact me at (410) 786-7561. You may also contact Karen Walsh at karen.Walsh@cms.hhs.gov or (617) 565-1237.

Sincerely,

George P. Failla, Jr., Director
Division of HCBS Operations and Oversight

Enclosure

cc:
Dr. Deidre Gifford, CT DSS Commissioner
Jennifer Cavallaro, CT DSS
Joel Norwood, CT DSS
Cynthia Nanes, CMS DHCBSO
Karen Walsh, CMS DHCBSO
Ciera Lucas, CMS DLTSS
Marie DiMartino, CMS DPO
Nancy Grano, CMS DPO
Karen Hatcher, CMS DPO
Mary Holly, CMS DPO
Jerica Bennett, CMS FMG
Elisa Jacobs, CMS FMG

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE AND MEDICAID SERVICES

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: CENTERS FOR MEDICARE AND MEDICAID SERVICES

1. TRANSMITTAL NUMBER: 22-0001

2. STATE: CT

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
CENTERS FOR MEDICARE AND MEDICAID SERVICES
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE:
February 1, 2022

5. TYPE OF STATE PLAN MATERIAL (Check One):

___ NEW STATE PLAN ___AMENDMENT TO BE CONSIDERED AS NEW PLAN _X_ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT (Separate Transmittal for each amendment)

6. FEDERAL STATUTE/REGULATION CITATION:
Section 1915(i) of the Social Security Act and 42 CFR 441, Subpart M

7. FEDERAL BUDGET IMPACT:
a. FFY 2022 $0
b. FFY 2023 $0

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Attachment 3.1-i, Pages 70-78 NEW
Attachment 3.1-i, Pages 1-69
Attachment 4.19-B, Pages 22-24

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (If applicable)
Attachment 3.1-i, Pages 1-69
Attachment 4.19-B, Pages 22-24

10. SUBJECT OF AMENDMENT: This SPA amends 3.1-i and 4.19-B of the Medicaid State Plan to renew the home and community-based services (HCBS) Medicaid State Plan option pursuant to section 1915(i) of the Social Security Act portion of the Connecticut Home Care Program for Elders (CHCPE) for an additional five-year period and make various technical updates, as described in the cover letter and set forth in the state plan pages. DSS estimates that this SPA will not change federal expenditures in FFY 2022 and 2023 because it is not making any substantive changes other than extending the program for another five-year period. Total expenditures for section 1915(i) CHCPE HCBS, accounting for projected trends, are anticipated to be approximately $4.6 million in in the first twelve-month period in which this SPA is effective and $4.7 million for the second twelve-month period in which this SPA is effective.

11. GOVERNOR'S REVIEW (Check One):

_X_GOVERNOR'S OFFICE REPORTED NO COMMENT
__COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
__NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
_OTHER, AS SPECIFIED:

12. SIGNATURE OF STATE AGENCY OFFICIAL:

13. TYPED NAME: Deidre S. Gifford, MD, MPH

14. TITLE: Commissioner

15. DATE SUBMITTED:
June 24, 2021

16. RETURN TO:

State of Connecticut
Department of Social Services
55 Farmington Avenue – 9th floor
Hartford, CT 06105
Attention: Ginny Mahoney

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: June 24, 2021

18. DATE APPROVED: January 19, 2022

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:
February 1, 2022

20. SIGNATURE OF REGIONAL OFFICIAL:

21. TYPED NAME: George P. Failla

22. TITLE: DHCBSO Director

23. REMARKS: Pen and ink changes to Box 8 to add new pages

FORM CMS-179 (07-92)

1915(i) State plan Home and Community-Based Services

Administration and Operation

The state implements the optional 1915(i) State plan Home and Community-Based Services (HCBS) benefit *for elderly and disabled individuals as set forth below.*

1. **Services.** *(Specify the state's service title(s) for the HCBS defined under "Services" and listed in Attachment 4.19-B):*

Adult Day Health, Care Management, Homemaker, Companion, Chore, Respite, Assisted Living, Assistive Technology, Environmental Accessibility Adaptations, Home Delivered Meals, Adult Family Living/Foster Care, Mental Health Counseling, Personal Emergency Response Systems, Non-Medical Transportation, Bill Payer, Care Transitions, Chronic Disease Self-Management Programs, Recovery Assistant, Personal Care Assistant

2. **Concurrent Operation with Other Programs.** (*Indicate whether this benefit will operate concurrently with another Medicaid authority)*:

***Select one*:**

○	**Not applicable**
●	**Applicable**

Check the applicable authority or authorities:

☐ **Services furnished under the provisions of §1915(a)(1)(a) of the Act.** 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 1915(i) State plan HCBS. 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. *Specify:*
(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 specific 1915(i) State plan HCBS furnished by these plans;
(d) how payments are made to the health plans; and
(e) whether the 1915(a) contract has been submitted or previously approved.

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

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

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

☐	§1915(b)(1) (mandated enrollment to managed care)	☐	§1915(b)(3) (employ cost savings to furnish additional services)

	☐	§1915(b)(2) (central broker)	☒	§1915(b)(4) (selective contracting/limit number of providers)
	CT Home Care Programs section 1915(b)(4) Freedom of Choice Waiver, which was previously approved through June 30, 2025			
☐	**A program operated under §1932(a) of the Act.** *Specify the nature of the State Plan benefit and indicate whether the State Plan Amendment has been submitted or previously approved:*			
☐	**A program authorized under §1115 of the Act.** *Specify the program:*			

3. State Medicaid Agency (SMA) Line of Authority for Operating the State plan HCBS Benefit. *(Select one):*

●	The State plan HCBS benefit is operated by the SMA. Specify the SMA division/unit that has line authority for the operation of the program *(select one)*:		
	●	The Medical Assistance Unit *(name of unit)*:	Department of Social Services, Division of Health Services, Community Options Unit
	○	Another division/unit within the SMA that is separate from the Medical Assistance Unit	
		(name of division/unit) *This includes administrations/divisions under the umbrella agency that have been identified as the Single State Medicaid Agency.*	
○	The State plan HCBS benefit is operated by *(name of agency)*		
	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 State plan HCBS benefit and issues policies, rules and regulations related to the State plan HCBS benefit. The interagency agreement or memorandum of understanding that sets forth the authority and arrangements for this delegation of authority is available through the Medicaid agency to CMS upon request.		

4. Distribution of State plan HCBS Operational and Administrative Functions.

☒ *(By checking this box the state assures that):* When the Medicaid agency does not directly conduct an administrative function, it supervises the performance of the function and establishes and/or approves policies that affect the function. All functions not performed directly by the Medicaid agency must be delegated in writing and monitored by the Medicaid Agency. When a function is performed by an agency/entity other than the Medicaid agency, the agency/entity performing that function does not substitute its own judgment for that of the Medicaid agency with respect to the application of policies, rules and regulations. Furthermore, the Medicaid Agency assures that it maintains accountability for the performance of any operational, contractual, or local regional entities. In the following table, specify the entity or entities that have responsibility for conducting each of the operational and administrative functions listed (*check each that applies*):

(*Check all agencies and/or entities that perform each function*):

Function	Medicaid Agency	Other State Operating Agency	Contracted Entity	Local Non-State Entity
1 Individual State plan HCBS enrollment	☑	☐	☐	☐
2 Eligibility evaluation	☑	☐	☑	☐
3 Review of participant service plans	☑	☐	☑	☐
4 Prior authorization of State plan HCBS	☑	☐	☐	☐
5 Utilization management	☑	☐	☐	☐
6 Qualified provider enrollment	☑	☐	☑	☐
7 Execution of Medicaid provider agreement	☑	☐	☐	☐
8 Establishment of a consistent rate methodology for each State plan HCBS	☑	☐	☐	☐
9 Rules, policies, procedures, and information development governing the State plan HCBS benefit	☑	☐	☐	☐
10 Quality assurance and quality improvement activities	☑	☐	☑	☐

(Specify, as numbered above, the agencies/entities (other than the SMA) that perform each function):

Access Agencies under contract to DSS provide care management functions, including to perform administrative tasks that assist DSS in its determination of eligibility. These entities are selected as a result of a competitive procurement. This service is limited to selected contractors and was approved in the state's section 1915(b)(4) waiver. The care managers perform multidimensional assessments to gather information and relevant documents related to functional eligibility for HCBS to assist DSS in making the final eligibility determination. The Access Agency care manager is required to review the plan of care with the HCBS client every 60 days or more frequently if identified needs changed. The fiscal intermediary, also selected as the result of a competitive procurement, does provider credentialing and facilitates enrollment with the Department's Medicaid Management Information System (MMIS) contractor.

(By checking the following boxes the State assures that):

5. ☒ **Conflict of Interest Standards.** The state assures the independence of persons performing evaluations, assessments, and plans of care. Written conflict of interest standards ensure, at a minimum, that persons performing these functions are not:
   - related by blood or marriage to the individual, or any paid caregiver of the individual
   - financially responsible for the individual
   - empowered to make financial or health-related decisions on behalf of the individual
   - providers of State plan HCBS for the individual, or those who have interest in or are employed by a provider of State plan HCBS; except, at the option of the state, when providers are given responsibility to perform assessments and plans of care because such individuals are the only willing and qualified entity in a geographic area, and the state devises conflict of interest protections. *(If the state chooses this option, specify the conflict of interest protections the state will implement):*

6. ☒ **Fair Hearings and Appeals.** The state assures that individuals have opportunities for fair hearings and appeals in accordance with 42 CFR 431 Subpart E.

7. ☒ **No FFP for Room and Board.** The state has methodology to prevent claims for Federal financial participation for room and board in State plan HCBS.

8. ☒ **Non-duplication of services.** State plan HCBS will not be provided to an individual at the same time as another service that is the same in nature and scope regardless of source, including Federal, state, local, and private entities. For habilitation services, the state includes within the record of each individual an explanation that these services do not include special education and related services defined in the Individuals with Disabilities Education Improvement Act of 2004 that otherwise are available to the individual through a local education agency, or vocational rehabilitation services that otherwise are available to the individual through a program funded under §110 of the Rehabilitation Act of 1973.

Number Served

1. **Projected Number of Unduplicated Individuals To Be Served Annually.**
   (Specify for year one. Years 2-5 optional):

Annual Period	From	To	Projected Number of Participants
Year 1	2/1/22	1/31/23	353
Year 2	2/1/23	1/31/24	350
Year 3	2/1/24	1/31/25	347
Year 4	2/1/25	1/31/26	344
Year 5	2/1/26	1/31/27	341

2. ☒ **Annual Reporting.** *(By checking this box the state agrees to):* aunually report the actual number of unduplicated individuals served and the estimated number of individuals for the following year.

Financial Eligibility

1. ☒ **Medicaid Eligible.** *(By checking this box the state assures that):* Individuals receiving State plan HCBS are included in an eligibility group that is covered under the State's Medicaid Plan and have income that does not exceed 150% of the Federal Poverty Line (FPL). (This election does not include the optional categorically needy eligibility group specified at §1902(a)(10)(A)(ii)(XXII) of the Social Security Act. States that want to adopt the §1902(a)(10)(A)(ii)(XXII) eligibility category make the election in Attachment 2.2-A of the state Medicaid plan.)

2. **Medically Needy** (*Select one*):

☒ The State does not provide State plan HCBS to the medically needy.
☐ The State provides State plan HCBS to the medically needy. (*Select one*):
☐ The state elects to disregard the requirements section of 1902(a)(10)(C)(i)(III) of the Social Security Act relating to community income and resource rules for the medically needy. When a state makes this election, individuals who qualify as medically needy on the basis of this election receive only 1915(i) services. ☐ The state does not elect to disregard the requirements at section 1902(a)(10)(C)(i)(III) of the Social Security Act.

Evaluation/Reevaluation of Eligibility

1. **Responsibility for Performing Evaluations / Reevaluations.** Eligibility for the State plan HCBS benefit must be determined through an independent evaluation of each individual). Independent evaluations/reevaluations to determine whether applicants are eligible for the State plan HCBS benefit are performed (*Select one*):

●	Directly by the Medicaid agency
○	By Other (*specify State agency or entity under contract with the State Medicaid agency*):

2. **Qualifications of Individuals Performing Evaluation/Reevaluation**. The independent evaluation is performed by an agent that is independent and qualified. There are qualifications (that are reasonably related to performing evaluations) for the individual responsible for evaluation/reevaluation of needs-based eligibility for State plan HCBS. *(Specify qualifications):*

The DSS staff who determine eligibility are Registered Nurses with three years of experience in a position involving home healthcare, nursing homes or other community-based nursing programs. Two years of the experience must have been in the areas of client care plans or utilization review.

3. **Process for Performing Evaluation/Reevaluation.** Describe the process for evaluating whether individuals meet the needs-based State plan HCBS eligibility criteria and any instrument(s) used to make this determination. If the reevaluation process differs from the evaluation process, describe the differences:

The process for evaluating whether clients meet the needs-based State plan HCBS eligibility will be based on the determination of whether the individual meets the minimum needs-based criteria.

The initial component of the evaluation is performed by evaluators employed by DSS (meeting the qualifications described above) utilizing a Department designed health screen tool that collects information on ADLs, IADLs, cognitive status, living arrangements, behavioral health and safety issues.

Each applicant who meets the evaluation screening criteria is then referred to the Access Agency for collection of more detailed information and documentation, as applicable. The Access Agency care manager meets with the client and their representative to explain the program. If consent is received, the Access Agency care manager collects information and documentation on behalf of DSS to enable DSS to perform a comprehensive evaluation for each applicant, including each of the components detailed below, and submits related details, documents and recommendation for the evaluators employed by DSS to determine eligibility for CHCPE 1915(i) HCBS. Access Agency staff conduct these activities with oversight by qualified DSS staff.

The Access Agency care manager or other qualified entity will then collect information and documentation to assist DSS in determining if the individual meets the remaining minimum critical needs within the needs-based criteria for the service, utilizing the State's Universal Assessment (UA). The UA, a web-based tool located on the State's server, is linked to the client's Medicaid coverage group identification number within the State's eligibility system. The UA is applicable to all clients in all of the state's 1915(c) waiver and 1915(i) state plan HCBS programs. The 1915(i) needs-based criteria are linked to clinical questions within the UA; and when individuals finalize the UA in the web-based system, clinical information entered into the tool is electronically analyzed against the State's 1915(i) 'at-risk' clinical criteria and the UA system generates a result.

The result of the UA predicts level of care and 'at-risk' to inform determination of whether the individual meets the minimum critical needs. In all cases, the person performing the UA conducts an individualized recommendation of whether the individual meets the minimum critical needs. If the person performing the UA justifies a recommendation that is not consistent with the predicted result of the UA, a supervisor of the individual reviews the result and the justification and makes a final recommendation to DSS based on the clinical justification of whether the individual meets the minimum critical needs.

After DSS receives that final recommendation from the Access Agency referenced above, a qualified evaluator employed by DSS reviews all of the documents included with the recommendation for accuracy, quality, completeness, and clinically appropriateness. After

completing that review, the qualified evaluator employed by DSS will make a final determination on the evaluation in accordance with the process detailed above.

The reevaluation process utilizes the Universal Assessment, as outlined above.

4. ☒ **Reevaluation Schedule**. *(By checking this box the state assures that):* Needs-based eligibility reevaluations are conducted at least every twelve months.

5. ☒ **Needs-based HCBS Eligibility Criteria.** *(By checking this box the state assures that):* Needs-based criteria are used to evaluate and reevaluate whether an individual is eligible for State plan HCBS.

The criteria take into account the individual's support needs, and may include other risk factors: *(Specify the needs-based criteria):*

In order to qualify for this section 1915(i) state plan HCBS benefit for the Connecticut Home Care Program for Elders (CHCPE), the applicant must require assistance with 1 or 2 critical needs. Critical needs are as follows: bathing, dressing, toileting, eating/feeding, transferring, and medication administration. Assistance includes supervision and cueing as well as direct, hands-on assistance. Individuals receiving services under this 1915(i) benefit for CHCPE must have needs that are less stringent than nursing facility level of care. Those whose needs meet a nursing facility level of care will be served under a 1915(c) waiver.

6. ☒ **Needs-based Institutional and Waiver Criteria.** *(By checking this box the state assures that):* There are needs-based criteria for receipt of institutional services and participation in certain waivers that are more stringent than the criteria above for receipt of State plan HCBS. If the state has revised institutional level of care to reflect more stringent needs-based criteria, individuals receiving institutional services and participating in certain waivers on the date that more stringent criteria become effective are exempt from the new criteria until such time as they no longer require that level of care. *(Complete chart below to summarize the needs-based criteria for State Plan HCBS and corresponding more-stringent criteria for each of the following institutions):*

State plan HCBS needs-based eligibility criteria	NF (& NF LOC** waivers)	ICF/IID (& ICF/IID LOC waivers)	Applicable Hospital* (& Hospital LOC waivers)
In order to qualify for this section 1915(i) state plan HCBS benefit for CHCPE, the applicant must require assistance with 1 or 2 critical needs. Critical	1. Supervision or cueing ≥ 3 ADLs + need factor 2. Hands-on ≥ 3 ADLs 3. Hands-on ≥ 2 ADLs + need factor 4. A cognitive impairment which requires daily supervision to prevent harm	Having a diagnosis of an intellectual disability as evidenced by testing and requiring substantial assistance with	Each chronic disease client must require services that can be provided safely and effectively at a chronic

needs are as follows: bathing, dressing, toileting, eating/feeding, transferring, and medication administration. Assistance includes supervision and cueing as well as direct, hands-on assistance. Individuals receiving services under this 1915(i) benefit for CHCPE must have needs that are less stringent than nursing facility level of care. Those whose needs meet a nursing facility level of care will be served under a 1915(c) waiver.	*Need factors are: 1. Rehabilitative Services PT, OT, ST. The individual has restorative potential. 2. Behavioral Need: Requires daily supervision to prevent harm 3. Medication supports: Requires assistance for administration of physician-ordered daily medications. Includes supports beyond set up	ADLs on a daily basis	disease hospital level, must be ordered by a physician and documented in the client's medical record, and must include at least a daily physician visit and assessment or the 24-hour availability of medical services and equipment available only in a hospital setting; and the client's medical condition and treatment needs are such that no effective, safe, less costly alternative placement is available to the client.

*Long Term Care/Chronic Care Hospital

**LOC= level of care

7. ☒ **Target Group(s).** The state elects to target this 1915(i) State plan HCBS benefit to a specific population based on age, disability, diagnosis, and/or eligibility group. With this election, the state will operate this program for a period of 5 years. At least 90 days prior to the end of this 5 year period, the state may request CMS renewal of this benefit for additional 5-year terms in accordance with 1915(i)(7)(C) and 42 CFR 441.710(e)(2). (*Specify target group(s)*):

Persons age 65 and older

☐ **Option for Phase-in of Services and Eligibility.** If the state elects to target this 1915(i) State plan HCBS benefit, it may limit the enrollment of individuals or the provision of services to enrolled individuals in accordance with 1915(i)(7)(B)(ii) and 42 CFR 441.745(a)(2)(ii) based upon criteria described in a phase-in plan, subject to CMS approval. At a minimum, the phase-in plan must describe: (1) the criteria used to limit enrollment or service delivery; (2) the rationale for phasing-in services and/or eligibility; and (3) timelines and benchmarks to ensure that the benefit is available statewide to all eligible individuals within the initial 5-year approval. (Specify the phase-in plan):

(By checking the following box the State assures that):

8. ☒ **Adjustment Authority**. The state will notify CMS and the public at least 60 days before exercising the option to modify needs-based eligibility criteria in accord with 1915(i)(1)(D)(ii).

9. **Reasonable Indication of Need for Services.** In order for an individual to be determined to need the 1915(i) State plan HCBS benefit, an individual must require: (a) the provision of at least one 1915(i) service, as documented in the person-centered service plan, and (b) the provision of 1915(i) 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 person-centered service plan. Specify the state's policies concerning the reasonable indication of the need for 1915(i) State plan HCBS:

i.	**Minimum number of services.** The minimum number of 1915(i) State plan services (one or more) that an individual must require in order to be determined to need the 1915(i) State plan HCBS benefit is: 1	
ii.	**Frequency of services**. The state requires (select one):	
	●	**The provision of 1915(i) 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 1915(i) services other than monthly (e.g., quarterly), specify the frequency:

Home and Community-Based Settings

(By checking the following box the State assures that):

1. ☒ **Home and Community-Based Settings.** The State plan HCBS benefit will be furnished to individuals who reside and receive HCBS in their home or in the community, not in an institution. (*Explain how residential and non-residential settings in this SPA comply with Federal home and*

community-based settings requirements at 42 CFR 441.710(a)(1)-(2) and associated CMS guidance. Include a description of the settings where individuals will reside and where individuals will receive HCBS, and how these settings meet the Federal home and community-based settings requirements, at the time of submission and in the future):

(Note: In the Quality Improvement Strategy (QIS) portion of this SPA, the state will be prompted to include how the state Medicaid agency will monitor to ensure that all settings meet federal home and community-based settings requirements, at the time of this submission and ongoing.)

The state submitted a statewide transition plan to CMS for review which was approved in 2019. The state continues to review these settings to ensure quality oversight and compliance with HCBS criteria. Adult Family Living was added to this CHCPE section 1915(i) state plan HCBS benefit effective February 1, 2017. For individuals who choose to receive Adult Family Living services, most will live in their own home or the home of a family member. Clients have the choice of a range of services but choose Adult Family Living so that a family member can provide their services. For those instances in which the home is owned by the provider, the contracted care management entity assesses each setting using the questions added to the universal assessment to evaluate compliance with the settings requirements. In addition, the state assures monitoring compliance by training the care management providers on the settings requirements and upon initial assessment visit as the care plan is being developed, as well as during ongoing monitoring and care plan updates, the care manager will assess the compliance of the service setting with CMS' requirements. The care managers have been trained to bring any concerns or questions to the Department for review and analysis. The setting will be assessed on an ongoing basis by utilizing the assessment tool annually. Some clients reside in residential care homes (RCHs). The state has surveyed residents and care managers in its assessment of the compliance of RCHs with the settings requirements. SMA Community Option Unit staff also visited each community in which clients reside and completed a survey based on direct observation and interaction with the clients. On an ongoing basis, the state has embedded settings questions into its standardized assessment tool that is being used broadly across all HCBS programs.

In accordance with Section 3715 of the CARES Act, CHCPE 1915(i) HCBS may also be provided in acute care hospitals, if the client experiences temporary institutionalization while receiving CHCPE 1915(i) HCBS under the following conditions:

- The HCBS are provided to meet needs of the individual that are not met through the provision of acute care hospital services and the HCBS are in addition to, and may not substitute for, the services the acute care hospital is obligated to provide. Likewise, the HCBS must be identified in the individual's person-centered service plan, the HCBS should be used to ensure smooth transitions between acute care setting and community-based settings and to preserve the individual's functional abilities and the 1915(i) HCBS in this SPA that can be provided by the 1915(i) HCBS provider are not duplicative of services available in the acute care hospital setting.
- The CHCPE 1915(i) HCBS will assist the individual in returning to the community by supporting the individual in the hospital with the goal of reduced behaviors, reduced anxiety and/or focus on rehabilitative efforts during hospitalization allowing for medical treatment to be provided and assist in returning to the community in an expediated manner.
- In accordance with all of the conditions listed immediately above, the CHCPE 1915(i) HCBS provider may provide companion services while the person is in an acute care hospital that are not duplicative of services available in the acute care hospital setting are in addition to, and may not substitute for, the services the acute care hospital is obligated to provide, which will primarily involve services related to decreasing client behaviors related to the stay in a setting unfamiliar to them. These services are beyond the typical availability of an inpatient hospital service.

Person-Centered Planning & Service Delivery

(By checking the following boxes the state assures that):

1. ☒ There is an independent assessment of individuals determined to be eligible for the State plan HCBS benefit. The assessment meets federal requirements at 42 CFR §441.720.

2. ☒ Based on the independent assessment, there is a person-centered service plan for each individual determined to be eligible for the State plan HCBS benefit. The person-centered service plan is developed using a person-centered service planning process in accordance with 42 CFR §441.725(a), and the written person-centered service plan meets federal requirements at 42 CFR §441.725(b).

3. ☒ The person-centered service plan is reviewed, and revised upon reassessment of functional need as required under 42 CFR §441.720, at least every 12 months, when the individual's circumstances or needs change significantly, and at the request of the individual.

4. **Responsibility for Face-to-Face Assessment of an Individual's Support Needs and Capabilities.** There are educational/professional qualifications (that are reasonably related to performing assessments) of the individuals who will be responsible for conducting the independent assessment, including specific training in assessment of individuals with need for HCBS. *(Specify qualifications):*

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

   Care managers must have the following additional qualifications:

   demonstrated interviewing skills which include the professional judgment to probe as necessary to uncover underlying concerns of the applicants; demonstrated ability to establish and maintain empathic relationships; experience in conducting social and health assessments; knowledge of human behavior, family/caregiver dynamics, human development and disabilities; awareness of community resources and services; the ability to understand and apply complex service reimbursement issues; and the ability to evaluate, negotiate and plan for the costs of care options.

   The registered nurse must hold a license to practice nursing in the State of CT. Care managers are encouraged but not required to be certified as a long-term care manager.

5. **Responsibility for Development of Person-Centered Service Plan**. There are qualifications (that are reasonably related to developing service plans) for persons responsible for the development of the individualized, person-centered service plan. *(Specify qualifications):*

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

Care managers must have the following additional qualifications:

demonstrated interviewing skills which include the professional judgment to probe as necessary to uncover underlying concerns of the applicants; demonstrated ability to establish and maintain empathic relationships; experience in conducting social and health assessments; knowledge of human behavior, family/caregiver dynamics, human development and disabilities; awareness of community resources and services; the ability to understand and apply complex service reimbursement issues; and the ability to evaluate, negotiate and plan for the costs of care options.

The registered nurse must hold a license to practice nursing in the State of CT. Care managers are encouraged but not required to be certified as a long-term care manager.

6. **Supporting the Participant in Development of Person-Centered Service Plan**. Supports and information are made available to the participant (and/or the additional parties specified, as appropriate) to direct and be actively engaged in the person-centered service plan development process. *(Specify: (a) the supports and information made available, and (b) the participant's authority to determine who is included in the process):*

Once the referral is processed by the DSS Community Options unit staff and the client appears to meet functional and financial eligibility criteria for CHCPE state plan HCBS, the referral is sent to an Access Agency for the initial evaluation. The care manager makes an appointment to meet with the client and his or her representative if the client chooses to have someone else present. People are encouraged to have someone else present during the visit if they so choose. Most often, that is identified at the time of referral. The care manager explains the program prior to initiating the assessment. If the client consents, the care manager initiates the assessment. The universal assessment instrument evaluates 7 domains: health, function, psychosocial, environment, cognition, support system and finances. The person-centered assessment process focuses on unmet needs as well as individual preferences, goals, strengths and desired outcomes.

To the extent possible, individuals are encouraged to lead the discussion.

Based on the assessment, unmet needs are identified and service options are discussed with the client and the client's representative. Options regarding service providers are presented for the client to choose their services and providers.

The assessment is utilized to develop client-centered goals and plans are developed that assist the client in achieving those goals.

7. **Informed Choice of Providers.** *(Describe how participants are assisted in obtaining information about and selecting from among qualified providers of the 1915(i) services in the person-centered service plan):*

During the development of the total Plan of Care (POC), clients will select providers from a list prepared by the fiscal intermediary. The fiscal intermediary maintains the list of service providers according to geographic areas within the state, and the availability may vary by geographic area. The client might choose a provider that will not extend their coverage outside of their service area. For example, in the western part of the state, a provider that serves the greater Danbury area may well not agree to provide services to a client living in Torrington. The care managers make a concerted effort to provide the clients with as many choices as possible and the expectation is that there is documentation in the clinical record of the choices given. The client may request a copy of the list at any time.

If the client does not choose a specific provider, providers are assigned on a rotating basis as long as the provider can meet all of the specifications requested by the client such as language spoken and the days and times that services are available. The care manager will describe the services available from providers on the list. Clients choose providers from the list and their signature on the total POC acknowledges freedom of choice.

Additionally, in every follow up monitoring contact the client is asked if they are satisfied with the services provided and if there are any problems with the delivery of the formal services. If the client indicates there are problems, then changing to another service provider is discussed as an option and the care manager reviews with the client the service providers available to choose from. Again, that documentation is found in the clinical record.

Provider enrollment is open and continuous. New providers are added to the list as they meet the qualifications and are enrolled. Once added to the list, the care managers provide the information to the client as part of the monitoring contact if the client wishes to change providers and is also provided as a choice to all new clients.

8. **Process for Making Person-Centered Service Plan Subject to the Approval of the Medicaid Agency**. *(Describe the process by which the person-centered service plan is made subject to the approval of the Medicaid agency):*

DSS Community Options unit staff review 100% of all new service plans and must authorize the plan before it can be implemented. Utilization review nurses match needs with services to ensure all health and safety needs are being met.

DSS Community Options unit staff conduct annual client record reviews for each of the Access Agencies. DSS randomly selects a sample of client records for review. In addition to the record reviews done by SMA Community Options unit staff, the Access Agencies are contractually required to perform record audits and produce quarterly reports to the Department summarizing those audits. The records selected by DSS for review, when combined with the reviews done by the Access Agency, are calculated in a manner that they are sufficient to constitute a representative sample. A representative sample is

achieved by combining the audits of both the Access Agency supervisors and Department staff. The reviews include an examination of the client's most recent reassessment and confirm that the identified critical needs are consistent with the POC. The POC is reviewed to ensure that all identified needs are being met. SMA Community Options unit staff conduct client satisfaction surveys in each of the areas of the state that define the Access Agencies service areas.

Both the Department and the Access Agencies perform client satisfaction surveys. HCBS client record reviews are conducted to monitor the Access Agencies compliance with its contract with the Department. The Access Agencies are contractually obligated to conduct client record reviews, including assessing appropriateness of the POC, and report annually to the Department.

Access Agencies must update the POC at the time of reassessment or when a significant change occurs in the client's status, and utilize care plans consistent with the program's uniform client care plan. The uniform client care plan identifies provider, type of service, number of hours provided, date service began, and date service was discontinued, noting the need for a backup plan. These services are monitored by the Department through quality assurance and client satisfaction annual reports generated by the Access Agencies.

9. **Maintenance of Person-Centered 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):*				

Services

1. **State plan HCBS.** *(Complete the following table for each service. Copy table as needed):*

Service Specifications *(Specify a service title for the HCBS listed in Attachment 4.19-B that the state plans to cover):*	
Service Title:	Adult Day Health
Service Definition (Scope):	
The service is provided 4 or more hours per day on a regularly scheduled basis for one or more days per week, or as specified in the service plan, in a center that is a non-institutional, community-based setting and must encompass both health and social services needed to ensure the optimal functioning of the client. Health services include personal care, health monitoring by a registered nurse, therapeutic diet meals and snacks, and social services including recreation and other social activities. See additional detail below. Transportation to and from the center is included in the service definition and in the rate structure. Meals provided as part of these services must not constitute a full nutritional regimen. Claims will	

be denied by any adult day health provider attempting to bill for non-medical transportation procedure codes. These procedure codes are not included on the adult day health fee schedule and will deny as edits are built into the claim processing system to prevent duplicative non-medical transportation services for adult day health from occurring.

Payment for adult day services under the rate for a medical model is limited to providers that demonstrate to the Department their ability to meet the following additional requirements:

- a program nurse must be available on site for not less than fifty percent of each operating day;
- the program nurse must be a registered nurse, except that a program nurse may be a licensed practical nurse if the program is located adjacent to a long-term care facility licensed by the Department of Public Health, with ready access to a registered nurse from such long-term care facility or the program nurse is supervised by a registered nurse who can be reached by telephone at any time during the operating day and who can be called to the center if needed within 30 minutes of the request. The program nurse is responsible for administering medications as needed and assuring that the client's nursing services are coordinated with other services provided in the adult day health center, health and social services currently received at home or provided by existing community health agencies and personal physicians;
- additional personal care services must be provided as specified in the individual plan of care, including, but not limited to, bathing and transferring;
- ongoing training must be available to the staff on a regular basis including, but not be limited to, orientation to key specialty areas such as physical therapy, occupational therapy, speech therapy and training in techniques for recognizing when to arrange or refer clients for such services; and
- individual therapeutic and rehabilitation services must be coordinated by the center as specified in the individual plan of care including, but not limited to, physical therapy, occupational therapy and speech therapy. The center must have the capacity to provide such services on site; this requirement must not preclude the provider of adult day health services from also arranging to provide therapeutic and rehabilitation services at other locations in order to meet the needs of individual clients.

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

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

Additional needs-based criteria for receiving the service, if applicable *(specify)*:

None

Specify limits (if any) on the amount, duration, or scope of this service. Per 42 CFR Section 440.240, services available to any categorically needy recipient cannot be less in amount, duration and scope than those services available to a medically needy recipient, and services must be equal for any individual within a group. States must also separately address standard state plan service questions related to sufficiency of services.

(Choose each that applies):

☒	Categorically needy *(specify limits):*
	May be provided up to 7 times per week
☐	Medically needy *(specify limits):*

Provider Qualifications *(For each type of provider. Copy rows as needed)*:

Provider Type *(Specify)*:	License *(Specify):*	Certification *(Specify):*	Other Standard *(Specify):*
Adult Day Center Provider Agency	None	Certified by Adult Day Care Association	Providers of adult day health services must: - meet all applicable federal, state and local requirements including zoning, licensing, sanitation, fire and safety requirements - provide, at a minimum, nursing consultation services, social work services, nutritionally balanced meals to meet specialized dietary needs as prescribed by health care personnel, personal care services, recreational therapy and non-medical transportation services for individuals to and from their homes; - provide adequate personnel to operate the program including: • a full-time program administrator; • nursing consultation during the full operating day by a registered nurse licensed in the State of Connecticut; and • the direct care staff-to-client ratio of at least one to seven. Staffing must be adequate to meet the needs of the client base. Volunteers may be included in the ratio only when

			they conform to the same standards and requirements as paid staff. In order to be a provider of services to Department clients, any facility located and operating within the State of Connecticut or located and operating outside the state, in a bordering state, must be certified by the Connecticut Association of Adult Day Centers Incorporated, its successor agency or a Department designee. A facility (center) located and operating outside the state in a bordering state must be licensed or certified by its respective state and comply at all times with all pertinent licensure or certification requirements in addition to the approved standards for certification by the Department. Certified facilities (centers) must be in compliance with all applicable requirements in order to continue providing services to Department clients. Failure to comply with any applicable requirements is grounds for the termination of its certification and participation as a Department service provider.

Verification of Provider Qualifications (*For each provider type listed above. Copy rows as needed)*:

Provider Type *(Specify)*:	Entity Responsible for Verification *(Specify)*:	Frequency of Verification *(Specify)*:
ADC Provider	**Department's Fiscal Intermediary**	**Initially to enroll and Every 2 years thereafter**

Service Delivery Method. *(Check each that applies)*:

☐	Participant-directed	☒	Provider managed

Service Specifications *(Specify a service title for the HCBS listed in Attachment 4.19-B that the state plans to cover):*

Service Title: Care Management

Service Definition (Scope):

Services that assist clients in gaining access to needed program and other State plan services, as well as medical, social, educational and other services, regardless of the funding source for the services to which access is gained. Care managers additionally are responsible for monitoring the ongoing provision of services in the client's plan of care and continually monitor that the client's health and safety needs are being addressed. They complete the initial and annual assessment and reassessment of an individual's needs in order to develop a comprehensive plan of care. They confirm the initial needs criteria determination done by Department staff and reassess the needs criteria annually and maintain documentation for department review.

DSS has implemented a tiered case management system. Tiered case management is based on client's level of need and the number and type of case management interventions required. TIER A clients, with the fewest needs, receive a quarterly contact and an annual reassessment. Leveling Criteria for TIER A is 3 or less care management interventions in a six-month period. If 2 of those interventions are crisis interventions, the client is automatically elevated to level 2. TIER B clients receive monthly monitoring, a six-month field visit and an annual reassessment. Leveling criteria is 4-6 care management interventions in a six-month period. TIER C clients, the highest level, receive monthly monitoring, quarterly field visits, six-month visit, and an annual reassessment. Leveling criteria is 7 or more care management interventions in a six-month period. There are four categories of case management intervention: crisis intervention, service brokerage and advocacy, risk management and client engagement/re-engagement. Crisis intervention efforts have two principle aims: 1) cushion the stressful event by immediate or emergency emotional or environmental first aid; and 2) strengthen the person in his or her coping through immediate therapeutic clarification and guidance during the crisis period. Examples of incidents that precipitate crisis interventions: suicide assessment, incidents of abuse, victimization, neglect, exploitation, and imminent threat of homelessness. Service brokerage and advocacy requires that the care manager facilitate continual interaction between various segments of the service delivery system. When service breakdowns or requests for service changes occur, the care manager assists clients to ensure their rights to receive services, based upon the person-centered model of care, are upheld. Service brokerage and advocacy interventions include activities around finding and keeping providers for clients with difficult service needs, pre and post transitioning from an inpatient setting to the community, hospice and end of life care. Risk management includes the identification of potential and perceived risks to the individual falling into four general categories; health, behavior, personal safety risks, and in-community risks. Managing these risks includes identification and documenting risks, developing written plans for addressing them, negotiating with clients the risks presented, keeping client choice central to the process, and monitoring outcomes related to the risk. Client engagement refers to the process through which clients become active or involved in their care plans and participation in the program. The engagement process has several conceptualizations where interventions are designed to enhance client receptivity,

expectancy, investment, and working relationship. Care management interventions are weighted according to complexity, severity and number of tasks required. Crisis intervention is weighted highest followed by service brokerage and advocacy, risk management and client engagement/re-engagement. Clients may move to a different tier based on their current needs with prior authorization from DSS. Care management per diem rates will be adjusted according to which tier the client is in.

Additional needs-based criteria for receiving the service, if applicable *(specify)*:

None

Specify limits (if any) on the amount, duration, or scope of this service. Per 42 CFR Section 440.240, services available to any categorically needy recipient cannot be less in amount, duration and scope than those services available to a medically needy recipient, and services must be equal for any individual within a group. States must also separately address standard state plan service questions related to sufficiency of services.

(Choose each that applies):

☒ Categorically needy *(specify limits)*:

Service may be billed on a per diem basis as long as the client remains in a community-based setting. Care management per diem may not be billed when a client is in an institutional setting.

☐ Medically needy *(specify limits)*:

Provider Qualifications *(For each type of provider. Copy rows as needed)*:

Provider Type *(Specify)*:	License *(Specify)*:	Certification *(Specify)*:	Other Standard *(Specify)*:
Care management Agency	The registered nurse must hold a license to practice nursing in the State of CT.	Care managers are encouraged but not required to be certified as a long-term care manager.	Providers are the Access Agencies selected by competitive procurement that are covered by the concurrent section 1915(b)(4) waiver. The care manager who conducts the assessments, develops care plans and provides ongoing monitoring must be either a registered nurse licensed in the state where care management services are provided or a social services worker who is a graduate of an accredited four-year college or university. The nurse or social services worker must have a minimum of two years of experience in health care or human services. A bachelor's degree in nursing, health, social work, gerontology or a related field may be substituted for one year of experience.

			Care managers must have the following additional qualifications: demonstrated interviewing skills, which include the professional judgment to probe as necessary to uncover underlying concerns of the applicants; demonstrated ability to establish and maintain empathetic relationships; experience in conducting social and health assessments; knowledge of human behavior, family/caregiver dynamics, human development and disabilities; awareness of community resources and services; the ability to understand and apply complex service reimbursement issues; and the ability to evaluate, negotiate and plan for the costs of care options.

Verification of Provider Qualifications (*For each provider type listed above. Copy rows as needed*):

Provider Type *(Specify)*:	Entity Responsible for Verification *(Specify)*:	Frequency of Verification *(Specify)*:
Care Management Agency	**Department of Social Services**	**Initially and annually based on field audits** **Access Agency is responsible to verify the qualifications and licenses of their care management staff upon employment and annually thereafter**

Service Delivery Method. *(Check each that applies)*:

☐	Participant-directed	☒	Provider managed

Service Specifications *(Specify a service title for the HCBS listed in Attachment 4.19-B that the state plans to cover)*:

Service Title:	Respite

Service Definition (Scope):

Services provided to individuals unable to care for themselves; furnished on a short-term basis because of the absence or need for relief of those persons normally providing the care. In-home respite providers include, but are not limited to, homemakers, companions or home health aides. Services may be provided in the home or outside of the home including, but not limited to, a licensed or certified facility such as a rest home with nursing supervision. Federal financial participation is not claimed for the cost of room and board except when provided as part of respite care furnished in a facility approved by the state that is not a private residence. Respite services do not duplicate or overlap existing services. The state ensures no overlap as the services have unique procedure codes.

Additional needs-based criteria for receiving the service, if applicable *(specify)*:

None

Specify limits (if any) on the amount, duration, or scope of this service. Per 42 CFR Section 440.240, services available to any categorically needy recipient cannot be less in amount, duration and scope than those services available to a medically needy recipient, and services must be equal for any individual within a group. States must also separately address standard state plan service questions related to sufficiency of services.

(Choose each that applies):

☒ Categorically needy *(specify limits)*:

Respite services provided in a licensed facility are limited to 30 days per calendar year per recipient. In-home respite services are limited to 720 hours per year per recipient.

☐ Medically needy *(specify limits)*:

Provider Qualifications *(For each type of provider. Copy rows as needed)*:

Provider Type *(Specify)*:	License *(Specify)*:	Certification *(Specify)*:	Other Standard *(Specify)*:
Agency (Nursing Homes)	For respite in a nursing home facility, facilities must be licensed by the CT Department of Public Health.		
Provider Agency (such as Homemaker, Companion or PCA)	Licensing is not applicable to homemakers and companions, however all requirements of a		

	homemaker/companion agency are applicable when providing respite services. Home health agencies must be licensed by the CT Department of Public Health.		

Verification of Provider Qualifications (*For each provider type listed above. Copy rows as needed*):

Provider Type *(Specify)*:	Entity Responsible for Verification *(Specify)*:	Frequency of Verification *(Specify)*:
Agency (NF or RCH)	**Fiscal Intermediary**	**Initially and every 2 years thereafter**
Agency (other)	**Fiscal Intermediary**	**Initially and every 2 years thereafter**

Service Delivery Method. *(Check each that applies)*:

☐	Participant-directed	☒	Provider managed

Service Specifications *(Specify a service title for the HCBS listed in Attachment 4.19-B that the state plans to cover)*:

Service Title:	Personal Care Assistant (PCA)

Service Definition (Scope):

One or more persons assisting an elder with tasks that the individual would typically do for him/herself in the absence of a disability. Such tasks may be performed at home or in the community. Such services may include physical or verbal assistance to the consumer in accomplishing any activity of daily living (ADL), or instrumental activity of daily living (IADL). ADLs include bathing, dressing, toileting, transferring, and feeding. IADLs include meal preparation, shopping, housekeeping, laundry and cueing/reminders for self-medication administration. PCA services in the state plan are agency-based, which complements the 1915(k) PCA service that offers self-directed PCA services and are not agency-based.

Additional needs-based criteria for receiving the service, if applicable *(specify)*:

None

Specify limits (if any) on the amount, duration, or scope of this service. Per 42 CFR Section 440.240, services available to any categorically needy recipient cannot be less in amount, duration and scope

than those services available to a medically needy recipient, and services must be equal for any individual within a group. States must also separately address standard state plan service questions related to sufficiency of services.

(Choose each that applies):

☒ Categorically needy *(specify limits):*

Up to 14 hours per week may be provided. Recipients of PCA services will not be eligible to receive homemaker or companion services. Edits have been created in the MMIS to deny any homemaker or companion claims for PCA service recipients. Personal care may not be provided to clients receiving assisted living services as all of the functions of personal care are provided by the assisted living service provider. The benefit plan for assisted living service recipients excludes personal care so that there could be no duplicative billing. Section 1915(k) and section 1915(i) personal care services may not be billed for the same hours. The services are authorized in the client's service plan and scheduled so there is no overlap. Section 1915(i) personal care is subject to electronic visit verification effective 1/1/17 which ensures that services that overlap would not be reimbursed. Edits in the MMIS prevent the procedure codes for self-directed and agency-based PCA from being provided at the same time.

☐ Medically needy *(specify limits):*

Provider Qualifications *(For each type of provider. Copy rows as needed)*:

Provider Type *(Specify)*:	License *(Specify):*	Certification *(Specify):*	Other Standard *(Specify):*
PCA Agency			The PCA hired by the agency must meet all of the same qualifications as an individual PCA as follows: • Be at least 18 years of age • Have experience doing personal care • Be able to follow written or verbal instructions given by the consumer or the consumer's conservator • Be physically able to perform the services required • Receive instruction/training from consumer or their designee concerning all personal care services delineated in the service plan • Be able to handle emergencies • Demonstrate the ability to implement cognitive behavioral interventions/take direction to carry out the plan.

Verification of Provider Qualifications (*For each provider type listed above. Copy rows as needed*):

Provider Type *(Specify)*:	Entity Responsible for Verification *(Specify)*:	Frequency of Verification *(Specify)*:
PCA Agency	**Fiscal Intermediary and employing agency**	At the time of enrollment and every 2 years thereafter

Service Delivery Method. *(Check each that applies)*:

☐	Participant-directed	☒	Provider managed

Service Specifications *(Specify a service title for the HCBS listed in Attachment 4.19-B that the state plans to cover)*:

Service Title:	Homemaker

Service Definition (Scope):

Services consisting of general household activities (meal preparation, laundry and routine household care) provided by a trained homemaker, when the individual regularly responsible for these activities is temporarily absent or unable to manage the home and care for him or herself or others in the home. Homemakers shall meet such standards of education and training as are established by the state for the provision of these activities.

Additional needs-based criteria for receiving the service, if applicable *(specify)*:

None

Specify limits (if any) on the amount, duration, or scope of this service. Per 42 CFR Section 440.240, services available to any categorically needy recipient cannot be less in amount, duration and scope than those services available to a medically needy recipient, and services must be equal for any individual within a group. States must also separately address standard state plan service questions related to sufficiency of services.

(Choose each that applies):

☒	Categorically needy *(specify limits)*:
	Up to 6 hours per week
☐	Medically needy *(specify limits)*:

Provider Qualifications *(For each type of provider. Copy rows as needed)*:

Provider Type *(Specify)*:	License *(Specify)*:	Certification *(Specify)*:	Other Standard *(Specify)*:
Agency		Certification required from Dept. of	

		Consumer Protection	

Verification of Provider Qualifications (*For each provider type listed above. Copy rows as needed*):

Provider Type *(Specify)*:	Entity Responsible for Verification *(Specify)*:	Frequency of Verification *(Specify)*:
Agency	**Fiscal Intermediary**	Initially and every 2 years thereafter

Service Delivery Method. *(Check each that applies)*:

☐	Participant-directed	☒	Provider managed

Service Specifications *(Specify a service title for the HCBS listed in Attachment 4.19-B that the state plans to cover):*

Service Title:	Companion

Service Definition (Scope):

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

Companion services may include, but are not limited to, the following activities:

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

(B) reading to or for an individual;

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

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

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

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

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

In addition to home and community-based settings, in accordance with section 3715 of the CARES Act, as set forth in the Home and Community-Based Settings section of this CHCPE Attachment 3.1-i of the Medicaid State Plan above, companion services may also be provided in an acute care hospital, provided that the services support the individual in the hospital in returning to the community and do not duplicate any service provided by the acute care hospital and are in addition to, and may not substitute for, the services the acute care hospital is obligated to provide.

Additional needs-based criteria for receiving the service, if applicable *(specify)*:

None

Specify limits (if any) on the amount, duration, or scope of this service. Per 42 CFR Section 440.240, services available to any categorically needy recipient cannot be less in amount, duration and scope than those services available to a medically needy recipient, and services must be equal for any individual within a group. States must also separately address standard state plan service questions related to sufficiency of services.

(Choose each that applies):

☒	Categorically needy *(specify limits)*:
	Companion Services may not be provided to a client receiving PCA services. An edit was built into the MMIS to reject any billing for the companion procedure code if the PCA procedure code is billed. The total plan of care specifies if both homemaker and companion services are authorized for the client. The duties of each are defined as part of the overall plan and are not duplicative. This service may not be provided by a relative of the client.
☐	Medically needy *(specify limits)*:

Provider Qualifications *(For each type of provider. Copy rows as needed)*:

Provider Type *(Specify)*:	License *(Specify)*:	Certification *(Specify)*:	Other Standard *(Specify)*:
Agency			Any homemaker/companion agency must register with the Department of Consumer Protection.

Verification of Provider Qualifications (*For each provider type listed above. Copy rows as needed*):

Provider Type *(Specify)*:	Entity Responsible for Verification *(Specify)*:	Frequency of Verification *(Specify)*:
Agency	**Fiscal Intermediary**	Initially and every 2 years thereafter

Service Delivery Method. *(Check each that applies)*:

☐	Participant-directed	☒	Provider managed

Service Specifications *(Specify a service title for the HCBS listed in Attachment 4.19-B that the state plans to cover):*

Service Title: Chore

Service Definition (Scope):

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

When an individual requires one-time only unique or specialized services in order to maintain a healthy and safe environment, they may receive highly skilled chore services which include moving, extensive cleaning or extermination services. Highly skilled chore services are subject to prior authorization by the Department. The Department may authorize services on a case-by-case basis such as extermination to be repeated if the initial treatment did not resolve the pest problem.

Additional needs-based criteria for receiving the service, if applicable *(specify):*

None

Specify limits (if any) on the amount, duration, or scope of this service. Per 42 CFR Section 440.240, services available to any categorically needy recipient cannot be less in amount, duration and scope than those services available to a medically needy recipient, and services must be equal for any individual within a group. States must also separately address standard state plan service questions related to sufficiency of services.

(Choose each that applies):

☐	Categorically needy *(specify limits):*
☐	Medically needy *(specify limits):*

Provider Qualifications *(For each type of provider. Copy rows as needed)*:

Provider Type *(Specify)*:	License *(Specify):*	Certification *(Specify):*	Other Standard *(Specify):*
Agency	n/a	If provider is a homemaker/companion/chore agency, they	n/a

		must be registered with the Department of Consumer Protection. Chore services providers shall demonstrate the ability to meet the needs of the individual seeking services.	
Individual	Electrician, plumbers and other contractors must hold the appropriate license such as extermination to perform highly skilled chore services.	n/a	n/a

Verification of Provider Qualifications (*For each provider type listed above. Copy rows as needed*):

Provider Type *(Specify)*:	Entity Responsible for Verification *(Specify)*:	Frequency of Verification *(Specify)*:
Agency	**Fiscal Intermediary**	**Initially and every 2 years thereafter**
Individual	**Fiscal Intermediary**	**At the time of service**

Service Delivery Method. *(Check each that applies)*:

☐	Participant-directed	☒	Provider managed

Service Specifications *(Specify a service title for the HCBS listed in Attachment 4.19-B that the state plans to cover)*:

Service Title:	Assisted Living

Service Definition (Scope):

Personal care and services, homemaker, chore, attendant care, companion services, medication oversight, therapeutic social and recreational programming, provided in a home-like environment in a managed residential community (MRC), in conjunction with residing

in the community. An MRC is a living arrangement consisting of private residential units that provides a managed group living environment including housing and services. A private residential unit means a living arrangement rented by the client that includes a private full bath within the unit and facilities and equipment for the preparation and storage of food. Each unit has lockable access, is free to receive visitors and leave the setting at times and durations of the individual's choosing, access to the greater community is easily facilitated and individuals can choose whether to share a living space. This service includes 24-hour on-site response staff to meet scheduled or unpredictable needs in a way that promotes maximum dignity and independence, and to provide supervision, safety and security. Other individuals or agencies may also furnish care directly, or under arrangement with the MRC, but the care provided by these other entities supplements that provided by the community care facility and does not supplant it. Mental health counseling and the personal emergency response system are services available to assisted living clients above and beyond the assisted living service. Nursing and skilled therapy services are incidental rather than integral to the provision of assisted living services. Payment is not made for 24-hour skilled care. Federal financial participation is not available for room and board, items of comfort or convenience, or the costs of facility maintenance, upkeep and improvement.

Personalized care is furnished to individuals who reside in their own living units (which may include dually occupied units when both occupants consent to the arrangement), which includes kitchenette and living rooms and which contain bedrooms and toilet facilities. The consumer has a right to privacy. Living units may be locked at the discretion of the consumer, except when a physician or mental health professional has certified in writing that the consumer is sufficiently cognitively impaired as to be a danger to self or others if given the opportunity to lock the door. Each living unit is separate and distinct from each other.

The communities have a central dining room, living room or parlor, and common activity center(s), which may also serve as living rooms or dining rooms. The consumer retains the right to assume risk, tempered only by the individual's ability to assume responsibility for that risk. Care must be furnished in a way that fosters the independence of each consumer. Routines of care provision and service delivery must be consumer-driven to the maximum extent possible and treat each person with dignity and respect.

Care plans will be developed based on the individual's service needs. There are four levels of service provided in assisted living facilities based on the consumer's combined needs for personal care and nursing services. The four levels are: (1) occasional, which is 1-3.75 hours per week of service; (2) limited, which is 4-8.75 hours per week of service; (3) moderate, which is 9-14.75 hours per week of service; and (4) extensive, which is 15-25 hours per week of service. Level of service assigned depends upon the volume and extent of services needed by each individual and is not a limitation of service.

Assisted living services are currently provided statewide in private assisted living facilities and in state-funded congregate and HUD-funded facilities. Additionally, assisted living services are provided in demonstration sites.

Additional needs-based criteria for receiving the service, if applicable *(specify)*:

None

Specify limits (if any) on the amount, duration, or scope of this service. Per 42 CFR Section 440.240, services available to any categorically needy recipient cannot be less in amount, duration and scope than those services available to a medically needy recipient, and services must be equal for any individual within a group. States must also separately address standard state plan service questions related to sufficiency of services.

(Choose each that applies):

☒	Categorically needy *(specify limits):*
	Persons receiving assisted living services may not receive PCA services and PCA is not included on the fee schedule for clients receiving assisted living services, preventing duplicative billing.
☐	Medically needy *(specify limits):*

Provider Qualifications *(For each type of provider. Copy rows as needed)*:

Provider Type *(Specify)*:	License *(Specify):*	Certification *(Specify):*	Other Standard *(Specify):*
Assisted Living Services Agency	The Assisted Living Service Agency (ALSA) provider is licensed by the CT Department of Public Health in accordance with chapter 368v. Regulations regarding a MRC and the ALSA are found in Regulations of the State of CT agencies in 19-13-D104 and 19-13-D105.		

Verification of Provider Qualifications (*For each provider type listed above. Copy rows as needed*):

Provider Type *(Specify)*:	Entity Responsible for Verification *(Specify):*	Frequency of Verification *(Specify):*

Agency	MMIS contractor and DSS Quality Assurance Staff	Initially and every two years thereafter

Service Delivery Method. *(Check each that applies)*:

☐	Participant-directed	☒	Provider managed

Service Specifications *(Specify a service title for the HCBS listed in Attachment 4.19-B that the state plans to cover)*:

Service Title:	Assistive Technology

Service Definition (Scope):

An item, piece of equipment, or product system, whether acquired commercially, modified, or customized, that is used to increase, maintain, monitor or improve functional capabilities of client to perform ADLs or IADLs. Assistive technology service means a service that directly assists a client in the selection, acquisition, or use of an assistive technology device.

A. Services consisting of purchasing, leasing, or otherwise providing for the acquisition of assistive technology devices.

B. Services consisting of selecting, designing, fitting, customizing, adapting, applying, maintaining, repairing, or replacing assistive technology devices.

C. Training or technical assistance for the client or for the direct benefit of the client receiving the service, and where appropriate, the family members, guardians, advocates or authorized representatives of the client.

Additional needs-based criteria for receiving the service, if applicable *(specify)*:

Care plans will be developed based on the needs identified in the comprehensive assessment. The cost of the assistive technology cannot exceed the yearly cost of the service it replaces. When an assistive technology device is identified that will support the client's independent functioning, the services will be reduced commensurate with the cost of the service it replaces. This reduction will be made with consideration of the client's health and safety needs.

Specify limits (if any) on the amount, duration, or scope of this service. Per 42 CFR Section 440.240, services available to any categorically needy recipient cannot be less in amount, duration and scope than those services available to a medically needy recipient, and services must be equal for any individual within a group. States must also separately address standard state plan service questions related to sufficiency of services.

(Choose each that applies):

☒	Categorically needy *(specify limits)*:
	The service is capped at an annual cost of $1,000.
☐	Medically needy *(specify limits)*:

Provider Qualifications *(For each type of provider. Copy rows as needed)*:

Provider Type *(Specify)*:	License *(Specify)*:	Certification *(Specify)*:	Other Standard *(Specify)*:
Agency	n/a	n/a	Medicaid provider status for assistive technology and supplies or agency that obtains Medicaid performing provider status
Agency-Pharmacy	State of CT Department of Consumer Protection Pharmacy Practice Act: Regulations concerning practice of pharmacy Sec. 20-175-4-6-7		

Verification of Provider Qualifications (*For each provider type listed above. Copy rows as needed*):

Provider Type *(Specify)*:	Entity Responsible for Verification *(Specify)*:	Frequency of Verification *(Specify)*:
Agency	**Fiscal Intermediary**	**At the start of service**

Service Delivery Method. (*Check each that applies*):

☐	Participant-directed	☒	Provider managed

Service Specifications (*Specify a service title for the HCBS listed in Attachment 4.19-B that the state plans to cover*):

Service Title:	Environmental Accessibility Adaptations

Service Definition (Scope):

Minor home adaptations required by the individual's plan of care which are necessary to ensure health, welfare and safety of the individual to function with greater independence in their home and without which the individual would require institutionalization. Such adaptations may include the installation of handrails and grab bars in the tub area, widening of doors and installation of ramps. Excluded are those adaptations or improvements to the home which are of general utility and are not of direct medical or remedial benefit to the individuals such as carpeting, roof repair or air conditioning. Adaptations which add to the total square footage of the home are excluded from this benefit. All services must be provided in accordance with applicable state or local building codes. Adaptations are excluded if the residence is owned by someone other than the client and the adaptations would be the responsibility of the owner/landlord.

Additional needs-based criteria for receiving the service, if applicable *(specify)*:	
None	
Specify limits (if any) on the amount, duration, or scope of this service. Per 42 CFR Section 440.240, services available to any categorically needy recipient cannot be less in amount, duration and scope than those services available to a medically needy recipient, and services must be equal for any individual within a group. States must also separately address standard state plan service questions related to sufficiency of services. *(Choose each that applies):*	
☒	Categorically needy *(specify limits)*:
	This service is subject to prior authorization by DSS staff
☐	Medically needy *(specify limits)*:

Provider Qualifications *(For each type of provider. Copy rows as needed)*:

Provider Type *(Specify)*:	License *(Specify)*:	Certification *(Specify)*:	Other Standard *(Specify)*:
Individual (non relative)		1. The vendor or contractor must provide all services, materials, and labor that are necessary to complete the project/minor home modification(s) as indicated. 2. The vendor or contractor must be registered with the Department of Consumer Protection to do business in the State of Connecticut. 3. The vendor or contractor must show evidence of a valid home	

		improvement registration and evidence of workers' compensation (if applicable) and liability insurance, at the time they provide an estimate for the project. 4. If applicable, the vendor or contractor must apply for, obtain, and pay for all permits. All work done must be done per applicable codes, regulations and standards of construction, including American National Standards Institute (ANSI) standards for barrier-free access and safety requirement. 5. The vendor or contractor must warranty all work, including labor and materials, for one year from the date	

		of acceptance and thereafter, one year from the date of completion of the project. 6. When equipment is required to make the home accessible, a separate vendor may provide and install the equipment.	

Verification of Provider Qualifications (*For each provider type listed above. Copy rows as needed*):

Provider Type *(Specify)*:	Entity Responsible for Verification *(Specify)*:	Frequency of Verification *(Specify)*:
Agency	**Fiscal Intermediary**	**Prior to the initiation of service**

Service Delivery Method. *(Check each that applies)*:

☐	Participant-directed	☒	Provider managed

Service Specifications *(Specify a service title for the HCBS listed in Attachment 4.19-B that the state plans to cover):*

Service Title:	Mental Health Counseling

Service Definition (Scope):

Mental health counseling services are professional counseling services provided to help resolve or enable the eligible individual to cope with individual, family, and/or environmentally-related problems and conditions. Counseling focuses on issues such as problems in maintaining a home in the community, relocation within the community, dealing with long-term disability, substance use disorder, and family relationships.

The Department pays for mental health services that conform to accepted methods of diagnosis and treatment, including:

(A) mental health evaluation and assessment;
(B) individual counseling;
(C) group counseling; and
(D) family counseling.

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

Additional needs-based criteria for receiving the service, if applicable *(specify)*:

None

Specify limits (if any) on the amount, duration, or scope of this service. Per 42 CFR Section 440.240, services available to any categorically needy recipient cannot be less in amount, duration and scope than those services available to a medically needy recipient, and services must be equal for any individual within a group. States must also separately address standard state plan service questions related to sufficiency of services.

(Choose each that applies):

☐ Categorically needy *(specify limits)*:

☐ Medically needy *(specify limits)*:

Provider Qualifications *(For each type of provider. Copy rows as needed)*:

Provider Type *(Specify)*:	License *(Specify)*:	Certification *(Specify)*:	Other Standard *(Specify)*:
Individual			A social worker who holds a master's degree from an accredited school of social work, or an individual who has a master's degree in counseling, psychology or psychiatric nursing and has experience in providing mental health services to the elderly may also provide mental health counseling.

Verification of Provider Qualifications (*For each provider type listed above. Copy rows as needed*):

Provider Type *(Specify)*:	Entity Responsible for Verification *(Specify)*:	Frequency of Verification *(Specify)*:
Individual	Fiscal Intermediary	At the time of enrollment as a provider and bi-annually thereafter

Service Delivery Method. *(Check each that applies)*:

☐	Participant-directed	☒	Provider managed

Service Specifications *(Specify a service title for the HCBS listed in Attachment 4.19-B that the state plans to cover):*

Service Title: Home-Delivered Meals

Service Definition (Scope):

Home-delivered meals, or "meals on wheels," include the preparation and delivery of one or two meals for persons who are unable to prepare or obtain nourishing meals on their own. Meals must meet a minimum of one-third for single meals and two-thirds for double meals of the daily recommended allowance and requirements as established by the Food and Nutrition Academy of Sciences National Research Council. Home-delivered meals do not constitute a full nutritional regime. Special diet meals are available such as diabetic, cardiac, low sodium and renal, as are ethnic meals such as Hispanic and Kosher meals.

Liquid supplements, such as Ensure may be provided to CHCPE section 1915(i) client where available when medically necessary.

Additional needs-based criteria for receiving the service, if applicable *(specify):*

None

Specify limits (if any) on the amount, duration, or scope of this service. Per 42 CFR Section 440.240, services available to any categorically needy recipient cannot be less in amount, duration and scope than those services available to a medically needy recipient, and services must be equal for any individual within a group. States must also separately address standard state plan service questions related to sufficiency of services.

(Choose each that applies):

☒	Categorically needy *(specify limits):*
	No more than two meals per day up to seven times per week as specified in the individual service plan. Liquid supplements are covered by the CT Medicaid program pharmacy benefit for persons where the supplement is determined to be medically necessary.
☐	Medically needy *(specify limits):*

Provider Qualifications *(For each type of provider. Copy rows as needed)*:

Provider Type *(Specify)*:	License *(Specify)*:	Certification *(Specify)*:	Other Standard *(Specify)*:
Home Delivered meals Provider			Reimbursement for home-delivered meals is available only to providers that provide meals that meet a minimum of one-third of the current daily recommended dietary allowance and requirements as established by the Food and Nutrition Board of the

			National Academy of Sciences National Research Council. All "meals on wheels" providers must provide their menus to the Department, contracted agencies or Department designee for review and approval. Quality assurance and quality control shall be performed by the Department's contracted providers to ensure that the "meals on wheels" service providers are in compliance with the dietary requirements and the requirements for the preparation and storage and delivery of food based on the Department of Aging and Disability Services policies for the elderly nutrition program and Title III of the Older Americans Act.

Verification of Provider Qualifications (*For each provider type listed above. Copy rows as needed*):

Provider Type *(Specify)*:	Entity Responsible for Verification *(Specify)*:	Frequency of Verification *(Specify)*:
Agency	**Fiscal Intermediary**	**At the time of enrollment and biannually thereafter**

Service Delivery Method. *(Check each that applies)*:

☐	Participant-directed	☒	Provider managed

Service Specifications *(Specify a service title for the HCBS listed in Attachment 4.19-B that the state plans to cover):*	
Service Title:	Personal Emergency Response System (PERS)
Service Definition (Scope):	
PERS is an electronic device which enables certain individuals at high risk of institutionalization to secure help in an emergency. The individual may also wear a portable "help" button to allow for mobility. The system is connected to the person's phone and programmed to signal a response center once a "help" button is activated. The response	

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

Additional needs-based criteria for receiving the service, if applicable *(specify)*:

None

Specify limits (if any) on the amount, duration, or scope of this service. Per 42 CFR Section 440.240, services available to any categorically needy recipient cannot be less in amount, duration and scope than those services available to a medically needy recipient, and services must be equal for any individual within a group. States must also separately address standard state plan service questions related to sufficiency of services.

(Choose each that applies):

☒	Categorically needy *(specify limits)*:
	Provider may bill for one-time only installation and monthly rate thereafter
☐	Medically needy *(specify limits)*:

Provider Qualifications *(For each type of provider. Copy rows as needed)*:

Provider Type *(Specify)*:	License *(Specify)*:	Certification *(Specify)*:	Other Standard *(Specify)*:
Agency-vendors who sell and install PERS equipment			Vendor that has an approved contract through DSS as a performing provider

Verification of Provider Qualifications (*For each provider type listed above. Copy rows as needed*):

Provider Type *(Specify)*:	Entity Responsible for Verification *(Specify)*:	Frequency of Verification *(Specify)*:
Agency	**Fiscal Intermediary**	**At the time of enrollment and biannually thereafter**

Service Delivery Method. *(Check each that applies)*:

☐	Participant-directed	☒	Provider managed

Service Specifications *(Specify a service title for the HCBS listed in Attachment 4.19-B that the state plans to cover)*:

Service Title:	Non-Medical Transportation

Service Definition (Scope):

Non-medical transportation services provide access to social services, community services and appropriate social or recreational facilities that are essential to help some individuals avoid institutionalization by enabling these individuals to retain their role as community members. This service is offered in addition to medical transportation offered under the state plan and must not replace it.

(A) These services are provided when non-medical transportation is required to promote and enhance independent living and self-support; and

(B) Non-medical transportation services may be provided by taxi, livery, bus, invalid coach, volunteer organization or individuals. Services are reimbursed when they are necessary to provide access to needed community-based services or community activities as specified in the approved plan of care. Relatives may not be reimbursed for non-medical transportation.

Additional needs-based criteria for receiving the service, if applicable *(specify)*:

None

Specify limits (if any) on the amount, duration, or scope of this service. Per 42 CFR Section 440.240, services available to any categorically needy recipient cannot be less in amount, duration and scope than those services available to a medically needy recipient, and services must be equal for any individual within a group. States must also separately address standard state plan service questions related to sufficiency of services.

(Choose each that applies):

☒ Categorically needy *(specify limits)*:

Adult day health providers cannot bill the non-medical transportation procedure code. Non-medical transportation is a separate and distinct procedure code and that service is not contracted to be provided by adult day health providers thus preventing duplicate billing. Relatives may not provide this service.

☐ Medically needy *(specify limits)*:

Provider Qualifications *(For each type of provider. Copy rows as needed)*:

Provider Type *(Specify)*:	License *(Specify)*:	Certification *(Specify)*:	Other Standard *(Specify)*:
Agency-Commercial Transportation Providers	In order to receive payment, all commercial non-medical transportation providers must be regulated carriers and meet all applicable state		

	and federal permit and licensure requirements, and vehicle registration requirements. Commercial non-medical transportation providers must also meet all applicable Medicaid program enrollment requirements		
Individual Provider	There are no enrollment requirements for private non-medical transportation. Private non-medical transportation is defined as non-medical transportation by a vehicle owned by a volunteer organization, or a private individual, provided the vehicle is not used for commercial carriage. The provider must possess a valid CT driver's license and provide		

	evidence of automobile insurance.		

Verification of Provider Qualifications (*For each provider type listed above. Copy rows as needed*):

Provider Type *(Specify)*:	Entity Responsible for Verification *(Specify)*:	Frequency of Verification *(Specify)*:
Agency	**Fiscal Intermediary**	**At the time of enrollment and bi annually thereafter**
Individual Provider	**Fiscal Intermediary**	**At the time of enrollment and biannually thereafter**

Service Delivery Method. *(Check each that applies)*:

☐	Participant-directed	☒	Provider managed

Service Specifications *(Specify a service title for the HCBS listed in Attachment 4.19-B that the state plans to cover):*

Service Title: Bill Payer

Service Definition (Scope):

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

Additional needs-based criteria for receiving the service, if applicable *(specify):*

None

Specify limits (if any) on the amount, duration, or scope of this service. Per 42 CFR Section 440.240, services available to any categorically needy recipient cannot be less in amount, duration and scope than those services available to a medically needy recipient, and services must be equal for any individual within a group. States must also separately address standard state plan service questions related to sufficiency of services.

(Choose each that applies):

☒	Categorically needy *(specify limits):*
	Service is limited to 3 hours per month.
☐	Medically needy *(specify limits):*

Provider Qualifications *(For each type of provider. Copy rows as needed)*:			
Provider Type *(Specify)*:	License *(Specify)*:	Certification *(Specify)*:	Other Standard *(Specify)*:
Agency		If the agency provider is a homemaker/companion agency, they must be registered with the Department of Consumer Protection.	Agency providing bill payer service is bonded and insured against fraudulent behavior. Bill payer's activities are overseen by the agency administrator or their designee. Cases are regularly reviewed and coaching is provided to the bill payer as needed. Online banking and bill paying is an option as part of this service

Verification of Provider Qualifications (*For each provider type listed above. Copy rows as needed*):		
Provider Type *(Specify)*:	Entity Responsible for Verification *(Specify)*:	Frequency of Verification *(Specify)*:
Agency	**Fiscal intermediary**	**At the time of enrollment and every two years thereafter**

Service Delivery Method. *(Check each that applies)*:			
☐	Participant-directed	☒	Provider managed

Service Specifications *(Specify a service title for the HCBS listed in Attachment 4.19-B that the state plans to cover)*:	
Service Title:	**Care Transitions**
Service Definition (Scope):	
An evidence-based set of actions designed to ensure health care coordination, continuity and avoidance of preventable poor outcomes in vulnerable clients as they move between institutional and home and community-based settings. Core activities include: facilitating coaching and teaching, helping clients identify "red flags" to prevent readmissions, understand contributing factors for current admission whether hospital or nursing facility, scheduling timely follow up with primary care provider, facilitating medical and non-medical transportation, partnering with hospital care coordinators and community providers to enhance continuity of care and prevent readmissions. Service iucludes either a home visit or telephone follow up no more than 72 hours after discharge. Service may be provided for up	

to 120 days prior to discharge and will be considered complete when the person is discharged back to the community.

This service also includes a status review visit by the care manager when a program client is in a hospital or nursing facility setting when the purpose of that visit is to reevaluate the total plan of care needs upon discharge back to the community-based setting. This care transitions service is provided one time in the first 45 days of a nursing home stay and/or one time only during a hospital stay. This can occur only within 180 consecutive days prior to discharge. Care transitions and status reviews are two separate and distinct procedure codes on the Department's published fee schedule.

Additional needs-based criteria for receiving the service, if applicable *(specify)*:

None

Specify limits (if any) on the amount, duration, or scope of this service. Per 42 CFR Section 440.240, services available to any categorically needy recipient cannot be less in amount, duration and scope than those services available to a medically needy recipient, and services must be equal for any individual within a group. States must also separately address standard state plan service questions related to sufficiency of services.

(Choose each that applies):

☒ Categorically needy *(specify limits)*:

Available only to those who have been enrolled in the program as an active client. Not available to program applicants. Limited to no more than one unit in 60 days. Cannot be billed concurrently with a status review, which is a face-to-face visit while the client is institutionalized.

☐ Medically needy *(specify limits)*:

Provider Qualifications *(For each type of provider. Copy rows as needed)*:

Provider Type *(Specify)*:	License *(Specify)*:	Certification *(Specify)*:	Other Standard *(Specify)*:
Access Agency	The care manager who conducts the assessments, develops care plans and provides ongoing monitoring must be either a registered nurse licensed in the state where care management	Care managers are encouraged but not required to be certified as a long-term care manager.	

	services are provided or a social services worker who is a graduate of an accredited four-year college or university. The nurse or social services worker must have a minimum of two years of experience in health care or human services. A bachelor's degree in nursing, health, social work, gerontology or a related field may be substituted for one year of experience. A licensed social worker is preferred for this service but not required.		

Verification of Provider Qualifications (*For each provider type listed above. Copy rows as needed*):

Provider Type *(Specify)*:	Entity Responsible for Verification *(Specify)*:	Frequency of Verification *(Specify)*:
Access Agency	**Department of Social Services**	**Annually**

Service Delivery Method. (*Check each that applies*):

☐	Participant-directed	☒	Provider managed

Service Specifications *(Specify a service title for the HCBS listed in Attachment 4.19-B that the state plans to cover):*

Service Title: **Chronic Disease Self- Management Programs**

Service Definition (Scope):

The chronic disease self-management program (Live-Well) is a two and a half hour workshop given once a week, for six weeks, in community settings such as senior centers, churches, libraries and hospitals. People with different chronic health problems attend together. Workshops are facilitated by two trained leaders, one or both of whom are non-health professionals with chronic diseases themselves.

Subjects covered include:

1) techniques to deal with problems such as frustration, fatigue, pain and isolation; 2) appropriate exercise for maintaining and improving strength, flexibility, and endurance; 3) appropriate use of medications; 4) communicating effectively with family, friends, and health professionals; 5) nutrition; 6) decision making; and 7) how to evaluate new treatments.

The program is helpful for people with chronic conditions as it gives them the skills to coordinate all the things needed to manage their health, as well as to help them keep active in their lives. The therapeutic goals of the service are adjustment to serious impairments, maintenance or restoration of physical functioning, self-management of chronic disease, acquisition of skills to address minor depression, management of personal care and development of skills to work with care providers, including behavior management. The program is also available in Spanish and is called Tomando Control de su Salud.

Additional needs-based criteria for receiving the service, if applicable *(specify):*

None

Specify limits (if any) on the amount, duration, or scope of this service. Per 42 CFR Section 440.240, services available to any categorically needy recipient cannot be less in amount, duration and scope than those services available to a medically needy recipient, and services must be equal for any individual within a group. States must also separately address standard state plan service questions related to sufficiency of services.

(Choose each that applies):

☐ Categorically needy *(specify limits):*

☐ Medically needy *(specify limits):*

Provider Qualifications *(For each type of provider. Copy rows as needed)*:

Provider Type *(Specify)*:	License *(Specify):*	Certification *(Specify):*	Other Standard *(Specify):*
Agency			Individual employee qualification: certification in an evidence-based chronic disease self-management training program such as the Stanford

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

Verification of Provider Qualifications (*For each provider type listed above. Copy rows as needed*):

Provider Type *(Specify)*:	Entity Responsible for Verification *(Specify)*:	Frequency of Verification *(Specify)*:
Agency	Provider Agency and Fiscal Intermediary	Initially upon enrollment and every two years thereafter
Individual	Fiscal Intermediary	Initially upon enrollment and every two years thereafter

Service Delivery Method. *(Check each that applies)*:

☐	Participant-directed	☒	Provider managed

Service Specifications *(Specify a service title for the HCBS listed in Attachment 4.19-B that the state plans to cover)*:

Service Title:	Recovery Assistant

Service Definition (Scope):

A flexible range of supportive assistance provided face-to-face for persons with a substance use disorder or behavioral health diagnosis. The service enables a client to maintain a home/apartment, encourages the use of existing natural supports, and fosters involvement in social and community activities. Service activities include: performing household tasks; providing instructive assistance, or cuing, to prompt the client to carry out tasks (e.g., meal preparation; routine household chores, cleaning, laundry, shopping, and bill-paying; and participation in social and recreational activities); and providing supportive companionship. The recovery assistant may also provide: instruction or cuing to prompt the client to dress appropriately and perform basic hygiene functions; supportive assistance and supervision of

the client; and short-term relief in the home for a client who is unable to care for himself/herself when the primary caregiver is absent or in need of relief. The recovery assistant service is provided only to persons with a mental health or substance use disorder diagnosis.

Additional needs-based criteria for receiving the service, if applicable *(specify)*:

None

Specify limits (if any) on the amount, duration, or scope of this service. Per 42 CFR Section 440.240, services available to any categorically needy recipient cannot be less in amount, duration and scope than those services available to a medically needy recipient, and services must be equal for any individual within a group. States must also separately address standard state plan service questions related to sufficiency of services.

(Choose each that applies):

☐ Categorically needy *(specify limits)*:

☐ Medically needy *(specify limits)*:

Provider Qualifications *(For each type of provider. Copy rows as needed)*:

Provider Type *(Specify)*:	License *(Specify)*:	Certification *(Specify)*:	Other Standard *(Specify)*:
Agency		Recovery assistant must have certification from the Dept. of Mental Health and Addiction Services in order to be a provider of this service.	

Verification of Provider Qualifications (*For each provider type listed above. Copy rows as needed*):

Provider Type *(Specify)*:	Entity Responsible for Verification *(Specify)*:	Frequency of Verification *(Specify)*:
Agency	Fiscal Intermediary	Upon enrollment and Every two years thereafter

Service Delivery Method. *(Check each that applies)*:

☐	Participant-directed	☒	Provider managed

Service Specifications *(Specify a service title for the HCBS listed in Attachment 4.19-B that the state plans to cover):*

Service Title:	Adult Family Living/Foster Care

Service Definition (Scope):

Personal care and supportive services (homemaker, chore, attendant services, meal preparation) that are furnished to program clients who reside in a private home by a principal caregiver who lives in the home. Adult family living/foster care is furnished to adults who receive these services in conjunction with residing in the home. Service includes 24-hour response capability to meet scheduled or unpredictable resident needs to provide supervision, safety and security based on ADL, IADL, cognitive or behavioral needs. Service allocation is based on ADL, IADL, cognitive or behavioral needs. Services also include social and recreational activities and cueing or reminders to take medications. Separate payment will not be made for homemaker or chore services furnished to an individual receiving adult family living/foster care services since these are integral to and inherent in the provision of adult family living/foster care services. Edits in MMIS do not allow these services to be billed when adult family living/foster care is in place as a service. Although this service has four levels, only the first two are applicable to the 1915(i) population. The last two are applicable only to those who meet nursing facility level of care and are served under the Department's 1915(c) waiver.

Level 1: service provided to individuals who, because of their impairments, require supervision on a daily basis and require cueing or supervision to perform ADLs and may also have cognitive or behavioral challenges

Level 2: services provided to individuals who require hands on assistance to perform 2 ADLs on a daily basis.

The agency that provides the adult family living/foster care service will supervise the supports delivered by the direct care provider. This service may be provided in the home of either the care provider or the client, whichever is preferable to the client. The direct provider may be a relative of the client as long as they are not a legally liable relative. Adult family living/foster care is limited to no more than 3 clients in a home. The adult family living/foster care provider may not administer medication but may supervise the client's self-administration of medication. Payments made for adult family living/foster care are not made for room and board, items of comfort or convenience, or the costs of home maintenance, upkeep and improvement. Room and board payments are excluded from the rate.

Additional needs-based criteria for receiving the service, if applicable *(specify):*

None

Specify limits (if any) on the amount, duration, or scope of this service. Per 42 CFR Section 440.240, services available to any categorically needy recipient cannot be less in amount, duration and scope than those services available to a medically needy recipient, and services must be equal for any individual within a group. States must also separately address standard state plan service questions related to sufficiency of services.

(Choose each that applies):

☐	Categorically needy *(specify limits):*
☐	Medically needy *(specify limits):*

Provider Qualifications *(For each type of provider. Copy rows as needed)*:

Provider Type *(Specify)*:	License *(Specify):*	Certification *(Specify):*	Other Standard *(Specify):*
Agency			In order to be an adult family living/foster care provider setting, the provider agency must certify that the home is regularly maintained and that the interior floors, walls, ceiling and furnishings must be clean and in good repair, including the kitchen area, bathroom and client's bedroom, ventilation, heating, lighting and stairs. The home should conform to all applicable building codes, health and safety codes and ordinances and meet the client's need for privacy. The home should also be equipped with a fire extinguisher and an emergency first aid kit. It is the responsibility of the provider agency to ensure that the home meets all of these specifications. In addition, the agency is responsible to verify that the provider is at least 18 year of age, in good health and able to follow written and verbal instruction, report changes in a client's condition, maintain confidentiality and complete record keeping requirements specified by the provider agency. The provider agency will provide nursing oversight / supervision of the provision of care by the adult family living/foster care provider on a minimum of a bi-monthly basis. Their role will include orientation, competency evaluations in the provision of daily care and ongoing continuing education for the direct caregiver. The agency provider

			as well as the care manager are responsible for ensuring the health and safety needs of the client are met. The direct caregiver will provide nutritionally balanced meals and healthy snacks each day to the program client, as dictated by their medical/nutritional needs. The reimbursement rate does not include room and board. The payment for room and board costs are negotiated between the direct service provider and the program client. The provider agency in order to be credentialed to provide adult family living/foster care must provide evidence of an ability to certify that the individual homes meet all of the requirements included in this description and can demonstrate an ability to monitor the delivery and quality of service provided to program clients. The agency may also provide relief to the direct service provider or the care manager can provide relief through the provision of other program services. The provider agency bills the MMIS directly. The provider is then responsible to pay the direct caregiver. Each home will be assessed for compliance with the CMS settings requirements utilizing the questions in the universal assessment that were added to address the required components that would constitute an integrated setting.

Verification of Provider Qualifications (*For each provider type listed above. Copy rows as needed*):

Provider Type *(Specify)*:	Entity Responsible for Verification *(Specify)*:	Frequency of Verification *(Specify)*:
Agency	Fiscal Intermediary	Upon enrollment and Every two years thereafter

Service Delivery Method. *(Check each that applies)*:		
☐	Participant-directed	☒ Provider managed

2. ☒ **Policies Concerning Payment for State plan HCBS Furnished by Relatives, Legally Responsible Individuals, and Legal Guardians.** *(By checking this box the state assures that):* There are policies pertaining to payment the state makes to qualified persons furnishing State plan HCBS, who are relatives of the individual. There are additional policies and controls if the state makes payment to qualified legally responsible individuals or legal guardians who provide State Plan HCBS. *(Specify (a) who may be paid to provide State plan HCBS; (b) the specific State plan HCBS that can be provided; (c) how the state ensures that the provision of services by such persons is in the best interest of the individual; (d) the state's strategies for ongoing monitoring of services provided by such persons; (e) the controls to ensure that payments are made only for services rendered; and (f) if legally responsible individuals may provide personal care or similar services, the policies to determine and ensure that the services are extraordinary (over and above that which would ordinarily be provided by a legally responsible individual):*

Program regulations specify policies regarding the provision of program services by relatives.

Relatives are defined in the regulations as follows: "Relative" means spouse, natural parent, child, sibling, adoptive child, adoptive parent, stepparent, stepchild, stepbrother, stepsister, father-in-law, mother-in-law, son-in-law, daughter-in-law, sister-in-law, grandparent and grandchild. Effective July 1, 2015, self-directed PCA services are not available under the CHCPE section 1915(i) because they are instead available under the state's Community First Choice program option in the Medicaid State Plan pursuant to section 1915(k).

Family members may provide adult family living/foster care services but only under the auspices of a provider agency. The agency is responsible to ensure that the services are in fact being rendered. The care manager, as part of the person-centered planning process, ensures that the provision of the service by a relative is in the best interest of the individual. An example might be a situation where the client has dementia and is resistant to care provided by someone they are unfamiliar with. The care manager monitors the appropriateness and effectiveness of the services provided as part of their required monthly monitoring contact.

The Department does not pay legally liable relatives or relatives of conservators of person (COP) or conservators of estate (COE) to provide care.

Participant-Direction of Services

Definition: Participant-direction means self-direction of services per §1915(i)(1)(G)(iii).

1. **Election of Participant-Direction**. *(Select one):*

◉	The state does not offer opportunity for participant-direction of State plan HCBS.

○	Every participant in State plan HCBS (or the participant's representative) is afforded the opportunity to elect to direct services. Alternate service delivery methods are available for participants who decide not to direct their services.
○	Participants in State plan HCBS (or the participant's representative) are afforded the opportunity to direct some or all of their services, subject to criteria specified by the state. *(Specify criteria):*

2. **Description of Participant-Direction. (Provide an overview of the opportunities for participant-direction under the State plan HCBS, including: (a) the nature of the opportunities afforded; (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 approach to participant-direction):**

3. **Limited Implementation of Participant-Direction**. (*Participant direction is a mode of service delivery, not a Medicaid service, and so is not subject to statewideness requirements. Select one):*

○	Participant direction is available in all geographic areas in which State plan HCBS are available.
○	Participant-direction is available only to individuals who reside in the following geographic areas or political subdivisions of the state. Individuals who reside in these areas may elect self-directed service delivery options offered by the state, or may choose instead to receive comparable services through the benefit's standard service delivery methods that are in effect in all geographic areas in which State plan HCBS are available. (*Specify the areas of the state affected by this option)*:

4. **Participant-Directed Services**. *(Indicate the State plan HCBS that may be participant-directed and the authority offered for each. Add lines as required):*

Participant-Directed Service	Employer Authority	Budget Authority
	☐	☐
	☐	☐

5. **Financial Management.** (*Select one)* :

○	Financial Management is not furnished. Standard Medicaid payment mechanisms are used.
○	Financial Management is furnished as a Medicaid administrative activity necessary for administration of the Medicaid State plan.

6. ☐ **Participant–Directed Person-Centered Service Plan.** *(By checking this box the state assures that):* Based on the independent assessment required under 42 CFR §441.720, the individualized person-centered service plan is developed jointly with the individual, meets federal requirements at 42 CFR §441.725, and:

- Specifies the State plan HCBS that the individual will be responsible for directing;
- Identifies the methods by which the individual will plan, direct or control services, including whether the individual will exercise authority over the employment of service providers and/or authority over expenditures from the individualized budget;

- Includes appropriate risk management techniques that explicitly recognize the roles and sharing of responsibilities in obtaining services in a self-directed manner and assures the appropriateness of this plan based upon the resources and support needs of the individual;
- Describes the process for facilitating voluntary and involuntary transition from self-direction including any circumstances under which transition out of self-direction is involuntary. There must be state procedures to ensure the continuity of services during the transition from self-direction to other service delivery methods; and
- Specifies the financial management supports to be provided.

7. **Voluntary and Involuntary Termination of Participant-Direction.** *(Describe how the state facilitates an individual's transition from participant-direction, and specify any circumstances when transition is involuntary):*

8. **Opportunities for Participant-Direction**

a. **Participant–Employer Authority** (individual can select, manage, and dismiss State plan HCBS providers). (*Select one):*

◉	The state does not offer opportunity for participant-employer authority.
○	Participants may elect participant-employer Authority *(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.
☐	**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.

b. **Participant–Budget Autbority** (individual directs a budget that does not result in payment for medical assistance to the individual). (*Select one):*

◉	The state does not offer opportunity for participants to direct a budget.
○	Participants may elect Participant–Budget Authority.
	Participant-Directed Budget. *(Describe in detail the method(s) that are used to establish the amount of the budget over which the participant has authority, including the method for calculating the dollar values in the budget based on reliable costs and service utilization, is applied consistently to each participant, and is adjusted to reflect changes in individual assessments and service plans. Information about these method(s) must be made publicly available and included in the person-centered service plan.):*

	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.*

Quality Improvement Strategy

Quality Measures

(Describe the state's quality improvement strategy. For each requirement, and lettered sub-requirement, complete the table below):

1. **Service plans a) address assessed needs of 1915(i) participants; b) are updated annually; and (c document choice of services and providers.**

2. **Eligibility Requirements: (a) an evaluation for 1915(i) State plan HCBS eligibility is provided to all applicants for whom there is reasonable indication that 1915(i) services may be needed in the future; (b) the processes and instruments described in the approved state plan for determining 1915(i) eligibility are applied appropriately; and (c) the 1915(i) benefit eligibility of enrolled individuals is reevaluated at least annually or, if more frequent, as specified in the approved state plan for 1915(i) HCBS.**

3. **Providers meet required qualifications.**

4. **Settings meet the home and community-based setting requirements as specified in this SPA and in accordance with 42 CFR 441.710(a)(1) and (2).**

5. **The SMA retains authority and responsibility for program operations and oversight.**

6. **The SMA maintains financial accountability through payment of claims for services that are authorized and furnished to 1915(i) participants by qualified providers.**

7. **The state identifies, addresses, and seeks to prevent incidents of abuse, neglect, and exploitation, including the use of restraints.**

(Table repeats for each measure for each requirement and lettered sub-requirement above.)

Requirement 1a	**Service plans address assessed needs of 1915(i) participants.**
Discovery	

Discovery Evidence *(Performance Measure)*	Number and percent of clients whose service plan includes services and supports that address assessed needs. N: Number of clients who service plans include service and supports that address needs. D: Total number of clients reviewed.
Discovery Activity *(Source of Data & sample size)*	Representative sample of record audits reviewed by both the contracted Access Agency and the SMA. Sample size to be determined by using online tool to determine representative sample size with a 95% confidence level.
Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	Contracted Access Agency and SMA
Frequency	Annually
Remediation	
Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	SMA When the SMA has audit findings, a response from the Access Agency is required within 30 days of the receipt of the audit report.
Frequency *(of Analysis and Aggregation)*	Audits are completed of all Access Agencies every 3 months so that each one is audited at least every 12 months.

Requirement 1b	**Service plans are updated annually.**
Discovery	
Discovery Evidence *(Performance Measure)*	Number and percent of service plans that are updated and revised annually. N: Number of service plans that were updated annually or as client's needs changed. D: Total number of service plans reviewed.
Discovery Activity	Representative sample of record audits reviewed by both the contracted Access Agency and the SMA.

(Source of Data & sample size)	Sample size to be determined by using online tool to determine representative sample size with 95% confidence level.
Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	Contracted Access Agency and SMA
Frequency	Annually
Remediation	
Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	SMA When the SMA has audit findings, a response from the Access Agency is required within 30 days of the receipt of the audit report.
Frequency *(of Analysis and Aggregation)*	Audits are completed of all Access Agencies every 3 months so that each one is audited at least every 12 months.

Requirement 1c	**Service plans document choice of services and providers.**
Discovery	
Discovery Evidence *(Performance Measure)*	Number and percent of clients educated about the full range of services and choices of providers available as evidenced by their signature on the W-990 form, "Your Rights and Responsibilities". N: Number of clients offered choices of services and providers as evidenced by their signature on W-990. D: Total number of records reviewed.
Discovery Activity *(Source of Data & sample size)*	Representative sample of record audits reviewed by both the contracted Access Agency and the SMA. Sample size to be determined by using online tool to determine representative sample size with a 95 %confidence level.
Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	Contracted Access Agency and SMA
Frequency	Annually

Remediation	
Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	SMA When the SMA has audit findings, a response from the Access Agency is required within 30 days of the receipt of the audit report.
Frequency *(of Analysis and Aggregation)*	Audits are completed of all Access Agencies every 3 months so that each one is audited at least every 12 months.

Requirement 2a	**Eligibility Requirements: (a) An evaluation for 1915(i) State plan HCBS eligibility is provided to all applicants for whom there is reasonable indication that 1915(i) services may be needed in the future.**
Discovery	
Discovery Evidence *(Performance Measure)*	Number and percent of applicants who receive an initial telephone 1915(i) eligibility screening by clinical staff of the SMA Community Options unit to validate the 1915(i) eligibility prior to the receipt of services. Numerator: Number of applicants who receive phone eligibility screening. Denominator: Total number of applicants
Discovery Activity *(Source of Data & sample size)*	Analyze collected data for every applicant. Sample size: 100%.
Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	SMA
Frequency	Continuously and Ongoing
Remediation	
Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required*	SMA will be responsible for remediatiou within 30 days.

timeframes for remediation)	
Frequency *(of Analysis and Aggregation)*	Continuously and ongoing

Requirement 2b Performance Measure # 1	**Eligibility Requirements: (b) The processes and instruments described in the approved state plan for determining 1915(i) eligibility are applied appropriately.**
Discovery	
Discovery Evidence *(Performance Measure)*	Number and percent of initial level of 1915(i) eligibility determinations that are made by SMA Community Options clinical staff utilizing standardized forms and approved procedures. Each applicant is screened to determine that they meet both the functional and financial criteria for participation in the HCBS program. Numerator: Number of clients reviewed using standardized forms and approved procedures. Denominator: Total number of clients reviewed.
Discovery Activity *(Source of Data & sample size)*	All initial eligibility determination data as well as reassessment summary data is captured in the department's database and reviewed by department staff. Sample size: 100 %
Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	SMA
Frequency	Continuously and ongoing
Remediation	
Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	SMA will be responsible for ensuring the process is followed in determination of CHCPE 1915 (i) eligibility within 30 days.

Frequency *(of Analysis and Aggregation)*	Annually

Requirement 2b Performance Measure # 2	**Eligibility Requirements: (b) The processes and instruments described in the approved state plan for determining 1915(i) eligibility are applied appropriately.**
Discovery	
Discovery Evidence *(Performance Measure)*	Number and percent of clients who are evaluated and reevaluated utilizing department's required assessment instrument. Numerator: Number of clients evaluated and reevaluated using department's tool. Denominator: Number of clients evaluated and reevaluated.
Discovery Activity *(Source of Data & sample size)*	Sample size: All eligibility determination data captured in the department's database.
Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	SMA
Frequency	Continuously and ongoing
Remediation	
Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	SMA will be responsible for proper use of assessment instruments in the determination of eligibility for CHCPE 1915 (i). For those determinations where the assessment tool is not properly applied, SMA will work with the access agency to ensure remediation takes place within 30 days.
Frequency *(of Analysis and Aggregation)*	Annually

Requirement 2c Performance Measure #1	**Eligibility Requirement: (c) The 1915(i) benefit eligibility of enrolled individuals is reevaluated at least annually or if more frequent, as specified in the approved state plan for 1915(i) HCBS.**
Discovery	
Discovery Evidence *(Performance Measure)*	Number and percent of clients who are reevaluated at least annually for 1915(i) eligibility. Numerator: Number of clients reviewed annually for 1915(i) eligibility. Denominator: Number of clients with annual review due.
Discovery Activity *(Source of Data & sample size)*	Reports to the SMA from contracted Access Agencies and review of collected data. Sample size: 100%
Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	Contracted entities submit a reassessment outcome on each client annually and the data system identifies the timeliness of the completion of the reassessment. In addition, the department conducts on site record audits of each contracted access agency.
Frequency	Annually
Remediation	
Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	SMA and contracted Access Agencies When the SMA has audit findings, a response from the Access Agency is required within 30 days of the receipt of the audit report.

Requirement 2c Performance Measure #2	**Eligibility Requirements: (c) The 1915(i) benefit eligibility of enrolled individuals is reevaluated at least annually or if more frequent, as specified in the approved state plan for 1915(i) HCBS.**
Discovery	
Discovery Evidence *(Performance Measure)*	Number and percent of clients whose total plan of care has been modified to reflect significant changes in the clients' condition. Numerator: Number of clients whose plans were modified after a change in condition.

	Denominator: Number of clients who had needs change requiring plan modification.
Discovery Activity *(Source of Data & sample size)*	Reports to the SMA from contracted Access Agencies and review of collected data. Sample size: 100%
Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	Contracted entities submit a status change outcome on each client. In addition, the department conducts on site record audits of each contracted access agency
Frequency	Annually
Remediation	
Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	SMA and contracted Access Agencies When the SMA has audit findings, a response from the Access Agency is required within 30 days of the receipt of the audit report.

Requirement 3 ***Performance Measure # 1***	**Providers meet required qualifications.**
Discovery	
Discovery Evidence *(Performance Measure)*	Number and percent of HCBS providers that meet qualifications for enrollment both initially and on an ongoing basis. Numerator: Nuunber of HCBS providers who meet required provider qualifications initially and ongoing. Denominator: Total number of HCBS providers reviewed.
Discovery Activity *(Source of Data & sample size)*	SMA MMIS Contractor Contracted Agencies doing FI fimctions Access Agency care managers and SMA Community Options unit staff Representative sample size with a 95% confidence level.
Monitoring Responsibilities	SMA

(Agency or entity that conducts discovery activities)	
Frequency	Initially upon enrollment and thereafter as required in this CHCPE section of Attachment 3.1-i of the Medicaid State plan.
Remediation	
Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	SMA and contracted Fiscal Intermediary collaboratively implements remediation plan for the provider. When the SMA has audit findings, a response from the provider is required within 30 days of the receipt of the audit report.
Frequency *(of Analysis and Aggregation)*	Continuously and ongoing

Requirement 3 ***Performance Measure # 2***	**Providers meet required qualifications.**
Discovery	
Discovery Evidence *(Performance Measure)*	Number and percent of SMA Community Options unit clinical staff licensure that is verified initially and annually. Numerator: Number of SMA Community Options clinical staff whose licensure is verified initially and annually. Denominator: Total number of SMA Community Options clinical staff records reviewed.
Discovery Activity *(Source of Data & sample size)*	SMA review of Dept. of Public Health Licensure Data base. Sample size: 100%
Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	SMA
Frequency	Annually
Remediation	

Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	SMA Community Options Unit verifies qualification standards annually. SMA Community Options clinical staff who do not meet qualifications standard will be required to update license immediately upon notification.
Frequency *(of Analysis and Aggregation)*	Continuously and ongoing

Requirement 4 ***Performance Measure # 1***	**Settings meet the home and community-based setting requirements as specified in this SPA and in accordance with 42 CFR 441.710(a)(1) and (2).**
Discovery	
Discovery Evidence *(Performance Measure)*	Number and percent of ALSAs that meet Federal HCBS settings requirements Numerator: Number of ALSAs that meet Federal HCBS settings requirements. Denominator: Number of ALSAs reviewed.
Discovery Activity *(Source of Data & sample size)*	DSS staff will utilize data taken from initial assessment and annual reassessments as completed by contracted Access Agency Care Managers. Sample size: 10% of the total assessments completed monthly.
Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	SMA with data from Access Agency.
Frequency	Continuously and ongoing.
Remediation	
Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	SMA When the SMA has audit findings, a response from the provider is required within 45 days of the receipt of the audit report.

Frequency *(of Analysis and Aggregation)*	Continuously and ongoing

Requirement 4 ***Performance Measure # 2***	**Settings meet the home and community-based setting requirements as specified in this SPA and in accordance with 42 CFR 441.710(a)(1) and (2).**
Discovery	
Discovery Evidence *(Performance Measure)*	Number and percent of residential care homes (RCHs) that meet Federal HCBS settings requirements. Numerator: Number of RCHs that meet Federal HCBS settings requirements. Denominator: Number of RCHs reviewed.
Discovery Activity *(Source of Data & sample size)*	DSS staff will utilize data taken from initial assessment and annual reassessments as completed by contracted Access Agency Care Managers. Sample size: 10% of the total assessments completed monthly.
Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	SMA with data from Access Agency.
Frequency	Continuously and ongoing.
Remediation	
Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	SMA When the SMA has audit findings, a response from the provider is required within 45 days of the receipt of the audit report.
Frequency *(of Analysis and Aggregation)*	Continuously and ongoing

Requirement 4 ***Performance Measure # 3***	**Settings meet the home and community-based setting requirements as specified in this SPA and in accordance with 42 CFR 441.710(a)(1) and (2).**
Discovery	

Discovery Evidence *(Performance Measure)*	Number and percent of adult day centers that meet Federal HCBS settings requirements. Numerator: Number of adult day centers that meet Federal HCBS settings requirements. Denominator: Number of adult day centers reviewed.
Discovery Activity *(Source of Data & sample size)*	DSS staff will utilize data taken from initial assessment and annual reassessments as completed by contracted Access Agency Care Managers. Sample size: 10% of the total assessments completed monthly.
Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	SMA with data from Access Agency.
Frequency	Continuously and ongoing.
Remediation	
Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	SMA When the SMA has audit findings, a response from the provider is required within 45 days of the receipt of the audit report.
Frequency *(of Analysis and Aggregation)*	Continuously and ongoing

Requirement 5 ***Performance Measure # 1***	**The SMA retains authority and responsibility for program operations and oversight.**
Discovery	
Discovery Evidence *(Performance Measure)*	Number and percent of Access Agencies that receive both a clinical and administrative review by Department staff in a twelve-month period. Numerator: Number of Access Agencies that receive a review within twelve months. Denominator: Total number of Access Agencies.

Discovery Activity *(Source of Data & sample size)*	SMA completes on-site audits of all Access Agency providers over a twelve-month period. Approximately 10 records per agency are reviewed. Sample size: 10 records
Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	SMA
Frequency	Each agency every 12 months.
Remediation	
Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	SMA When tbe SMA has audit findings, a response from the provider is required within 30 days of the receipt of the audit report.
Frequency *(of Analysis and Aggregation)*	Continuously and ongoing

Requirement 5 ***Performance Measure # 2***	**The SMA retains authority and responsibility for program operations and oversight.**
Discovery	

	Discovery Evidence *(Performance Measure)*	Number and percentage of required aggregate reports received from the Access Agencies in the time frame required in their contract. Numerator: Number of reports received on time. Denominator: Total number of reports due.
	Discovery Activity *(Source of Data & sample size)*	Reports are reviewed annually for compliance with time frame and format requirements. Sample size: 100%
	Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	SMA
	Frequency	Annually
Remediation		
	Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	SMA When the SMA has audit findings, a response from the provider is required within 30 days of the receipt of the audit report.
	Frequency *(of Analysis and Aggregation)*	Continuously and ongoing

Requirement 6 ***Performance Measure # 1***	**The SMA maintains financial accountability through payment of claims for services that are authorized and furnished to 1915(i) participants by qualified providers.**
Discovery	
Discovery Evidence *(Performance Measure)*	Number and percent of claims paid with documentation that services were actually rendered. Numerator: Number of claims paid with documentation that services were actually rendered. Denominator: Number of paid claims that were reviewed.

Discovery Activity *(Source of Data & sample size)*	Reports from contracted MMIS vendor based on claims from the data warehouse. Representative sample with 95% confidence level.
Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	SMA and MMIS contractor
Frequency	Continuously and ongoing.
Remediation	
Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	SMA and fiscal intermediary When the SMA has audit findings, a response from the provider is required within 30 days of the receipt of the audit report.
Frequency *(of Analysis and Aggregation)*	Continuously and ongoing

Requirement 6 ***Performance Measure # 2***	**The SMA maintains financial accountability through payment of claims for services that are authorized and furnished to 1915(i) participants by qualified providers.**
Discovery	
Discovery Evidence *(Performance Measure)*	Number and percent of claims that correctly denied due to system edits and audits. Numerator: Number of claims correctly denied due to system edits and audits. Denominator: Total number of denied claims.
Discovery Activity *(Source of Data & sample size)*	Reports from contracted MMIS vendor based on claims from the data warehouse. Sample size: Representative sample with 95% confidence level.
Monitoring Responsibilities	SMA and MMIS contractor

(Agency or entity that conducts discovery activities)	
Frequency	Continuously and ongoing
Remediation	
Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	SMA and fiscal intermediary When the SMA has audit findings, a response from the provider is required within 30 days of the receipt of the audit report.
Frequency *(of Analysis and Aggregation)*	Continuously and ongoing

Requirement 7 ***Performance Measure # 1***	**The state identifies, addresses, and seeks to prevent incidents of abuse, neglect, and exploitation, including the use of restraints.**
Discovery	
Discovery Evidence *(Performance Measure)*	The number and percent of critical incidents that were correctly reported to Protective Services for Elders (PSE) staff. Numerator: Total number of incidents correctly reported to PSE. Denominator: Total number of incidents.
Discovery Activity *(Source of Data & sample size)*	Critical Incident Reports. The SMA conducts a 100% review of all critical incidents
Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	Contracted Access Agency and SMA
Frequency	Continuously and ongoing

Remediation	
Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	SMA Remediation requirements vary depending on the severity of the incident. Timeframes vary from the same day to 30 days and are determined by clinical staff.
Frequency *(of Analysis and Aggregation)*	Continuously and ongoing

Requirement 7 ***Performance Measure # 2***	**The state identifies, addresses, and seeks to prevent incidents of abuse, neglect, and exploitation, including the use of restraints.**
Discovery	
Discovery Evidence *(Performance Measure)*	Number and percent of critical incident reports that are submitted to the SMA Community Options Unit within 48 hours as required. Numerator: Number of critical incidents reported within 48 hours as required. Denominator: Number of critical incidents reported.
Discovery Activity *(Source of Data & sample size)*	Critical Incident Reports. The SMA conducts a 100% review of all critical incidents
Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	Contracted Access Agency and SMA
Frequency	Continuously and ongoing
Remediation	
Remediation Responsibilities *(Who corrects, analyzes, and aggregates*	SMA Remediation requirements vary depending on the severity of the incident. Timeframes vary from the same day to 30 days and are determined by clinical staff.

remediation activities; required timeframes for remediation)	
Frequency *(of Analysis and Aggregation)*	Continuously and ongoing

Requirement 7 ***Performance Measure # 3***	**The state identifies, addresses, and seeks to prevent incidents of abuse, neglect, and exploitation, including the use of restraints.**
Discovery	
Discovery Evidence *(Performance Measure)*	Number and percent of allegations regarding wrongful restraint and involuntary seclusion where appropriate actions and follow up occurred. Numerator: Number of allegations regarding wrongful restraint and involuntary seclusion where appropriate actions and follow up occurred. Denominator: Total number of incidents that included allegations of wrongful restraint and involuntary seclusion.
Discovery Activity *(Source of Data & sample size)*	Critical Incident Reports. The SMA conducts a review of all critical incidents
Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	Contracted Access Agency and SMA
Frequency	Continuously and ongoing
Remediation	
Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	SMA Remediation requirements vary depending on the severity of the incident. Timeframes vary from the same day to 30 days and are determined by clinical staff.

Frequency *(of Analysis and Aggregation)*	Continuously and ongoing

System Improvement

(Describe the process for systems improvement as a result of aggregated discovery and remediation activities.)

1. Methods for Analyzing Data and Prioritizing Need for System Improvement

The State of Connecticut has been utilizing a comprehensive system of checks and balances in order to establish consistent quality assurance within services provided to clients through its Medicaid waiver and state funded Home Care Program for Elders. The state has been utilizing the same QIS for the CHCPE section 1915(i) clients. The state has been guided by state and federal regulations to assist in establishing procedures and the many varied data collection, aggregation and analysis processes that are currently utilized. Through the productive process of analysis, discovery, remediation and improvement, the state recognizes the benefit to client services that can be obtained through some system design changes. Statewide chart audits of Access Agency clients are conducted quarterly. Sampling size of client chart reviews requires a representative sample. Therefore, DSS has developed a system in which the Access Agencies provide data on supervisory record audits utilizing a tool developed by a Quality Improvement Committee consisting of both Access Agency and DSS Community Options unit (SMA) staff. A system was designed to accomplish a representative sample review by utilizing the data from that supervisory review supplemented by annual reviews done by SMA staff. A quarterly reporting requirement has been added for the Access Agencies to provide a summary report of supervisory record reviews done on a regular basis.

Service Plan: The SMA contracts with Access Agencies who provide independent care managers. The care managers complete a comprehensive, multi-dimensional assessment that is consumer-centered and is the basis for the development of the service plan. The assessment instrument is designed to identify unmet needs and health and safety risk factors as well as personal goals. Service plans are updated and revised as clients' needs change but no less frequently than annually. DSS utilization review nurses review and approve every initial plan of care before the services are implemented. The care manager monitors the clients' needs and the delivery of the authorized service plan on a monthly basis. DSS Community Options unit staff also review a representative sample of reassessment plans of care. In addition, DSS staff conducts annual record audits of the care managers' records. This, combined with the Access Agency supervisory record review, constitutes a representative sample. Access Agency care managers have been trained in person-centered planning and further training is planned. A tool was developed for Access Agency supervisors to complete when conducting supervisory record reviews. The data is summarized and reported to the SMA quarterly. Consumer satisfaction surveys are conducted by both the Access Agency and SMA staff. The surveys are useful in identifying trends that may require system remediation. The Department is currently using the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey tool.

Qualified Providers: The state's contracted fiscal intermediary currently credentials all state plan HCBS providers initially and every two years thereafter. Once credentialed, the provider must enroll directly with the department's MMIS contractor and sign the Medicaid provider agreement. The certifications and qualifications are incorporated into the regulations that govern CHCPE (17b-342). The Department has incorporated an expanded administrative review of audits to include contracts, policies and procedures. The State Plan HCBS operates under the same rules as the HCBS waiver. The Department cross matches providers with the HHS-OIG Fraud Protection and Detection Exclusion list to block participation of providers found on this list. Access Agencies perform checks of staff licensure (registered nurse and social worker, if applicable) routinely at time of hire and annual performance review.

The Access Agencies are required to have procedures in place to verify that subcontractors meet all of the criteria to be a HCBS provider. They must provide documentation that the subcontractor meets Department standards and requirements to assure provider eligibility, adherence to program requirements and standards, quality of service delivery and that services are delivered in accordance with clients' plans of care. Access Agencies are contractually obligated to assist providers in meeting the provider qualifications needed to be a participating provider. They offer training programs both for existing providers as well as for providers who wish to enroll.

Documentation of the grievances and all of the accompanying correspondence is maintained in a central file in the SMA Community Options unit. Access Agencies are also contractually required to audit a sample of the HCBS providers to ensure that they have appropriate documentation to substantiate the claims that are billed.

Health and Welfare: The Department holds Access Agency meetings bi-monthly for the purpose of disseminating information and discussing issues of concern. PSE, SMA Community Options unit and Access Agencies collaborate to identify and resolve health and safety concerns. The SMA Community Options unit manager and/or health and safety nurse consultant have ongoing consultation and dialogue with the PSE manager as needed on a case-by-case basis. A workgroup was developed to facilitate discussions between Access Agencies, PSE and SMA Community Options unit staff with respect to informed risk versus self-determination, i.e., what is an acceptable level of risk to both the client and the program. All findings related to client safeguards are entered into a data base within the SMA Community Options unit. Communications occur with the care manager and other Access Agency staff as appropriate for any corrective action or interventions. Access Agency staff monitor the HCBS clients on a monthly basis and follow up on the identified problem as needed. Self-neglect was identified as a trend in health and safety reporting. Improved collaboration between Community Option unit, PSE and Access Agencies was established for the purpose of updating "best practices" guidelines for care managers when addressing self-neglect issues. Health standard monitoring is already in place at the Access Agency level, but data aggregation and reporting, including analysis for trending of this information, has been initiated by the SMA Community Options unit. Health promotion and prevention questions have been added to the universal assessment instrument and reported annually, allowing for further analysis. The Department has initiated a fully web based critical incident reporting system that allows for tracking and trending, including tracking of client specific data as well as provider trends. A performance measure has been added to the Department's critical incident reporting system to identify any use of restrictive interventions such as restraints and seclusion. The care managers, as part of their face-to-face assessments and reassessments, will review for the use of restrictive interventions and intervene as indicated by the presenting situation. There are no HCBS that are provided in a 24-hour supervised environment in which medication administration is done by waiver providers. In MRCs, persons lease an independent apartment and waiver services are not provided on a 24-hour basis.

Financial Accountability: DSS cnrrently contracts with Gainwell (formerly HP) to employ a data system to ensure reimbursement is consistent with HCBS requirements. The Department introduced the MMIS Interchange for the purpose of upgrading the old claims processing system. It is now a Windows environment. The provider relations unit oversees the contract with Gainwell, as part of the medical operations process. They can make changes to procedure codes, edits and audits. Clients are identified by Medical eligibility or benefit plan code. Providers are based on type and specialty. The system is designed to make sure it can be billed only for what is allowed through the edits and audits system. There are reporting procedures in place to identify potential fraud, waste, abuse, and other over-billing, which are updated periodically. The SMA uses the reports to identify further remediation needs or system changes.

2. Roles and Responsibilities

The DSS (SMA) Community Options Unit is responsible for the Quality Management and compliance with the performance measures in this CHCPE section 1915(i) state plan HCBS benefit.

3. Frequency

Monitoring activities are continuous and ongoing.

4. Method for Evaluating Effectiveness of System Changes

Evaluation methods are varied and are described in the narrative above.

Methods and Standards for Establishing Payment Rates

1. **Services Provided Under Section 1915(i) of the Social Security Act.** For each optional service, describe the methods and standards used to set the associated payment rate. *(Check each that applies, and describe methods and standards to set rates)*:

☒	HCBS Case Management	
	Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and non-governmental providers of CHCPE section 1915(i) state plan HCBS. The agency's fee schedule rates were set as of February 1, 2022 are effective for services provided on or after that date. All rates are published on the Connecticut Medical Assistance Program Website: https://www.ctdssmap.com. From this web page, go to "Provider," then to "Provider Fee Schedule Download," then select the Connecticut Home Care Program for Elders fee schedule.	
☒	HCBS Homemaker	
	Same as HCBS Case Management above	
☐	HCBS Home Health Aide	
☐	HCBS Personal Care	
☒	HCBS Adult Day Health	
	Same as HCBS Case Management above	
☐	HCBS Home Health Aide	
☒	HCBS Respite Care	
	Same as HCBS Case Management above	
For Individuals with Chronic Mental Illness, the following services:		
	☐	HCBS Day Treatment or Other Partial Hospitalization Services
	☐	HCBS Psychosocial Rehabilitation
	☐	HCBS Clinic Services (whether or not furnished in a facility for CMI)
☒	Other Services (specify below)	
	HCBS Companion: Same as HCBS case management above	
	HCBS Chore: Same as HCBS case management above	
	HCBS Assisted Living: Same as HCBS Case Management above	
	HCBS Assistive Technology: Manual pricing is used for assistive technology equipment or other services such as home modifications that require manual pricing. These services	

	are, however, capped at the limit set forth in Attachment 3.1-i of the Medicaid State Plan. Rates for assistive technologies are case-specific and not published in the fee schedule. Reimbursement for assistive technology is based on actual service contracts for the services rendered. The fiscal intermediary reimburses the contractor. The fiscal intermediary is reimbursed through the MMIS based upon submitted claims.
	HCBS Environmental Accessibility Adaptations: Manual pricing is used for home modifications that require manual pricing. These services are, however, capped at the limit set forth in Attachment 3.1-i of the Medicaid State Plan. Minor home modifications required by the individual's plan of care which are necessary to ensure health, welfare and safety of the individual to function with greater independence in their home and without which the individual would require institutionalization. Such adaptations may include the installation of handrails and grab bars in the tub area, widening of doors and installation of ramps. Excluded are those adaptations or improvements to the home which are of general utility and are not of direct medical or remedial benefit to the individual such as carpeting, roof repair or air conditioning. Adaptations which add to the total square footage of the home are excluded from this benefit. All services must be provided in accordance with applicable state or local building codes. Adaptations are excluded if the residence is owned by someone other than the client and the adaptations would be the responsibility of the owner/landlord. Rates for environmental modifications are case-specific and not published in the fee schedule. Reimbursement for environmental modifications is based on the lower of at least two bids from licensed contractors. The fiscal intermediary reimburses the contractor. The fiscal intermediary is reimbursed through the MMIS based upon submitted claims. This service is subject to Department prior authorization
	HCBS Home-Delivered Meals: Same as HCBS case management above
	HCBS Adult Family Living: Same as HCBS case management above
	HCBS Mental Health Counseling: Same as HCBS case management above
	HCBS Personal Emergency Response Systems: Same as HCBS case management above
	HCBS Non-Medical Transportation: Same as HCBS case management above
	HCBS Bill Payer: Same as HCBS case management above
	HCBS Chronic Disease Self-Management Programs: Same as HCBS case management above
	HCBS Recovery Assistant: Same as HCBS case management above
	HCBS Agency Based Personal Care Assistant: Same as HCBS case management above
	HCBS Care Transitions: service will not be billed until the individual is discharged from the institution. Otherwise, same as HCBS case management above

PRA Disclosure Statement

data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.