



**CT Department of Developmental Services**

**HCBS Waivers Operations Manual**

**Individual and Family Support Waiver  
And  
Comprehensive Support Waiver**

**Effective October 1, 2005  
Issued October 11, 2005  
Version 1**

**Edited May 22, 2007  
Version 2**

**Edited November, 2008  
Issued January 5, 2009  
Version 3**

# HCBS Consolidated Waiver Operations Manual

## TABLE OF CONTENTS

Section	Subject	Page #
<b>1</b>	<b>Introduction and Overview of the IDDS Waivers</b>	1
1.1	Waiver Administration and Operation	2
1.2	DDS Operating Units for Waiver Administration	2
1.2.1	Central Office Waiver Units	2
1.2.2	Operations Center	2
1.2.3	Quality Management	2
1.2.4	Regional Planning and Resource Allocation Teams	3
1.2.5	Regional Resource Administration	3
1.2.6	Regional Administration/Case Management	3
1.3	Waiver Eligibility	3
1.4	Process Overview and General Principles	3
1.4.1	Initial Resource Allocation and Individual Planning	4
1.4.2	Service Arrangement and Provider Choice	4
1.4.3	Consumer Direction	4
<b>2</b>	<b>Services</b>	5
2.1	Individualized Home Supports	6
2.2	Personal Support	9
2.3	Adult Companion Services	12
2.4	Supported Employment Services	14
2.5	Group Day Services	17
2.6	Individualized Day Support	19
2.7	Adult Day Health	21
2.8	Healthcare Coordination	23
2.9	Live In Caregiver	24
2.10	Respite	25
2.11	Personal Emergency Response Systems (PERS)	28
2.12	Transportation	29
2.13	Environmental Modifications	30
2.14	Vehicle Modification Services	31
2.15	Specialized Medical Equipment and Supplies	32
2.16	<i>IFS</i> - Family Training	33
2.17	Clinical Behavioral Support Services	34
2.18	Nutrition	36
2.19	Interpreter Services	37
2.20	Independent Support Broker	38
2.21	Residential Habilitation	40
2.21	<i>Comprehensive Support</i> -Residential Habilitation (CLA and CTH)	40
2.21	<i>IFS</i> -Residential Habilitation (CTH)	40
2.22	<i>Comprehensive Support</i> - Assisted Living	40
2.23	Individual Directed Goods and Services	43
<b>3</b>	<b>Application and Enrollment</b>	44
3.1	Planning and Resource Allocation Team (PRAT)	44
3.1.1	PRAT Data Maintenance	44
3.1.2	Initial Referral for Services and Supports	44
3.1.3	Request for Services	44
3.1.4	Priority Assignment	45
3.1.5	Review and Change in Priority Assignment	45
3.1.7	Administrative Review Process and Fair Hearing Rights	46

## HCBS Consolidated Waiver Operations Manual

3.1.8	Assignment of Resources	46
3.1.9	Waiver Slot Authorization	46
3.2	Resource Allocation, the Level of Need and Service Limits	47
3.2.1	Level of Need	47
3.2.2	Service Limits	47
3.3	Waiver Application	47
3.3.1	ICF/MR Level of Care Determination	48
3.3.2	Waiver Application Packet	48
3.3.3	Waiver Application Without Prior Award of Funding	49
3.3.4	Waiver Enrollment Eligibility Decision	49
3.3.5	Changes in Individual Plan	50
3.3.6	Discharge from DDS Waiver Due to Entering a Long Term Care or Rehabilitation/Mental Health Facility	50
3.3.7	Refusal or Inability to Enroll in a DDS HCBS Waiver	50
3.3.8	Annual Re-determinations	51
3.4	Utilization Review	51
3.4.1	IFS Waiver	52
3.4.2	Comprehensive Supports Waiver	52
3.4.3	Review Process and Timelines	52
3.5	DSS Appeals	53
3.6	Change in Eligibility and Subsequent Discharge from a HCBS Waiver	54
3.6.1	Notification Process	54
3.6.2	Removal from Waiver for Lack of Level of Care	54
3.6.3	Removal from Waiver for Leaving Target Group	54
3.6.4	Removal from the Waiver for Failure to Maintain Medicaid Eligibility	55
3.6.5	Medicaid Operations Unit Removal Process	55
3.7	Regional Audit	55
<b>4</b>	<b>Individual Planning</b>	<b>56</b>
4.1	Individual Planning Process	56
4.1.1	Identify Participants in the Person-Centered Planning Process	56
4.1.2	Scheduling the planning meeting	57
4.1.3	Support the Individual to Prepare for the Planning Meeting	57
4.1.4	Level of Need Assessment and Screening Tool	58
4.1.5	Gather a good understanding of the individual	58
4.1.6	Develop an action plan to achieve desired outcomes	59
4.1.7	Summarize the plan of supports and services	60
4.1.8	Identify how progress on the individual's plan will be monitored	60
4.1.9	Staff Qualifications	60
4.1.10	Emergency Back-up	61
4.1.11	HCBS Re-Determination	61
4.1.12	Aquatic Activity Screening	61
4.1.13	Agreement with the Individual Plan	62
4.1.14	Put the plan into action	62
4.2	Monitor and revise the Individual Plan as needed	62
4.2.1	Monitoring Plan Implementation	62
4.2.2	Periodic Review of the Plan IP.12	63
4.2.3	Changes to the Individual Plan	63
4.2.4	Service and/or Provider Changes to the Plan	63
4.3	Individual Plan 6 Database (IP.6 Database)	64
4.4	Waiver Service Packages and Limits	64
4.4.1	IFS Waiver Service Packages and Limits	64
4.4.2	Comprehensive Waiver Service Packages and Limits	65
4.4.3	Funding Limits by Level of Need	66

## HCBS Consolidated Waiver Operations Manual

4.5	Plan and Individual Budget Approval	66
4.6	Utilization Review	68
4.7	IFS Waiver—Exceeding the IFS Waiver Limits	69
4.8	Denial of Services and/or Enrollment and Notice of Appeal	70
4.9	Service Authorization Procedure	70
4.9.1	Provider Service Authorization Form--Instructions	70
4.10	Consumer Directed Options	70
4.10.1	Agreement for Self Directed Supports	71
4.10.2	Instructions IP.6 Database	71
4.10.3	Individual Plan and Budget Approval Process	71
4.10.4	Service Authorization	72
4.10.5	Individual/Family Provider Agreement Form Instructions	72
4.10.6	Individual/Family Employee Agreement Instructions	72
<b>5</b>	<b>Case Manager Responsibilities</b>	74
5.1	Choice of Service Options	75
5.2	Arranging Services and Free Choice of Providers	75
5.3	Coordination	75
5.4	Monitoring	75
5.5	Maintaining Medicaid Eligibility	76
<b>6</b>	<b>Provider Options</b>	77
6.1	Qualified Provider Requirements	77
6.2	Self-Directed Options	78
6.3	Agency with Choice	78
<b>7</b>	<b>Provider Qualifications and Training</b>	79
7.1	Provider Standard Qualifications and Training	79
7.2	Documentation of Qualifications and Training	81
<b>8</b>	<b>Service Documentation and Records</b>	83
8.1	How Long Records Must Be Kept	83
8.2	Availability of Records	83
8.3	What the Qualified Provider or the Individual who self-directs services keeps	83
8.4	Service Documentation	83
<b>9</b>	<b>Invoices, Billing, Payments</b>	84
9.1	Instruction for completing Provider Billing Invoice Form	85
9.2	Medicaid Billing	86
9.3	Documentation for Medicaid Billing	86
9.3.1	Performing Provider Agreement	86
9.3.2	Qualified Provider Documentation	87
9.3.3	Self-Directed Employee Documentation	87
<b>10</b>	<b>Appeals</b>	87
10.1	Enrollment Denial	88
10.2	Service Denial	88
10.3	Request for Hearing	88
<b>11</b>	<b>Quality Management</b>	89
11.1	Quality Service Reviews	90
11.2	Trending, prioritizing, and implementing system improvements	90
11.3	Roles and responsibilities for monitoring and assessing system design changes	91
11.4	Periodic evaluation of the quality improvement strategy	92

# HCBS Consolidated Waiver Operations Manual

## 1. Introduction and Overview of the DDS Waivers

Waivers granted by the Centers for Medicare & Medicaid Services (CMS) under Section 1915 (c) of the Social Security Act authorize the Individual and Family Support Waiver (IFS) and the Comprehensive Support Waivers. The IFS waiver is also designated as an *Independence Plus* Waiver by CMS because it provides the authority for individuals to self-direct a number of services and supports to the extent desired. This waiver was renewed effective February 1, 2008 for a period of five years with an amendment to the renewal application effective October 1, 2008. The Comprehensive Supports waiver renewal was approved effective October 1, 2008 for a period of five years. It also permits self-direction for the majority of services and supports, but is not designated as an *Independence Plus* waiver. Both offer specific services and supports in the community for individuals age three and above who require ICF/MR level of care.

The Individual and Family Support Waiver is authorized to provide direct services and supports to people who live in their own or their family home. It is approved for individuals who do not require 24- hour paid supports. Services and supports are organized in four categories:

Home and Community Supports – Personal Support, Adult Companion, Individualized Home Supports, Community Training Home, Personal Emergency Response Systems, Healthcare Coordination, Live-In Caregiver and Respite;

Day/Vocational Supports – Group Day, Adult Day Health, Individualized Day Supports, and Supported Employment;

Ancillary Supports –Clinical Behavioral Supports, Nutrition, Specialized Medical Equipment and Supplies, Interpreter Services and non-medical Transportation; and,

Additional support services including Home and Vehicle Modifications, Family Training, and Independent Support Broker.

The Comprehensive Supports waiver is authorized to provide direct services and supports for people who live in licensed settings, and those who live in their own or their family home and require a level of support not available under the IFS waiver, usually due to significant behavioral, medical and/or physical support needs and/or the absence of available natural supports. Services and Supports are organized in three categories:

Residential Supports – Personal Support, Adult Companion, Individualized Home Supports, Residential Habilitation (CLA and CTH), Assisted Living, Healthcare Coordination, Live-In Caregiver, Personal Emergency Response Systems and Respite

Day/Vocational Supports – Group Day, Supported Employment, Adult Day Health, and Individualized Day Supports

Ancillary Supports – Clinical Behavioral Supports, Nutrition, Interpreter, Specialized Medical Equipment and Supplies, and non-medical Transportation; and,

Additional support services including Home and Vehicle Modifications, and Independent Support Broker.

Both waivers further set specific dollar limits of services and supports that can be offered based on an individual's assessed level of support need.

The requirements for the administration of the IFS and Comprehensive Support waivers are established in the approved HCBS Waiver applications. CMS negotiates the content of the application with the state. Once approved, the waiver specifies the following:

- The target population and related eligibility criteria;
- Lists the services to be provided, including the service definition, Provider requirements, direct service employee competencies, and expected utilization of each service;
- Estimates the number of people to be served each year with associated costs, and specifies maximum number of individuals who can be enrolled in each year

# HCBS Consolidated Waiver Operations Manual

- Describes the Plan of Care requirements [Individual Plan (IP)] and Individual Budgeting methodology;
- Describes and provides assurances for assuring the quality of services;
- Demonstrates cost neutrality; and,
- Describes the payment and audit mechanisms.

These elements can only be changed by CMS review and approval of amendments to the waiver.

## 1.1 Waiver Administration and Operation

The Department of Developmental Services (DDS) is considered the Operating Agency for day-to-day implementation of the IFS and Comprehensive Supports waivers. The Department of Social Services (DSS), as the Single State Medicaid Agency, oversees DDS's operation of the waivers. The departments cooperate in the operation of the waiver under a Memorandum of Understanding that delineates each department's responsibilities.

## 1.2 DDS Operating Units for Waiver Administration

### 1.2.1 Central Office Waiver Units

#### 1.2.1.1 Waiver Policy Unit

This unit is responsible for the development of policies and procedures, providing notification to participants of service reduction or denial decisions, and the provision of training and technical assistance. This unit participates with DSS in the submission of waiver applications and amendments to CMS, and in the development of required quality monitoring reports to CMS.

#### 1.2.1.2 Medicaid Operations Unit

This unit is responsible for the processing of waiver applications, providing notification to applicants and participants of eligibility decisions, maintaining current data on the number of waiver participants, attendance and billing reports for submission to the Department of Administrative Services (DAS) for Medicaid billing to CMS, collaborating with DSS to resolve Medicaid eligibility issues, participating in Medicaid Rate Setting decisions with DSS, maintaining records of federal financial reimbursement, resolving rejected Medicaid claims, and participating in audits of service utilization and billing.

### 1.2.2 Operations Center

This unit is responsible for the certification and enrollment of qualified providers, participation in the rate setting process, management of the Master Contract system of payment and cost reporting for private providers, management of the Fiscal Intermediary contracts, and management of the department's fiscal spend plan for private services.

### 1.2.3 Quality Management

This unit is responsible for the overall establishment and maintenance of a system that provides for continuous monitoring of the provision of waiver services

# HCBS Consolidated Waiver Operations Manual

to assure compliance with applicable health and welfare standards and evaluate individual outcomes and satisfaction.

## 1.2.4 Regional Planning and Resource Allocation Teams

This team is responsible for the prioritization of individuals who make application for enrollment in either Waiver, recommendations regarding waiver eligibility and enrollment, service authorization/utilization management functions, and regional management of the number of enrolled participants.

## 1.2.5 Regional Resource Administration

This unit in each region is responsible for providing oversight and technical assistance to private providers of services and supports, and coordinating payments for services to private providers through Master Contracts and Fiscal Intermediary services. The Resource Administration unit coordinates with the Regional PRAT on resource allocation management.

## 1.2.6 Regional Administration/Case Management

The DDS Regional Administration is responsible for the delivery of case management services for individuals enrolled in either waiver. Once an individual is enrolled, case management is responsible for the completion of service needs assessments, the development and implementation of the Individual Plan, the effective use of waiver services as well as other available services and natural supports, the coordination and linkages of services, and the monitoring of the delivery of services and supports as described in the Individual Plan.

## 1.3 Waiver Eligibility

The following requirements determine if an individual is eligible to apply for enrollment in a DDS HCBS Waiver:

- Individual lives in his/her own (individual holds the lease, mortgage or owns outright) or family home (with parent(s) or other relatives) or, will reside in a licensed setting (IFS Waiver, CTH only and Comprehensive Waiver CTH or CLA);
- Individual is eligible for Medicaid (Title 19) as a child or adult regardless of enrollment in the waiver; or
- Individual is eligible for Medicaid (Title 19) by virtue of enrollment in a DDS HCBS Waiver due to increased income limits or waiving spouse/parent income (deeming);
- The individual requires the level of care provided by an ICF/MR facility;
- The individual's health and safety can be reasonably assured through a combination of: the appropriate type, duration and amount waiver services based on an individual's level of need; Medicaid State Plan services; DDS state-funded services and supports; community/generic services; and natural supports;
- There is an available opening under the approved cap on the number of individuals who may participate in the waiver at the time of application.

## 1.4 Process Overview and General Principles

How an individual and his/her family will experience participation in a waiver is broadly described in the following sections. Detailed instructions and guidance follows in each Section area of the Manual.

# **HCBS Consolidated Waiver Operations Manual**

## **1.4.1 Initial Resource Allocation and Individual Planning**

Through the Regional Planning and Resource Allocation Team process, individuals identified as having the most urgent need for supports through the prioritization process are provided a resource funding range or Individual Budget limit based on his/her assessed level of need. The individual, case manager, and other members of the planning and support team will initiate the person-centered planning process to identify needs, preferences and desired personal outcomes. An Individual Budget in an amount up to the allocated resource range or Individual Budget limit will be developed by choosing the type, amount and duration of services and supports from the list of waiver service and support options that meet the identified personal outcomes.

## **1.4.2 Service Arrangement and Provider Choice**

Upon approval of the Individual Budget, which provides authorization to initiate and purchase approved services and supports, the individual may choose from any qualified provider to deliver the services and supports specified in the Individual Budget. Individuals and families are offered options on how much control and flexibility they choose to have over their supports. They may choose to hire their own staff to provide a number of services in this waiver, choose an agency to deliver the service, select an Agency with Choice option, or choose a combination of agency delivered and self-directed service options. The case manager will provide a list of qualified providers, and information or assistance as requested to ensure that the individual and other members of the planning and support team successfully arrange the initiation of approved services.

## **1.4.3 Consumer Direction**

Individuals who self-direct their services and request enhanced assistance to manage the Individual Budget, hire and manage staff, support self-advocacy or provide enhanced service coordination may request that a DDS Broker provide case management and enhanced information and support services, or may choose to purchase Independent Support Broker services from a qualified provider or direct hire. When an individual uses an Independent Support Broker, a DDS case manager continues to deliver Targeted Case Management services to ensure the delivery of services and supports, overall implementation of the Individual Plan, and provide general information and referral services.

# HCBS Consolidated Waiver Operations Manual

## 2. Services

This section describes the services that are covered under the IFS and the Comprehensive Supports Waivers. When reviewing these services, the following apply:

- These services as defined in this manual are for Waiver recipients only;
- How much of each service a person will receive, how often it will be provided, and how long it will be provided must be specified in the person's Individual Plan and authorized by the region before services can be started and funded;
- Specialized Medical Equipment and Supplies that exceed \$750 require Prior Approval.
- Only one service that directly involves the person is provided at a time unless specifically permitted in the definition;
- Waiver funding may only be used to purchase or acquire service as defined in this section;
- The definitions of waiver services do not specify any named technique or therapy. These definitions have been written to meet general best practice habilitation principles and not to approve/deny any type of training. The decisions regarding techniques should be based on the needs/preferences of the person, the development of the Individual Plan, and Service Authorization and DDS Policies and Procedures;
- As a Medicaid recipient, the individual is also eligible to receive regular Medicaid services in addition to waiver services according to Medicaid policies and procedures;
- Payment will not be made for waiver services when a person is a patient or resides in a hospital, nursing facility, or ICF-MR facility.

### Individual/Group Services

- Services that have a group rate are Supported Employment Services, Group Day, Adult Day Health, Residential Habilitation and Respite. Group Services apply to situations involving the provision of services by one staff to two or more waiver recipients;
- All waiver services/supports are to be provided with a staffing ratio of one direct service employee to the person unless otherwise provided in the service definition or the service is provided in accordance with a group rate; (exceptions can be made if consumer-directed, such as if two individuals agree to share a support provider and the total rate paid for the service does not exceed the published provider rate)
- If a waiver recipient receives a service with a group rate in a setting where two or more individuals receive that service at the same time of day, then the presumption is that the person will receive the service at the group rate;
- If the person normally receives a group rate, then that rate must be billed regardless of the attendance of the other individuals in the group;
- When services are provided to a group of individuals, back-up staff must be available in the event of an emergency.

# HCBS Consolidated Waiver Operations Manual

## 2.1 Individualized Home Supports (formerly Supported Living or Individual Support and Habilitation)

### Definition

This service provides assistance with the acquisition, improvement and/or retention of skills and provides necessary support to achieve personal habilitative outcomes that enhance an individual's ability to live in their community as specified in the plan of care. This service includes a combination of habilitative and personal support activities as they would naturally occur during the course of a day. This service is not available for use in licensed settings. The service may be delivered in a personal home (one's own or family home) and in the community.

### Habilitation

Assist with the acquisition, improvement and /or retention of skills and provide necessary support to achieve personal outcomes that enhance an individual's ability to live in their community as specified in their Individual Plan. This service is specifically designed to result in learned outcomes, but can also include elements of personal support that occur naturally during the course of the day. Examples of the type of support that may occur in these settings include:

- Provision of instruction and training in one or more need areas to enhance the individual's ability to access and use the community;
- Implement strategies to address behavioral, medical or other needs identified in the Individual Plan;
- Implement all therapeutic recommendations including Speech, O.T., P.T., and assist in following special diets and other therapeutic routines;
- Mobility training or Travel training;
- Adaptive communication training;
- Training or practice in basic consumer skills such as shopping or banking; and,
- Assisting the individual with all personal care activities.

### Personal Support

Assistance necessary to meet the individual's day-to-day activity and daily living needs and to reasonably assure adequate support at home and in the community to carry out personal outcomes. Cueing and supervision of activities is included. This service may not be used in place of eligible Medicaid State Plan Home HealthCare services. Provision of services is limited to the person's own or family home and/or in their community

### Service Settings

Provision of services is limited to the person's own home or family home and/or in their community.

### General Service Limitations

Payments for Individualized Home Support are not made for room and board, the cost of facility maintenance, upkeep and improvement. This services cannot be used in combination with Respite, Personal Support, Adult Companion Services, Group Day, Individualized Day, Supported Employment, and/or Individualized Goods and Services.

### Service Utilization

Typical utilization is five to 20 hours per week.

### Participant Directed Individual

Verified by the FI:

Prior to Employment

- 18 yrs of age
- criminal background check

## HCBS Consolidated Waiver Operations Manual

- registry check
- have ability to communicate effectively with the individual/family
- have ability to complete record keeping as required by the employer

Prior to being alone with the Individual:

- demonstrate competence in knowledge of DDS policies and procedures: abuse/neglect; incident reporting; client rights and confidentiality; handling fire and other emergencies, prevention of sexual abuse, knowledge of approved and prohibited physical management techniques
- demonstrate competence/knowledge in topics required to safely support the individual as described in the Individual Plan
- demonstrate competence, skills, abilities, education and/or experience necessary to achieve the specific training outcomes as described in the Individual Plan
- ability to participate as a member of the team if requested by the individual
- demonstrate understanding of Person Centered Planning
- demonstrate competence/knowledge in positive behavioral programming, working with individuals who experience moderate to severe psychological and psychiatric behavioral health needs and ability to properly implement behavioral support plans\*
- Medication Administration\*

\* if required by the individual supported

### Qualified Provider Direct Service Staff Requirements

Prior to Employment

- 18 yrs of age
- criminal background check
- registry check
- have ability to communicate effectively with the individual/family
- have ability to complete record keeping as required by the employer

Prior to being alone with the Individual:

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

\* if required by the individual supported

### Unit of Service and Method of Payment

The basis of payment for services is a fifteen (15) minute unit of direct service time. Billing should be rounded to the nearest hour.

### Qualified Provider Rate for Services

See Rate Table

## HCBS Consolidated Waiver Operations Manual

**Self-directed:** Negotiated Rate. Prior approval must be obtained from the DDS to exceed published waiver rate (Procedure: I.C.2.PR 009). Allowable costs are based on the Department of Developmental Services *Individual Support Cost Standards 7/1/2008*

### Service Documentation

Maintain documentation by the individual providing the service that includes at a minimum: the date of the service; the start time and end time of the service, a description of the activities related to outcomes/goals/objectives, care or transportation provided to the person, and the signature of the person providing the service. The person receiving the service or their legal representative has the option of signing the provider documentation form. For individuals who hire their own staff the employer of record must sign the time sheet to verify the employee worked the hours reported on the time sheet and provided the support noted in the service documentation.

# HCBS Consolidated Waiver Operations Manual

## 2.2 Personal Support

### Definition

Assistance necessary to meet the individual's day-to-day activity and daily living needs and to reasonably assure adequate support at home and in the community to carry out personal outcomes. Cueing and supervision of activities is included. This service may be self-directed.

### Examples

- Provide assistance to maintain activities of daily living that may include:
  - Personal hygiene
  - Dressing
  - Eating and meal prep
- Provide assistance to attain and maintain safe and sanitary living conditions and manage a household that may include:
  - General housekeeping
  - Washing and drying laundry
  - Shopping
- Provide assistance to access and attend community activities that may include:
  - Accompanying the individual while traveling to community activities
  - Accessing leisure activities such as the library, fitness center, self-advocacy meeting, and community events.

### Service Settings

Provision of services is limited to the person's own or family home and/or in their community. This service shall not be provided while the consumer is attending day program.

### General Services Limitations

This service may not be used in place of eligible Medicaid State Plan Home Health Care services or be used in combination with residential habilitation. This service should not supplant the care provided by the consumer's natural supports. Personal care providers may be members of the individual's family with prior approval from DDS. Payment will not be made for services furnished to a minor by the child's parent (or step-parent), or to an individual by that person's spouse. For other family members, payment is made only when the service is not a function that a family member normally provides for the individual without charge as a matter of course in the usual relationship among members of a nuclear family, and the service would otherwise need to be provided by a qualified provider. Family members who provide personal care services must meet the same standards as providers who are unrelated to the individual.

May not be provided at the same time as Individualized Day Supports, Group Day , Supported Employment, Adult Day Health, Respite, Individualized Home Support, Adult Companion, or Residential Habilitation (CTH or CLA)

This service may not be used in combination with (as part of the same plan) as residential habilitation.

### Service Utilization

Typical utilization is seven to 20 hours per week.

# HCBS Consolidated Waiver Operations Manual

## **Direct Service Staff Requirements**

### **Participant directed Individual**

Verified by the FI:

#### Prior to Employment

- 18 yrs of age
- criminal background check
- registry check
- have ability to communicate effectively with the individual/family
- have ability to complete record keeping as required by the employer

Prior to being alone with the Individual:

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

\* if required by the individual supported

### **DDS Qualified Provider**

#### Prior to Employment

- 18 yrs of age
- Criminal background check
- Abuse Registry check
- Have ability to communicate effectively with the individual/family
- Have ability to complete record keeping as required by the employer

#### Prior to being alone with the Individual:

- Demonstrate competence and knowledge of DDS policies and procedures in: abuse/neglect; incident reporting; human rights; confidentiality; handling fire and other emergencies, prevention of sexual abuse; knowledge of approved and prohibited physical management techniques;
- Demonstrate competence in their role necessary to safely support the individual as described in the Individual Plan;
- Medication Administration\*

\* if required by the individual supported

### **Unit of Service and Method of Payment**

The basis of payment for services is a quarter-hour unit of direct service time. Billing should be rounded to the nearest quarter hour.

### **Qualified Provider Rate for Services**

See Rate Table

**Self-directed:** Negotiated Rate. Prior approval must be obtained from the DDS to exceed published waiver rate (Procedure: I.C.2.PR 009). Allowable costs are based on the Department of Developmental Services *Individual Support Cost Standards 7/1/2008*

# HCBS Consolidated Waiver Operations Manual

## Service Documentation

Maintain documentation by the individual providing the service that includes at a minimum: the date of the service; the start and end time of the service, and a description of the activities related to outcomes/goals/objectives, care or transportation provided to the person, and the signature of the person providing the service. The person receiving the service or their legal representative has the option of signing the provider documentation form. For individuals who hire their own staff the employer of record must sign the time sheet to verify the employee worked the hours reported on the time sheet and provided the support noted in the service documentation.

# HCBS Consolidated Waiver Operations Manual

## 2.3 Adult Companion Services

### Definition

Non-medical care, supervision, and socialization provided to an adult. Service may include assistance with meals and basic activities of daily living and/or completion of light housekeeping tasks, which are incidental to the care and supervision of the individual. This service is provided to carry out personal outcomes identified in the Individual Plan. This service does not entail hands-on nursing care, except as permitted under the *Nurse Practice Act (CGS 20-101)*. This service may be self-directed.

### Examples

- Provide companionship and social interactions;
- Companions may assist or supervise the individual with such tasks as light housekeeping, meal preparation, laundry and shopping, but do not perform these activities as discrete services or more than 20% of time worked.

### Service Settings

Provision of services is limited to the person's own or family home and/or in their community.

### General Service Limitations

Adult Companion Services are not made for room and board, the cost of facility maintenance, upkeep and improvement. A qualified family member or relative, independent contractor or service agency may provide services. In the case of providers who are family members, federal financial participation is excluded when the provider is a parent providing services for a minor child under the age of 18, a participant's spouse, conservator, or a relative of a conservator. For other family members, payment is only made when: the service provided is not a function that a family member would normally provide for the individual without charge as a matter of course in the usual relationship among members of a nuclear family, and the service would otherwise need to be provided by a qualified provider. Prior approval from DDS is required for family members to qualify.

This service may not be used in combination with (as part of the same plan) Residential Habilitation (CLA).

This service may not be provided at the same time as Group Day, Individualized Day Supports, Supported Employment, Adult Day Health, Respite, Personal Support, Individualized Home Supports, Residential Habilitation (CTH) and/or Individualized Goods and Services.

### Service Utilization

Two to 16 hours per day.

### Qualified Provider or Self-directed Direct Service Staff Requirements

#### Prior to Employment

- 18 yrs of age
- Criminal background check
- Abuse Registry check
- Have ability to communicate effectively with the individual/family
- Have ability to complete record keeping as required by the employer.

#### Prior to being alone with the Individual:

- Demonstrate competence in knowledge of DDS policies and procedures: abuse/neglect; incident reporting; human rights and confidentiality; handling fire and other emergencies, prevention of sexual abuse; and knowledge of approved and prohibited physical management techniques;

## HCBS Consolidated Waiver Operations Manual

- Demonstrate competence in their role necessary to safely support the individual as described in the Individual Plan;
- Medication Administration if required by the Individual Plan.

### **Unit of Service and Method of Payment**

The basis of payment for services is a quarter-hour unit of direct service time. Billing should be rounded to the nearest quarter hour.

### **Qualified Provider Rate for Services**

See Rate Table

**Self-directed:** Negotiated Rate. Prior approval must be obtained from the DDS to exceed published waiver rate (Procedure: I.C.2.PR 009). Allowable costs are based on the Department of Developmental Services *Individual Support Cost Standards 7/1/2008*

### **Service Documentation**

Maintain documentation by the individual providing the service that includes at a minimum: the date of the service; the start and end time of the service, and a description of the activities related to outcomes/goals/objectives, care or transportation provided to the person, and the signature of the person providing the service. The person receiving the service or their legal representative has the option of signing the provider documentation form. For individuals who hire their own staff the employer of record must sign the time sheet to verify the employee worked the hours reported on the time sheet and provided the support noted in the service documentation.

# HCBS Consolidated Waiver Operations Manual

## 2.4 Supported Employment Services

### Definition

Supported Employment consists of intensive, ongoing supports that enable participants, for whom competitive employment at or above the minimum wage is unlikely absent the provision of supports, and who because of their disabilities, need supports to perform in a regular work setting. Supported employment may include assisting the participant to locate a job or develop a job on behalf of the participant. Supported employment is conducted in a variety of settings, particularly work sites where persons without disabilities are employed. Supported Employment includes activities needed to sustain paid work by participants, including supervision and training. When supported employment services are provided at a work site where persons without disabilities are employed, payment is made only for adaptations, supervision and training required by participants receiving waiver services as a result of their disabilities but does not include payment for supervisory activities rendered as a normal part of the business setting. Supported employment does not include sheltered work or similar types of vocational services furnished in specialized facilities. Supported employment services may be furnished to participants who are paid at a rate more than minimum wage, provided that the participant requires supported employment services in order to sustain employment. Supported employment services may be furnished by a co-worker or other sob-site personnel provided that the services which are furnished are not part of the normal duties of the co-worker or other personnel and those individuals meet the pertinent qualifications for providers of the service. Supported employment may include services and supports that assist the participant in achieving self-employment through the operation of a business. However, Medicaid funds may not be used to defray the expenses associated with starting up or operating a business. This service may be self-directed.

1. Individual placement: A supported employment placement strategy in which an employment specialist (job coach) places a participant into competitive employment through a job discover process, provides training and support, and then gradually reduces time and assistance at the worksite. This service option may also include development and on-going support for self employment by the participant. This assistance consists of: (a) assisting the participant to identify potential business opportunities; (b) assisting the participant in the development of a business plan, including potential sources of business financing and other assistance in developing and launching a business; (c) identification of the supports that are necessary in order for the participant to operate the business; and, (d) ongoing assistance, counseling and guidance once the business has been launched.
2. Group Supported Employment (GSE): a) A supported employment situation in a competitive employment environment in which a group of participants with disabilities are working at a particular work setting. The participants may be disbursed throughout the company and among workers without disabilities or congregated as a group in one part of the business; or b) Mobile Work Crew: A group of participants who perform work in a variety of locations under the supervision of a permanent employment specialist (job coach/supervisor).

### Examples

- Supported employment includes activities needed to sustain paid work by individuals receiving waiver services, including supervision and training;
- Evaluate the Individual's appropriateness, desire, strengths, and abilities for supported employment;
- Job development;
- Assist in finding employment;
- Provide job coaching/teaching;

# HCBS Consolidated Waiver Operations Manual

- Monitor job performance;
- Support work crews and teams;

## Service Settings

Supported employment is conducted in a variety of community settings.

## General Service Limitations

This service may only be used when the individual is not eligible for state Vocational Rehabilitation services. A qualified family member or relative, independent contractor or service agency may provide services. In the case of providers who are family members, federal financial participation is excluded when the provider is a parent providing services for a minor child under the age of 18, a participant's spouse, conservator, or a relative of a conservator. For other family members, payment is only made when: the service provided is not a function that a family member would normally provide for the individual without charge as a matter of course in the usual relationship among members of a nuclear family, and the service would otherwise need to be provided by a qualified provider. Prior approval from DDS is required for family members to qualify. This service may not be provided at the same time as Group Day, Individualized Day Supports, Adult Day Health, Respite, Personal Support, Adult Companion, or Individualized Home Supports.

## Service Utilization

**Individual Supported Employment** services will vary in the intensity of initial job development, intensive training, and decreasing periodic monitoring. This service is not for use to provide ongoing long-term 1:1 support to enable an individual to complete work activities. The individual, parent and/or guardian, and her/his team should discuss a support plan that addresses how and when the staff would begin to fade direct supports. An individual who needs long-term 1:1 on the job supports to maintain their job would utilize the Individualized Day model with a negotiated rate. Although there is no set time limit, a reasonable time frame from when an individual begins a job with staff supports to independently working on their own is generally 3-6 months. A few hours of ongoing weekly and/or monthly support is part of the Individual Supported Employment model.

Typical **Group Supported Employment** ranges from six to eight hours per day for small groups of consumers.

## Qualified Provider or Direct Hire Direct Service Staff Requirements

### Prior to Employment:

- 18 yrs of age
- Criminal background check
- Abuse Registry check
- Have ability to communicate effectively with the individual/family
- Have ability to complete record keeping as required by the employer.

### Prior to being alone with the Individual:

- Demonstrate competence in knowledge of DDS policies and procedures: abuse/neglect; incident reporting; human rights and confidentiality; handling fire and other emergencies, prevention of sexual abuse; knowledge of approved and prohibited physical management techniques;
- Demonstrate competence in their role necessary to safely support the individual as described in the Individual Plan;
- Demonstrate competence, skills, abilities, education, and/or experience necessary to achieve the specific outcomes as described in the Individual Plan;
- Ability to participate as a member of the circle if requested by the individual.

# HCBS Consolidated Waiver Operations Manual

## **Unit of Service and Method of Payment Qualified Provider**

### Hourly Fee

The basis of payment for services is a quarter-hour unit of direct service time. Billing should be rounded to the nearest quarter hour.

## **Qualified Provider Rate for Services**

### ***Individual***

See Rate Table

**Self-directed:** Negotiated Rate. Prior approval must be obtained from the DDS to exceed the published waiver rate (Procedure: I.C.2.PR 009). Allowable costs are based on the Department of Developmental Services *Individual Support Cost Standards 7/1/2008*

### ***Group***

See Rate Table 1:4 ratio on average

## **Service Documentation**

Maintain documentation by the individual providing the service that includes at a minimum: the date of the service; the start time and end time of the service, a description of the activities related to outcomes/goals/objectives provided to the person, and the signature of the person providing the service. The person receiving the service or their legal representative has the option of signing the provider documentation form. For individuals who hire their own staff the employer of record must sign the time sheet to verify the employee worked the hours reported on the time sheet and provided the support noted in the service documentation.

# HCBS Consolidated Waiver Operations Manual

## 2.5 Group Day Service

### Definition

Services and supports lead to the acquisition, improvement, and/or retention of skills and abilities to prepare an individual for work and/or community participation, or support meaningful socialization, leisure, and retirement activities.

### Examples

- Develop and implement an individualized support plan;
- Develop, maintain or enhance independent functioning skills in the areas of sensory-motor, cognition, personal grooming, hygiene, toileting, etc.;
- Assist in developing and maintaining friendships of choice and skills to use in daily interactions;
- Develop work skills;
- Provide opportunities to earn money;
- Provide opportunities to participate in community activities.

### Service Settings

These services are delivered in or from a facility-based program or appropriate community locations.

### General Service Limitations

Service only provided by an enrolled provider in a facility-based program or appropriate community setting. This service may not be self-directed. This service may not be provided at the same time as Individualized Day Supports, Supported Employment, Adult Day Health, Respite, Personal Support, Adult Companion or Individualized Home Supports.

### Service Utilization

Five to eight hours per day.

### Qualified Provider Requirements and Individual Provider Qualifications

#### Prior to Employment:

- 18 yrs of age
- Criminal background check
- Abuse Registry check
- Ability to communicate effectively with individual/family
- Ability to complete necessary documentation.

Training w/in 60 days (cannot work alone until training completed)

- Medication Administration, if required in the Individual's Plan
- Communicable disease/OSHA
- First Aid and CPR
- Abuse and Neglect
- Sexual Abuse Prevention
- Confidentiality
- Human Rights
- Incident Reporting
- Planning and Provision of services
- Behavioral techniques based on the individual(s) supported and knowledge of approved and prohibited physical management techniques.
- Additional training as required by the team/circle specific to support the individual's health, welfare and personal outcomes as described in the Individual Plan.

# HCBS Consolidated Waiver Operations Manual

## **Unit of Service and Method of Payment: Qualified Provider**

### Hourly Fee

The basis of payment for services is a quarter-hour unit of direct service time. Billing should be rounded to the nearest quarter hour.

## **Qualified Provider Rate**

Day Support Options-- See Rate Table 1:3 ratio on average

Sheltered Work-- See Rate Table 1:8 ratio on average

## **Service Documentation**

As services are provided in Group settings the provider documents the delivery of services for each date of service which includes: the date of service, the start time, the end time, and a note on the activity related to the outcomes/goals/ objectives, care or transportation of the person. The service delivery record can be bi-weekly or monthly and is signed by the provider representative. The Group Day provider will maintain service records related to the acquisition of outcomes/goals/objectives, provided to the person.

# HCBS Consolidated Waiver Operations Manual

## 2.6 Individualized Day Support

### Definition

Services and supports provided to individuals tailored to their specific personal outcomes related to the acquisition, improvement, and/or retention of skills and abilities to prepare and support an individual for work and/or community participation and/or meaningful retirement activities, or for an individual who has their own business, and could not do so without this direct support. This service may be self-directed.

### Examples

- Develop and implement an individualized support plan;
- Develop, maintain or enhance independent functioning skills in the areas of sensory-motor, cognition, personal grooming, hygiene, toileting, etc.;
- Assist in developing and maintaining friendships of choice and skills to use in daily interactions;
- Provide support to explore job interests, retirement options;
- Provide opportunities to participate in community activities;
- Provide support to complete work or business activities;
- Training and supervision to increase or maintain self-help, socialization, and adaptive skills to participate in own community.

This service includes the transportation required by the individual to participate in these activities.

### Service Settings

This service originates from the home and is generally delivered in the community.

### General Service Limitations

This service is not provided in or from a facility-based day program. A qualified family member or relative, independent contractor or service agency may provide services. In the case of providers who are family members, federal financial participation is excluded when the provider is a participant's spouse, conservator, or a relative of a conservator. For other family members payment is only made when the service provided is not a function a family member would normally provide for the individual without charge as a matter of course in the usual relationship among members of a nuclear family; and the service would otherwise need to be provided by a qualified provider. DDS Prior Approval required for family members. This service may not be provided at the same time as Group Day, Adult Day Health, Supported Employment, Respite, Personal Support, Adult Companion, or Individualized Home Supports.

### Service Utilization

Five to eight hours per day.

### Qualified Provider or Self-directed Direct Service Staff Requirements

#### Prior to Employment:

- 18 yrs of age
- Criminal background check
- Abuse Registry check
- Have ability to communicate effectively with the individual/family
- Have ability to complete record keeping as required by the employer

#### Prior to being alone with the Individual:

- Demonstrate competence in knowledge of DDS policies and procedures: abuse/neglect; incident reporting; human rights and confidentiality; handling fire and other emergencies, prevention of sexual abuse; knowledge of approved and prohibited physical management techniques;

## HCBS Consolidated Waiver Operations Manual

- Demonstrate competence in their role necessary to safely support the individual as described in the Individual Plan;
- Demonstrate competence, skills, abilities, education, and/or experience necessary to achieve the specific training outcomes as described in the Individual Plan;
- Demonstrate understanding of Person-Centered Planning.

### **Unit of Service and Method of Payment**

#### Hourly Fee

The basis of payment for services is an hourly unit of direct service time. Billing should be rounded to the nearest hour.

### **Qualified Provider or Self-directed Rate for Service**

Negotiated rate. (Procedure: I.C.2.PR 009). Allowable costs are based on the Department of Developmental Services *Individual Support Cost Standards 7/1/2008*

### **Service Documentation**

Maintain documentation by the individual providing the service that includes at a minimum: the date of the service; the start time and end time of the service, a description of the activities related to outcomes/goals/objectives provided to the person, and the signature of the person providing the service. The person receiving the service or their legal representative has the option of signing the provider documentation form. For individuals who hire their own staff the employer of record must sign the time sheet to verify the employee worked the hours reported on the time sheet and provided the support noted in the service documentation.

# HCBS Consolidated Waiver Operations Manual

## 2.7 Adult Day Health Services

### Definition

Adult day health services are provided through a community-based program designed to meet the needs of cognitively and physically impaired adults through a structure, comprehensive program that provides a variety of health, social and related support services including, but not limited to, socialization, supervision and monitoring, personal care and nutrition in a protective setting during any part of a day. There are two different models of adult day health services: the social model and the medical model. Both models shall include the minimum requirements described in Section 17b-342-2(b)(2) of the DSS regulations. In order to qualify as a medical model, adult day health services shall also meet the requirements described in Section 17b-342-2(b)(3) of the DSS regulations.

### Service Settings

Adult Day Health Service providers approved by the Department of Social Services.

### General Service Limitations

Service only provided by an enrolled provider in a facility-based program. This service may not be self-directed. May not be provided at the same time as Group Day, Supported Employment, Respite, Personal Support, or Individualized Home Supports

### Service Utilization

Generally five to eight hours per day.

### Qualified Provider Requirements

Provider must meet the requirements of Section 17b-342-2(b)(2) of the DSS regulations. Providers of the medical model of Adult Day Health must also meet the requirements of Section 17b-342-2(b)(3) of the DSS regulations.

### Direct Service Staff Requirements

#### Prior to Employment

- 18 yrs of age
- criminal background check
- registry check
- have ability to communicate effectively with the individual/family
- have ability to complete record keeping as required by the employer

#### Prior to being alone with the Individual:

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

\*if required by the individual supported

### Unit of Service and Method of Payment

Per Diem rate based on actual attendance.

# HCBS Consolidated Waiver Operations Manual

## **Qualified Provider Rate**

Rates set by Department of Social Services.

## **Service Documentation**

As services are provided in group settings the provider documents the delivery of services for each date of service which includes: the date of service, the start time, the end time, and a note on the activity related to the outcomes/goals/ objectives, care or transportation of the person. The service delivery record can be bi-weekly or monthly and is signed by the provider representative.

# HCBS Consolidated Waiver Operations Manual

## 2.8 Healthcare Coordination

### Definition

Assessment, education and assistance provided by a registered nurse to those waiver participants with identified health risks, who, as a result of their intellectual disability, have limited ability to identify changes in their health status or to manage their complex medical conditions. These participants have medical needs that require more healthcare coordination than is available through their primary healthcare providers to assure their health, safety and well-being. This service will ensure that there is communication between primary care physicians, medical specialists, and behavioral health practitioners, and will provide a resource person to communicate to direct support staff and consumers and train them to follow through on medical recommendations enabling the participants to live in the least restrictive setting possible with the greatest level of independence. The RN Healthcare Coordinator will complete a comprehensive nursing assessment on each participant and develop an integrated healthcare management plan for the participant and his/her support staff to implement. This service shall provide the clinical and technical guidance necessary to support the participant in managing complex health care services and supports to improve health outcomes and prevent admission to a licensed group home or nursing facility. The level of technical coordination related to interpretation and monitoring of health issues requires a clinical expertise that cannot be provided by the case manager. Support provided includes, but is not limited to, the following: train/retrain staff on interventions, monitor the effectiveness of interventions, coordinate specialists, evaluate treatment recommendations, review lab results, monitor, coordinate tests/results, and review diets.

### Service Settings

This service originates from the home and is generally delivered in the community.

### General Service Limitations

This service is only available to participants who live in their own homes with less than 24 hour support.

### Service Utilization

The intensity of supports provided by the RN will vary depending on the complexity of the participant's needs. General usage is expected to be 1-5 hours per week.

### Qualified Provider or Self-directed Direct Service Staff Requirements

Registered Nurse (RN) with two years of nursing experience and experience with DDS clients or individuals with Behavioral Health needs or specialized training by DDS.

### Unit of Service and Method of Payment

Hourly Fee. The basis of payment for services is a quarter-hour unit of direct service time. Billing should be rounded to the nearest quarter hour.

### Qualified Provider or Self-directed Rate for Service

See rate table.

### Service Documentation

As individual services are provided in the person's own home, or the community the provider documents the delivery of services for each date of service. The documentation includes the date of service, the start time and end time of the service for each date, a signature of the person providing the service, and documentation on the reason for the service, the outcome, and follow up activities. The person receiving the service or their legal representative has the option of signing the provider documentation form. For individuals who hire their own provider directly the employer of record must sign the time sheet to verify the provider worked the hours reported on the time sheet and provided the support noted in the service documentation.

# HCBS Consolidated Waiver Operations Manual

## 2.8 Live In Caregiver

### Definition

When a waiver service such as Individualized Home Supports or Personal Support is provided by an unrelated, live-in caregiver, funding is available to cover the additional costs of rent and food that can be reasonably attributed to the unrelated live-in personal caregiver who resides in the waiver participant's home. The reimbursement for the increased rental costs will be based on the DDS Rent Subsidy Guidelines and will follow the limits established in those guidelines for rental costs. The reimbursement for food costs will be based on the USDA Moderate Food Plan Cost averages. Payment will not be made when the participant lives in the caregiver's home or in a residence that is owned or leased by the service provider.

### Service Settings

The waiver participant's own home.

### Qualified Provider Requirements

#### Prior to Employment

- 21 yrs of age
- criminal background check
- registry check
- have ability to communicate effectively with the individual/family
- have ability to complete record keeping as required by the employer

#### Prior to Being Alone with the Individual

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

\*if required by the individual supported

**Interim Rate Guidelines** (may be adjusted when sufficient data is collected on use of the service)

The waiver participant is reimbursed for the increased rent and utility costs based on the DDS Rent Subsidy Guidelines and the limits established those guidelines for rental costs. The reimbursement for food costs will be based on the USDA Moderate Food Plan Cost averages.

**Interim Service Documentation** (may be adjusted when sufficient data is collected on use of the service)

Rent, utility and food receipts.

# HCBS Consolidated Waiver Operations Manual

## 2.10 Respite

### Definition

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. This service may be self-directed.

### Examples

Weekend stay at certified respite provider's home, four hours of in-home respite relief for parents, Saturday group respite at a community center, and attendance at approved respite/camp facilities.

### Service Settings

Consumer's home, home of Qualified Respite Provider, DDS operated Respite Centers, Private Certified Respite Homes, community locations, approved respite facilities.

### General Service Limitations

Stay in respite home/center cannot exceed 30 consecutive days without prior approval from DDS. Family members who reside in the same household as the individual may not provide respite.

### Service Utilization

More than 13 hours in a given day the basis of payment is a daily unit of direct service. Less than 13 hours per day the basis of payment for services is a quarter-hour unit of direct service time. Billing should be rounded to the nearest quarter hour.

#### Qualified Provider Requirements

##### Out of Home Respite Home/Center/Facility

Meets all requirements under CT General Statute (CGS) CGS 17a-218 and State Administrative Code 17a-218-1 to 17a-218-17.

Approved facilities licensed by Department of Public Health, Department of Education or other state licensing entity.

#### Self –Directed Requirements

##### Out of Home Respite

###### Prior to Employment

- 18 yrs of age
- Criminal background
- Abuse Registry check
- Have ability to communicate effectively with the individual/family
- Have ability to complete record keeping as required by the employer.

###### Prior to being alone with the Individual:

- Demonstrate competence in knowledge of DDS policies and procedures: abuse/neglect; incident reporting; human rights and confidentiality; handling fire and other emergencies, prevention of sexual abuse; knowledge of approved and prohibited physical management techniques;
- Demonstrate competence in their role necessary to safely support the individual as described in the Individual Plan;
- Medication Administration, if required in the Individual's Plan.

# HCBS Consolidated Waiver Operations Manual

## Qualified Provider Requirements In Home/Community Respite

### Prior to Employment

- 18 yrs of age
- Criminal background check
- Abuse Registry check
- Have ability to communicate effectively with the individual/family
- Have ability to complete record keeping as required by the employer

### Prior to being alone with the Individual:

- Demonstrate competence and knowledge of DDS policies and procedures in: abuse/neglect; incident reporting; human rights; confidentiality; handling fire and other emergencies, prevention of sexual abuse; knowledge of approved and prohibited physical management techniques;
- Demonstrate competence in their role necessary to safely support the individual as described in the Individual Plan
- Medication Administration, if required in the Individual's Plan.

## Unit of Service and Method of Payment Qualified Provider

### Daily Fee

The basis of payment for services is a daily unit after 13 hours in one 24-hour period

### Hourly Fee of direct service

The basis of payment for services is a quarter-hour unit of direct service time. Billing should be rounded to the nearest hour.

## All Respite Rates Out of Home Respite Home/Center/Facility, In-home Respite

### Daily

Individual	Group
See Rate Table	

### Hourly

Individual	Group
See Rate Table	

## Self-Directed Requirements In Home/Community Respite

### Prior to Employment

- 16 yrs of age--IFS Waiver Only, for services delivered in the family home
- 18 yrs of age
- Abuse Registry check
- Have ability to communicate effectively with the individual/family
- Have ability to complete record keeping as required by the employer

### Prior to being alone with the Individual:

- Demonstrate competence and knowledge of DDS policies and procedures in: abuse/neglect; incident reporting; human rights; confidentiality; handling fire and other emergencies, prevention of sexual abuse; knowledge of approved and prohibited physical management techniques;
- Only those respite providers who are over 18 years old may transport participants in a vehicle
- Demonstrate competence in their role necessary to safely support the individual as described in the Individual Plan
- Medication Administration, if required in the Individual's Plan.

## Unit of Service and Method of Payment Self-Directed

### Daily Fee

The basis of payment for services is a daily unit after 13 hours in one 24- hour period

### Hourly Fee of direct service

The basis of payment for services is a quarter-hour unit of direct service time. Billing should be rounded to the nearest hour.

## Self-Directed Rates

Prior approval must be obtained from DDS to exceed published waiver rate. (Procedure: I.C.2.PR 009). Allowable costs are based on the Department of Developmental Services *Individual Support Cost Standards 7/1/2008*

## HCBS Consolidated Waiver Operations Manual

### **Service Documentation**

As respite services are provided in the community, the person's own home, or a family home, or a provider residence, the provider documents the delivery of services for each date of service which includes the date of service, the start time and end time of service, and the signature of the person providing the service. The person receiving the service or their legal representative has the option of signing the provider documentation form. For individuals who hire their own staff the employer of record must sign the time sheet to verify the employee worked the hours reported on the time sheet and provided the support noted in the service documentation.

# HCBS Consolidated Waiver Operations Manual

## 2.11 Personal Emergency Response Systems (PERS)

### Definition

PERS is an electronic device which enables certain individuals at high risk of institutionalization to secure help in an emergency.

### Examples

The individual wears a portable "help" button to allow for mobility.

### Service Settings

The system is connected to the person's phone and programmed to signal a response center once a "help" button is activated.

### General Service Limitations

Trained professionals staff the response center. PERS services are limited to those individuals who live alone, or who are alone for significant parts of the day and have no regular caregiver for extended periods of time, and who would otherwise require extensive routine supervision.

### Service Utilization

Ongoing service billed on a monthly basis.

### Qualified Provider Direct Service Staff Requirements

N/A

### Unit of Service and Method of Payment Qualified Provider

Installation

Monthly Fee

### Qualified Provider Rate for Service

Installation See Rate Table

Two-way See Rate Table

### Service Documentation

Maintain a record that documents the date service is started, the dates that it is provided, and the date it is terminated.

# HCBS Consolidated Waiver Operations Manual

## 2.12 Transportation

### Definition

Service offered in order to enable individuals served under the Waivers to gain access to waiver and other community services, activities and resources, specified by the plan of care. This service may be self-directed.

Transportation services under the waiver shall be offered in accordance with the individual's plan of care.

### Examples

Travel to and from day program, travel for shopping or recreation.  
In group transportation models the rate includes the driver of the vehicle

### Service Settings

N/A

### General Service Limitations

This service is offered in addition to medical transportation required under 42 CFR 431.53 and transportation services under the State Plan, defined at 42 CFR 440.170(a) (if applicable), and shall not replace them. Whenever possible, family, neighbors, friends, or community agencies that can provide this service without charge will be utilized. Payment for service may not be made when provided by the parent of a minor child or the individual's spouse, or when delivered by other family members who would normally provide the service for the individual without charge as a matter of course in the usual relationship among members of a nuclear family.

### Service Utilization

N/A

### Qualified Provider or Self-directed Direct-Service Staff Requirements

Valid CT driver's license  
Criminal Background Check

### Unit of Service and Method of Payment Qualified Provider

- Per Mile Fee/Per trip Fee upon receipt of invoice
- Signed Provider Agreement

### Qualified Provider Rate for Service

See Rate Table

**Self-directed:** Negotiated Rate. Prior approval must be obtained from the DDS to exceed published waiver rate (Procedure: I.C.2.PR 009). Allowable costs are based on the Department of Developmental Services *Individual Support Cost Standards 7/1/2008*

### Service Documentation

Maintain a record that documents the date that the service is provided, the specific activity that the person is being transported to/from, and the mileage or trips related to transporting the person. The signature of a representative from the Qualified Provider or the directly hired employee providing the transportation is required.

# HCBS Consolidated Waiver Operations Manual

## 2.13 Environmental Modifications

### Definition

Those physical adaptations to the home which are necessary to ensure the health, welfare, and safety of the individual, or which enable the individual to function with greater independence in the home, and without which, the individual would require institutionalization.

### Examples

Such adaptations may include the installation of ramps and grab-bars, widening of doorways, modification of bathroom facilities, or installation of specialized electric and plumbing systems, which are necessary to accommodate the medical equipment and supplies, which are necessary for the welfare of the individual.

### Service Settings

The individual's or individual's family home.

### General Provider/Service Limitations

Excluded are those adaptations or improvements to the home that are of general utility and are not of direct medical or remedial benefit to the individual, such as carpeting, roof repair, central air conditioning, etc. This service is not self-directed.

### Service Utilization

Up to \$15,000 over the term of this waiver (five years).

### Unit of Service and Method of Payment Qualified Provider

Provider paid through the Fiscal Intermediary upon receipt of invoice and signed Provider Agreement.

### Qualified Provider Rate for Service

Lowest of three bids. Documentation of bids is required.  
Payment based on lowest bid.

### Service Documentation

All home improvements and renovation projects must be documented through the submission of a proposal that includes, (1) the disclosure of the full scope of the project including a budget that identifies the cost for the entire project, (2) documentation that the project has the approvals from local building inspectors and fire marshals, (3) the documentation that the project has been competitively bid with the documentation that the bids are from three qualified bidders, that each bidder is currently licensed with the State of Connecticut's Department of Consumer Protection to perform the work, craft, or skill for the portion of the project they are bidding, that the bidders are insured, that the bids are competitive and the bids are comparable. A signed Provider Agreement is required before payment is made.

# HCBS Consolidated Waiver Operations Manual

## 2.14 Vehicle Modification Services

### Definition

Alterations made to a vehicle that is the individual's primary means of transportation when such modifications are necessary to improve the individual's independence and inclusion in the community, and to avoid institutionalization. The vehicle may be owned by the individual, a family member with whom the individual lives or has consistent and on-going contact, or a non-relative who provides primary long-term support to the individual and is not a paid provider of such services. This service explicitly excludes: 1) adaptations or improvements to the vehicle that are of general utility, and are not of direct medical or remedial benefit of the individual; 2) purchase or lease of a vehicle; 3) regular scheduled upkeep and maintenance of a vehicle except upkeep and maintenance of the modifications.

### Examples

Wheelchair lift, wheelchair tie downs, grab bar.

### Service Settings

The vehicle may be owned by the individual, a family member with whom the individual lives or has consistent and ongoing contact, or a non-relative who provides primary long-term support to the individual and is not a paid provider of such services.

### General Provider Limitations

This service is not self-directed.

### Service Utilization

Up to \$10,000 over the term of this waiver (five years). Once this cap is reached, \$750 per individual per year may be allowable for repair, replacement or additional modification with prior approval.

### Qualified Provider Direct Service Staff Requirements

N/A

### Unit of Service and Method of Payment Qualified Provider

Provider paid through the Fiscal Intermediary upon receipt of invoice and signed Provider Agreement.

### Qualified Provider Rate for Service

Lowest of three bids. Documentation of bids is required.

Payment based on lowest bid.

### Service Documentation

All vehicle modifications must be documented through the submission of a proposal that includes, (1) the disclosure of the full scope of the project including a budget that identifies the cost for the entire project, (2) the documentation that the project has been competitively bid with the documentation that the bids are from three qualified bidders, that each bidder is currently licensed with the State of Connecticut's Department of Consumer Protection to perform the work, craft, or skill for the portion of the project they are bidding, that the bidders are insured, that the bids are competitive and the bids are comparable. A signed Provider Agreement is required before payment is made.

# HCBS Consolidated Waiver Operations Manual

## 2.15 Specialized Medical Equipment and Supplies

### Definition

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

This service also includes items necessary for life support, ancillary supplies, and equipment necessary to the proper functioning of such items, and durable and non-durable medical equipment not available under the Medicaid State Plan.

### Examples

Generators, adaptive switches or controls, specialized communication devices

### Service Settings

N/A

### General Service Limitations

Items reimbursed with waiver funds shall be in addition to any medical equipment and supplies furnished under the State Plan and shall exclude those items that are not of direct medical or remedial benefit to the individual. Prior approval required for single items that cost more than \$750. This service is not self-directed.

All items shall meet applicable standards of manufacture, design, and installation.

### Service Utilization

\$750/yr., with prior approval \$5,000/five yrs.

### Qualified Provider Direct Service Staff Requirements

N/A

### Unit of Service and Method of Payment Qualified Provider

Item or supply upon receipt of invoice and signed Provider Agreement. Must follow DDS Cost Standards and provide notice of denial from DSS.

### Service Documentation

The Qualified Provider provides an invoice that documents the date the item was provided to the person, a description of the item, and the cost of the item, including charges for delivery, supplies, or medical equipment. A signed Provider Agreement is required before payment is made.

# HCBS Consolidated Waiver Operations Manual

## 2.16 IFS Family Training

### Definition

Training and counseling services for the families of individuals served on this waiver.

### Examples

Training includes instruction about treatment regimens and use of equipment specified in the Individual Plan, and shall include updates as necessary to safely maintain the individual at home.

### Service Settings

For purposes of this service, "family" is defined as the persons who live with or provide care to a person served on the waiver and may include a parent, spouse, children, relatives, foster family, or in-laws. "Family" does not include individuals who are employed to care for the consumer.

All family training must be included in the individual's written Individual Plan.

### General Service Limitations

This service can only be provided by Department of Developmental Services staff. This service may not be self-directed.

### Service Utilization

#### Qualified Providers Direct Service Staff Requirements

#### Unit of Service and Method of Payment Qualified Providers

N/A

#### Qualified Provider Rate for Service

N//A

### Service Documentation

Maintain service documentation for each service event, including a description of activities completed related to outcomes/goals/objectives identified in the Individual Plan. Maintain a record of the dates and times that the service was provided, where it was provided, and the signature of who provided the service. Professional standards apply.

# HCBS Consolidated Waiver Operations Manual

## 2.17 Clinical Behavioral Support Services (formerly Consultant Services)

### Definition

Clinical and therapeutic services which are not covered by the Medicaid State Plan, necessary to improve the individual's independence and inclusion in their community.

Professional clinical services include:

- Assess and evaluate the behavioral and clinical need(s);
- Develop a behavioral support plan that includes intervention techniques as well as teaching strategies for increasing new adaptive positive behaviors, and decreasing challenging behaviors addressing these needs in the individual's natural environments;
- Provide training to the individual's family and the support providers in appropriate implementation of the behavioral support plan and associated documentation; and,
- Evaluate the effectiveness of the behavioral support plan by monitoring the plan on a monthly basis, and by meeting with the team one month after the implementation of the behavior plan, and in future three month intervals. The service will include any changes to the plan when necessary and the professional(s) shall be available to the team for questions and consultation.

The professional(s) shall make recommendations to the Individual Support Team and Case Manager for referrals to community physicians and other clinical professionals that support the recommendations of the assessment findings as appropriate. Use of this service requires the preparation of a formal comprehensive assessment and submission of any restrictive behavioral support program to the DDS Program Review Committee for approval prior to implementation.

This service may self-directed.

### Examples

Professionals in psychology, counseling, behavior management and other related disciplines provide consultation activities. The service may include the development of a home treatment/support plan, training to carry out the plan and monitoring of the individual and the provider in the implementation of the plan.

### Service Settings

This service may only be delivered in the individual's home or in the community as described in the treatment/support plan.

### General Service Limitations

This service may be delivered at the same time as Individualized Home Supports, Personal Support, Adult Companion and Individualized Day Supports

### Service Utilization

Service limited to \$2,500 per year for this service. Prior approval required for additional services in a plan year.

### Qualified Provider Direct Service Staff Requirements

**All qualified providers**--Providers of this service to children must have 3 years of experience in working with children and adolescents with intellectual disabilities.

Psychology	Licensure per CGS Chapter 383
Licensed Clinical Social Workers	Licensure per CGS Chapter 383b
Professional Counselor	Licensure per CGS Chapter 383a or 383c (Marriage and Family Therapist or Professional Counselor)
Behavior Management	Masters degree in psychology, special

## HCBS Consolidated Waiver Operations Manual

education, applied behavior analysis, or other related field and course work in human behavior.  
One year experience working with people with intellectual disabilities.  
Criminal background check if requested by the participant.  
Registry check if requested by the participant.

-or-

Bachelor's degree in psychology, special education or other related field and review and approval by either the Autism Services Clinical Review Panel or the DDS Clinical Review Panel.  
One year experience working with people with intellectual disabilities.

### **Unit of Service and Method of Payment Qualified Provider**

Quarter hour (15-minute) unit. The basis of payment for services is an hourly unit of direct service time. Billing should be rounded to the nearest 15-minute interval.

### **Qualified Provider Rate for Service**

See Rate Table *Self-directed participants may negotiate rate.*

### **Service Documentation**

As individual services are provided in the community, the person's own home, or a family home, the provider documents the delivery of services for each date of service. The documentation includes the date of service, the start time and end time of the service for each date, a signature of the person providing the service, and documentation on the reason for the service, the outcome, and follow up activities. The person receiving the service or their legal representative has the option of signing the provider documentation form. For individuals who hire their own provider directly the employer of record must sign the time sheet to verify the provider worked the hours reported on the time sheet and provided the support noted in the service documentation.

# HCBS Consolidated Waiver Operations Manual

## 2.18 Nutrition (formerly Consultative Services)

### Definition

Clinical assessment and development of special diets, positioning techniques for eating; recommendations for adaptive equipment for eating and counseling for dietary needs related to medical diagnosis for participants and paid support staff.

### Service Settings

This service may only be delivered in the individual's home, or in the community as described in the Individual Plan. This service is limited to 25 hours of service per year.

### Qualified Provider Direct Service Staff and Self-Directed Requirements

Dietitian/Nutrition Licensure per CGS Chapter 384b

### Unit of Service and Method of Payment Qualified Provider

Quarter hour (15-minute) unit. The basis of payment for services is an hourly unit of direct service time. Billing should be rounded to the nearest 15-minute interval.

### Qualified Provider Rate for Service

See Rate Table

### Service Documentation

As individual services are provided in the community, the person's own home, or a family home, the provider documents the delivery of services for each date of service. The documentation includes the date of service, the start time and end time of the service for each date, a signature of the person providing the service, and documentation on the reason for the service, the outcome, and follow up activities. The person receiving the service or their legal representative has the option of signing the provider documentation form. For individuals who hire their own provider directly the employer of record must sign the time sheet to verify the provider worked the hours reported on the time sheet and provided the support noted in the service documentation

# HCBS Consolidated Waiver Operations Manual

## 2.19 Interpreter Services

### Definition

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

### Examples

Interpretation at community activities to access generic services and supports, to receive training, etc.

### Service Settings

This service may only be delivered in the individual's home, or in the community as described in the Individual Plan.

### General Service Limitations

This service cannot be utilized as a substitute for staff who are able to communicate with the individual in his/her primary language in the provision of approved waiver services.

### Qualified Provider Direct Service Staff and Self-Directed Requirements

#### Prior to Employment:

- 18 yrs of age
- Criminal background if required by participant
- Abuse Registry check if required by participant
- Have ability to communicate effectively with the individual/family
- Be proficient in both languages
- Be committed to confidentiality
- Understand cultural nuances and emblems
- Understand the interpreter's role to provide accurate interpretation.

### Sign language interpreter:

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

### Service Utilization

Typical utilization will be to attend meetings, provide orientation to employer responsibilities, etc.

### Unit of Service and Method of Payment Qualified Provider

The basis of payment for services is an hourly unit of direct service time. Billing should be rounded to the nearest 15-minute interval. Provider Agreement required.

### Qualified Provider Rate for Service

See Rate Table *Self-directed participants may negotiate rate.*

### Service Documentation

Maintain service documentation signed and dated by the interpreter providing the service that documents the date of the service; the start time and the end time of the service for each date of service, the purpose of the service and the signature of the person providing the service. The person receiving the service or their legal representative has the option of signing the provider documentation form. For individuals who hire their own interpreter the employer of record must sign the time sheet to verify the employee worked the hours reported on the time sheet and provided the support noted in the service documentation.

# HCBS Consolidated Waiver Operations Manual

## 2.20 Independent Support Broker (formerly FICS)

### Definition

Support and Consultation provided to individuals and/or their families to assist them in directing their own plans of individual support. This service may be self-directed.

### Examples

- Assistance with managing the Individual Budget;
- Support with and training on how to hire, manage and train staff;
- Assistance with negotiating service rates with Provider agencies.
- Accessing community activities and services including helping the individual and family with day-to-day coordination of approved services;
- Developing an emergency back-up plan;
- Self-advocacy training;
- Assistance with developing a circle of support.

### Service Settings

This service may only be delivered in the individual's home, meeting locations or in the community as described in the Individual Plan.

### General Service Limitations

Qualified Provider cannot be a direct provider of services for the individual. This service is limited to those who direct their own supports. Individual support person may participate in emergency back up plan. Cannot be a guardian of the person or an immediate relative (mother, father, sibling).

### Service Utilization

Utilization will vary in intensity depending upon the stage of the implementation of the Individual Plan.

### Provider Requirements

#### Prior to Employment:

- 21 yrs of age
- Criminal background check
- Abuse Registry check
- Demonstrated ability, experience and/or education to assist the individual and/or family in the specific areas of support as described by the circle in the Individual Plan.
- Five years experience in working with people with mental retardation involving participation in an interdisciplinary team process and the development, review and/or implementation of elements in an individual's plan of care.
- One year of the experience must have involved supervision of direct care staff in OR responsibility for developing, implementing and evaluating individualized supports for people with mental retardation in the areas of behavior, education or rehabilitation.

**Substitutions Allowed:** College training in programs related to supporting people with disabilities (social service, education, psychology, rehabilitation, etc.) may be substituted for the experience on the basis of 15 semester hours equaling one-half year of experience to a maximum of four years.

- Demonstrate competence in knowledge of DDS policies and procedures: abuse/neglect; incident reporting; human rights and confidentiality; handling fire and other emergencies, prevention of sexual abuse; knowledge of approved and prohibited physical management techniques;
- Demonstrate understanding of the role of the service, of advocacy, person-centered

## HCBS Consolidated Waiver Operations Manual

- planning, and community services;
- Demonstrate understanding of individual budgets and DDS fiscal management policies.

### **Unit of Service and Method of Payment Qualified Provider**

#### Hourly Fee

The basis of payment for services is an hourly unit of direct service time. Billing should be rounded to the nearest hour.

### **Qualified Provider Rate for Services**

See Rate Table

**Self-directed:** Negotiated Rate. Prior approval must be obtained from the DDS to exceed published waiver rate (Procedure: I.C.2.PR 009). Allowable costs are based on the Department of Developmental Services *Individual Support Cost Standards 7/1/2008*

### **Service Documentation**

As individual services are provided in the community, the person's own home, or a family home, the provider documents the delivery of services. The documentation includes the date of service, the start time and end time for each date of service, a signature of the person providing the service, and a description of the purpose of the service, the activities/tasks, outcomes and follow up tasks with responsible person. The person receiving the service or their legal representative has the option of signing the provider documentation form. For individuals who hire their own Independent Support Broker the employer of record must sign the time sheet to verify the employee worked the hours reported on the time sheet and provided the support noted in the service documentation.

# HCBS Consolidated Waiver Operations Manual

## 2.21 Residential Habilitation Comprehensive Waiver (CLA and CTH) IFS Waiver (CTH only)

### Definition

Assistance with acquisition, retention, or improvement in skills related to activities of daily living, such as personal grooming and cleanliness, bed making and household chores, eating and the preparation of food, and the social and adaptive skills necessary to enable the individual to reside in a non-institutional setting.

### Examples

- Provide instruction and training in one or more need areas to enhance the person's ability to live independently and enhance the individual's ability to access and use the community;
- Implement strategies to address behavioral, medical or other needs identified in the Individual Plan;
- Implement all therapeutic recommendations including speech, O.T., P.T., and assist in following special diets and other therapeutic routines;
- Mobility training;
- Adaptive communication training;
- Provide training or practice in basic consumer skills such as banking;
- Assist the individual with all personal care activities.

### Service Settings

Provision of services is limited to licensed CLA and CTH settings located in Connecticut.

### General Service Limitations

Payments for residential habilitation are not made for room and board, the cost of facility maintenance, upkeep and improvement. This is an all inclusive support model and cannot be used in combination with Personal Support or Adult Companion services.

### Service Utilization

24 Hour Services available.

### Qualified Provider Requirements--CLA

Has an executed DDS standard contract or has been awarded a CLA through the RFP process.

C.G.S. 17a-227 State Administrative Code 17a-227-31 to 17a-227-37.

Public services must follow all DDS policies and procedures.

### Direct Service Staff and CTH Provider Requirements

Standards as described in current contract, DDS Licensing regulations or DDS employee training requirements.

#### Prior to Employment

- 21 yrs of age
- criminal background check
- registry check
- have ability to communicate effectively with the individual/family
- have ability to complete record keeping as required

#### Prior to being alone with the Individual:

- demonstrate competence in knowledge of DDS policies and procedures: abuse/neglect; incident reporting; client rights and confidentiality; handling fire and other emergencies,

## HCBS Consolidated Waiver Operations Manual

- prevention of sexual abuse, knowledge of approved and prohibited physical management techniques
- demonstrate competence/knowledge in topics required to safely support the individual as described in the Individual Plan
  - demonstrate competence, skills, abilities, education and/or experience necessary to achieve the specific training outcomes as described in the Individual Plan
  - ability to participate as a member of the circle if requested by the individual
  - demonstrate understanding of Person Centered Planning
  - demonstrate competence/knowledge in positive behavioral programming, working with individuals who experience moderate to severe psychological and psychiatric behavioral health needs and ability to properly implement behavioral support plans\*
- \*if required by the participant

### **Unit of Service and Method of Payment: Qualified Provider**

Daily Per Diem (CLA)  
Monthly Stipend (CTH)

### **Qualified Provider Rate for Services**

DDS Master Contract. (Private CLA)

### **Service Documentation**

Documentation maintained as directed in CLA and CTH regulations.

# HCBS Consolidated Waiver Operations Manual

## 2.22 Assisted Living--Comprehensive Support Waiver only

### Definition

Personal care and services, homemaker, chore, attendant care, companion services, medication oversight (to the extent permitted under State law), therapeutic social and recreational programming, provided in a home-like environment in a licensed (where applicable) community care facility, in conjunction with residing in the facility. 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 community care facility, but the care provided by these other entities supplements that provided by the community care facility and does not supplant it.

Personalized care is furnished to individuals who reside in their own living units (which may include dually occupied units when both occupants consent to the arrangement) which may or may not include kitchenette and/or 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. (This requirement does not apply where it conflicts with fire code.) Each living unit is separate and distinct from each other. The facility must 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 to facilitate aging in place. Routines of care provision and service delivery must be consumer-driven to the maximum extent possible, and treat each person with dignity and respect.

Assisted living services may also include:

Home health care

Medication administration

Intermittent skilled nursing services

Transportation specified in the plan of care

### Provider Qualifications

ALSA License from the Dept of Public Health Public Health Code 19-13-D105 and Enrolled as a Qualified Provider of Assisted Living with DDS.

#### A. Service Level Packages (Rates: see Rate Table)

##### SP-1 per Diem

Occasional Personal Service - 1 hour per week, up to 3.75 hours per week of personal services plus nursing visits as needed.

##### SP-2 per Diem

Limited Personal Service - 4 hours per week, up to 8.75 hours per week of personal services plus nursing visits as needed

##### SP-3 per Diem

Moderate Personal Service - 9 hours per week, up to 14.75 hours per week of personal services plus nursing visits as needed.

##### SP-4 per Diem

Extensive Personal Services - 15 hours per week, up to 25 hours per week of personal services plus nursing visits as needed.

#### B. Core Assisted Living Services

##### Additional Core Services: per Diem

Additional Basic Core Services e.g. housekeeping, laundry and meal preparation, beyond the level provided by the MRC under its core services will also be allowed.

### Service Documentation

Maintain attendance records and service documentation notes signed by the individual provider if applicable.

# HCBS Consolidated Waiver Operations Manual

## 2.23 Individual Goods and Services

### Definition

Services, equipment or supplies that will provide direct benefit to the individual and support specific outcomes identified in the Individual Plan. The service, equipment or supply must either reduce the reliance of the individual on other paid supports, be directly related to the health and/or safety of the individual in his/her home, be habilitative in nature and contribute to a therapeutic goal, enhance the individual's ability to be integrated into the community, provide resources to expand self-advocacy skills and knowledge, and, the individual has no other funds to purchase the described goods or services.

### Examples

Examples would include cleaning services, specialized clothing for work or safety for the individual, public speaking training, and specialized therapies.

### Service Settings

May be delivered in the individual's home, at work, vocational or retirement location, or in the community.

### Service Utilization

Must be pre-approved by DDS and follow DDS Cost Standards.

### Service/Provider Limitations

Experimental and prohibited treatments are excluded. This service is only available for individuals who self-direct his/her own supports; DDS applies consistent guidelines in respect to the appropriateness of the services or items to be approved in this service definition. This service may not duplicate any Medicaid State Plan service.

### Unit of Service and Method of Payment

All services or items are pre-approved by DDS and follow DDS Cost Standards. Unit may be an item, or hourly, ½ hour, or daily service unit. Costs and rates are negotiable.

### Provider/Service Qualifications

Supplier or Individual selected by participant and approved by DDS including signed Medicaid Provider agreement. Meets any applicable state regulations for the type of supply or service as described in the Individual Plan approved by DDS.

### Service Documentation

Documentation requirements are set at the time of the service authorization.

# HCBS Consolidated Waiver Operations Manual

## 3. Application and Enrollment

Individuals who are receiving or are offered services and supports that are covered under a DDS HCBS waiver agree to participate in the waiver application and enrollment process at the time DDS determines it has the resources and waiver slots available. (see also CGS-17-218(g)). Waiver enrollment enables the State to bill Medicaid and receive federal assistance in funding waiver services, and thereby assists the State of Connecticut in its goal of supporting individuals who are served by the Department of Developmental Services to live safely and successfully in their communities.

Consumers/families/guardians/representatives will be provided with information about the DDS waivers that includes a summary of approved waiver services, the application and enrollment process, and hearing rights for decisions related to waiver(s) at the time of the Individual Planning meeting.

### 3.1 Planning and Resource Allocation Team (PRAT)

Each DDS region has a PRAT responsible for: the prioritization of individuals who seek to make an application to a DDS HCBS waiver; recommendations regarding waiver eligibility and enrollment; service authorization/utilization management functions; and regional management of the number of enrolled participants in each waiver.

#### 3.1.1 PRAT Data Maintenance

Each region, using the department's statewide Planning and Resource Allocation Tracking database, shall maintain data about the individuals who request waiver enrollment or new service requests, their priority and level of need, the estimated cost of the service and the nature of the request (new service or enhancement).

#### 3.1.2 Initial Referral for Services and Support

When the individual, his or her family or planning and support team identifies a need for service(s), the request is submitted to the region's PRAT following the process outlined below.

#### 3.1.3 Request for Services

The individual's case manager submits a request for services consisting of:

1. Request for Services form,
2. Current Level of Need Assessment Summary Report
3. Current Priority checklist, if applicable
4. The person's current approved IP-6, if participant is already receiving services.

The Request for Service packet is reviewed for completeness by the case manager's supervisor, prior to submission to PRAT.

The chairperson or other team members may request additional information or the participation of other parties at the PRAT meeting to assist with decision making or to address areas of concern. PRAT reviews the Priority checklist and Level of Need assessment (LON). The PRAT may question the referral source, typically the case manager, to confirm, clarify, or request additional, information before assigning a priority to the individual.

# HCBS Consolidated Waiver Operations Manual

## 3.1.4 Priority Assignment

PRAT reviews the Priority Checklist in relation to any reports or assessments submitted with the request for services. The Team may question the referral source, typically the Case Manager, to confirm or clarify information before assigning a priority to the individual.

PRAT determines the person's Priority assignment; Emergency, Priority 1, Priority 2, or Priority 3, based on the score obtained on the Priority checklist. The Priority assignment determines whether the individual is assigned to the Waiting List (Emergency or Priority 1) or the Planning List (Priority 2 or 3).

PRAT notifies the Case Manager of the outcome of the Priority assignment within 14 days of receiving a complete Request for Services packet by returning the last page of the Request for Services, completed and signed by the PRAT Manager indicating the results of the determination. The PRAT also sends a letter to the individual and his/her personal representative notifying them of the Priority Assignment. Individuals who do not agree with their Priority Assignment have the right to a DDS Administrative Hearing under CGS Section 17a-210(e). Individuals also have the right to a Programmatic Administrative Review (PAR) on Priority Assignment if desired. If a PAR is requested it does not alter the individual's right to request an Administrative Hearing at any time.

## 3.1.5 Review and Change in Priority Assignment

While the individual is on the Waiting or Planning List, the Case Manager reviews and re-administers the priority checklist on an as needed basis. If there is a change in the individual's urgency for the need for services the Case Manager submits an updated Priority Checklist with supporting documentation to the PRAT for review. At the annual Individual Plan or the Individual Plan—Short Form meeting the case manager will review the Priority Checklist with the individual and family and confirm the person's Priority assignment. The individual and/or his or her representatives will be notified of their right to request an Administrative Hearing and/or a PAR if they do not agree with the Priority Assignment.

When a change in Priority assignment occurs, the PRAT will notify the individual/family in writing of the change and their right to request an Administrative Hearing and/or a PAR if they do not agree with the Priority Assignment. The individual/family's refusal to accept available resources may result in a review and reassessment of the individual's priority status

An individual's name may be removed from a specific list for the following reasons:

1. The individual is placed or receives individual support funding in the amount indicated by their Level of Need assessment;
2. The individual is denied the waiver service by the CO Waiver Policy and Planning Unit and does not request a DSS Hearing
3. The individual, after being denied a waiver service, exercises their rights to a DSS Fair Hearing and the DDS service denial is upheld through that process.
4. The individual/family refuses to apply for enrollment in an HCBS waiver if required to do so.

## HCBS Consolidated Waiver Operations Manual

5. The individual is no longer eligible for services from the department based on CGS 1-1g and receives written notification from DDS.
6. The individual moves out of state and receives written notification of the discontinuation of services from the Case Manager;
7. The individual/family cannot be contacted after repeated attempts and, after the case manager sends a registered letter notifying the individual/family of the department's intent to remove their name from the list.

### 3.1.7 Administrative Review Process and Fair Hearing Rights

If an individual/family does not agree with the priority assignment they have the right to request an Administrative Hearing with DDS per CGS Section 17a-210(e) and/or a Programmatic Administrative Review. The case manager will assist in making this request as needed. A request for a PAR does not in any manner alter or preclude the person's right to request an Administrative Hearing related to a Priority assignment at any time.

### 3.1.8 Assignment of Resources

PRAT reviews the available resources and first considers people on the Emergency list for the assignment of resources taking into account any legislative or department mandates for how those resources are to be used including, but not limited to: Age-outs, OBRA, STS, people on the waiver with unmet health and safety needs.

Those people on the Priority 1 list are considered next taking into account the mandates listed above and:

1. The length of time on the DDS Waiting List, and
2. The age of the primary caregiver.

### 3.1.9 Waiver Slot Authorization

The PRAT maintains data on waiver service requests, manages available resources and awards funded waiver slots to individuals based on:

- a. Any legislatively mandated funding targets, e.g. DDS budget allocation specifies people living at home with elderly caregivers;
- b. The urgency of the individual's need for services as detailed in 3.1.4;
- c. The person's preferences.

If both DDS waivers have available slots at the time of the referral or resource allocation award, the application will be guided by the target criteria in the DDS waivers defined in Section 1 of this Manual. The PRAT notifies the individual/family and the case manager of the availability of a waiver opening and initial resource allocation or referral(s). The case manager notifies the individual/family of the HCBS Waiver enrollment requirements.

Emergency service authorization can occur outside of this process if time sensitive health and safety concerns exist, such as the department is directed to take custody of an individual by a court or the Office of Protection and Advocacy, or the individual has experienced a sudden loss of his/her home. These cases are reviewed at the first PRAT meeting following the authorization of services covered by a waiver.

# HCBS Consolidated Waiver Operations Manual

## 3.2 Resource Allocation, the Level of Need and Service Limits

The DDS HCBS waivers cover a level of services for an individual as determined by an individual's assessed Level of Need. The level of services is governed by the dollar limits approved for the individual's Level of Need.

### 3.2.1 Level of Need

An individual's Level of Need is determined based on the results of a completed Connecticut DDS Level of Need Assessment and Screening Tool (LON) and any other information provided by the support team including the individual and his or her representatives. The Level Of Need assessment is then correlated to an amount of funding.

### 3.2.2 Service Limits

The DDS waivers further set upper limits for the level of services covered as expressed through a dollar limit.

The IFS Waiver prescribes three broad categories of support services: Home and Community Supports, Day and Vocational Supports, and Ancillary Supports. Each category separately specifies the total amount of available services within each package based first on the individual's assessed level of need and may not exceed those amounts unless the CT Department of Developmental Services approves an exception to the service limit. The specific dollar limits and services for each support category are found in Section 4 of the Manual. The IFS Waiver in total is approved to cover annualized service needs for each individual up to a maximum of \$58,000 per year, as determined by the assessed Level of Need, and adjusted thereafter for any additional legislatively approved increases/decreases. Service costs that may be incurred on a one time basis such as Home and Vehicle Modifications, may be approved in any plan year beyond the annualized service limit per the service definition limits as described in Section 2 of the Manual.

The Comprehensive Supports Waiver prescribes two broad categories of annualized support services: Residential/Home and Community Supports, and Day and Vocational Supports. Home and Vehicle modifications are included as an Other category with distinct service limitations as described in the Service Definitions in Section 2 of this Manual. The Comprehensive Waiver also sets funding limits based on the results of an individual's Level of Need (underline added) Assessment, with specific upper limits set by Level of Need for **each support category. The specific dollar limits and services designated for each support category by Level of Need are found in Section 4 of this Manual.** The funding range limits apply to each participant on an annualized basis, unless the CT DDS approves an exception to this limit through Utilization Review. Criteria for Utilization Review approval as prescribed in the waiver application are also found in Section 3.4 of this Manual.

## 3.3 Waiver Application

Following the award of funding for waiver enrollment by the PRAT, the DDS case manager coordinates the completion of the waiver Application with the individual/personal

## HCBS Consolidated Waiver Operations Manual

representative. See sub-section 3.3.3 for information regarding the submission of a waiver application if the individual has completed the initial Request for Services process described in sub-section 3.1.3, but has not been awarded a funded waiver opening by the PRAT.

### 3.3.1 ICF/MR Level of Care Determination

Individuals who seek to enroll in a DDS Waiver must meet the ICF/MR level of care determination. In Connecticut, that determination is based on the following:

1. The individual has mental retardation or a related condition,
  - a. Mental Retardation as defined in Connecticut General Statute 1-1g, or otherwise eligible for services from CT DDS under state law, Con Gen Stat Sec 17a-210. Also included are those determined eligible for DDS services as a result of a hearing conducted by DDS according to the Uniform Administrative Procedures Act or administrative determination of the Commissioner
  - b. Related condition - limited to persons who currently reside in general nursing facilities, but who have been shown, as a result of the Pre-Admission Screening and Annual Resident Review process mandated by P.L. 100-203 to require active treatment at the level of care of an ICF/MR. Also included are young children between age three and seven years of age; and
2. There is a reasonable indication that the person, but for the provision of waiver services coupled with other available supports, would need services in an ICF/MR, as evidenced by one or more of the following:
  - a. The services/support provided and sought (including waiver, state-funded, generic/community, natural and family supports) is critical to maintaining the individual in his or her current living situation;
  - b. Without such services/support, the individual would require the level of care provided in an ICF/MR institutional setting;
  - c. In the absence of such services/support, the individual would present an immediate need for an ICF/MR institutional placement; OR,
  - d. There are other compelling indications of an immediate risk of institutional placement.

This determination is documented on **DDS Form # 219, HCBS ICF/MR Level of Care Form**, and submitted to the regional Planning and Resource Allocation Team (PRAT).

### 3.3.2 Waiver Application Packet

Since waiver services are provided under a Medicaid program, the individual must be a current Medicaid beneficiary (have Title 19) or be willing to apply for Medicaid and agree to continue to maintain eligibility. Under the DDS waivers, persons not otherwise eligible for Medicaid may qualify for Medicaid so long as their income is less than three times the monthly Federal Benefit Rate (SSI). In addition, family income is not taken into account when determining Medicaid eligibility under a DDS waiver. Individuals who are employed and eligible for Medicaid through the Medicaid for the Working Disabled, or SO5, program will also be eligible for enrollment in a DDS waiver.

## HCBS Consolidated Waiver Operations Manual

The case manager coordinates the Individual Plan process and completes the waiver application and enrollment packet with the individual, family or personal representative.

The packet contains:

- a. **DDS 219**, Level of Care Form, initially completed.
- b. Medicaid (Title 19) Application, if needed.
- c. **DDS 222**, Service Selection, which documents that the individual was informed of the feasible alternatives for available services and chose home and community-based services.
- d. **Automated IP 6** proposed Individual Budget or the IP.6, Summary of Supports and Services and **DDS 223**, Notification of Waiver Services, that lists the individual's waiver services at enrollment.
- e. **DSS W-1518 (Rev. 2/05)**, HCBS Referral to Regional DSS Office, which summarizes information required by the Department of Social Services in order to enroll the individual in the DDS IFS or Comprehensive Waiver.
- f. **DDS 225**, PRAT HCBS Waiver Recommendation

The Case Manager must submit this packet along with the completed Individual Plan to the case management supervisor for quality review. If the cost of the service plan is within the original resource allocation, the Individual Plan is approved, service authorizations are processed and the waiver application is forwarded to PRAT. The PRAT reviews the waiver packet and records the recommendation (approve or deny) for enrollment in either the IFS or Comprehensive waiver based on the outcome of the planning and budgeting process. This recommendation is recorded on the **DDS 225**, PRAT HCBS Waiver Recommendation and is sent to the DDS Central Office Medicaid Operations Unit with the entire waiver packet.

When the Individual Plan and budget exceed the allocated budget limit from PRAT or previously authorized Individual Budget, the Case Manager will submit a request for additional resources to PRAT.

### 3.3.3 Waiver Application Without Prior Award of Funding

Individuals who seek to apply to a DDS waiver without the advance award by the PRAT of a funded waiver opening, may do so by submitting through the case manager an ICF/MR Level of Care Determination on DDS Form 219 and a DDS Form 222, Service Selection, which documents that the individual was informed of the feasible alternatives for available services and chose Home and Community-Based Services. Those forms are submitted to the PRAT. The PRAT reviews the waiver application and records the enrollment recommendation (approve or deny) for enrollment in either the IFS or Comprehensive waiver by following the Priority Assignment process. This recommendation is recorded on the **DDS 225**, PRAT HCBS Waiver Recommendation and is sent to the DDS Central Office Medicaid Operations Unit within 10 business days of receipt of the packet

### 3.3.4 Waiver Enrollment Eligibility Decision

The CO Medicaid Operations Unit records the receipt of the application, reviews the contents of the packet and issues the final decision on enrollment. The approval or denial and due process notice is then sent to the individual/legal

## HCBS Consolidated Waiver Operations Manual

representative by return receipt with a copy forwarded to the case manager within 10 business days of receipt of the application.

A person may be denied enrollment in a DDS waiver based on any one of the following circumstances:

- ❑ the individual is determined by DSS to be ineligible for Medicaid;
- ❑ the individual fails to complete the Medicaid application process for eligibility;
- ❑ the *proposed* initial Individual Plan and Budget exceeds the allowable service/dollar limits prescribed in the waiver and is subsequently not approved through the Utilization Review process;
- ❑ or, the individual is determined by the PRAT to not be eligible for a waiver slot based on the established priority of need system. (DDS Administrative Hearing and/or PAR rights apply)

If services have been denied in whole or part, the decision will include the DSS Fair Hearing Rights Request for an Appeal.

### 3.3.5 Changes in Individual Plan

Any changes in waiver services at the time of the annual review, or at any time during the year, will be reported to the Medicaid Operations Unit by the case manager on the automated **IP 6** or **Form 223 Notification of Waiver Services** and updated in CAMRIS by the end of the month in which the change occurs..

### 3.3.6 Discharge from DDS Waiver Due to Entering a Long Term Care Facility or Rehabilitation/Mental Health Facility

When entry into a Long Term Care(LTC), Rehabilitation or Mental Health facility is likely because the current provider is unable to continue services based on medical support needs of the individual, the individual and/or his or her representatives have the option of exercising portability of funds if they do not wish to lose home and community based waiver supports and services. This allows them to secure waiver services from another provider or to hire staff directly. Their case manager will provide them information regarding portability.

When the individual who is on a DDS home and community based waiver enters a LTC, Rehabilitation or mental health facility for a short period of time (usually for rehabilitation) and is expected to return to the community within 90 days the Case Manager notifies the DDS Medicaid Operations Unit. After 90 days the individual will be discharged from the waiver. In some cases it is medically necessary for the individual to stay in the facility for longer than 90 days for rehabilitation. In these cases an additional 30 days will be granted if a written statement from a physician reports that the person will be able to leave the facility within the 30 additional days. This letter must be received by the DDS Medicaid Operations Unit prior to the expiration of the initial 90 day period. When the need for a facility is projected to be short term, the person's residential and other services will be held for them until a decision is made by the support team that the need is permanent.

Admission to a LTC, Rehabilitation or mental health facility beyond short-term rehabilitation or stabilization will result in discharge from the DDS home and community based waiver.

## HCBS Consolidated Waiver Operations Manual

Individuals discharged from the waiver may re-apply when the individual is ready to return to the community again and is eligible for the waiver. When the person has stayed in the facility for over 120 days and is ready to move out consideration will be given to prior waiver status and the Omnibus Budget Reconciliation Act (OBRA) requirement to move the person to an appropriate setting.

*Note: For people with mental retardation admitted on a permanent basis to a nursing facility, Federal Regulation (42CFR 483.116(b)(2)) requires that the State must provide or arrange for provision of the specialized services needed by the individual while he or she resides in the nursing facility. This usually takes the form of an appropriate day program.*

### 3.3.7 Refusal or Inability to Enroll in a DDS HCBS Waiver

When individuals are seeking either new or additional supports but are not eligible for Medicaid due to excess income and/or assets, or the individual / legal representative declines to apply for Medicaid and/or complete the enrollment process for a DDS HCBS waiver, the DDS case manager must complete DDS Form 224, Reasons for Declining to Submit Medicaid and/or DDS HCBS Waiver Applications, and return to the PRAT for submission to the CO Medicaid Operations Unit.

The PRAT will suspend consideration for services/supports for the individual until notified by the CO Waiver Operations Unit of a final determination of eligibility for DDS funded services/supports. The CO Medicaid Operations Unit will make a formal written request to the individual, guardian, and legal/personal representative to explain the basis for refusal and review documentation in support of the refusal.

After review the Medicaid Operations Unit will issue their findings and notify the individual, guardian, and legal/personal representative. Individuals and families who are seeking new supports will be advised of their right to a Programmatic Administrative Review at the Regional Level if they do not agree with the findings.

### 3.3.8 Annual Re-determinations

All individuals who are enrolled in a DDS waiver must be reviewed annually for re-determination of continued eligibility for waiver status at the time of their individual plan review by the case manager. Annual re-determination is recorded in the Individual Plan, IP.10 or Form 219 ICF/MR Level of Care and kept in the individual's file.

## 3.4 Utilization Review

Individual Plans and budgets that exceed the resources allocated to the individual by PRAT or Individual Budget limits based on the Level of Need Assessment and additional information as presented by the support team proceed through utilization review (UR). Each waiver specifies circumstances where services can exceed established Level of Need limits.

# HCBS Consolidated Waiver Operations Manual

## 3.4.1 IFS Waiver

PRAT Utilization Review may approve service packages up to \$30,000 in Day and Vocational Services. The Regional Director can approve Day and Vocational service packages in excess of \$30,000 and up to \$32,000 in Home and Community Services, when considered separately. Such approvals are made based on the existence of health and safety needs that could not be addressed within the original Level of Need allocation for that individual. The total annualized cost of the individual's services and supports may not exceed the current IFS Waiver covered services limit described in Section 4.9.1.

## 3.4.2 Comprehensive Supports Waiver

Utilization Review is required for any service package that exceeds the initial allocation range or Individual Budget limit as determined by the Level of Need assessment. PRAT Utilization Review may approve up to the established limits found in Section 4.9.1 for each Level of Need in total. Such approvals are made based on the existence of health and safety needs that could not be addressed within the original Level of Need allocation for that individual.

Regional Director review and approval is required for any service package that exceeds the identified total limits for each Level of Need range.

## 3.4.3 Review Process and Timelines

Individual Plans and budgets are reviewed to evaluate the amount, type, frequency, and intensity of services directly related to health and safety needs of the individual, and desired outcomes based on the individual's preferences and needs as described below:

- a) Requests for resource allocations exceeding original range or Individual Budget limit by the Regional PRAT are made to the PRAT. PRAT has up to 10 business days to issue a decision on the request.
- b) The Regional Director, or designee, is required to review and approve PRAT decisions that exceed PRAT approval limits and will do so within 5 business days.
- c) Regional Directors, or designee, may provide immediate temporary approval for requests to address immediate threats to the individual's health and/or safety.
- d) The PRAT notifies the case manager of the UR decision within 10-12 business days of the submission.
- e) The case manager will contact the individual or personal representative by phone to inform them of the decision within 2 business days. If the request has been denied by UR, the individual or personal representative will be offered the following options:
  - o revise the service plan to fall within the original resource allocation;
  - o request an informal negotiation with DDS to determine if a compromise can be reached; or,
  - o request that the decision be forwarded to the Central Office Waiver Policy Unit for formal action and Medicaid Fair Hearing rights if the UR denial is upheld.

## HCBS Consolidated Waiver Operations Manual

- f) The telephone contact and outcome of the discussion will be documented in the case manager's running case notes in the individual's master record. If the individual requests an opportunity to further discuss and negotiate the region's decision, the case manager will notify his/her supervisor and the region will designate an administrator from a different regional Division to meet with the individual and family or other support persons within 10 working days. The outcome of this meeting will either be an agreement on a service package, or continued disagreement and submission of the proposed plan to the DDS CO Waiver Policy Unit for a final determination. The outcome of the meeting will be documented by the regional administrator in a letter to the individual and family immediately following the meeting, with a copy to the case manager and the PRAT.
- g) If the individual and personal representative request that the decision be reviewed by the Central Office Waiver Policy Unit, the complete packet will be forwarded to the Unit within 1 day of that decision by the PRAT.

Individuals who are seeking enrollment in a DDS HCBS waiver whose service package exceeds the prescribed allocation range or Individual Budget limits may not initiate services until the application has been accepted and approved through either Utilization Review, the negotiation process, or through the results of a DSS Fair Hearing Appeal Process.

Requests for additional services later in a plan year that exceed the previously approved Individual Plan and Budget are submitted to the Regional PRAT following a review of an individual's plan, and are subject to the same approval and/or Utilization Review process and criteria as described in this sub-section.

### 3.5 DSS Appeals

If an individual is denied access to a preferred waiver program (DDS's IFS or Comprehensive waiver), a notice of denial and fair hearing rights will be provided to the applicant by the CO Medicaid Operation Unit. If an individual is denied requested services as a result of a Level of Need Determination, a notice of denial and fair hearing rights will be provided to the applicant by the CO Waiver Policy Unit.

All determinations by the Medicaid Operations Unit to deny waiver eligibility or the Waiver Policy Unit to deny a request for new or additional waiver services are subject to a request for a hearing before the Department of Social Services in accordance with the Uniform Administrative Procedures Act. The DDS Division of Legal and Governmental Affairs will coordinate the hearing process and assist with the presentation of the department's position at such hearings. See Section 10 of this manual.

If an applicant/waiver participant prevails at the DSS hearing, the DDS regional office will be notified and DDS shall implement the hearing decision as soon as possible thereafter.

# HCBS Consolidated Waiver Operations Manual

## 3.6 Change in Eligibility and Subsequent Discharge from a HCBS Waiver

### 3.6.1 Notification Process

DDS is notified of any change in the individual's status that may affect waiver eligibility through the following actions:

- ❑ Case Managers must notify the Central Office Medicaid Operations unit when an individual loses Medicaid eligibility, leaves DDS services, no longer meets the level of care requirements or chooses to be removed from the HCBS waiver.
- ❑ The Medicaid Operations unit may identify individuals who are no longer eligible for one of the HCBS Waivers through record reviews.
- ❑ DSS may notify the Medicaid Operations unit that a person is no longer eligible for Medicaid.
- ❑ Department of Administrative Services (DAS) may notify the Medicaid Operations unit that an individual has lost their Medicaid eligibility. This is usually detected through rejected Medicaid billing.

### 3.6.2 Removal from Waiver for Lack of Level of Care

If the DDS region determines that a person no longer meets the level of care requirements for an ICF/MR the case manager notifies the Central Office Medicaid Operations unit that the person should be removed from the waiver. Individuals with a composite score of 0 on the DDS Level of Need Assessment and Screening Tool will not be enrolled in the DDS waivers. Notification is made on a DSS form W-1576 countersigned by the PRAT manager to indicate that PRAT has been notified of the issue.

If the Medicaid Operations unit discovers through a review of service utilization that no level of care determination for ICF/MR, or IP.10 HCBS Redetermination form has been completed for on an individual they notify the Case Manager and the region's PRAT manager. The region is given 30 days to review the issue, correct the issue and notify the Medicaid Operations in writing. If it is determined that the individual does not meet the ICF/MR Level of Care the Case Manager sends a DSS form W-1576 to the Medicaid Operations unit to remove the person from the waiver. The Medicaid Operations unit completes a DSS form W-1576 and processes it as specified below in section 3.6.5.

### 3.6.3 Removal from Waiver for Leaving Target Group

If the DDS Region determines that the person is no longer in the waiver target group, the case manager notifies the Central Office Medicaid Operations unit to remove the person from the waiver. Notification is made on a DSS form W-1576 and countersigned by the PRAT manager to indicate that PRAT has been notified of the information. This most often happens when a child is assessed and found not to have mental retardation or when an individual leaves the state.

The Medicaid Operations unit may determine through a search of the DDS client database that a person is no longer an active DDS consumer. The Medicaid Operations unit completes a DSS form W-1576 and processes it as specified below in section 3.6.5.

## HCBS Consolidated Waiver Operations Manual

### 3.6.4 Removal from the Waiver for Failure to Maintain Medicaid Eligibility

Medicaid recipients are responsible for maintaining Medicaid eligibility and may be assisted by family, friends, service providers or case managers. The most common causes of loss of Medicaid eligibility are failure to complete an annual Medicaid re-determination form, or possessing assets that exceed the Medicaid limit.

The Medicaid Operations unit can be notified of loss of Medicaid eligibility by the region, DAS, DSS, or through a records review by staff in the unit. If the individual is no longer eligible for Medicaid and has not been eligible for more than 60 days the person will be removed from the waiver immediately. If the person has not been eligible for Medicaid for less than 60 days and it appears that Medicaid can be re-instated within 30 days the individual will not be removed from the waiver until a final determination of Medicaid eligibility has been made.

Individuals who have been discharged from the waiver can re-apply once their Medicaid eligibility has been restored.

### 3.6.5 Medicaid Operations Unit Removal Process

When a DSS form W-1576 is processed by the Medicaid Operations unit copies of the completed form are sent to DSS, DAS, the individual's case manager, and the region's PRAT manager. A letter notifying the individual that he/she is being removed from the waiver is sent by the Medicaid Operations unit with copies to:

- ❑ The primary responsible person listed in the DDS client database (eCAMRIS)
- ❑ The Case Manager for inclusion is the individual's master file

This letter will include the individual's right to appeal to DSS for an Administrative Hearing and a form to request the appeal within 60 days of the decision by the DDS Medicaid Operations unit. The individual's waiver services at the time of the DDS decision will be unchanged until:

- a) 60 days has passed with no request for a hearing, When no appeal is requested within 60 days the DDS Medicaid Operations unit will advise the individual and the region to implement the Central Office determination. The Medicaid Operations unit will properly annotate computer records and CAMRIS.  
-or-
- b) the DSS Hearing decision has been issued and the individual has been advised of the outcome and the impact on their current situation. The Medicaid Waiver Operations unit and the DDS Region will take whatever action is indicated in the hearing officer's decision.

## 3.7 Regional Audit

Each region will conduct an internal audit at least annually. The audit addresses areas such as consistency in prioritization and resource allocation as well as the removal of individuals no longer interested in obtaining services and supports from DDS from the list.

# HCBS Consolidated Waiver Operations Manual

## 4. Individual Planning

The individual planning process results in the development of a comprehensive Individual Plan, which is the document to guide all supports and services provided to the individual. Individual planning, a form of person-centered planning, is a way to discover the kind of life a person desires, map out a plan for how it may be achieved, and ensure access to needed supports and services. Individual planning is an approach to planning driven by a respect for the individual, a belief in the capacities and gifts of all people, and the conviction that everyone deserves the right to create their own future.

Individual planning supports people to achieve the outcomes of the mission of the Department of Developmental Services, which states that all people should have opportunities to experience:

- Presence and participation in Connecticut town life.
- Opportunities to develop and exercise competence.
- Opportunities to make choices in the pursuit of a personal future.
- Good relationships with family members and friends.
- Respect and dignity

The individual planning process promotes and encourages the person and those people who know and care for him or her to take the lead in directing this process and in planning, choosing, and evaluating supports and services. Individual planning puts the person at the “center” of the plan. Individual planning offers people the opportunities to lead self-determined lifestyles and exercise greater control in their lives.

With individual planning, the person is viewed holistically to develop a plan of supports and services that is meaningful to him or her. Services and supports are identified to meet the person’s unique desires and needs, regardless of funding source and may include state plan services, generic resources, and natural support networks.

Individuals meeting the eligibility requirements for a DDS HCBS waiver must initiate a HCBS waiver application at the time of the new resource allocation or requested service notice. To access waiver services, a current Individual Plan, and accompanying Individual Budget, if applicable, must be developed or updated to identify specific needs, preferences and individual outcomes that will be addressed by waiver services. The DDS Individual Plan serves as the Medicaid Plan of Care that supports and prescribes the need for the specific type(s), frequency, amount and/or duration of waiver services. Without a complete plan as described below, Medicaid waiver services cannot be authorized.

### 4.1 Individual Planning Process

Following are the major steps of the Individual Planning process:

#### 4.1.1 Identify Participants in the Person-Centered Planning Process

The individual and his or her family members should be comfortable with the people who help to develop the Individual Plan and should consider inviting a balance of people who can contribute to planning, including friends, family, support providers, professional staff. The individual should be supported to include people in the planning and support team who:

- Care about the individual and see him or her in a positive light.
- Recognize the individual’s strengths and take the time to listen to him or her
- Can make a commitment of time and energy to help the individual to develop, carry out, review and update the plan.

## HCBS Consolidated Waiver Operations Manual

- At the very minimum, all planning and support teams shall include the individual who is receiving supports, his or her guardian if applicable, his or her case manager, and persons whom the individual requests to be involved in the individual planning process. Planning and support teams for individuals who receive residential, employment, or day support should include support staff chosen by the individual and who know the person best. Depending upon the individual's specific needs, health providers, allied health providers, and professionals who provide supports and services to the individual should be involved in the individual planning process and may be in attendance at the individual planning meeting. Individuals who are interested in self-directing their supports should be made aware of the opportunity to hire an independent support broker. If selected, the independent support broker would become a member of the person's planning and support team.

### 4.1.2 Scheduling the planning meeting

Every effort will be made to schedule the planning meeting at times and locations that will facilitate participation by the individual and his or her family, guardian, advocate or other legal representative as applicable. The case manager will ensure that the individual and/or the person's family are contacted to schedule a meeting at their convenience.

If the person, family, or guardian refuses to participate in the Individual Plan meeting, the case manager should document his or her attempt(s) to invite participation and the responses to those attempts in the individual record and in the Individual Plan, Section 5 - Summary of Representation, Participation, and Plan Monitoring. In these situations, the case manager should pursue other ways to involve the individual, family, or guardian in the planning process outside of the meeting.

### 4.1.3 Support the Individual to Prepare for the Planning Meeting

The case manager should develop strategies to assist the person and his or her family to be actively involved in the planning process. The case manager and other team members assemble as much information as possible before the meeting to assist the individual and his or her family to prepare for the meeting. This helps the meeting to be shorter, more focused on decision making, and more efficient. Before the meeting, the case manager or another team member may assist the individual and his or her family to begin to update the Information Profile and develop the Personal Profile and Future Vision. The case manager may provide a copy of "My Health and Safety Screening" to the individual or his or her family so they may identify health and safety concerns they want to be sure are addressed in the plan. The case manager should complete the Level of Need Assessment and Screening Tool (LON) with information from the individual, the family, providers and/or the master file prior to the planning meeting.

Providers of supports and services should share current assessments, reports and evaluations with the case manager at least 14 days prior to the scheduled meeting. The case manager should share the LON and LON Summary Report with team members prior to the planning meeting. It is helpful before the meeting to ensure that the person and his or her family has a chance to review the information in current Assessments, Reports, and Evaluations that will be discussed at the meeting. Supporting the individual to prepare for the meeting

## HCBS Consolidated Waiver Operations Manual

offers an opportunity to express his or her desires or concerns to the case manager or another team member with whom he or she is comfortable and who can assist the individual to share these issues with the larger group.

There may be circumstances when the individual does not want to discuss something in a meeting. This preference should be respected when possible, however, personal information that affects supports or impacts the individual's health or safety should be addressed. In these circumstances, the topic should be acknowledged and dealt with respectfully and privately outside of the meeting with the person and with others who need to know this information to provide appropriate supports.

### **4.1.4 Level of Need Assessment and Screening Tool**

The Level of Need Assessment and Screening Tool (LON) should be completed prior to the meeting. The LON should be updated annually or more often as needed to identify and document changes in the individual's needs or concerns or issues that may pose a health and safety risk to the individual. The case manager should ensure the LON Summary Report is reviewed at the Individual Plan meeting.

An optional format, My Health and Safety Screening is a screening tool designed to help individuals and their families identify risk issues of concern to them prior to the individual plan being developed. If available, this information should be incorporated in the individual plan developed by the planning and support team.

### **4.1.5 Gather a good understanding of the individual.**

During the planning meeting, the individual and his or her planning and support team completes a profile or assessment of the person's current life situation and future vision. The team completes an analysis of the person's preferences, desired outcomes, and support needs. They also review the information profile, personal profile, future vision, current assessments, reports, and evaluations, including the health and safety screening, to identify what is important to include in the plan and identify any additional assessments needed. The sections of the plan completed or reviewed during this stage of plan development include the:

- Information Profile
- Personal Profile
- Future Vision
- Level of Need Assessment and Screening Tool Review
- LON Summary Report Review
- Assessment Review
- Assessments, Screenings, Evaluations, and Reports form.

#### **4.1.5.1 Information Profile—IP.1**

The Information Profile, IP.1, is a form to update and document basic demographic information about the individual. After the meeting, any updated information should be entered into the department's automated data system, CAMRIS.

#### **4.1.5.2 Personal Profile—IP.2**

## HCBS Consolidated Waiver Operations Manual

The Personal Profile, IP.2, describes information that members of the planning and support team and other support providers need to know in order to assist the individual to achieve what is important to him or her and to stay healthy and safe. The Personal Profile includes information about the individual's significant life history; accomplishments and strengths; relationships; home life; work, day, retirement, or school situation; leisure and community life; health and wellness; and finances. The Level of Need Assessment and Screening Tool and all other relevant assessments are completed prior to the meeting and the information is available during the planning process.

### **4.1.5.3 Future Vision—IP.3**

Within the Future Vision section of the Individual Plan, IP.3, the individual and his or her planning and support team describe his or her hopes and dreams for one to three years into the future and for the coming year.

### **4.1.5.4 Assessments, Screenings, Evaluations, and Reports—IP.4**

The Assessments, Screenings, Evaluations, and Reports section of the Individual Plan, IP.4, lists the current assessments, screenings, evaluations, and reports that are available or needed by the individual. Any assessments or reviews identified as needed must be referenced in IP.5—the Action Plan and should be done within three months. However, any issue or concern that poses an immediate risk must be addressed immediately. Once the assessments and reviews are completed, all recommended supports or procedures identified must also be referenced in the action plan. The action plan may reference documents such as specific service plans, health care plans, guidelines, procedures, or protocols that describe the detailed supports to be provided. The planning and support team is responsible to ensure that recommended supports and procedures are in place, required staff training is completed and documented, and ongoing supervision provided.

### **4.1.6 Develop an action plan to achieve desired outcomes.**

The action plan should include desired outcomes, needs or issues addressed, actions and steps, responsible person(s), and by when and should consider the individual's choices and preferences. The section of the plan completed during this stage of plan development includes the:

- **Action Plan—IP.5**

The Issues or Needs Addressed section of the Action Plan, IP.5, describes the current status of the area(s) the person wants to improve or change, or why it is important to work towards the desired outcome. The Desired Outcome section describes the outcome the person hopes to accomplish as a result of the actions and supports and services to be provided. The Action and Steps section should be specific and should indicate all actions to be taken to address the need or should reference a teaching strategy, specific service plan, guideline, procedure, protocol, health care plan, behavior plan, or other document that contains the step by step actions to take. The Individual Plan should address each identified risk area that was identified by the LON. If new action is required then the Action Plan must include services or supports that are needed to address an identified risk.

# HCBS Consolidated Waiver Operations Manual

## 4.1.7 Summarize the plan of supports and services.

Once the individual and team have completed the action plan, they identify the type of services and supports that will address the Action Plan. Specific agencies and/or individuals who will provide service or support are further identified. The need for a waiver service that addresses specific outcomes included in the Action Plan must be clearly identified and supported by the Individual Plan. The case manager ensures that the individual and his or her family or guardian have sufficient information available to make informed selections of support providers, and information to make informed decisions regarding the degree to which the individual and his or her family or guardian may wish to self-direct services and supports. The section of the plan completed during this stage of plan development includes the:

- **Summary of Supports and Services—IP.6**

The Summary of Supports and Services, IP.6, identifies the individual's support providers. The information documented in the plan should include the agency or individual who will provide support, the type of service or support, and the amount of service or support. Included in this information is the type and frequency of contact the case manager will have with the person. For individuals with individual budgets this section of the plan is completed in the automated IP.6 database.

## 4.1.8 Identify how progress on the individual's plan will be monitored.

During the planning meeting, the individual and planning and support team discuss plans to monitor progress and to evaluate whether the supports are helping the person to reach desired outcomes. At a minimum, the case manager initiates a contact quarterly to evaluate the implementation or satisfaction with the plan. An Individual Plan is reviewed and updated at least annually and may be reviewed sooner if the individual experiences a life change, identifies a need to change supports, or requests a review. The section of the plan completed during this stage of plan development includes the:

- **Summary of Monitoring and Evaluation of the Plan—IP.9**

The Summary of Representation, Participation & Plan Monitoring, IP.9 summarizes four areas: the person's understanding and capacity to make important decisions/choices, accept assistance from others, and possible need for guardian/advocate/legal or personal representative; the team's efforts to involve the person in planning, the person's actual participation in the planning process, and planned efforts to enhance the person's future participation in planning; the team's efforts to involve the person's family/guardian/advocate/legal or personal representative in the planning process; and the team's plans to ensure that the Individual Plan will be implemented and that progress is made toward achieving desired outcomes.

## 4.1.9 Staff Qualifications

Each waiver service specifies the experience, background and training requirements for the agency and/or individual providing the support. Services delivered in licensed settings and in facility day programs are governed by regulation and contract requirements. In addition, the planning and support team should designate specific training, experience or background for the provider

## HCBS Consolidated Waiver Operations Manual

staff based on the specific needs of the individual. Specific training and/or experience and the timeframe for completion of any training is recorded on the:

- **Provider Qualifications and Training Form—IP.7**

The Provider Qualifications and Training Form – IP.7 is to be used for individuals enrolled in a DDS HCBS waiver who require specially qualified or trained support staff. Each waiver service identifies standard qualifications that employee(s) who provide the service must meet. During the planning meeting, the Planning and Support team may identify additional or specific qualifications (expertise, competence, and or training) that staff should possess to effectively support the individual to achieve personal outcomes and maintain a healthy and safe lifestyle. The additional qualifications or training requirements should be documented on this form.

### 4.1.10 Emergency Back up

If the individual is receiving waiver services in their own or family home or other settings where staff might not be continuously available, the individual plan must include a backup plan to address contingencies such as emergencies, including the failure of an employee to appear when scheduled to provide necessary services. The section of the plan completed during this stage of plan development includes the:

- **Emergency Back Up Support Plan—IP.8**

The Emergency Back Up Support Plan – IP.8 is to be completed for individuals on the waivers who live in their own or family homes and who receive personal care and/or supervision supports that must be available as described in the Individual Plan or it would lead to an immediate risk to the individual's health and/or safety. The form documents specific protocols to follow in the event that these needed supports are not available.

### 4.1.11 HCBS Re-Determination

On an annual basis, during the Individual Planning process, the case manager and the planning and support team complete an HCBS Level of Care Re-determination for continued waiver eligibility. The section of the plan completed during this stage of plan development is the:

- **HCBS Re-Determination form—IP.10**

At the time of the Individual Planning meeting the planning and support team should also complete the IP.10 HCBS Re-determination form to indicate whether there is a reasonable indication that the person, but for the provision of waiver services would need services in an ICF/MR.

### 4.1.12 Aquatic Activity Screening

The Planning and Support Team completes the Aquatic Activity Screening form, as an addendum to the plan, annually at the time of the Individual Plan meeting. The purpose of the Aquatic Activity Screening form is to have accurate information about an individual's abilities and safety needs around water activities. The section of the plan completed during this stage of plan development is the:

# HCBS Consolidated Waiver Operations Manual

## IP Addendum: Aquatic Activity Screening

The purpose of the Aquatic Activity Screening form is to have accurate information about an individual's abilities and safety needs around water activities.

### 4.1.13 Agreement with the Individual Plan.

Once the plan is completed and the individual and planning and support team agrees with the plan, the case manager should ensure the plan is documented on the appropriate forms. Those who participated in the planning process are listed on the Signature Sheet and those who attended the meeting check that they were present at the team meeting.

- **Individual Plan Signature Sheet—IP.11**

The case manager obtains the signatures of those who participated in planning on the Individual Plan Signature Sheet, IP.11. The plan should be distributed to the individual, parent, guardian or advocate and other team members within 30 days of the plan meeting. The individual, parent, guardian or advocate, should contact the case manager within two weeks of receipt of the written plan if they do not agree with the plan as written.

### 4.1.14 Put the plan into action.

Every effort should be made to arrange for needed supports and to implement the plan as soon as possible after the final approval is obtained as outlined in Sections 4.7 through 4.10. Supports and services are expected to be implemented within 60 days of plan approval, or within 30 days in licensed settings, and should be provided as described in the Individual Plan.

## 4.2 Monitor and revise the Individual Plan as needed.

The team shall review all areas of the individual plan when there are any changes in the individual's life situation and at least annually, or more frequently as required by state or federal regulations.

### 4.2.1 Monitoring Plan Implementation

The case manager has responsibility to ensure approved waiver services are delivered according to the Individual Plan, and to routinely review and monitor all aspects of service delivery. Case managers should engage in activities to evaluate whether supports and services are meeting the desired outcomes for the individual and should work with the individual and his or her family or legal representative to make adaptations to plans and service arrangements as needed.

The case manager should monitor progress on plan goals on an ongoing basis through contacts, site visits, review of individual progress reviews, review of provider documentation, and Quality Service Reviews (QSRs). Through ongoing monitoring and review the case manager is able to:

- Determine that needed supports and services in the Individual Plan have been provided

## HCBS Consolidated Waiver Operations Manual

- Review implementation of strategies, guidelines, and action plans to ensure specific needs, preferences and desired outcomes are being addressed.
- Review the individual's progress and accomplishments
- Review the individual's satisfaction with supports and with service providers
- Identify any changes in the individual's needs, preferences and desired outcomes
- Identify the need to change the amount or type of supports and services
- Identify the need to revise and update the individual's plan of services.

On an ongoing basis, individual service providers should review and document progress on the specific personal outcomes and actions for which they are responsible. Providers of residential and day services are required to submit a written six month Individual Progress Review to the case manager and other team members prior to the annual plan and six months thereafter.

When a case manager identifies or is notified that an individual may be in need of additional support, is at risk, or may be entering a crisis, the case manager shall take steps to notify appropriate parties, convene the planning and support team to make needed support changes, make referrals to the region's Planning and Resource Allocation Team (PRAT), implement appropriate practices or procedures, or manage the crisis as appropriate to respond to the situation. If the issue is related to the individual's program or plan the case manager should bring the issue to the planning and support team and may schedule a meeting to update the plan.

Team members should inform case managers at any time an individual's life circumstances or needs change resulting in a need to convene the planning and support team to change the plan of services. The case manager may convene a team meeting at any time to update the plan. The team shall be convened when:

- The individual, family or guardian requests a meeting, for example to plan a different outcome, new service, or different provider.
- The person's needs change resulting in an increase or decrease in services.
- One or more new service is added or discontinued.
- There is a change in a service provider.

### 4.2.2 Periodic Review of the Plan – IP.12

The periodic review form, Periodic Review of the Plan, IP.12, should be used to document reviews of the plan for individuals who live in Community Training Homes and may be used in other settings where more frequent reviews of the plan are required by state or federal regulations.

### 4.2.3 Changes to the Individual Plan

The Individual Planning process is an ongoing process that changes as the needs and circumstances of the individual change. The individual or his or her legal representative may request a meeting to revise the Individual Plan at any time. Individuals who have Individual Budgets should have a revised budget completed if there are changes to the existing budget.

### 4.2.4 Service and/or Provider Changes to the Plan

If changes are made to types of or providers of supports and services, a revised Summary of Supports and Services IP.6, or an Individual Budget in the automated IP.6 database, should be completed. If the changes do not result in an increase in the approved Individual Budget, submit a copy of the Summary

## HCBS Consolidated Waiver Operations Manual

and Individual Budget to the Resource Administrator or designee who will issue new service authorizations to the Vendor and FI as needed. See Section 4.10 for more about service authorization.

If a change in services will exceed the dollar limit in the approved Individual Budget, the case manager must submit a Request for Services to the PRAT detailing the type and amount of services requested and the reasons for the requested services. The PRAT is responsible to approve increased service requests based on identified needs and any Utilization Review criteria if applicable.

### 4.3 Individual Plan 6 Database (IP 6 Database)

The IP 6 Database is an electronic database that is used by the case manager to develop the IP.6, Summary of Supports and Services, the individual budget replaces the waiver form 223 for eligible clients who have been allocated funds from PRAT or who have DDS resources in a Master Contract and wish to move their resources from the contract to individualize their services or to change vendors. The IP 6 database is used for eligible clients to develop an array of services that is consistent with the person's individual plan.

### 4.4 Waiver Service Packages and Limits

Each waiver prescribes packages of services and supports with associated dollar limits for each package, as described below.

#### 4.4.1 IFS Waiver Service Packages and Limits

The maximum amount of annualized funding available to individuals enrolled in this waiver for purchase of waiver goods and services is \$58,000. Each individual receives a budget allocation based on the results of the participant's assessed Level of Need. The Level of Need is determined as a result of the completed CT Level of Need Assessment and Risk Screening Tool (LON). The resulting score of 0-8 is associated with a prospective individual funding amount for vocational related services and home and community services. The LON Assessment and preliminary associated funding levels were developed under the CMS Independence Plus Grant using qualitative and quantitative methodologies. The bulk of the historical financial data used to calculate these rates includes information on individuals who were served on Master Contracts prior to the conversion to the present Fee for Service model. The Department is continuing to analyze the historical funding data and refine the prospective allocation methodology from the present allocation method of categorizing people with a LON of 1 or 2 as Minimum with an allocation range up to \$27,300; those with an LON scores of 3 or 4 as Moderate with an allocation range up to \$60,100 and those with LON scores of 5, 6, and 7 as Comprehensive with an allocation range up to \$92,800 to an allocation amount based on more current use data. Individuals with scores of 8 have exceptional support needs and will receive an allocation based on their individual support needs. People with an LON score of 0 will not be eligible to enroll in a waiver since they will not meet the Level of Care criteria. People whose needs require a support package that exceeds \$58,000 are not enrolled in this waiver and are enrolled in the Comprehensive Waiver. During the period covered by this waiver the analysis of the data will continue and allocations will be modified according to the results of the analyses.

The **IFS Waiver** covers the following service packages and associated service limits defined by total cost for groups of waiver services and supports. IFS Waiver Service Packages and Limits: total amount of available services within

## HCBS Consolidated Waiver Operations Manual

each package is based first on the individual's assessed level of need, and, for any individual may not exceed without prior approval, the following limits:

<b>Home/Community Package to \$28,000</b>	<b>Day/Vocational Package to \$26,000</b>	<b>Ancillary Package to \$6,000</b>	<b>Other -require individual approvals</b>
Individualized Home Supports	Group Day Options	Specialized Medical Equipment and Supplies	Environmental Modification
Personal Support	Individualized Day Supports	Clinical Behavioral Support up to \$2,500 per year	Vehicle Modifications
Community Training Home	Supported Employment	Interpreter Services	Family Training
Adult Companion	Adult Day Health Services	Transportation	Health Care Coordination
Respite		Nutrition up to 25 hours per year	Individual Goods and Services
Live-In Companion			
Individual Support Broker	Individual Support Broker		
PERS			

The DDS Regional Planning and Resource Allocation Team notifies the applicant of the funding limit via letter. The budget allocation limits apply to all services with the exception of Specialized Adaptive Equipment, Vehicle Modification and Environmental Modifications, which are not annualized services. Adjustments to the budget allocation limit can be made either as a result of a higher assessed Level of Need leading to an increased LON score, or due to short-term circumstances necessitating an increased amount of services to address short term health and safety needs. If the need for services required to address health and safety needs appears to be long-term and the cost to provide those services exceed the overall limit of the IFS waiver, the participant will be referred for enrollment in the DDS Comprehensive waiver. The state applies legislatively approved adjustments to these dollar amounts each year the waiver is in effect.

### 4.4.2 Comprehensive Waiver Service Packages and Limits

The **Comprehensive Supports Waiver** covers the following service packages and associated service limits defined by total cost for groups of waiver services and supports. This waiver is intended to support individuals who: utilize or require structured comprehensive group residential settings; individuals who use the Community Training Home model for support; and, for those who choose and are able to live in his/her own or family home with a more comprehensive amount and/or array of waiver services than is available in the Individual and Family Support waiver, in combination with his/her State Plan services and natural supports.

<b>Residential/Home and Community Supports</b>	<b>Day and Vocational Supports</b>	<b>Other Services</b>
Residential Hab <sup>1</sup>	Group Day Supports	Home Modifications <sup>2</sup>
Assisted Living <sup>1</sup>	Supported Employment	Vehicle Modifications <sup>2</sup>
Supported Living	Individualized Day Support	
Personal Support	Transportation	
Adult Companion	Clinical Behavioral Supports	
Respite	Interpreter	

## HCBS Consolidated Waiver Operations Manual

Clinical Behavioral Supports	Independent Support Broker	
Transportation	Medical Equipment and Supplies	
<b>Residential/Home and Community Supports</b>	<b>Day and Vocational Supports</b>	<b>Other Services</b>
Independent Support Broker	Individual Directed Goods and Services	
Interpreter		
Medical Equipment and Supplies		
PERS		
Individual Directed Goods and Services		
Nutrition		

<sup>1</sup>Res Habilitation and Assisted Living may not be utilized at the same time,

<sup>2</sup>Can be authorized as separate service costs above the Residential and Day/Vocational Package funding level limits, see also service definition limitations.

### 4.4.3 Funding Limits by Level of Need

The total amount of services within each package that is available to each individual is based first on the individual's assessed level of need. Then, each service package is further limited to a specific range of funding based on the results of an individual's Level of Need Assessment. This funding range is used to build the Individual Budget that meets the needs of the individual as determined by the plan of care. For example, an individual is assessed as having Moderate Support needs and is provided an Individual Budget limit of \$65,000 for combined Residential and Day/Vocational services based on the Level of Need assessment findings. The individual and his/her planning and support team then initiate the person-centered planning process and build an Individual Budget up to the \$65,000 limit to carry out the Individual Plan. Funding levels may exceed \$65,000 at any time during a plan year if Home and Vehicle Modifications services authorizations occur as one-time service costs. Requests to exceed \$65,000 of annualized supports and services, in this example, are addressed through Utilization Review detailed in Section 4.9.4.

Service Package	Minimum	Moderate	Comprehensive
<b>Res/Home and Community Supports</b>	up to \$30,000	up to \$60,000	up to \$90,000
<b>Day and Vocational Supports</b>	up to \$17,500	up to \$24,000	up to \$35,000
<b>Home Modifications/ Vehicle Modifications</b>	up to \$15,000/10,000 for each service during the term of the waiver (5 years)	up to \$15,000/10,000 for each service during the term of the waiver (5 years)	up to \$15,000/10,000 for each service during the term of the waiver (5 years)

Changes to these budget limits will be made based on analysis of actual utilization relative to Level of Need, and on COLA increases, for each year of the waiver. Adjustments to the service limits can occur at any time during the term of the waiver.

### 4.5 Plan and Individual Budget Approval

When the Individual Plan is completed, the case manager, individual, family, and planning and support team address the services and support needs identified in the plan as outlined below:

## HCBS Consolidated Waiver Operations Manual

- The type and amount of waiver services to be purchased based on the identified needs and desired outcomes in the Individual Plan is entered into the IP 6 database.
- Individuals and families choose providers from the qualified provider list at DDS established rates.
- After providers have been chosen, the IP 6 is completed in the IP 6 database using the support type, the qualified provider, the units (per day or per week), and the duration (days per year or weeks per year). If the total cost of DDS funded waiver services is within the original assigned PRAT resource allocation range, the case manager changes the status of the IP 6 in the IP 6 database to pending. The case manager's supervisor is notified.
- Individual Budgets exceeding the original resource allocation range are submitted back to PRAT with the Individual Plan and waiver application packet for further utilization management review as described in Section 4.6 of this manual.
- Following CM supervisor or designee approval verifying the IP 6 approval guidelines have been met, the waiver application packet submitted, and the budget is within the PRAT assigned allocation the supervisor changes the status of the IP 6 in the database to A1 and notifies the Resource Manager 2.
- The Resource Manager assigns a fiscal intermediary to manage the authorized budget funds and provider payments that are managed through a Fiscal Intermediary contracts.
- The regional Resource Administration office prepares a contract or contract amendment for the selected provider if needed for services provided through a Qualified Provider Master Contract.
- The regional Fiscal office enters the budget into the spend plan.
- The resource administrator or designee changes the status of the IP 6 in the IP 6 database to A (authorized) after verification that the IP 6 guidelines have been met. This includes verification that the current and annual costs are within the PRAT authorized allocation. The Resource Manager authorizes the release of funds to the fiscal intermediary or to the contract.
- The approved IP 6 is accessed by the FI, the case manager, PRAT, and the DDS waiver unit electronically. A copy is sent to the consumer. PRAT processes the waiver application packet.
- The regional Fiscal office issues the payments to the Fiscal intermediary quarterly prospectively according to IS Procedure PR 012. (Fiscal Intermediary Contracting Management).
- The FI sends periodic expenditure reports to the individual and family to review with a copy to the case manager.

### Implementation for Adjustments up to \$5000

- Adjustments are allowed once a quarter.
- The planning and support team can make service changes up to \$5000 for the year within existing line items. This can be done as one adjustment of \$5000 or two or three smaller ones that are up to or less than \$5000. Case Manager/Broker revises the Individual Budget in the IP 6 and forwards to the Fiscal Intermediary and the resource administrator. The change must be to add or to increase a **waiver service** in the authorized budget and cannot be a new waiver service or a change from a waiver service to a state funded service. The resource administrator will issue a revised vendor authorization when appropriate.

### Implementation for Adjustments over \$5000.

- Adjustments are allowed once a quarter

## HCBS Consolidated Waiver Operations Manual

- The case manager makes service changes in the IP 6 and other parts of the IP as required, Waiver form 223 or the automated IP.6. The case manager supervisor authorizes the adjustment. (electronically or signs off until the electronic system is operational). A copy of the adjustment is sent to the Fiscal Intermediary and the Resource Administration Unit. The Waiver form 223 is sent to the Medicaid Operations Unit or the Medicaid Operations Unit is notified that a new automated IP.6 is in the database.
- The resource administration unit issues a new or revised provider authorization when applicable.

### 4.6 Utilization Review

Individual Plans and budgets exceeding the overall original resource allocations or Individual Budget limits based on the Level of Need Assessment proceed through utilization review. Individual Plans and budgets are reviewed to evaluate the amount, type, frequency, and intensity of services directly related to health and safety needs of the individual, and desired outcomes based on the individual's preferences and needs. Utilization review consists of regional and state level review processes outlined below:

- a) Requests for resource allocations exceeding original range or Individual Budget limit by the Regional PRAT are made to the PRAT. PRAT has up to 10 business days to issue a decision on the request.
- b) The Regional Director is required to review and approve PRAT decisions that exceed PRAT approval limits and will do so within 5 business days.
- c) The State UR Committee is required to review and approve Regional Director decisions that exceed the Regional approval limits and will do so within 25 business days.
- d) Regional Directors may provide immediate temporary approval for requests to address immediate threats to the individual's health and/or safety.

Each waiver has specific established limits and Utilization Review criteria.

#### **IFS Waiver**

Regional Utilization Review may approve service packages up to \$30,000 in Day and Vocational Services and up to \$30,000 in Home and Community Services, when considered separately. State Utilization Review is required beyond those amounts. Such approvals are made based on the existence of health and safety needs that could not be addressed within the original Level of Need allocation for that individual. The total annualized cost of the individual's services and supports may not exceed the current IFS Waiver covered services limit.

#### **Comprehensive Supports Waiver**

Regional Utilization Review is required for any service package that exceeds the initial allocation range or Individual Budget limit as determined through the Level of Need assessment outcome. Regional Utilization may approve up to the established limits found in Section 4.4.3 for each Level of Need in total. Such approvals are made based on the existence of health and safety needs that could not be addressed within the original Level of Need allocation for that individual.

## HCBS Consolidated Waiver Operations Manual

State Utilization Review is required for any service package that exceeds the identified total limits for each Level of Need range. Specific criteria for approval of such requests are:

- Funding, or allowable, service costs which exceed those amounts may be permitted if necessary to access 24-hour supervised "group living" arrangements; and/or,
- To access specialized day/vocational supports due to specific and identified behavioral, medical, and physical support needs; and/or,
- For specialized service costs for individuals who may present threats of harm to others, as assessed on an individual basis; and/or,
- When needed to assure the health and welfare of a self-directed participant, the funding limit may be exceeded if needed to approve additional Independent Support Broker services.

Individuals who are seeking enrollment in a DDS HCBS waiver whose service package exceeds the prescribed allocation range or Individual Budget limits may not initiate services until the application has been accepted and approved through either Utilization Review, the negotiation process, or through the results of a DSS Fair Hearing Appeal Process.

Requests for additional services later in a plan year that exceed the previously approved Individual Plan and Budget are submitted to the Regional PRAT following a review of an individual's plan, and are subject to the same approval and/or Utilization Review process and criteria as described in this sub-section.

### 4.7 IFS Waiver- Exceeding the IFS Waiver Limits

Individuals participating in this (IFS) waiver will not lose their eligibility for the waiver due an increase in the need for covered service that causes the total need for the relevant service(s) to exceed the maximum permitted amounts established by the state, unless the state has evaluated the individual and determined that the individual's health and welfare cannot be assured by any one or any combination of the following:

- Adding more available natural supports; and/or,
- Accessing available non-waiver services, other than natural supports; and/or,
- Accessing funds held in CT DDS Regional risk funds on a non-annualized basis.

To the extent that the above efforts are unsuccessful, and the state finds that the absence of sufficient service(s) prevents the state from being able to assure the individual's health and welfare, the following shall apply:

- Individuals will be given the opportunity to apply for an alternative CT DDS HCBS waiver for which the individual is eligible that may more adequately respond to the service needs of the individual, to the extent that such waiver openings exist.
- Individuals in emergency situations are permitted to access services on a priority basis before other individuals on the waiting list.
- Individuals will be afforded an opportunity for placement in an ICF/MR including a state operated Regional Center.
- Individuals will be informed and given the opportunity to request a fair hearing if the state proposes to terminate the individual's waiver eligibility consistent with the requirements under 42 CFR 431.210, .211, .221 and .430 subpart D. Waiver services will be continued during the pendency of a timely requested hearing including the provision of any emergency services

# HCBS Consolidated Waiver Operations Manual

available within the DDS Regional Risk Pool, even if the services exceed the total benefit package limitation in this waiver.

## 4.8 Denial of Services and/or Enrollment and Notice of Appeal

Any PRAT or Utilization review resulting in a recommendation to deny an initial Individual Plan and Budget, or an additional service request in whole or part is submitted to the Central Office Waiver Policy Unit. The Waiver Policy Unit will review the request and issue a final decision. If the initial Individual Plan and Budget, or additional service request, is approved following a Central Office Case review, the reasons for the approval are documented in a Waiver Services Review summary and returned to the Regional office for processing and service authorization. If denied, the Waiver Policy Unit will issue a denial with notice of appeal rights to the individual, responsible person and case manager. For any determinations of the CO Waiver Policy Unit that constitute a denial of or reduction in a waiver service, the CO Waiver Policy Unit will provide information and forms to initiate an administrative hearing through the Department of Social Services. The Appeal process is further outlined in Section 10 of this Manual.

## 4.9 Service Authorization Procedure

Upon final approval of the IP 6 in the IP 6 database, the resource administrator/designee authorizes release of DDS funds for the approved services in the IP 6 to the fiscal intermediary and sends a service authorization form to the provider (Provider Service Authorization), or processes the DDS Master Contract amendment.

### 4.9.1 Provider Service Authorization Form – Instructions

- The Service Authorization Form is generated from the IP 6 database for all approved qualified provider services.
- The Service Authorization Form includes the individual's name, the authorized services including rate, units, duration and annualized costs, the fiscal intermediary, the case manager, and the approval date.
- The provider provides services as authorized in the Service Authorization Form and documents the date of service, type of service, and the number of units and/or costs;
- The provider submits the monthly Billing Invoice Form for each person served, with the dates, number of units and/or costs, provider billing information, and consumer information;
- The fiscal intermediary makes payment up to the amounts authorized in the authorized IP 6 to the provider.

## 4.10 Consumer-Directed Options

Individuals and families can choose the level of control and flexibility they want to exercise over their supports. The options for self-direction include:

- Choosing qualified providers and negotiating rates below the established DDS rates;
- Agency with Choice, the provider provides the individual and family an opportunity to participate in selecting and dismissing staff;
- Hiring individuals, with the individual or family as the employer of record,
- A combination of provider services and hiring individuals.

The case manager/support broker will provide information and assistance to ensure that the individual and his/her planning and support team successfully arrange the initiation of approved services in the desired approach. The case manager/support broker will provide

## HCBS Consolidated Waiver Operations Manual

individuals who are interested in self-directing their supports with the opportunity to hire an independent support broker. If selected, the independent support broker will become a member of the person's planning and support team.

Individuals who choose to manage his/her supports through the direct hiring of support staff can utilize up to \$1200 per year of his/her annual resource allocation to purchase non-waiver supports. Requests for non-waiver services/supports in excess of this amount may only be made through the one-time funding procedures managed by the PRAT.

Individuals who create consumer-directed plans and budgets including the direct hiring of staff are subject to The *Department of Developmental Services Individual Support Cost Standards 7/1/2008*. For individuals who self-direct services and supports through an Agreement for Self Directed Supports, the Medicaid Agency (DSS) has designated the Fiscal Intermediary to obtain and hold individual Medicaid Provider Agreements for their employees. Individuals who only select the Agency with Choice Option use the IP 6 database process.

### 4.10.1 Agreement for Self Directed Supports

The case manager/support broker will review the requirements for self-direction and the **Agreement for Self Directed Supports** with the individual and family. The requirements for self-direction are: the sponsoring person reviews the **Agreement for Self Directed Supports** and identifies any support that is needed to self direct services. These supports if needed are included in the IP. The sponsoring person demonstrates the ability to manage supports and signs the **Agreement for Self Directed Supports.**, and selects an approved fiscal intermediary or has one assigned. The sponsoring person may need assistance with managing their supports as identified in the Individual Plan. Individuals who seek additional assistance may request a DDS broker who will provide both Targeted Case Management and the additional support functions to effectively self-direct services. The waiver service, Independent Support Broker, can also be used to assist the sponsoring person with the management of supports. The sponsoring person can be the individual receiving services, a family member, or a member of the planning and support team, with the exception of the case manager/support broker.

### 4.10.2 Instructions IP 6 Database

- The Individual IP 6 database was designed to allow automated budgeting for individual services and support. This version provides detail for Day and Residential Services. It will allow the use of 620 for residential, 617 for day, and one other account for both day and residential.
- The services and providers are selected from drop downs that are managed by the Operations Center. The application alerts the user when they have exceeded the PRAT authorization. The user enters the services on an annual basis and the application pro rates the costs based on the start and end dates of the IP 6. A user manual is available with step by step instructions and each region has identified technical assistants to support case managers.

### 4.10.3 Individual Plan and Budget Approval Process

- The case manager/support broker assist the individual, family, and planning and support team to complete the person centered planning process and the Individual Plan;
- Supports are crafted with a combination of natural supports, community supports, and DDS supports;

## HCBS Consolidated Waiver Operations Manual

- The case manager/support broker build the IP 6 that captures the DDS supports within the DDS Individual Support Cost Standards and Cost Guidelines;
- If the total cost of DDS funded services is within the original assigned PRAT resource allocation range, the case manager changes the status of the IP 6 in the IP 6 database to P (pending). The Individual Plan and waiver application packet are submitted to his/her case management supervisor;
- IP 6 costs exceeding the original resource allocation range are submitted back to PRAT with the Individual Plan and waiver application packet for further utilization review;
- Following case management supervisor approval verifying the IP 6 guidelines and individual planning requirements are met the case management supervisor changes the status of the IP 6 in the IP 6 database to A1. The waiver application packet is submitted to the regional designee;
- The Resource Manager or designee reviews the IP 6 and verifies the IP 6 guidelines are met and the current and annual costs are within the PRAT authorization.
- The Resource Manager approves the IP 6 in the IP 6 database and changes the status to A (authorized) Funds are authorized for release to the fiscal intermediary when the IP 6 in the IP 6 database is approved.
- The Fiscal Intermediary, the Case Manager, the DDS business office, the DDS Waiver Unit access the IP 6 electronically. An approved copy of IP is included with the IP. The consumer and family get a copy of the IP.
- The regional fiscal office enters the budget into the spend plan;
- Funds are paid to the Fiscal Intermediary quarterly, in advance;
- The **Fiscal Intermediary** sends periodic expenditure reports to the individual and family to review with a copy to the case manager. The individual and family have flexibility to make changes in their budget according to the DDS IS Fiscal Management Procedure No. I.C.2.PR.008.

### 4.10.4 Service Authorization

The individual or sponsoring person for self directed services completes agreements with employees and with providers when a rate is negotiated. (Individual/ Family Agreement with Provider and Individual /Family Agreement with Employee) These agreements reflect the type and amount support, any special conditions, and the effective date.

### 4.10.5 Individual /Family Provider Agreement Form Instructions

Individuals who self-direct their services and choose qualified providers at negotiated rates are required to complete an Individual/ Family Provider Agreement. The agreement includes the type of Waiver support, the hours per week and schedule of support, agency with choice arrangements, the negotiated rate when below the DDS established rate, the billing method, terms for discontinuation, and the effective date. A provider agreement is required prior to authorization of an IP 6 in the IP 6 database when the rate is negotiated.

### 4.10.6 Individual/ Family Employee Agreement Instructions

Individuals who hire their own staff are required to have an agreement with each employee. The agreement (Individual/ Family Employee Agreement) includes the

## **HCBS Consolidated Waiver Operations Manual**

type of Waiver support, the hours per week and the schedule of hours, the hourly rate of pay (within DDS Cost Guidelines), employee information, a commitment to complete training requirements, and work rules as determined by the individual or family.

# HCBS Consolidated Waiver Operations Manual

## 5 Case Manager Responsibilities

The role of the DDS case manager in individual planning is to support the person and other team members to develop and implement a plan that addresses the individual's needs. Case managers support individuals to be actively involved in the planning process. They are responsible to ensure that individual planning meetings are scheduled at times when the person, his or her family and other team members can attend. Prior to the meeting, the case manager should ensure that any individuals who express interest in self-directing supports are made aware of the opportunity to hire an independent support broker to assist with planning. The case manager is responsible to facilitate the annual individual planning meeting unless the individual requests another team member facilitate the meeting. The case manager ensures the meeting is facilitated in line with the individual planning process and encompasses input across services settings.

At the time of the individual's planning meeting, the case manager is responsible for ensuring the individual, and his or her family, guardian, advocate or other legal representative, if applicable, is informed of the rights extended to them by DDS, including the right to appeal any decision that is made at the meeting through the Programmatic Administrative Review (PAR) process. The case manager should inform individuals on the waiting list of their priority status, and should inform waiver participants and their families about Medicaid Fair Hearing rights. The case manager should make other notifications and share additional information with the individual and family or guardian as required.

The case manager should ensure the individual has been offered a choice of supports, service options, and providers and that the plan represents the individual's preferences. The case manager ensures the plan is documented on the Individual Plan forms, though other team members or clerical staff may do the actual transcription of the plan. He or she ensures the plan is distributed to all team members, though this task may also be assumed by another team member or clerical staff.

The case manager is responsible to ensure a HCBS waiver application is completed during the initial planning process and been included in the Individual Plan and Budget package submitted for authorization. The case manager monitors implementation of the plan and ensures supports and services match the individual's needs and preferences. He or she ensures the plan is periodically reviewed and updated based on individual circumstances and regulatory requirements.

The case manager has overall responsibility for ensuring that Waiver services are coordinated with other services, resources, and supports available to the person, including state plan, generic, and informal services and supports. The case manager also has responsibility to ensure approved waiver services are delivered according to the Individual Plan, and to routinely review and monitor all aspects of service delivery.

The individual and his or her planning and support team, including his or her family or legal representative and support providers, also have roles in assuring that services are delivered as described in the plan to meet the person's needs. The individual and the planning and support team members should inform the case manager of any changes in the person's situation or needs and provide access to locations and information that will enable the case manager to monitor supports and services.

Case managers specifically carry out the following requirements under a DDS HCBS waiver.

# HCBS Consolidated Waiver Operations Manual

## 5.1 Choice of Service Options

The case manager is responsible to ensure that the individual and his or her family or legal representative have sufficient information about support and service options to make informed choices during the planning process. Individuals may self-direct their supports and services, may select to have services delivered by qualified providers, or may use a combination of both options. To the extent that they choose, individuals will be supported to self-direct and manage the supports and services identified in their individual plans.

## 5.2 Arranging Services and Free Choice of Providers

Case managers should assist individuals to obtain supports and services identified in their individual plans to the extent that individuals request their assistance. This may include assisting the individual to gain access to supports and services from qualified providers or from other sources including state plan, generic, and informal supports and services.

For those individuals who self-direct a plan of supports that includes the hiring of staff, the individual and his or her family or legal representative may request the additional support offered by a DDS Broker, or choose to obtain assistance from an Independent Support Broker. In these cases, the broker will assume responsibility to fully arrange and coordinate consumer-directed services and supports. In these cases, the individual will continue to also receive DDS Targeted Case Management services.

Individuals will be offered choices of qualified providers and will be fully informed of their right to freely select among qualified providers. Case managers will ensure that individuals have sufficient information about qualified providers to make informed choices. Case managers will refer the individuals who request supports and services from an agency to the list of qualified providers that provide supports within the region. The list is located on the DDS website. Case managers may accompany individuals to interviews, tours, and initial visits. Case managers may also assist individuals and their families or legal representatives to evaluate several different options and providers to ensure the best selection.

Supports and services should be implemented within 60 days of plan approval, 30 days within licensed settings, and should be provided as described in the Individual Plan. If supports and services cannot be promptly implemented, the case manager, individual and planning and support team should consider the need to revise the Individual Plan to meet the person's needs.

## 5.3 Coordination

Case managers will assist individuals to coordinate the services identified in the individual plan and will promote cooperative communication among support providers.

## 5.4 Monitoring

Case managers shall engage in activities to evaluate whether supports and services are being delivered as described in the Individual Plan and are adequate to meet the desired outcomes for the individual and address his or her needs. Case managers shall work with the individual and his or her family, guardian or legal representative to make adaptations to plans and service arrangements as needed. Monitoring of supports and services will include visits to service locations and gathering input from the individual, family or support providers including review of individual progress reviews. Case managers will document ongoing monitoring in the case manager case notes and/or Quality Service Review system.

When a case manager identifies or is notified that an individual may be in need of additional support, is at risk, or may be entering a crisis, the case manager shall take steps to notify

## **HCBS Consolidated Waiver Operations Manual**

appropriate parties, convene the planning and support team to make needed support changes, make referrals to the region's Planning and Resource Allocation Team (PRAT), implement appropriate practices or procedures, or manage the crisis as appropriate to respond to the situation.

### **5.5 Maintaining Medicaid Eligibility**

The individual and his or her family or legal representative will maintain Medicaid eligibility and submit required documents to the Medicaid agency. The case manager is responsible for verifying a person's continuing eligibility for Medicaid. During the planning meeting, the case manager will review documents to ensure the individual and his or her family or legal representative have submitted required information and may ask to view the person's Medicaid card. On an annual basis, the case manager coordinates the completion of a Level of Care re-determination for continued waiver eligibility.

# HCBS Consolidated Waiver Operations Manual

## 6. Provider Options

### 6.1 Qualified Provider Requirements

Private agencies/organizations seeking enrollment as a qualified provider to deliver services and supports in this waiver will meet the following requirements through demonstration of knowledge, policy and practice, and agreement to assurances as part of the DDS provider enrollment process. Each agency upon approval by DDS must enter into a Provider Agreement with the Medicaid Agency (DSS). DDS will hold the Provider Agreements and will make payments on behalf of the Medicaid agency (DSS).

- Meets all applicable federal and state regulations;
- Meets and keeps current all state licensing/certification;
- Understands and follows all applicable DDS policies and procedures
- Is able to communicate clearly and effectively with individuals and their families;
- Protects the confidentiality of the individual and family's information;
- Operates a drug-free workplace;
- Maintains documentation of services provided as described in Section 2 of this manual for a period of six years;
- Bills only for services that are actually provided;
- Submits billing documents after service is provided and within 90 days;
- Accepts payment from DDS as payment in full
- Retains financial and statistical records for six years from date of service provision;
- Allows state and federal offices responsible for program administration and audit to review service records and have access to program sites;
- Assures it will carry sufficient general liability insurance;
- Agrees to comply with State of Connecticut Ethics Protocols;
- When transporting a consumer as part of the service: the vehicle in which the transportation is provided must have valid license plates and at a minimum the State of CT required level of liability insurance; vehicles must be maintained in safe working order; consumers with special mobility needs shall be provided transportation in a vehicle adapted to those needs as required to facilitate adequate access to services; and, if the vehicle is used to transport consumers in wheelchairs, it should be equipped with floor mounted seat belts and wheel chair lock downs for each wheel chair it transports;
- Demonstrate in its policies and procedures that criminal background, abuse and neglect (Registry), Sexual Offender Registry, driver's license checks, and any future pre-employment requirements are completed and updated as required for all direct service employees prior to employment;
- Will not discriminate against any employee, applicant for employment or participant because of race, age, color, religion, sex, handicap, national origin or sexual orientation;
- Demonstrate that it can train Direct Service staff in required areas;
- Demonstrate competence and knowledge of DDS policies and procedures in: abuse/neglect; incident reporting; human rights; confidentiality; handling fire and other emergencies, prevention of sexual abuse; knowledge of approved and prohibited physical management techniques; all required DDS policies and procedures as they apply to the services;
- Demonstrate that it can make information about staff qualifications and training records and Direct Service staff's time and attendance records available to DDS;
- Demonstrate that Direct Service staff receive supervision;
- Demonstrate the capacity to:
  - Assume responsibility
  - Respond to emergency situations and follow emergency procedures
  - Assure that in the delivery of services, specific service related activities as well as staffing are:

## HCBS Consolidated Waiver Operations Manual

- Available and provided at any time as specified in the individual's Individual Plan
- Delivered in a manner that takes into consideration the primary language of the consumer and their representatives as well as cultural diversity issues;
- Demonstrate that it can provide back up staff when the lack of immediate care poses a threat to the individual's health and welfare;
- Demonstrate that it will participate in individual's person-centered planning if requested by the individual;
- Demonstrate that it can obtain adequate information necessary to meet the needs of the individual;
- Demonstrate that it can observe and report all changes, which affect the individual and take action if necessary;
- Assure it will sign a provider agreement with the individual and family;
- Assure it will not require a participant to sign an agreement that they will not change agencies as a condition of providing services;
- Assure it will not subcontract ongoing direct services unless approved by the DDS Operations Center. The subcontracting of nursing supports (where nursing supports are allowed under the waiver), clinical supports, and occasional, time limited, direct staff supports are allowable provided that the vendor maintains primary responsibility for the oversight of all supports and services. The provider assures the subcontractors meet all DDS required qualifications and training for the service(s) provided.
- Demonstrates a commitment to Quality Improvement;
- Demonstrates financial stability.

### 6.2 Self-Directed Options

Individuals and families are offered options on how much control and flexibility they choose to have over their supports. They may choose a provider agency to deliver the service, choose an Agency with Choice option, hire their own staff through the use of an approved Fiscal Intermediary to provide a number of services in this waiver, choose an agency at the DDS established rate, or choose a combination of provider delivered and self-directed service options. This process is described in section 4.10. The case manager will provide information about Qualified Providers, information and assistance as requested to ensure that the individual and his/her circle successfully select and arrange the initiation of approved services in his/her desired approach.

### 6.3 Agency with Choice

Agencies with Choice are those agencies that provide individuals and families the ability to choose and dismiss staff. This allows families a role in self-directing their services without the responsibilities of becoming an employer. The staffs are employed by the agency, but the individual and family participate in choosing staff. Individuals and families who select an agency with choice option are required to fill out an Individual/Family Provider Agreement, which identifies the role of the individual and family in choosing and dismissing staff.

# HCBS Consolidated Waiver Operations Manual

## 7. Provider Qualifications and Training

Each Waiver Service identifies the standard qualifications that the employee(s) must meet prior to employment and prior to being alone with the individual for whom the service is being provided. The Provider Qualifications are listed for each service in Section 2 of this manual.

It is also necessary for the planning and support team to identify the **additional or specific qualifications** (expertise, competence, and or training) required to effectively support the individual to **achieve the personal outcomes** identified in his or her plan and to maintain a **healthy and safe lifestyle**.

Based on the preferences and support needs of the individual, the following information is documented for each employee who may require additional or specific qualifications in the Individual Plan form IP.7 Provider Qualifications and Training:

- The **additional or specific qualifications** (expertise, competence, and or training) required to effectively support the individual to **achieve personal outcomes** and maintain a **healthy and safe lifestyle**
- The timeframe in which the specific qualification(s) must be met.

Employers (provider agencies or individuals/families) are responsible to ensure that employees meet the standard and specific qualifications identified. Employers must provide the necessary training and support for employees to acquire identified competencies and verify that all qualifications are met within required timeframes.

### 7.1 Provider Standard Qualifications and Training

QUALIFICATION/ TRAINING AREA	KNOWLEDGE, COMPETENCIES, OR EXPERTISE REQUIRED (Prior to being alone/within 30 days)	AVAILABLE TRAINING RESOURCES
<b>ABUSE AND NEGLECT (INCLUDING SEXUAL ABUSE)</b>	<ul style="list-style-type: none"> <li>✓ Understand the definitions of abuse (including sexual abuse) and neglect</li> <li>✓ Know the signs of possible abuse and neglect</li> <li>✓ Understand conditions that may lead to abuse and neglect</li> <li>✓ Understand strategies for preventing abuse and neglect</li> <li>✓ Know how to respond if abuse or neglect is suspected or reported</li> </ul>	Abuse and Neglect Policy and Procedures  Abuse and Neglect Direct Hire Training Material

## HCBS Consolidated Waiver Operations Manual

<p><b>HUMAN RIGHTS</b></p>	<ul style="list-style-type: none"> <li>✓ Understand that people with disabilities are entitled to the same rights afforded to all citizens</li> <li>✓ Understand their responsibility to assist the person they support to understand and exercise their rights</li> <li>✓ Understands guardianship role and responsibilities</li> <li>✓ Understand and can use processes designed to safeguard rights, i.e., human rights committees</li> </ul>	<p>Human Rights Policy and Procedures</p> <p>Abuse and Neglect Direct Hire Training Material</p>
<p><b>CONFIDENTIALITY</b></p>	<ul style="list-style-type: none"> <li>✓ Understand that any individual identifiable health information is kept private</li> <li>✓ Understand that confidential information cannot be disclosed without written, informed consent</li> </ul>	<p>HIPAA Policy and Procedure</p> <p>HIPAA Fact Sheet</p> <p>Confidentiality Direct Hire Training Material</p>
<p><b>HANDLING FIRE AND OTHER EMERGENCIES</b></p>	<ul style="list-style-type: none"> <li>✓ Understand basic principles of fire prevention and personal safety</li> <li>✓ Know the appropriate actions to take in response to fire emergencies</li> <li>✓ Know the appropriate actions to take in response to other emergencies, such as severe weather, hazardous materials, missing person and others</li> </ul>	<p>DDS Fire Safety Guidelines</p> <p>Websites or pamphlets on fire safety or emergency management</p> <p>Handling Fire and Other Emergencies Direct Hire Training Material</p>
<p><b>PHYSICAL MANAGEMENT</b></p>	<ul style="list-style-type: none"> <li>✓ Understand the limitations placed on the use of involuntary physical restraint by Connecticut state law and DDS regulations, policies and procedures</li> <li>✓ Understand what constitutes life-threatening physical restraint, and that its use is prohibited under any circumstances</li> <li>✓ Understand that physical management techniques may only be applied by individuals who are certified through DDS approved training programs</li> </ul>	<p>Policy and Procedure Physical Management</p> <p>Physical Management Direct Hire Training Material</p>

## HCBS Consolidated Waiver Operations Manual

<b>INCIDENT REPORTING</b>	<ul style="list-style-type: none"> <li>✓ Know incidents and accidents to be reported</li> <li>✓ Understand required timelines for incident and accident reporting</li> <li>✓ Understand employer protocol for reporting incidents and accidents</li> </ul>	<p>Incident Policy and Procedures</p> <p>Family Fact Sheets</p>
<b>MEDICATION ADMINISTRATION</b>	<ul style="list-style-type: none"> <li>✓ Completion of DDS certified Medication Administration training if required by DDS regulations and the individual's specific support needs.</li> </ul>	<p>DDS</p>
<b>INDIVIDUAL PLANNING AND PERSON-CENTERED SERVICES</b>	<ul style="list-style-type: none"> <li>✓ Understands the DDS Individual Planning Process</li> <li>✓ Understand the importance of language that demonstrates respect, shared control, and use of "person first language"</li> <li>✓ Understand the basic philosophy of person centered planning</li> <li>✓ Understand the methods for gathering information about the person</li> <li>✓ Understand support staff roles and responsibilities in developing and implementing a plan with the person, his or her family, and circle or team</li> <li>✓ Understand that the plan changes as the person's life circumstances change</li> </ul>	<p>Individual Planning Policy and Procedure</p> <p>PPT Presentation on Individual Person-centered Planning Direct Hire Training Material</p>
<b>PARTICIPATION IN A PLANNING AND SUPPORT TEAM OR CIRCLE OF SUPPORT</b>	<ul style="list-style-type: none"> <li>✓ Understand the importance of listening, and takes direction from the person, identifying and building upon strengths and talents, and working as an effective, collaborative member of the person's circle or team.</li> </ul>	<p>Individual Planning Policy and Procedure</p> <p>PPT Presentation on Individual Planning</p> <p>Person-centered Planning Direct Hire Training Material</p>

# HCBS Consolidated Waiver Operations Manual

## 7.2 Documentation of Qualifications and Training

Provider agencies must have a system to verify employee qualifications, screenings and training required by the waivers. Department staff will conduct periodic audits of provider records.

Individuals or families hiring employees will use the Provider Qualifications and Training Verification Record to document that each employee meets the standard and additional provider qualifications, screenings and training requirements. Upon verifying that all qualifications, screenings and training have been met, the verification form will be sent to the Fiscal Intermediary. The Fiscal Intermediary will assist the individual or families with obtaining needed screenings and may provide assistance with arranging staff training. The FI is not authorized to make any payments for services until the individual provider has met the initial entry qualifications and screening requirements. Department staff will conduct periodic audits of employee records on file with the Fiscal Intermediary.

# HCBS Consolidated Waiver Operations Manual

## 8. Service Documentation and Records

Qualified Provider staff and individual employees hired by people who self-direct must document services delivered and keep records according to Medicaid requirements as well as DDS Policies and Procedures. A Qualified Provider staff person or individual employee must document the provision of a service before seeking Medicaid payment.

The Medicaid requirements for specific services are outlined in this section. Qualified Providers and individuals and/or their legal representatives who self-direct services must also keep related personnel, financial and other management records as required by the Medicaid Provider Participation Agreement, the policies and procedures in this manual, Medicaid rules, and state and federal law.

### 8.1 How Long Records Must Be Kept

The records must be maintained for six years from the date of service. For individuals who self-direct services and hire their own staff those records will be maintained by the Fiscal Intermediary.

### 8.2 Availability of Records

The Qualified Provider or the individual who self-directs services and/or his or her legal representative must furnish information regarding Medicaid payments received upon request by DDS and its agents, the Office of the Attorney General, the Department of Social Services, the Centers for Medicare and Medicaid Services, and any other entities specified in the Medicaid Provider Participation Agreement. In addition, the DDS Case Manager, DDS Staff, DSS, and/or CMS must be permitted to review the documentation that supports a claim for Waiver services rendered and billed. Requested documents must be mailed or delivered to designated sites during state and/or federal reviews.

### 8.3 What the Qualified Provider or the Individual who self-directs services keeps

- Copy of the Individual Service Plan, including current outcomes;
- Service documentation;
- Provider Service Authorization, or approved ISA Budget; and
- Provider copies of claims submitted to Fiscal Intermediary or individual/family as well as related correspondence.

In addition, the information needed in all records includes:

- The person 's name and DDS Number;
- What service was provided;
- Procedure code of the service type
- The date that the service was provided;
- Duration of service, if applicable;
- Where the service was provided;
- Signature of the person providing the service; and
- The requirements listed in Section 2

### 8.4 Service Documentation

Documentation requirements differ according to the service type. Note that DDS only considers that a service has been provided if there is documentation of the provision of the service. The minimum service documentation requirements for Waiver services are described in Section 2 of this manual.

# HCBS Consolidated Waiver Operations Manual

## 9. Invoices, Billing, Payments

The Provider can bill monthly or bi-monthly for service provided during the billing period. Providers will submit invoices to the Fiscal Intermediary designated on the Provider Authorization Form authorized by the Regional Resource Administrator or their designee.

Invoices are required to include the following data:

- Consumer Name, DDS #,
- Qualified Provider name and Address
- Federal Taxpayer ID number
- Medicaid Provider Number
- Service month
- Procedure Code
- Date of service, unit type (hours, miles, trips, days), number of units for each date of service.
- Unit rate
- Total for reimbursement for each date of service
- Total for all services on the invoice
- Signature of provider representative submitting the invoice. Electronic invoices or stamped invoices are acceptable when the provider designee signs an authorization letter provided by the Fiscal Intermediary identifying the authenticity of the PIN or stamped signature.

Direct service time is the period of time spent with the consumer and verified by the consumer or their family when required.

When billing, the Qualified Provider should use the procedure code for the specific service that is authorized on the consumer's we combined these into one form. **Provider Authorization form**. Each waiver service has a specific procedure code.

When billing, the Qualified Providers should submit the number of units (hours, days, miles) for each service provided. Each service has a specific unit of service that is the minimum amount of direct service time that can be billed. Direct service time is the period of time spent face to face with the consumer. Qualified Providers should round their direct service time to the nearest unit increment.

For example, when billing for **Personal Supports** the basis for payment is a quarter-hour unit; therefore, the Qualified Provider should round its direct service time to the nearest 15-minute increment.

- If services were provided for **67** minutes, bill for **1** hour.
- If services were provided for **68** minutes, bill for **1.25** hours.
- If services were provided for **50** minutes, bill for **.75** hours.

Absences do not constitute a billable unit. The DDS will not compensate a Qualified Provider for absences. Providers who submit a bill for more than the number of hours authorized in the Provider authorization form may experience delays in payments. If a consumer stops attending the Qualified Provider's program, they shall notify their Regional Contract Manager and the consumer's F.I.

Services authorized for payment through a Master Contract require that monthly attendance records be submitted to the Central Office Medicaid Operations Unit. Payments are made per the Master Contract agreement in place.

# HCBS Consolidated Waiver Operations Manual

## 9.1 Instruction for completing Provider Billing Invoice Form

---

**Consumer Name:** Individual's name as it appears on the *Provider Service Authorization*

**DDS Number:** Consumer's Department of Developmental Services Identification number

**Provider Name/ Address:** Provider name and address as listed on the Qualified Provider application

**Provider EIN#:** Federal Tax Identification Number

**T-XIX Provider #:** Department of Social Services Medicaid Provider Number when applicable

**F.I.:** Fiscal Intermediary used by that consumer

**Billing Month:** Month that the services were provided for example- October,2008

**Date:** Date that the service was provided, for example 12 (twelfth day of month)

**Service/Commodity Type:** The authorized service listed on the individual's *Provider Service Authorization*

**Procedure Code:** Code that corresponds to the authorized service listed on the individual's *Provider Service Authorization* (see *Individual and Family Waiver Service: Codes-Units- Rates* table and *Comprehensive Supports Waiver Service: Codes-Units* table)

**Service Units:** Unit of service that corresponds with that service code (see : *Codes-Units-Rates* tables)

**# Units:** The number of units provided for that particular date for that service. Units (hours, days, miles) should be entered in whole numbers or whole numbers with decimals. For example 6 and a half hours of DSO support would be recorded as **6.5** in the unit column.

**Unit Rate:** The fee set by the DDS for one unit of the corresponding service.

**Total:** The # of units times the Unit Rate (# Unit X Unit Rate)

**Subtotal:** Total of Column Total

**Grand Total:** The total of all Subtotals for that Individual for that month if more than one service is included in the invoice or an additional Billing Invoice Form is used

### Qualified Provider Certification

**Signature:** Signature of the staff of the Qualified Provider authorized to certify the accuracy and authenticity of the billing

**Printed Name:** Print or type name of individual's signature

**Date:** Date of signature

**Telephone:** Telephone number of the individual who signed the *Request for Payment*

---

# HCBS Consolidated Waiver Operations Manual

## 9.2 Medicaid Billing

DDS serves as the billing provider for the DDS HCBS Waiver. Medicaid billing received at DDS Central Office Medicaid Operations is reviewed and processed through the Department of Administrative Services Financial Services Center. The fiscal intermediaries will prepare the Fiscal Intermediary Waiver Service Documentation Form on a monthly basis for all waiver services received by the individuals they serve. The completed forms will be sent to DDS Central Office Medicaid Operations Unit. The fiscal intermediary will only report services that are:

- a. Provided according to the individual's plan of care.
- b. Provided by qualified providers who are enrolled with DDS and have a Medicaid performing provider number. Or,
- c. Provided through an approved consumer-directed Agreement to Self Direct, Individual Plan and budget, and
- d. The provider has signed a Medicaid Provider Agreement. The Fiscal Intermediary has been deemed by the Medicaid Agency (DSS) as the entity authorized to obtain and hold those Provider Agreements.

Master Contract authorized services submit monthly attendance records to the DDS Central Office Medicaid Operations Unit..

## 9.3 Documentation for Medicaid Billing

Services provided under a DDS HCBS Waiver are billed to Medicaid and any provider accepting payment for those services must complete a Medicaid Provider Agreement, which requires them to:

- a. Accept payment, in form of check(s), from the fiscal intermediary.
- b. Agree to keep records of the service(s) or purchase(s).
- c. Provide only the service(s) or item(s) authorized.
- d. Accept the check(s) as payment in full for the service(s) or item(s) purchased.
- e. No additional charges will be made or accepted from clients.
- f. Upon request, provide DSS or its designee information regarding the service(s) or purchase(s) for which payment was made.

### 9.3.1 Performing Provider Agreement

All Qualified Providers of waiver services will complete an application for a Medicaid performing provider number from DSS prior to receiving any payment for services. In these cases, the enrollment procedure is:

- a. Providers apply to the DDS Operation Center to become qualified providers for Waiver Services. A Provider Agreement must be completed by all providers who are not on a Purchase of Service Contract to receive payment for services. Providers with a Purchase of Service contract complete a Provider agreement through the Medicaid Operations Unit in order to obtain a number. The Operations Center will inform the Medicaid Operations Unit when they have approved a provider to provide waiver services. Information will include the services the provider is authorized to provide.
- b. DDS Medicaid Operations Unit will complete specific information pertaining to providers on a Purchase of Service Contract on the Waiver Performing Provider Registration Form.
- c. A Provider Registration packet will be sent to the provider along with instructions and guidelines for completion.

## HCBS Consolidated Waiver Operations Manual

- d. The provider will complete the packet and send it back to the DDS Medicaid Operations Unit within 10 working days.
- e. The DDS Medicaid Operations Unit forwards the Registration Form to the DSS Provider Relations Unit requesting Medicaid Performing Provider Number along with the procedure codes relating to the services the provider is authorized to provide.
- f. DSS sends DDS Medicaid Operations Unit Performing Provider Number.
- g. DDS Medicaid Operations Unit tracks progress of Provider Enrollment from date sent to Provider through date EDS loads approved rates and procedure codes.

### 9.3.2 Qualified Provider Documentation

The provider will maintain the following:

- a. A record of the type of service, date of service, units of service and the name of the person performing the service.
- b. A record of the training and qualifications of anyone providing services.
- c. A record of any licenses or certifications of persons providing services
- d. Documentation that services are provided in accordance with an Individual Plan approved by the DDS Region.
- e. Records will be maintained for a minimum of six years.

### 9.3.3 Self-Directed Employee Documentation

Where services are provided by a person hired directly by the waiver recipient, the Fiscal Intermediary will maintain the following documentation: Medicaid Provider Agreement signed by the employee, copy of the criminal history background check, copy of the registry check, a copy of the provider qualification verification record, copy of licenses or certifications, the employment application form, the Individual/Family Employee Agreement, all federal and state employment related forms, payroll records and time sheets, quarterly expenditure reports, Medicaid monthly billing reports, and documentation of goals/tasks/activities performed by the employee.

# HCBS Consolidated Waiver Operations Manual

## 10. Appeals

Individuals have a right to request an evidentiary hearing from the Department of Social Services (The State Medicaid Agency) if they are aggrieved by a decision concerning their participation in the Home and Community-Based Services Waiver. This may be as a result of denied enrollment in a waiver or a denial of or reduction in waiver services.

### 10.1 Enrollment Denial

Once an individual has formally applied for enrollment in a DDS HCBS Waiver, the application is processed through the region's PRAT team and sent with a recommendation to the Central Office Waiver Operations Unit. The Waiver Operations Unit will review the PRAT recommendation and available documentation and render a decision within 10 business days of receipt of the PRAT recommendation. An applicant who is denied enrollment in a waiver will receive written notification of the reason for the denial including notice of the right to request a Fair Hearing convened by the Department of Social Services (DSS). Forms and directions for initiating the DSS hearing process will be included with any Notice of Denial. DSS, as the single state Medicaid agency, makes the final administrative Medicaid Waiver eligibility decision. Typical reasons why a person may be denied enrollment are:

- a. The individual's income or assets exceed the waiver limit.
- b. The person does not meet the ICF/MR level of care requirement.
- c. The individual does not have and/or does not qualify for Medicaid.
- d. The person's service needs exceed the covered waiver service limits.
- e. The individual does not need waiver services covered by the waiver.
- f. There is no available waiver opening.
- g. The individual plan budget exceeds approved limits, has been denied by Utilization Review to exceed limits, and subsequently denied enrollment by the CO Waiver Unit.
- h. The individual has not met the priority requirements to access waiver services.

### 10.2 Service Denial

Individuals may also request an Administrative Hearing if a request for increased services provided in the waiver is denied. This is usually the result of a determination that current services are adequate to meet the individual's needs. If the individual applicant and the DDS Region are not in agreement with the Individual Plan and/or Individual Budget and PRAT recommends that the enrollment or additional services be denied the PRAT, and subsequent Utilization Review body, if applicable, must submit a DDS Form 225, PRAT HCBS Waiver Recommendation Form stating the specific nature of the dispute, the recommended decision and the justification for the decision, along with all records and forms considered in the decision to the DDS Central Office Waiver Policy Unit.

The Central Office Waiver Policy Unit will issue a final decision to the applicant and/or his/her family or legal representative, with a copy to the Case Manager within 10 business days of submission of the complete file. A waiver recipient who is denied new or additional waiver services will receive written notification of the reason for the denial including notice of the right to request a Fair Hearing convened by the Department of Social Services (DSS). Forms and directions for initiating the DSS hearing process will be included with any Notice of Denial. DSS, as the single state Medicaid agency, makes the final administrative Medicaid Waiver eligibility decision.

### 10.3 Request for Hearing

The individual will have 60 days from the date of the notice to request a hearing. The DSS Office of Legal Counsel, Regulations and Administrative Hearings will schedule and conduct

## HCBS Consolidated Waiver Operations Manual

the hearing. The DDS Region will be expected to provide any necessary documentation and testimony for the hearing.

### 11. Quality Management

The Centers for Medicare and Medicaid Services (CMS) requires that each waiver contain a Quality Management Strategy to ensure compliance with the following Federal Assurances and sub-assurances that includes:

- Process to trend and analyze discovery and remediation information.
- Process to prioritize and implement system design changes.
- Process to monitor and analyze the results of system design changes.
- Level of Care
  - An evaluation for LOC is provided to all applicants for whom there is reasonable indication that services may be needed in the future.
  - The levels of care of enrolled participants are reevaluated at least annually or as specified in the approved waiver.
  - The processes and instruments described in the approved waiver are applied appropriately and according to the approved description to determine participant level of care.
- Service Plans
  - Service plans address all participants' assessed needs (including health and safety risk factors) and personal goals, either by the provider of waiver services or through other means.
  - The state monitors service plan development in accordance with its policies and procedures.
  - Service plans are updated/revised at least annually or when warranted by changes in the waiver participant's needs.
  - Services are delivered in accordance with the service plan, including the type, scope, amount, duration and frequency specified in the service plan.
  - Participants are afforded choice: Between waiver services and institutional care; and between/among waiver services and providers.
- Qualified Providers
  - The state verifies that providers, initially and continually meet required licensure and/or certification standards and adhere to other standards prior to their furnishing waiver services.
  - The state monitors non-licensed/non-certified providers to assure adherence to waiver requirements.
  - The state implements its policies and procedures for verifying that provider training is conducted in accordance with state requirements and the approved waiver.
- Health and Welfare
  - The state, on an ongoing basis, identifies, addresses and seeks to prevent the occurrence of abuse, neglect and exploitation.
- Administrative Authority
  - The Medicaid Agency retains ultimate administrative authority and responsibility for the operation of the waiver program by exercising oversight of the performance of waiver functions by other state and local/regional non-state agencies (if appropriate) and contracted entities.
- Financial Accountability
  - State financial oversight exists to assure that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver.

# HCBS Consolidated Waiver Operations Manual

The department's approach to quality management is designed to assure that individual participants achieve meaningful personal outcomes, have the supports necessary to make choices, informed decisions, experience community opportunities and individual relationships, benefit from system safeguards, and experience satisfaction with their services, supports and desired lifestyle. The DDS Quality Management Strategy uses the automated Quality Service Review (QSR) data application to provide discovery data related to Service Plans, Level of Care Health and Welfare, and Qualified Providers.

## 11.1 Quality Service Reviews

The Quality Service Review (QSR) is the process by which the Department conducts formal reviews of Qualified Providers and the systems processes associated with supporting individuals who hire their own staff. Quality indicators are measured utilizing varied review methods including: Consumer Interview (incorporates elements of the National Core Indicators Consumer Interview and additional items for the purpose of the QSR); Support Staff Interview; Observation; Document Review; and, Safety Review.

The content of the QSR is built around seven focus areas: Planning and Personal Achievement; Relationships and Community Connections; Choice and Control; Rights, Respect and Dignity; Safety; Health and Wellness; and, Satisfaction. Within these seven focus areas, Individual Personal Outcomes and Support Expectation indicators are assessed. The review process measures both the individuals' experiences with the services and supports and the Provider and System effectiveness in supporting the individual to achieve positive personal outcomes.

## 11.2 Trending, prioritizing, and implementing system improvements

DDS has structured its Quality Improvement System (QIS) to systemically address all requirements of the Federal Assurances listed above through its organizational structures and the standing committees related to the HCBS Waivers. Regional offices assume responsibility for implementation of access to services, planning and delivery (Level of Care and Service Planning) and for substantial elements of the quality system through provision of Targeted Case Management (TCM), quality review activities, system safeguards and the maintenance of administrative functions. DDS Central Office maintains responsibility for the Division of Investigations, oversight of TCM, provider qualification, licensure and certification activities, and for systemic oversight, evaluation and analysis of data related to provider performance, system safeguards, fiscal accountability, administrative authority and quality improvement.

QSR data is aggregated and analyzed by the Department quarterly. This data, along with the routine collection of incident data, abuse and neglect data, mortality review, behavioral program review and medication management review activities, is monitored to identify particular trends or issues that may require interim quality improvement activities.

A DDS Management Information Report (MIR) is prepared quarterly by the DDS Waiver Policy Unit. It includes information on the following: DDS participant demographics; DDS referral and eligibility; service utilization; placement/access to services; waiting list data; waiver enrollment; incident data; abuse/neglect data; worker's compensation data; federal revenue; referrals to the Abuse/Neglect Registry; and psychiatric hospitalization utilization.

Annual business plans are developed by DDS Central Office divisions in conjunction with regional staff. Goals and objectives are prepared each year to support department goals generated internally or through external direction. Quality improvement information is considered in goal development and QI projects are included and integrated into these plans. Quarterly progress reports are prepared and shared with all divisions, and will be available for review by Executive staff and Quality Committees.

## HCBS Consolidated Waiver Operations Manual

Individual provider licensing results reports are posted to the DDS website. Summary deficiencies and subsequent follow-up are prepared quarterly for administrative monitoring and oversight. Statewide aggregate licensing results are prepared annually to identify trends for quality improvement.

The Department's Quest for Excellence report is prepared annually by DDS Central Office. This report includes summary information on provider performance; critical incidents and abuse/neglect allegations; mortality review; behavior medication use; and audit and revenue. The report is posted to the web, provided to the State Medicaid Agency (DSS), Legislature, Governor, all Quality Committees and Councils and is available on request to any stakeholder.

The department prepares a mortality review report in which mortality data and analysis is compiled on an annual basis to report causes of death, trends regarding mortality of individuals supported by DDS, and recommendations for systemic DDS and health care system improvement. In addition to DDS's internal mortality review process, the DDS responds to recommendations from the state's Independent Fatality Review Board annual report about system improvements needed based on their findings of mortality reviews of selected individuals served by the DDS.

The department initiates, for special circumstances, a Root Cause Analysis (RCA) for the purpose of eliminating or reducing risk of future unusual incidents that could result in untimely death or serious injury. The RCA process produces programmatic and system improvement strategies that are incorporated into the department's QIS.

The findings from the above sources are evaluated against past department performance and against other states (in the case of NCI). The information is used in the development of quality improvement initiatives and assignment of their respective priority. Discovery data and the progress and success of remediation strategies from various reports will be aggregated and shared quarterly, semi-annually, annually or as needed with a variety of department functional units as well as standing DDS committees and interest groups associated with the department. The need for improvement strategies is identified through the analysis of qualitative and quantitative data and are developed, assigned to and implemented by the appropriate organizational entity at either the regional or central office level.

Key DDS committees (DSS/DDS Joint Committee, DDS System Design Team, DDS Quality Systems Improvement (QSI) Committee, DDS Regional Quality Councils, and the DDS Private Provider Council) are responsible for trending, prioritizing, and recommending improvement strategies and system changes prompted as a result of analysis of discovery and remediation information. These committees meet periodically throughout the year to review data, make recommendations and follow up on status of improvement projects.

### **11.3 Roles and responsibilities for monitoring and assessing system design changes**

The DDS Central Office and Regional Quality Improvement Directors track and monitor overall system improvement strategies and related design changes resulting from continuous analysis of information generated by various DDS functional units. Identified improvement strategies are reviewed periodically by the key committees described below.

#### **DSS/DDS Joint Committee**

Membership: DSS and DDS Medicaid Operations and Waiver Policy and Planning Managers

The purpose of this joint committee is for DSS to assure that DDS meets federal quality requirements and expectations for the operation of its two HCBS Waivers. DSS monitors DDS's activities and performance according to the Memorandum of Understanding between

## HCBS Consolidated Waiver Operations Manual

the two agencies and associated requirements found in the Administrative Authority assurance.

### **DDS System Design Team**

Membership: DDS Central Office and Regional Executive Managers

The purpose of this committee is to monitor compliance with the six HCBS Waiver assurances and other federal, state, and agency requirements. Their responsibilities include a routine administrative review of key organizational and programmatic issues and data trends associated with the department's quality management system in order to determine and/or recommend changes in agency policy, program, infrastructure, and funding levels. The System Design Team ensures that all changes in program and practice are appropriately reflected in the agency policy, procedure, and operations manuals and communicated to stakeholders. This group works in conjunction with regional and central office Executive Management Teams to make final decisions on improvement and implementation strategies and new systems design development to advance the HCBS Waivers. They are informed by the following department functional units: Medicaid Operations, Waiver Policy and Planning, Quality Improvement, Quality Management, Provider Operations, Provider Administration and Resource Management, Legal Services and Fiscal Audit.

### **DDS Quality Systems Improvement (QSI) Committee**

Membership: DDS Central Office and Regional staff representatives from Medicaid Operations, Provider Operations, Quality Management, Quality Improvement, Information Technology, and Waiver Policy and Planning.

The purpose of this committee is to develop and/or enhance systems to collect, analyze, and report on data critical to the department's continuous quality improvement effort. This includes responsibility for developing and enhancing data collection tools/processes, overseeing the design and maintenance of data applications, compiling and interpreting quality review findings, analyzing data trends and patterns, developing and prioritizing state and regional systems improvement recommendations for administrative review, and tracking state and regional level system improvement efforts. The QSI Committee or its subcommittees work collaboratively with the Regional Quality Improvement Divisions and Quality Councils on system improvement efforts and provides regular status reports to the Systems Design Team.

### **Regional Quality Councils**

Membership: Individuals and families receiving DDS services and supports and DDS regional management team members

The purpose of the three regional Quality Councils (usually a subcommittee of the Regional Advisory Council) is to provide opportunity for consumer and family input and to review key quality findings and data trends in order to make recommendations for regional and state level systems improvement that will have a positive impact on individuals and families receiving DDS supports and services. With the support of the Regional Quality Improvement divisions, the Regional Quality Council recommendations are shared with regional management teams, and the DDS QSI Committee and Systems Design Team.

## **11.4 Periodic evaluation of the quality improvement strategy**

The department's waiver related committee structures as well as its operational units address compliance with the six waiver assurances. This allows for ongoing opportunities to modify the department's QIS. Development and deployment of new information technology applications and management reports support new levels of data collection, management, aggregation and analysis, helping the department keep pace with positive system changes resulting from successful implementation of various improvement strategies. Additionally,

## **HCBS Consolidated Waiver Operations Manual**

DDS seeks formal input and feedback from DSS about its ability to meet the HCBS Waiver requirements and assurances and how effective its QIS is in this effort. DDS works with DSS to incorporate any recommended processes that will improve the state's overall QIS.