Table of Contents

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
JFK Federal Building, Government Center
Room 2275
Boston, Massachusetts 02203

Division of Medicaid and Children's Health Operations / Boston Regional Office

July 22, 2015

Roderick Bremby, Commissioner
Department of Social Services
55 Farmington Avenue
Hartford, CT 06105

Dear Mr. Bremby:

We are pleased to enclose a copy of approved Connecticut State Plan Amendment (SPA) No 15-012, submitted to my office on June 23, 2015. Pursuant to section 1915(k) of the Social Security Act, this SPA establishes a new 1915(k) attachment to the State Plan in order to implement a Community First Choice (CFC) State Plan Option to provide home and community-based attendant services and supports. This SPA also amends section 4.19B of the State Plan to set forth the reimbursement methodology for CFC. Specifically, this SPA includes the following categories of services: Attendant Care, Home Delivered Meals, Assistive Technology, Environmental Accessibility, Transitional Services, and Coaching Services.

This SPA has been approved effective July 1, 2015, as requested by the State.

Changes are reflected in the following sections of your approved State Plan:

- Attachment 3.1K, Page 1-23
- Attachment 4.19B, Page 27-29

If you have any questions regarding this matter you may contact Marie DiMartino (617) 565-9157 or by e-mail at Marie.DiMartino@cms.hhs.gov

Sincerely,

/s/

Richard R. McGreal
Associate Regional Administrator

cc: Kate McEvoy, Director of Medical Administration - Health Services and Supports

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: 15-012

2. STATE: CT

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

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

4. PROPOSED EFFECTIVE DATE: July 1, 2015

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

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

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

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

7. FEDERAL BUDGET IMPACT:
a. FFY 2015 $5,149,000
b. FFY 2016 $33,018,000

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:

Attachment 3.1-K (all pages)
Attachment 4.19-B, Pages 27, 28, and 29

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (If applicable)
New
New

10. SUBJECT OF AMENDMENT: Effective July 1, 2015, pursuant to section 1915(k) of the Social Security Act, this SPA establishes a new Attachment 3.1-K of the State Plan to implement a Community First Choice (CFC) State Plan Option to provide home and community-based attendant services and supports. This SPA also amends Attachment 4.19-B to set forth the reimbursement methodology for CFC. CFC includes a variety of services in order to provide beneficiaries with access to home and community-based long term services and supports. Specifically, this SPA includes the following categories of services: Attendant Care, Home Delivered Meals, Assistive Technology, Environmental Accessibility, Transitional Services, and Coaching services. This SPA also describes the CFC Development Council and quality assurance measures.

11. GOVERNOR'S REVIEW (Check One):
_X GOVERNOR'S OFFICE REPORTED NO COMMENT
__COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
__NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
__OTHER, AS SPECIFIED:

12. SIGNATURE OF STATE AGENCY OFFICIAL:
/s/

13. TYPED NAME: Roderick L. Bremby

14. TITLE: Commissioner

15. DATE SUBMITTED: June 23, 2015

16. RETURN TO:

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

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: June 23 2015

18. DATE APPROVED: July 22 2015

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:
July 1 2015

20. SIGNATURE OF REGIONAL OFFICIAL:
/s/

21. TYPED NAME:
Richard R. McGreal

22. TITLE: Associate Regional Administrator
Division of Medicaid & Children's Health Operations

23. REMARKS:

FORM HCFA-179 (07-92)

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State: Connecticut

Community First Choice State Plan Option Pursuant to Section 1915(k) of the Social Security Act

1. Eligibility

A. The State determines eligibility for Community First Choice (CFC) services in the manner prescribed under 42CFR § 441.510. To receive CFC services and supports under this section, an individual must be eligible for medical assistance under the State plan and must be in an eligibility group that includes nursing facility services or must have income below 150% of the Federal Poverty Level (FPL) if they are in an eligibility group that does not include Nursing Facility services.

Individuals who are receiving medical assistance under the special home and community-based waiver eligibility group defined at section 1902(a)(10)(A)(ii)(VI) of the Act must continue to meet all 1915(c) requirements and must receive at least one home and community-based waiver service per month. Individuals receiving services through CFC will not be precluded from receiving other home and community-based long-term services and supports through the Medicaid State plan, waiver, grant or demonstration but will not be allowed to receive duplicative services as between CFC and any other available source of Medicaid coverage for home and community-based services.

For the time period between January 1, 2014 through December 31, 2018, the financial eligibility rules of section 1924 of the Act will be used to determine eligibility for married individuals who are eligible for 1915(k) services.

B. The State determines initially, and at least annually, that individuals require the level of care provided in a hospital, nursing facility, an intermediate care facility for individuals with intellectual disabilities (ICF/IID), an institution providing psychiatric services for individuals under 21, or an institution for mental diseases for individuals age 65 and older. The institutional level of care screen is completed by staff of the Department of Social Services on each individual referred to the program. Once an individual successfully completes the screen, the Department refers the individual to contracted entities for assessment. Staff at contracted entities complete the universal assessment for each individual. The universal assessment confirms institutional level of care and individual level of need.

C. The Universal Assessment (UA) is a comprehensive and person-centered assessment, surveying the -individual's physical, cognitive, and psychosocial functioning, and identifying risk factors, individual choices, and preferences, and the status of service needs. The UA identifies needs that are met utilizing voluntary natural supports, and state plan and waiver

services, thus allowing for a comprehensive assessment, including need for social supports, and service plan. The UA documents each individual's level of need and calculates that individual's budget allocation. Individuals are actively involved in the assessment process and have the opportunity to identify goals, strengths, and needs. Individuals affirm if they would like to identify anyone to participate in the planning process.

The assessors at contracted agencies who complete the universal assessment and confirm level of care assess the individual's service needs and level of care at least annually. The individual may be assessed more frequently if his or her functional needs change or if he or she or an authorized representative of the individual so requests. The assessment must include the date of review and the signature of the person conducting the assessment, indicating that the review has been completed and that the individual continues to meet the Level of Care (LOC) criteria. The assessor must also place a case note regarding this assessment in the individual's case management file. The assessor who conducts the assessments and provides ongoing monitoring is either a registered nurse (RN) licensed in Connecticut or a social services worker who is a graduate of an accredited four-year college or university. The nurse or social services worker has a minimum of two years of experience in health care or human services, but may substitute a bachelor's degree in nursing, health, social work, gerontology or a related field for one year of experience.

D. The State may permanently waive the annual LOC recertification for an individual) as defined in 42 CFR 441.510(c)(1) and (2) if it is determined that there is no reasonable expectation of improvement or significant change in the individual's condition because of the severity of a chronic condition or the degree of impairment of functional capacity. In the event that the State administering agency waives the annual recertification, the State will retain documentation of the reason for waiving the annual recertification requirement.

2. Statewideness Assurance

The state assures that CFC services and supports will be offered statewide.

3. Service Delivery Model (Agency, Self-directed model with Service Budget and/or Other)

_____ Agency Model: The Agency Model is based on the person-centered assessment of need. The Agency Model is a delivery method in which the services and supports are provided by entities under a contract.

____ Self-Directed Model with service budget: This Model is one in which the individual has both a service plan and service budget based on the person-centered assessment of need.

_____ Direct Cash

_____ Vouchers

__**X**__ Financial Management Services in accordance with 441.545(b)(1).

__X___Other Service Delivery Model as described below:

The State has an Other Service Delivery Model that largely aligns with the self-directed model with service budget. The individual has a service plan and an individual service budget based on the person-centered assessment of need. The individual has the opportunity to hire, supervise, and train their own staff as well as the opportunity to manage their own budget, either on their own or with support from someone of their choosing, but not the individual's spouse or legally liable family member.

Individual service budgets are based on need grouping categories. Need grouping categories reflect expected resource utilization based on functional needs and risks. There are 8 different categories of need based on the algorithm. Risks identified within the various domains are weighted to determine a score. Domain scores are compiled to determine a total score. Scores are grouped within the 8 categories. The state utilizes the applicable CFC rate as set forth in Attachment 4.19-B in developing individual service budgets.

4. Provider Qualifications (Other Service Delivery Model)

The Provider Qualifications for the Self-Directed/Other Model is consistent with the language under 42 CFR § 441.565: An individual has the option to permit family members or any other individuals, to provide Community First Choice services and supports identified in the person-centered plan, provided they meet the qualifications to provide services and supports established

by the individual, including additional training. However, Connecticut does not allow a spouse or legally liable family member to provide paid support under Community First Choice.

5. Included Services (Required Services & Permissible Purchases)

A. Assistance with Activities of Daily Living (ADLs), or Instrumental Activities of Daily Living (IADLs) and health-related tasks through hands-on assistance, supervision, and/or cueing.

Attendant Care

Service Definition: The State will cover Attendant Care services, which are supports related to core activities of daily living including; physical assistance and/or verbal assistance to the individual in accomplishing any Activities of Daily Living (ADLs), or Instrumental Activities of Daily Living (IADLs). ADLs may include, but not limited to, bathing, dressing, toileting, transferring, and feeding. IADLs means activities related to living independently in the community, including, but not limited to, meal planning and preparation, managing finances, shopping for food, clothing, and other essential items, performing essential household chores, communicating by phone or other media, and traveling to participate in the community. In accordance with section 20-101 of the Connecticut General Statute, Attendants may complete health maintenance tasks. These tasks may include, but are not limited to, medication administration, wound care, and vital signs under the supervision of the CFC participant.

An individual may select an Attendant care of his or her choosing but is not permitted to hire his or her spouse or anyone serving as his or her Health Care Representative, Conservator or Guardian. Under the Self-Directed/Other Model, the CFC participant has the authority to define the qualifications for his or her Attendants. Although an individual may set the qualifications for his or her Attendants, it is the State's recommendation that any Attendant hired by a participant meet the following standards:

- Be at least 16 years of age;
- Have experience providing personal care;
- Be able to follow written or verbal instructions given by the individual or the individual's representative or designee;
- Be physically able to perform the services required; and
- Receive and follow instructions given by the individual or the individual's representative or designee.

Two individuals may share an Attendant.

The State assumes the cost for a comprehensive background check on all Attendants that an individual seeks to hire. The individual receives a copy of the results in order to make an informed decision as to whether to hire the Attendant. If any criminal record is found, the individual may elect to hire the Attendant but must sign a waiver stating that he or she is aware of and understands the criminal findings.

The CFC participant will have the option to include the cost of Workers Compensation Coverage for their employees as part of their individual budget.

Limits on amount, duration or scope: The department assigns an overall budget based on need grouping that is determined by algorithm. Natural supports are based on the individual's functional assessment, which will take into consideration the availability of natural supports. Natural supports are identified during the person-centered service planning process and utilized when available to the individual. Natural supports are defined as voluntary unpaid care provided on a regular and consistent basis by a parent, spouse, or other person.

Transitional Services

Service Definition: Transitional services are non-recurring services for individuals who are transitioning from a nursing facility, institution for mental diseases, or intermediate care facility for Individuals with Intellectual Disabilities to a home and community-based setting where the individual resides. Allowable transitional services are those necessary to enable a person to establish a basic household and may include:

- essential household furnishings and moving expense required to occupy and use a community domicile, including furniture, window coverings, food preparation items and bed/bath linens;
- transportation expenses to pay for trips associated with locating housing;
- set-up fees or deposits for utility or service access, including telephone, electricity, heating and water;
- services necessary for the individual's health and safety such as pest eradication and one-time cleaning prior to occupancy.

Limit on amount and duration of scope: Transitional services funds are furnished only to the extent that they are necessary as determined through the service plan development process and

clearly identified in the service plan. The state utilizes a transitional budget form that details an inventory of services deemed necessary to move from an institution and establish a home in the community. The funds are only available if the individual is unable to meet such expenses or when the services are not voluntarily provided by a parent, spouse, or other person. Transitional services do not include room and board; monthly rental or mortgage expense; regular utility charges; and/or household appliances or items that are intended for purely diversional/recreational purposes.

Limit on amount and scope: The maximum benefit per individual over a 2 year period is $2,000. This benefit is in addition to the individual budget calculated by the need grouping.

Home-Delivered Meals

Service Definition: Home-delivered meals include the preparation and delivery of one or two meals per day for individuals who are unable to prepare or obtain nourishing meals on their own. Meals must meet a minimum of one-third of the daily recommended allowance and requirements as established by the Food and Nutrition Academy of Sciences National Research Council and double meals must meet a minimum of two-thirds of such daily recommended allowance and requirements. Special diet meals are available such as diabetic, cardiac, low sodium and renal, as are ethnic meals such as Hispanic and Kosher meals.

Limit on amount and scope: Maximum of 2 meals delivered per day.

Environmental Accessibility Adaptations

Service Definition: Those physical adaptations to the home, required by the individual's plan of care, which are necessary to ensure the health, welfare and safety of the individual, or which enable the individual to function with greater independence in the home, and without which, the individual would require institutionalization. Adaptations meet the requirement under 42 CFR § 441.520(b)(2) which provides for "expenditures relating to a need identified in an individual's person-centered service plan that increases an individual's independence or substitutes for human assistance, to the extent that expenditures would otherwise be made for the human assistance." Such adaptations may include, but are not limited to, the installation of ramps and grab bars, widening of doorways, modification of bathroom facilities, or installation of specialized electric and plumbing systems that are necessary to accommodate the medical

equipment and supplies that are necessary for the welfare of the individual. Excluded are those adaptations or improvements to the home that are of general utility, and are not of direct medical or remedial benefit to the individual. Adaptations that add to the total square footage of the home are excluded from this benefit. All services shall be provided in accordance with applicable State or local building codes.

Limit on amount and scope: The maximum benefit per individual over a 5 year period is $15,000. This benefit is in addition to the individual budget calculated by the need grouping.

Assistive Technology (AT)

Service Definition: Any item, piece of equipment, or product system, whether acquired commercially, modified, or customized, that is used to increase, maintain, or improve functional capabilities of participants to perform or seek assistance with Activities of Daily Living (ADLs) or Instrumental Activities of Daily Living (IADLs). Assistive Technology meets the requirement under 42 C.F.R. § 441.520(b)(2), which provides for "expenditures relating to a need identified in an individual's person-centered service plan that increases an individual's independence or substitutes for human assistance, to the extent that expenditures would otherwise be made for the human assistance." Assistive technology service means a service that directly assists a participant in the selection, acquisition, or use of an assistive technology device, including:

- services consisting of purchasing, leasing, or otherwise providing for the acquisition of assistive technology devices;
- services consisting of selecting, designing, fitting, customizing, adapting, applying, maintaining, repairing, or replacing assistive technology devices; and/or
- training or technical assistance for the participant, Attendant, or where appropriate, the participant's family members, guardian, advocate or authorized representative.

Limit on amount and scope: The maximum allowance per individual is $5,000 per calendar year

B. Acquisition, maintenance, and enhancement of skills necessary for the individual to accomplish ADLs, IADLs, and health-related tasks.

Service Definition: Services to support the acquisition, maintenance, and enhancement of skill in order for the individual to accomplish ADLs, IADLs and health-related tasks. Providers for

acquisition, maintenance, and enhancement of skill in order for the individual to accomplish ADLs, IADLs: Attendants

Providers for acquisition, maintenance, and enhancement of skills in order for the individual to accomplish health related tasks: Registered Nurses, Occupational Therapists, Physical Therapists, and Speech Therapists provide maintenance, and enhancement of skill in order for the individual to accomplish health related tasks. These services provide teaching strategies and educational opportunities for individuals to become more independent in their health-related tasks. These services are provided by licensed staff at home health agencies. Staff are required to complete a certification in person-centered planning.

Limit on amount and scope of services to support the acquisition, maintenance, and enhancement of skill in order for the individual to accomplish ADLs, IADLs and health-related tasks. Services associated with skill acquisition, maintenance and enhancement are on a per person basis. Support is time-limited and may not exceed 25 hours per three-month period. It is available only when there is a reasonable expectation that the individual will acquire the skills necessary to perform the task within the time period. Services exceeding this limit may be re-authorized by the Department if significant progress has been made, or if services are determined to be medically necessary and there is a reasonable expectation that services will support skill acquisition.

C. Backup systems or mechanisms to ensure continuity of services and supports

Backup Systems

Service Definition: Each person-centered care plan will include a formal backup system. This "system" will vary based on the individual's needs and concerns. A formal backup system may consist of Assistive Technology devices and monitoring systems to help ensure the health and safety needs of the individual, as well as names and numbers of paid support and unpaid natural supports who can be called on in an emergency. Monitoring systems include, but are not limited to, home video monitoring systems, Personal Emergency Response Systems, and wireless sensors. Each backup system is individualized and identified in the person-centered care plan.

Limit on amount and scope: Back-up systems are created based on outcomes of the UA and the person-centered planning process.

D. Voluntary training on how to hire, manage or dismiss staff

Training

Service Definition: Training will be offered to participants via one-on-one (1:1) assistance or web-based training. 1:1 assistance will be fulfilled through a self-hired support and planning coach. The web-based option may be fulfilled through free online e-learning modules through the State of Connecticut Connect-Ability website or other on-line training programs.

Support and Planning Coach Qualifications:
- Be 21 years of age;
- have a completed criminal background check;
- have a completed registry check;
- demonstrate ability, experience and/or education to assist the individual and/or family in the hiring, management of personal care assistance and with other community services detailed in the participant's plan;
- demonstrate competence in knowledge of DSS policies and procedures: abuse/neglect; incident reporting; human rights and confidentiality; handling fire and other emergencies, prevention of sexual abuse, knowledge of approved and prohibited physical management techniques;
- demonstrate understanding of the role of the service, of advocacy, person-centered planning, and community services;
- demonstrate understanding of self-hiring protocols and DSS fiscal management policies;
- have certification as Aging and Disability Specialist or person centered planning certificate and continue to meet annual recertification in person centered planning requirements; and
- Other qualifications as determined by the participant.

Experience: Five years of experience in a professional capacity in a disability or health organization. College training may be substituted for the General Experience on the basis of fifteen (15) semester hours equaling one half (1/2) of a year of experience to a maximum of four (4) years for a Bachelor's degree. A Master's degree in public health, social work, or rehabilitation may be substituted for General Experience.

Limit on amount and scope: This service is limited to an annual limit of $500 per participant.

6. Home and Community-Based Services (HCBS) Setting

CFC services will be provided in residential settings that have been determined by the State to have met the home and community-based setting requirements outlined in 42 C.F.R. § 441.530. CFC residential settings include individual homes or apartments that meet CFC residential criteria.

CFC services are not available in any of the settings outlined in Section 1915(k)(1)(A)(ii) of the Social Security Act. These include nursing facilities, institutions for mental diseases, and intermediate care facilities for individuals with intellectual disabilities. In addition, CFC services are not available in group homes that serve individuals with developmental disabilities, group homes that serve people with psychiatric conditions, or assisted living environments. CFC services are also not provided in non-residential provider-owned or operated settings. These settings are explicitly excluded either because the state has determined that these settings do not meet the settings requirements in 42 CFR 441.530.

7. Assessment of Need– Who is conducting and frequency

A DSS nurse or social worker performs a level of care screening evaluation of each applicant. Level of Care will be met if the individual requires the level of care provided in a hospital, nursing facility, an intermediate care facility for individuals with intellectual disabilities (ICF/ID), an institution providing psychiatric services for individuals under 21, or an institution for mental diseases for individuals age 65 and older. Confirmation of a participant's level of care is determined by information gathered by assessors at contracted entities during initial assessment and annual re-assessment via face-to-face interviews utilizing the Universal Assessment (UA). Both assessment and re-assessment include a thorough evaluation of the client's individual circumstances.

The UA is based on the InterRAI tool. The UA is a validation tool used to confirm level of care and calculate a level of need based on the identified needs of the participant. The UA assesses a participants Activities of Daily Living (ADLs) and Instrumental Activities of Daily Living (IADLs) needs as well as taking into account their health, rehabilitation needs, and their natural supports.

Assessor qualifications: The assessorwho conducts the assessments and provides ongoing monitoring is either a registered nurse (RN) licensed in Connecticut or a social services worker

who is a graduate of an accredited four-year college or university. The nurse or social services worker has a minimum of two years of experience in health care or human services, but may substitute a bachelor's degree in nursing, health, social work, gerontology or a related field for one year of experience.

Additional qualifications of assessors:

The assessor must demonstrate interviewing skills that include: the professional judgment to probe as necessary to uncover underlying concerns of the applicants; demonstrate ability to establish and maintain empathetic relationships; experience in conducting social and health assessments; knowledge of human behavior, family/caregiver dynamics, human development and disabilities; awareness of community resources and services; and the ability to understand and apply complex service reimbursement issues.

8. Person-Centered Service Plan (PCSP)

Assessors complete the assessment which confirms level of care and level of need. The need grouping is associated with a budget allocation. The assessment produces a person-centered summary that the individual may use to help inform their care planning process. Assessors are responsible for informing individuals about the care planning process, how to use an individual budget, the various services available, the assessment summary, and the option to either develop a care plan independently, with support of family and/or friends, or with a Support and Planning Coach. Each individual has a Person-Centered Service Plan (PCSP). A PCSP is intended to meet all of the individual needs of the participant. This planning process, and the resulting person-centered service plan, provides the framework for the individual to achieve personally defined outcomes in the most integrated community setting, ensure delivery of services in a manner that reflects personal preferences and choices, and contribute to the assurance of health and welfare. The individual has the ability to select from the services offered within CFC as well as the existing Medicaid State Plan based on the areas of need determined in the UA aligned with their personal goals. The PCSP addresses individual's' need for assistance with Activities of Daily Living (ADLs), Instrumental Activities of Daily Living (IADLs), and health-related tasks through hands-on assistance, supervision, and/or cueing. It also addresses the acquisition, maintenance, and enhancement of skills necessary for the individual to accomplish ADLs, IADLs, and health-related tasks.

9. Describe how Support Services are provided

Fiscal Intermediary Services (FI)

Service Definition: The role of the fiscal intermediary (FI) will be to provide FI Management Services, through which individuals will be able to manage their individual budgets and to pay providers. Individuals will also have access to the FI for the purpose of paying for other services that are approved within their PCSP. Principal functions of the FI will include:

- collection and processing of timesheets submitted by the individual's Attendant;
- processing payroll, withholding, filing, and payment of applicable Federal, State, and local employment-related taxes and insurance;
- individual tracking of budget funds and expenditures for each individual;
- tracking and reporting of disbursements and balances of each individual's funds;
- processing and payment of invoices for services in each PCSP; and
- provision of periodic reports to each individual and the State of each individual's expenditures and the status of each approved service budget.

10. State Assurances

(A) The State assures that any individual meeting the eligibility criteria for Community First Choice Option (CFCO) will receive CFC services.

(B) The State assures there are necessary safeguards in place to protect the health and welfare of individuals who are provided services under this State Plan Option, and to assure financial accountability for funds expended for CFCO services.

(C) The State assures the provision of consumer-controlled home and community-based attendant services and supports to individuals on a statewide basis, in a manner that provides such services and supports in the most integrated setting appropriate to the individual's needs, and without regard to the individual's age, type or nature of disability, severity of disability, or the form of home and community-based attendant services and supports that the individual requires in order to lead an independent life.

(D) With respect to expenditures during the first full fiscal year in which the State plan amendment is implemented, the State will maintain or exceed the level of State

expenditures for home and community-based attendant services and supports provided under section 1905(a), section 1915, section 1115, or otherwise to individuals with disabilities or elderly individuals attributable to the preceding fiscal year.

(E) The State assures the establishment and maintenance of a comprehensive, continuous quality assurance system with respect to community-based attendant services and supports.

(F) The State assures the collection and reporting of information, including data regarding how the State provides home and community-based attendant services and supports and other home and community-based services, the cost of such services and supports, and how the State provides individuals with disabilities who otherwise qualify for institutional care under the State plan or under a waiver the choice to instead receive home and community-based services in lieu of institutional care.

(G) The State shall provide the Secretary with the following information regarding the provision of home and community-based attendant services and supports under this subsection for each fiscal year for which such services and supports are provided:

(i) The number of individuals who are estimated to receive home and community-based attendant services and supports under this option during the fiscal year.

(ii) The number of individuals that received such services and supports during the preceding fiscal year.

(iii) The specific number of individuals served by type of disability, age, gender, education level, and employment status.

(iv) Whether the specific individuals have been previously served under any other home and community-based services program under the State plan or under a waiver.

(H) The State assures that home and community-based attendant services and supports are provided in accordance with the requirements of the Fair Labor Standards Act of 1938 and applicable Federal and State laws.

(I) The State assures it established a Development and Implementation Council prior to submitting a State Plan Amendment in accordance with section 1915(k)(3)(A). The council is primarily comprised of consumers who are individuals with disabilities, elderly individuals and their representatives.

11. Describe the State's Quality Assurance and Improvement Plan

The Quality Management (QM) system will at a minimum address:

- Health and safety issues of consumers receiving HCBS
- Abuse/neglect/exploitation of consumers
- Consumer access to services
- Availability of services
- Complaints regarding service delivery
- Training of providers, assessors and other stakeholders
- Emergency procedures
- Provider qualifications
- Consumer choice

The QM system shall continuously improve quality through discovery, remediation and system improvement process. Data shall come from a variety of sources, including HCBS provider databases, site reviews, follow-up compliance reviews, complaint investigations, evaluation reports, consumer satisfaction surveys, consumer interviews and consumer records.

There are three components to the QM system: quality control, quality assurance and quality improvement (QI). Each component is responsible for discovery, remediation and improvement.

At a local or direct service level, quality control standards will establish an expectation of quality service. Examples of quality service will include, but are not limited to, direct care workers arriving on time to assist participants, person-centered planning, and completing the level of care assessment in a consistent manner. Persons involved in the care delivery system at a local level are expected to hold themselves accountable for quality service. Local level management of those providing care is expected to implement an effective quality control plan. An effective plan includes the provision of routine and consistent checks to ensure the integrity, correctness and completeness of the operation, and to identify and address errors and omissions. Quality control

procedures are the responsibility of each contractor or operating agency providing services under CFC.

CFC QA staff will be accountable to ensure effective quality assurance. The primary responsibility of QA staff is to seek evidence that required quality controls are in place at a service or support delivery level. Data from all QA activities will be compiled by the CFC evaluation staff on a regular basis and presented to the CFC program manager. Evaluation staff will analyze the data in coordination with QA staff to determine patterns, trends, problems and issues in delivery of CFC services. This process will identify opportunities to improve the delivery system through training and technical assistance (TTA). CFC TTA staff will be responsible for coordinating training opportunities designed to improve performance. CFC staff will prepare and submit quarterly QA reports to the Medicaid Director. The reports will also be shared with the CFC Development Council and the QI Committee, which will make recommendations regarding follow-up to the Medicaid Director.

The third component of the quality management system is the QI initiative. While the CFC staff will provide assurances that controls are functioning at a local level to continually improve performance, quality control and assurance alone cannot address system-wide problems. CFC provides the opportunity to address weaknesses in the State's community long-term services and supports (LTSS) system that impact the delivery of services across all agencies and negatively impact participant satisfaction. Analysis of QA data that points to systemic problems require broader policy change and will be referred to the QI Committee. The QI Committee will be comprised of identified HCBS staff from various State agencies, a representative from the CFC Advisory Council, selected providers and selected participants.

12. How the State will conduct activities of discovery, remediation, and quality improvement in order to ascertain whether the program meets assurances, corrects shortcomings, and pursues opportunities for improvement

A. Community First Choice will adopt the waiver Quality Management Strategy where appropriate.

B. CFC will have a Quality Management Strategy designed to review operations on an ongoing basis, discover issues with operations, remediate those issues, and develop quality improvement strategies to prevent the repeat of operational problems. The

State Medicaid Agency will oversee the cross-agency Quality Improvement Committee (QIC). The QIC will meet regularly to address quality issues through data analysis, share program experiences and information, and further refine the community long-term services and supports (LTSS) quality management systems. Quality Management strategies will be coordinated with ongoing waiver quality management strategies since many CFC participants will also be served under 1915(c) waivers.

C. CFC will require regular reporting and communication among the providers, the fiscal intermediary, and other stakeholders, including the CFC council, which will facilitate discovery and remediation. The Medicaid agency (the Department of Social Services) is the lead entity responsible for trending, prioritizing and determining system improvements in coordination with the QI Committee and based on analysis of relevant data. If needed, topical task groups, which may include stakeholders, may also be formed.

D. CFC staff will document receipt of program data. Data sources include, but are not limited to: provider enrollment documents, provider and participant audits, the critical incident reporting system, utilization review data, participant quality of life data and other reporting. Data reflecting systemic problems will be documented and presented by CFC staff to the QI Committee for discussion and recommendation of systems improvement strategy.

E. In accordance with the DSS policies and procedures, all critical events will be reported in the DSS critical event tracking system according. All Critical Incident events will be reviewed by CFC staff and resolved. The review process will include analysis. If the analysis points to a systemic problem, the matter will be forwarded to the QI Committee for review and recommendation.

13. The system performance measure, outcome measures, and satisfaction measures that the State will monitor and evaluate

Community First Choice will utilize the performance, outcome and satisfaction measures as established by the State. Connecticut's participation with the Testing Experience and Functional Tools in Community- Based Long Term Services and Supports, Planning and Demonstration (TEFT) Grant will help inform CFC on satisfaction measures.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State: Connecticut

Community First Choice State Plan Option Pursuant to Section 1915(k) of the Social Security Act

Requirement	Monitoring Activity	Monitoring Responsibilities	Evidence	Reports	Frequency
Level of care	1) Review of assessment after developed 2) QA review process	1) Assessors' Supervisor, CFC staff 2) DSS QA staff	1) Timeliness and appropriateness of level of care 2) Level of care determination consistent with policies and procedures; paperwork in file	Yes	1) All plans every 12 months 2) Continuous; representative sample of all assessors per year

Service Plans address assessed needs of enrolled participants, are updated annually, and document choice of services and providers.	1) Review of plan after developed 2) QA review process	1) Contracted assessors; CFC staff 2) DSS staff	1) Service plan checklist in file 2) Consumer interview	Yes	1) All plans every quarter; 2) Continuous; representative sample of case plans per year
Requirement	**Monitoring Activity**	**Monitoring Responsibilities**	**Evidence**	**Reports**	**Frequency**
Providers meet required qualifications	1) Annual compliance review; 2) QA files and organization outcomes review	1) Central office staff, case managers and fiscal intermediaries 2) DSS QA staff	1) Documentation of certification; reliability of performance 2) Required certification or licensure; access for participants and reliability of performance	Yes	1) Sample 100 CFC providers per year 2) All files annually

Health and welfare	1) Service plans address health/welfare; individualized emergency back-up plans. 2) Incident reporting to DSS 3) Abuse and neglect	1) Case managers 2) Providers with compliance checks by QA staff 3) Waiver managers and/or DSS Protective Services	1) Service plans 2) Incident reports 3) Abuse/neglect reports, Consumer Satisfaction Survey/interview	Yes	1) Continuous 2) Continuous 3) Continuous

Requirement	Monitoring Activity	Monitoring Responsibilities	Evidence	Reports	Frequency
The DSS retains authority and responsibility for program operations and oversight	1) Program oversight by DSS' Division of Health Services 2) DSS' QA initiative	1) Program specialist 2) QA coordinator	1) State Plan, administrative rules, provider manuals 2) QA plan and activity tracking — Data sources: Medicaid claims, Pharmacy claims,	1) Yes	1) Continuous 2) Continuous

			Assessment data, Consumer survey, Program records/reports, Chart review		
Settings meet HCB settings rule	1)Service plan addresses setting rule – LRE document completed 2)QoL collects data from participant 3)QA Initiative -Webbased system documents compliance at service approval	1)Case Managers 2)QA coordinator 3)QA coordinator	1) Service Plan;LRE document 2)QA plan activity tracking 3QA plan activity tracking	1) Yes 2)Yes 3)Yes	1)Continuous 2)Continuous 3)Continuous
DSS maintains financial accountability through payment of claims for services that are authorized and furnished to enrolled participants by qualified providers	1) MMIS system assures claims are paid within authorized limits for each individual 2) QA audits	1) Program specialist 2) QA coordinator	1) Authorization data 2) Financial reports, management letters; state audit	1) Yes	1) Continuous 2) Continuous

The State will be responsible to meet all required benchmarks as stipulated under the Final Rule. The State will:

1) Develop its Community First Choice benefit with the input of a stakeholder council that includes a majority of members with disabilities, elderly individuals, and their representatives;
2) Establish and maintain a comprehensive continuous quality assurance system specifically for this Community First Choice benefit;
3) Collect and report information for Federal oversight and the completion of a Federal evaluation of the program; and
4) For the first 12-month period in which the Community First Choice benefit is implemented, maintain or exceed the level of State expenditures for home and community-based attendant services provided under the State plan, waivers or demonstrations for the preceding 12-month period.

14. Describe the system for mandatory reporting, investigation and resolution of allegations of neglect, abuse, and exploitation in connection with the provision of CFC services and supports

Connecticut employs strict procedures regarding the reporting of abuse, neglect, and exploitation. These procedures are established by State statute and regulation. While the procedures and managing systems differ for those agencies serving children, individuals with intellectual disability, individuals with significant and persistent mental illness, individuals with physical disabilities and elders, each has the same objective: to identify, address and seek to prevent instances of abuse, neglect and exploitation. CFC participants could be served by the agencies listed below. Those agencies' abuse and neglect polices are also provided below.

State case managers and contracted assessors are required to provide information on reporting of abuse, neglect and exploitation to participants at least annually. The State is responsible for all caregiver training content including the obligations of mandatory reporters per statute.

Department of Social Services (DSS)

DSS utilizes standard language in its contracts with the Access Agencies that are providing home and community-based services that addresses incident reporting for clients served. All members

of the participant's care planning team, support staff and service agency staff members are required to report critical incidents. Recipients of Critical Incident reports include:

- Participant's case manager or social worker depending on the program;
- Cognitive behaviorist (if there is one);
- Participant and/or Conservator;
- DSS Central Office (program manager/social work supervisor) if applicable;
- DDS Central Office, if applicable; and
- DMHAS Central Office, if applicable.

Relevant policies on incident reporting are posted on the Department's website at http://www.ct.gov/dss.

15. Describe the State's standards for all service delivery models for training, appeals for denials and reconsideration procedures for an individual's person-centered service plan

Applicants for and participants under this State Plan Amendment may request and receive a fair hearing in accordance with standard procedures and requirements applicable to all Medicaid fair hearings. Applicants will receive a copy of appropriate materials describing informed consent and beneficiary rights and responsibilities during the first visit with the Assessor.

16. Describe the quality assurance systems' methods that maximize consumer independence and control and provide information about the provision of quality improvement and assurance to each individual receiving such services and supports

Community First Choice will be entirely self-directed. The following options will be offered to all participants to ensure the individual has independence and control:

- The individual will be offered voluntary training on self-direction through the provision of support broker services. This training will be available to all participants who request assistance with matters related to hiring, firing, and managing employees.

- Participants will be directed to free web-based trainings and e-learning opportunities that will help with self-direction and staff management.

- At all assessments, assessors will provide the participant with a list of community resources specific to their region of the state as well as statewide resources.

- Participants will be offered opportunities to request meetings with their assessors if they feel they need to review or revise their service plans.

- The public will have the opportunity to comment ongoing on the Community First Choice Initiative via public meetings and publication of email addresses for the members of the CFC Development Council.

- Contractors will be subject to routine oversight to ensure they are satisfying the terms of CFC and their contracts.

- The CFC Development Council will continue to meet regularly and will ensure that at least 51% of membership consists of members with disabilities, elderly individuals, their representatives, and advocates.

- Participants will annually have the opportunity to complete surveys that document their experience with self-direction.

17. Describe how the State will elicit feedback from key stakeholders to improve the quality of CFC services

The State, in collaboration with the Community First Choice Development Council, will elicit feedback from individuals and their representatives, disability organizations, providers, families of disabled or elderly individuals, members of the community and others to improve the quality of the community-based attendant services and supports benefit. The council played an integral role in the development of this State Plan Amendment and will continue to play an integral role. Members of the CFC Development Council will publish their e-mail addresses on the State website for CFC and will hold public meetings to elicit feedback.

18. The state must submit a 4.19B page to describe the Payment Methodology.
Attachment 4.19-B pages are being submitted simultaneously with the 3.1-K pages.

Community First Choice State Plan Option
Pursuant to Section 1915(k) of the Social Security Act

The payment methodology described below applies to all services and supports provided under Connecticut's Community First Choice (CFC) State Plan Option pursuant to section 1915(k) of the Social Security Act, as described in and provided in accordance with Attachment 3.1-K of the Medicaid State Plan.

Except as otherwise provided below, CFC services are paid pursuant to the current fee schedule for CFC, which was set as of July 1, 2015, and is effective for services provided on or after that date. The fee schedule can be accessed and downloaded by going to the Connecticut Medical Assistance Program website: www.ctdssmap.com. From this web page, go to "Provider," then to "Provider Fee Schedule Download." All governmental and private providers are reimbursed according to the same fee schedule. Medicaid payment under CFC does not include payment for room and board.

Payments are made by the Medicaid agency directly to the providers of State plan services or to the Fiscal Intermediary to disperse payments. Payments for all State plan services are made through the State's Medicaid Management Information System (MMIS).

As set forth on the fee schedule referenced above, the following CFC services are reimbursed as described below:

Attendant Care: Attendant care rates are billed under five distinct payment methodologies, each of which is based on the plan of care and the specific circumstances of the services provided, as follows:

1. Hourly Rate: When care is provided over a period of time which is neither live-in care for a continuous twenty-four hour period, nor a 12-hour overnight shift, a quarter-hour rate is used.

2. Per Diem Rate: When care is provided for a continuous twenty four hour period by a live-in attendant, a per diem rate is billed, which assumes that the attendant receives at least eight hours of sleep, at least five of which is uninterrupted.

3. Pro-Rated Per Diem Rate: When the 24 hour shift is not completed, services are billed at a pro-rated per-diem rate.

4. Overnight Rate: When care is provided overnight for a twelve-hour period, services are billed under an overnight rate, which assumes that the attendant sleeps for half of the hours.

Community First Choice State Plan Option
Pursuant to Section 1915(k) of the Social Security Act

5. Pro-rated Overnight Rate: The pro-rated overnight rate is used when the twelve hour shift is not completed.

The client who self-hires an attendant can decide the pay rate up to the maximum allowable rate. The attendant rate is now determined by a collective bargaining agreement between the state and SEIU 1199 and ranges from $12 to $13.03 per hour for the time period of 7/1/13 through 6/30/17. A renegotiation of the terms of the contract will take place beginning between September 1, 2015 and October 1, 2015 absent mutual agreement to a different time period. Sharing an attendant is also an option. The rate for sharing an attendant between 2 participants is 150% of the rate applicable to an attendant providing services to a single participant. The shared attendant rate is distributed evenly between the individual budgets for the 2 participants. All applicable employer taxes are added to the pay rate to determine the Medicaid rate.

Attendant Care services that are not currently covered under the collective bargaining agreement include: overnight attendant care, pro-rated overnight attendant care, per diem attendant care, and pro-rated per diem attendant care. Max fees are published on the CFC Fee Schedule.

Workers Compensation: The CFC participant will have the option to include the cost of Workers Compensation Coverage for their employees as part of their individual budget. Workers Compensation will be calculated in accordance with the State of Connecticut Worker's Compensation Commission and the State of Connecticut Department of Labor.

Transitional Services: The cost of transitional services is over and above the cost limit for the reoccurring individual service budget. The total permissible allocation per individual will be $1,200.00 over a 2 year period. Transitional services are subject to prior authorization. Department utilizes an approved inventory of transitional services as a standard for the transitional service needs assessment. Funding is provided for the participant to acquire services detailed within the inventory based on the participant's need for the service.

Assistive Technology (AT): Purchase of AT is subject to prior authorization by the State. In support of this, the participant is required to submit three bids for the purchase. The aggregate limit for this service is $5,000 per individual budget year.

Home-Delivered Meals: Services will be reimbursed in accordance with the current negotiated rates for these services found on the CFC fee schedule.

Community First Choice State Plan Option
Pursuant to Section 1915(k) of the Social Security Act

Environmental Accessibility Adaptations: Costs must be substantiated by invoices prepared and submitted by approved State vendors and are subject to prior authorization by the State. The aggregate cost for this service is $15,000 over a 5 year period.

Home Health Services: Services will be reimbursed in accordance with section 7 of Attachment 4.19-B of the State Plan.

Backup Systems: Electronic monitoring service rates will track the current Medicaid rates as indicated on the CFC Fee Schedule. If there is not a current rate on the CFC fee schedule for the proposed Backup System, a minimum of three invoices will be submitted by approved State vendors and are subject to prior authorization by the State.

Training: The Planning and Support Coach will be providing 1:1 training to educate individuals on how to hire, manage, and self-direct their staff. The Planning and Support Coach will be reimbursed in accordance with the CFC fee schedule.

Acquisition, maintenance, and enhancement of skill in order for the individual to accomplish health related tasks: Registered Nurses, Occupational Therapists, Physical Therapists, and Speech Therapists may provide services for acquisition, maintenance, and enhancement of skills in order for the individual to accomplish health related tasks. These services provide teaching strategies and educational opportunities for individuals to become more independent in their health-related tasks. Services are provided by licensed staff from home health agencies. These providers are required to complete a certification in person-centered planning. Payment for this service is in accordance with the current Medicaid negotiated Provider Specific Rates for the Home Health Agency the individual chooses to work with.