Community First Choice

Operating Manual

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Contents

Introduction to Community First Choice Option

Community First Choice (CFC) is a Medicaid state plan option that offers services and supports to Medicaid participants who are at institutional level of care so that they can live in the community rather than in an institution. Modeled after the successful Cash and Counseling Demonstration[1], CFC includes services such as personal care assistance as well as services that increase independence such as health coaches.

Administered by the Money Follows the Person Unit of the Department of Social Services' Division of Health Services, CFC is a self-directed alternative to traditionally delivered and managed services, such as an agency delivery model. It allows participants to have the responsibility for managing all aspects of service delivery in a person-centered planning process.

Self-direction promotes personal choice and control over the delivery of services, including who provides the services and how services are provided. For example, participants are afforded the decision-making authority to recruit, hire, train and supervise the individuals who furnish their services. This is called "employer authority." Participants also have decision-making authority over how the Medicaid funds in a budget are spent. This is referred to as "budget authority".

Budget authority represents a key difference between CFC and waivers. A CFC participant's budget is based on his or her level of need for supports and services. CFC budgets are separated into four sections. The sections are as follows:

- assistance with hands-on-care, cueing, and supervision;
- assistance with managing an individual budget and/or staff;
- assistance with back-up supports;
- assistance to increase independence with health-related tasks and/or daily living tasks.

Within these four sections, participants may reallocate funds. Reallocation between sections is not permitted without approval of the Universal Case Manager and the Department. The fiscal intermediary (FI) supports the participant by tracking expenditures and unspent budgeted funds. The FI ensures that the participant does not spend more money than available within his or her individual budget and that funds are spent according to the approved plan.

"This approach gives people with disabilities more freedom and responsibility in the same way that all of us want to be in charge of our lives and our choices. It lets the individuals themselves decide how to best use the Medicaid dollars they are already entitled to."—Tommy G. Thompson, HHS Secretary during the *Cash & Counseling* demonstration phase.

[1] Robert Woods Johnson Program Results Report- Cash and Counseling, Originally Published: June 11, 2013, Last Updated: February 28, 2015

Another key difference between CFC and waivers is the degree of control participants are given regarding development of their service plan. CFC begins with the assumption that participants choose to develop and manage their own service plan. Development of the service plan in the waiver system is typically assigned to a case manager. If CFC participants choose to have formal assistance with development and management of their service plan, they may choose from a list of Support and Planning Coaches. Support and Planning Coach is a case management service designed to empower the individual. Within the CFC model, the participant develops his or her own service plan with the support of a Coach; the Coach does not develop the plan for the participant.

Community First Choice establishes a new paradigm. For those who seek the highest degree of choice and control, the option now exists. In addition, this new benefit establishes an entitlement of community service and supports so that people who were once limited by waiting lists or lack of community options, can now choose to continue participating in their community in lieu of moving to a nursing home.

CFC Frequently Used Terms

Fiscal Intermediary (FI) – The FI supports participants with payroll assistance and with budget assistance. Assistance includes enrolling the participant as an employer, paying the participant's staff, ensuring appropriate payroll taxes are paid, keeping track of participant expenditures against his or her approved budget, and submitting all approved expenditures to the MMIS. The FI also provides service authorization to agency providers selected by the participant.

Health Coach – A health coach works for a licensed home health agency. The coach may be a licensed, registered nurse, an occupational therapist, a speech therapist, or a physical therapist. The service differs from the existing home health service since within the stated authorization limits of CFC, the service does not have to meet the medical necessity rule. The service may be used by a participant for education and empowerment or for purposes that support goals related to community participation.

Individual Budget – The individual budget is the portion of the participant's total budget that is managed by the participant. The individual budget funds CFC services. Payments approved within the Individual Budget are paid by the participant's FI.

Need Grouping – The need grouping is calculated by an algorithm which is based on information entered into the UA. There are 8 need groupings with group 1 indicating the lowest level of need and group 8 indicating the highest level of need. Each need group is associated with a total budget limit.

Support and Planning Coach – The Support and Planning Coach is a participant directed case management service. The service includes support with developing a service plan, support managing an individual budget, and support recruiting, hiring and managing employees.

Total Budget – The total budget is determined based on the UA need grouping. The total budget includes funding for both traditional and CFC services.

Traditional Services – Traditional services are home and community based services, other than CFC services, provided under the Medicaid state plan or a waiver.

Universal Application (UAPP) – The UAPP is a single web based assessment applicable to all CFC and waiver participants. It is based on functional status rather than age, diagnosis, or disability type.

Universal Assessment (UA) – The UA is a single application for services accepted by CFC and all waivers.

Universal Case Manager (UCM) – The UCM is authorized to complete assessments for CFC participants, Personal Care Assistance Waiver participants, certain participants of the Acquired Brain Injury Waiver, and Elder Waiver participants including participants of the broader Connecticut Home Care Program. If participants are enrolled in both CFC and one of the other aforementioned programs, the UCM is the single case manager.

Universal Supervisor (US)- The US supervises the UCM.

Implementation of CFC Statewide

The Department of Social Services, Division of Health Services submitted a request to amend the state's Medicaid State Plan for the purpose of implementing the CFC option effective June 23, 2015. The amendment was approved on July 22. There are four phases to implementation of CFC.

Phase 1 Implementation

Effective July 1, DSS began accepting applications from eligible individuals. Applicants are encouraged to apply electronically utilizing the state's universal application (UApp) located at https://www.ctmfp.com/cfc/. Paper UApps are also available upon request. People who need assistance with completing the UApp should dial 211 between the hours of 8:30 AM and 5 PM. DSS accepts a completed inter-agency referral form, in lieu of the UAPP, for those applicants who have submitted a waiver application

Phase 2 Implementation

Participants who currently receive personal care assistance under the Personal Care Assistance Waiver and the Acquired Brain Injury Waiver II began receiving personal care assistance under CFC with an effective date of July 1, 2015. Payroll statements reflecting service dates of August 9, 2015 or after reflect the new CFC format. Budgets for participants covered under a waiver automatically convert to individual budgets. For those covered under the PCA waiver, CFC Individual budgets are based on the current annualized service budget for personal care assistance, PERs, and assistive technology. For those covered under the ABI II waiver, CFC individual budgets are based on the current annualized service budget for personal assistance. This excludes any costs for monthly tiered case management which continues as a waiver service. Notice of the change was sent to waiver participants through the mail.

Phase 3 Implementation

Participants who currently receive personal care assistance under the Elder Waiver began receiving personal care assistance under CFC with an effective date of July 1, 2015. Payroll statements reflecting service dates of November 9, 2015 or after reflect the new CFC format. Notice of the change was sent to waiver participants through the mail.

Phase 4 Implementation

Participants who currently receive personal care assistance under the ABI 1 waiver began receiving personal care assistance under CFC with an effective date of December 1, 2015. Payroll statements reflecting service dates of January 20 or after reflect the new CFC format. Notice of the change was sent to waiver participants through the mail.

Evaluation

The University of Connecticut's Center on Aging is conducting an evaluation of the universal assessment implemented with CFC, and more specifically, of the algorithm and budget allocation methodology. A report including recommendations for any needed revisions will be provided following the evaluation period. Recommended changes to the Universal Assessment will be considered before the Universal Assessment is fully launched in 2017. At that time, the algorithm and budget allocation methodology will be implemented statewide.

1 Program Eligibility and Access to CFC

CFC is a new comprehensive Medicaid State Plan benefit for those who choose to self-direct. For most people, this flexible benefit provides all of the self-directed supports and services necessary for an individual to remain in or return to the community. Like other State Plan benefits, participants must be eligible for coverage under a Medicaid coverage group. Coverage groups include Husky A, Husky C and Husky D. This includes participants who are covered under a home and community-based waiver and participants who are covered under Med-Connect. If participants are covered under a waiver, they must continue to receive at least one waiver service in order to maintain Medicaid coverage under the waiver. For participants who are covered under the Medically Needy category, spend-down rules apply.

In addition to having Medicaid, participants must meet institutional level of care criteria.

CFC participants who are receiving services under a waiver must count the cost of CFC services toward their monthly waiver service plan caps.

Specific eligibility requirements are as follows:

- the participant must meet Medicaid financial eligibility requirements;
- a Universal Assessment completed by an authorized professional must confirm that the participant requires institutional level of care;
- the participant must need CFC services to remain in or move to the community;
- there must not be an alternate means of paying for the service;
- the CFC service plan, when implemented, must reasonably ensure the health and safety of the person;
- the participant must both choose to self-direct and be capable of self-directing with or without paid support, or have a representative act on his or her behalf;
- the participant must choose to live in a qualified community setting, including an individual home or an apartment with a landlord tenant lease. Settings including licensed group homes, residential care homes, assisted living and board and care homes are not qualified community settings. [Note: If a residential care home has a landlord tenant lease with the participant, the participant may request an exception to the qualified housing rule. Requests must be submitted directly to CFC Program Manager.]

Any person who meets all of the above eligibility criteria may choose the CFC benefit.

Screening for financial eligibility is based on data from the eligibility management system. All referrals to Universal Case Management agencies are prescreened for financial eligibility and level of care prior to referral. All referrals have Medicaid coverage. Participants covered under the Medically Needy category must meet spend-down requirements before they can access CFC. Agencies may receive referrals for participants who have not yet met spend-down requirements. Agencies should proceed to assess the individual, remind the participant about spend-down requirements, and to follow the CFC protocol with

respect to submission of a service plan. Requirements must be met before a participant can access CFC services.

Spend-down is managed by DSS. Participants receive correspondence from DSS when they meet spend-down requirements. It is the responsibility of the participant to notify Allied when he or she meets the spend-down requirement and is active on Medicaid. CFC budgets are only authorized after the participant meets spend-down requirements. The authorization is for the remaining active months within the spend-down period. Allied sends authorization to the UCM and to central office detailing the eligibility of the participant to begin services and the remaining period of coverage. Please note that the participant becomes ineligible when the next sequential 6 month spend-down period begins until the spend-down requirements are met. It is possible that a participant may only have access to CFC one or two months during a six month period. If the participant chooses to hire a personal assistant and pay privately during the spend-down period, they may submit the claims to help meet the spend-down requirement but they are responsible for all payroll including taxes during the uninsured period. Medicaid funds cannot be used to pay for the FI or personal assistance until the participant is active on Medicaid.

2 How CFC works

- The UApp is submitted electronically through MFP/CFC web portal, screened for Medicaid financial eligibility and institutional level of care.
- If the applicant previously applied for a waiver and level of care has been determined, a CFC referral may be submitted to the CFC eligibility unit utilizing the CFC referral form. The CFC referral form is accepted in hard copy or electronic transmission. Electronic transmissions should be sent securely to xx and to xx.
- The person is determined eligible Medicaid.
- The Applicant is assigned to a Universal Supervisor (US) in the MFP/CFC web based reporting system.
    - If the applicant is already active on a waiver where Access Agencies provide case management such as the PCA or the Elder Waiver, the Universal Supervisor is the same person for both CFC and for the waiver.
- The US assigns the Universal Case Manager (UCM).
- The UCM completes the assessment in the BIP system.
- If level of care is not affirmed, UCM recommends denial to CFC Utilization Review Nurse (URN), XXX.
- The participant's personal preferences are combined with assessment information to discuss a service plan.
- The UCM provides information about different services that can meet the participant's needs and preferences, including CFC and waivers.
- The UCM provides information about how to access waivers.
- The person selects CFC.
- The UCM gives the participant the 'My Service Planning Tool'.
- The 'My Service Planning Tool' outlines the participant's role and responsibility under CFC, the list of allowable and unallowable expenditures, the general service plan requirements and criteria for the participant developed service plan.
- The UCM discusses with the participant his or her responsibility for development and submission of the completed service plan to the UCM within 30 days.
- The UCM provides the participant with information about who may assist with the development of the service plan, including a Support and Planning Coach.
    - If applicable, the UCM shares with the participant information regarding Support and Planning Coach providers.
    - If the participant chooses to have the assistance of a Support and Planning Coach, the UCM assists the participant with the development of roles and responsibilities of the Support and Planning Coach, including tasks, schedule of service and negotiated payment for tasks.
    - The UCM should assume no more than 3 hours of authorized time for Support and Planning Coach to assist participant with development of the service plan.

    - The UCM reminds participant that if they are choosing to hire an individual Support and Planning Coach, the Support and Planning Coach must first enroll with Allied and meet required qualifications within 90 days.
    - Support and Planning Coaches who assist with development of service plan are paid within 30 days of the date of service plan authorization.
    - Support and Planning Coaches who assist with development of the service plan which is not subsequently approved are paid through administrative funds.
- The UCM gives the participant 'My Assessment'. If 'My Assessment' is not available, the UCM gives the participant the 2 page UCM summary.
- The participant develops the service plan within 30 days of assessment, with or without assistance from others.
- The participant is the employer of individual providers (Support and Planning Coach and personal care assistants).
- The participant may use their budget to pay a Support and Planning Coach to assist with the hiring and managing of personal care assistants and to assist with ongoing management of the individual budget.
- The plan must include emergency and backup plans and break out of services into CFC service categories. Service categories include:
    - assistance with hands-on care, cueing and supervision;
    - assistance with service planning, managing individual budgets, hiring, managing, and scheduling PCAs
    - back-up systems;
    - assistance to increase independence in health-related tasks and/or daily living tasks.
- The participant defines provider qualifications for personal care assistants (PCAs).
- The plan must include a methodology for how the participant will document that PCAs meet the stated qualifications.
- Background checks are completed by fiscal intermediary (FI) on all proposed employees.
- Participants may elect to hire PCAs or other employees after receiving information regarding the background check.
- The participant's service plan must outline how he or she plans to monitor service implementation and quality.
- The plan includes results or outcomes the person wants to achieve by implementing the plan.
- Participants are not permitted to hire their spouse, legally liable relative, conservator or guardian.
- Participants may hire PCAs for more than 25.75 hours but less than 40 hours per week and use their budget to purchase workman's compensation insurance.
- The UCM applies stated criteria to recommend approval of the plan to DSS or outline changes that need to be made to receive approval. The UCM recommends service plan approval or recommendation of denial within 30 calendar days of proposed plan receipt from the participant.
- The UCM uploads approved service plans to the MFP web for approval and authorization.

    - If CFC participant is also a waiver participant, the existing protocol for waiver service plan approval is followed.
    - After wavier approval, the CFC service plan is forwarded to CFC unit for final budget authorization of CFC services and transmitted to the FI.
- The UCM receives electronic notice of service plan approval from DSS HCBS waiver unit if the participant is covered under a DSS waiver and from the CFC unit if the participant is not covered under a waiver or is covered under a waiver operated by DDS or DMHAS.
- The UCM sends a copy of the authorized plan to the participant and to the conservator or guardian if applicable.
- A written denial of the plan, or reduction in service proposed in the plan, must include specific reasons and appeal rights (Fair Hearing).
- The participant enters into agreement with selected PCAs; payroll support is provided by the participant's fiscal intermediary (FI).
- For agency based supports, the FI supports the participant by sending authorization for services.
- Home health agency services require doctor's orders other than Nurse Health Coach.
- The plan is implemented.
- The FI receives invoices for approved expenditures including support staff timesheets.
- The FI records the expenditures into the appropriate budget categories of the participant's budget. The four categories include, ADL – IADL; Acquisition – maintenance- enhancement of skills necessary for the individual to accomplish ADLs, IADLs, and health-related tasks; back- up system; Voluntary training on how to hire, manage or dismiss staff.
- The FI provides monthly reports to the participant or legal representative.
- The FI is required to notify the UCM agency when monthly invoices or timesheets significantly exceed the approved budget for 3 months (not consecutively) or when spending falls short of projected spending in excess of 80% in order to identify potential problems with the service plan implementation. [Note: invoices which exceed approved budget will not be paid]
- There are opportunities for the UCM agency to provide interventions to help the participant succeed in the community with CFC when status review indicates a need. (MyPlaceCT resources, Support and Planning Coach)
- There are criteria for involuntary exit from CFC for a participant.
- The participant with or without paid support monitors and evaluates the implementation of the plan, the quality of service, and progress toward or achievement of outcomes.
- Protective services referrals continue to protect CFC participants who are age 60 or over, according to DSS regulations.
- Reassessments are performed by the UCM at least annually and when significant change occurs.
- Participants require only 1 assessment annually. If the participant is covered under a waiver, the waiver assessment may serve as the assessment date.
- The participant can make changes to their plan within the 4 budget categories without approval by contacting the FI
- Requests for reallocation of funds from one budget category to another require approval. Revisions are submitted to UCMs for recommendation of approval to DSS.

3 Person Centered Planning

3.1 Person-Centered Planning Process: The foundation

The philosophy and process of person-centered planning provides the foundation for participant-directed home and community-based services. Home and community-based services support people in everyday life. These services have an impact on the person's ability to participate as a member within his or her community, and to fulfill his or her own life-style choices.

Person-centered planning organizes and directs resources in a manner that makes a difference in a person's quality of life, level of independence, and satisfaction with public services. While person-centered planning should be the foundation for all home and community-based services planning, an explicit person-centered planning process is required when an individual selects CFC. Understanding the person-centered planning process is a key and necessary Universal Case Manager skill.

CFC allows greater flexibility than the traditional system in tailoring services to meet individual needs and preferences. It is through a person-centered planning process that the participant, along with self-selected friends, family, and providers, determines what, where, when, how, and from whom they will receive the assistance that is needed. The resulting plan reflects services and supports designed by the participant to meet identified needs and achieve individually identified results or outcomes.

Person-centered planning is an ongoing activity that includes monitoring the effectiveness of the plan and progress toward achieving results, and changing the plan over time to incorporate new types of services or ways of delivering services, or to address changed needs, or support revised personal goals or desired results.

There are various approaches to the person-centered planning process that have been put into public practice, and different approaches are preferred by individuals. Some participants may choose to develop their CFC plan with little or no assistance, while others may want more support in plan development.

The UCM must provide resources and information about the person-centered planning process, which includes the availability of the Support and Planning Coach service to assist in plan development.

3.2 Participant Role in CFC Person-Centered Planning and Plan Management

Each CFC participant must take responsibility for developing his/her service plan with or without assistance. The service plan must be developed utilizing person centered planning. Each participant will have personal preferences about the level of control he or she wishes to assume in the person-centered planning process. The participant has the right to select other people to assist with the tasks listed below, as long as the person selected is not otherwise prohibited from preforming these tasks.

Initial/Annual Activities Performed by the Participant
Direct development of service plan
Participate in formal or informal person-centered planning process that addresses personal strengths, needs, and preferences
Choose people to assist them in the planning process including family, friends or a Support and Planning Coach
Choose who will provide the service and the amount of each service within their budget allocation
Determine qualifications for personal care assistants
Negotiate payment rates for personal care assistants and Support and Planning Coaches
Develop a plan to monitor service delivery and effectiveness. Outline desired outcomes and a way to measure successful attainment of outcomes
Submit a plan to the UCM Agency for approval within 30 days of assessment
Hire, manage and supervise staff
Ongoing Activities Performed by the Participant
Monitor implementation of plan including achievement of outcomes
Make revisions to plan and report changes to FI within the 4 budget categories prior to expenditure
Notify UCM of significant changes in need, function or condition
Hire, manage and supervise staff- sign timesheets
Manage individual budget
Inform the fiscal intermediary of hospitalizations
Ensure enrollment of all new staff with FI prior to initiating service
Ensure that all staff meet stated qualifications and maintain records verifying that qualifications are met
Verify that all time sheets are accurate and reflect actual hours worked.

3.2 UCM Agency Role and Tasks in CFC Person-Centered Planning

- Information: Informed choice requires that participants are given accurate information about options. The UCM Agency:
    - Provides information and education about services that may be purchased with the CFC budget;
    - Provides information that helps the participant understand their role and responsibility within CFC;
    - Provides information about resources, tools and technical assistance available;
    - Provides information about the FI;
    - Provides information about qualifications for Support and Planning Coach.
- Budget: The UCM completes the assessment and determines level of need. If the budget allocation is insufficient to meet the needs of the participant, the UCM completes and submits for DSS approval for the budget allocation increase request form with justification. The UCM:
    - Informs the participant about the budget allocation;
    - Describes services available to the participant including waiver services, if applicable;
    - Provides the participant with the option to use their budget to hire a Support and Planning Coach;
    - Subtracts services selected from the waiver menu from the individual budget, if applicable;
    - Provides the participant with the individual budget available for CFC services.
- Facilitation: The UCM facilitates the Person-Centered Planning Process: The UCM Agency:
    - Helps the participant identify their interests, strengths and needs during the assessment process;
    - Provides the participant with My Assessment or information from the UA Summary;
    - Gives professional feedback regarding provider training and qualifications for staff;
    - Recommends service plan approval to DSS.
- Quality Management: The UCM agency ensures quality management. UCM Agency:
    - Verifies and document appropriateness of level of care;
    - Documents that service plans address assessed needs of enrolled participants, updates plans annually, and documents choice of services and providers;
    - Ensures health and welfare by:
        - Verifying that service plans address health/welfare and individualized emergency back-up plans;
        - Reviewing FI reports that document participant expenditures outside of normal parameters;

        - Reporting critical incidents, abuse and neglect.
    - Documents that participant lives in a qualified community setting

3.3 Tools and Resources that Support Person-Centered Planning and Self-Direction

Participants have access to a Support and Planning Coach to assist with service plan development. Expenses associated with hiring a Support and Planning Coach are subtracted from the budget. If a participant chooses to hire a Support and Planning Coach to assist with service plan development, the UCM may authorize up to 3 hours of service. The Support and Planning Coach is considered case management and for this reason the Support and Planning Coach selected by the participant may be an employee of the UCM agency. The participant must be informed regarding choice of Support and Planning Coach provider. The cost for the Support and Planning Coach is added to the service plan budget when the service plan is submitted.

There are also various free resources available to support participants with the person-centered planning process. The CFC 'My Service planning Tool Kit' is a resource designed specifically for this purpose. General information may be found at MyPlaceCT.org and Connect-ability.org. MyPlaceCT provides a general overview of the type of supports and services available in the state. Connect-Ability is more focused on employment but provides excellent resources to support participant self-direction including e-learning courses.

Connect-Ability offers e-learning courses at: https://elearning.connect-ability.com/catalog.cfm?pag=2&strSearch=&sort=courseNumber&sd=DESC

The courses represent a great way for participants who have internet access to learn about the planning process and about how to manage supports in the community. A few of the courses which may be of interest are detailed below:

Personal Care Assistance: This course provides an overview of Personal Assistance for individuals with disabilities. At the conclusion of this course you should have: completed your own assessment of needs form to identify tasks you need assistance with; established a plan to hire an assistant to meet your needs; demonstrated the basic skills of management and communication through the use of interactive exercises. Resources and sample documents are included. The course also includes audio narration, tests to check your knowledge and a Certificate of Completion.

https://elearning.connect-ability.com/courseDetail.cfm?courseid=18

Independent Living Skills Overview: This module serves as an overview for people who may need services, supports, or accessibility options to live in the community. The course includes a Self-Assessment, Independent Living Plan and Resources.

https://elearning.connect-ability.com/courseDetail.cfm?courseid=39

Emergency Preparedness: This course provides an overview of Emergency Preparedness for individuals with disabilities. In this course you will learn about different types of emergencies, key questions to ask yourself, how to start preparing for an emergency, developing an evacuation kit, developing an evacuation plan, and further resources. The course includes audio narration, a post test and a Certificate of Completion.

https://elearning.connect-ability.com/courseDetail.cfm?courseid=14

4 Service Plan

4.1 Plan format

The plan format for CFC is detailed in the 'My Service Planning Tool Kit' in Appendix XX. The service plan is a multiple page document that helps the individual build his or her budget. A sample of the CFC Budget Approval Form is below.

Name:		**Medicaid #:**	
		Date:	
Do you have someone to help you complete this form?		**YES NO**	
If yes, name of the person:		**Phone Number:**	
Annual Budget Allocation:		**Average Monthly Allocation:**	
A. Monthly amount used for waiver services			
B. Monthly amount used for Husky Home Health Services Nursing, Physical Therapy, Occupational Therapy, and Speech Therapy			
C. **SUBTRACT** the totals for A and B from your monthly allocation Remaining amount is your INDIVIDUAL BUDGET FOR CFC SERVICES			
D. Review your service plan budget worksheets and input totals from each section	Section 1 total	$	
	Section 2 total	$	
	Section 3 total	$	
	Section 4 total	$	
	Add Sections 1-4 and total → →		
Requested One Time Expenses pending authorization, describe below. (environmental accessibility modifications and transition costs) _____ _____			
Additional comments:			

Participant signature:		Date:	
Universal Case Manager approval:		Date:	
Review by DSS CO staff:		Date:	

Many participants may choose to complete the service plan independently. The 'My Service Planning Tool Kit' is intended to guide the CFC participant through the service planning process. The UCM should encourage maximal independence of the participant and offer the additional tools as referenced in section 3 of this guide before discussing the services of Support and Planning Coach. If after consideration, the participant chooses to have the support of a Coach, the UCM assists the participant with completion of the Support and Planning Coach Plan Development Authorization form on the next page. The completed form is submitted with the completed service plan to DSS.

Please review the 'My Service Planning Tool Kit' for more information on service planning and authorization.

4.2 Support and Planning Coach Plan Development Authorization

Participant Name: Date of Birth: Medicaid ID:

This tool is used to inform all parties of the use of Support and Planning Coach to develop an initial community service plan for Community First Choice (CFC)

I understand that I have the option to develop my own service plan utilizing the "My Service Planning Tool Kit' or to have a friend or family member help me develop the plan.

I understand that I have the choice to hire a Support and Planning Coach and that this person could be someone that I know who meets the qualifications or could work for an agency.

I understand that hiring a Support and Planning Coach to assist in the development of my plan is estimated to cost _____ (funding for up to 3 hours of service).

I understand that this cost is subtracted from my CFC individual budget and therefore I will have less money for other services.

I understand that my Support and Planning Coach must enroll with my fiscal intermediary before they can provide me with any services.

I understand that my plan must be developed and submitted to my UCM within 30 days of the date on this authorization.

I understand that my Support and Planning Coach will not be paid until my plan is approved.

Name of Support and Planning Coach or agency that I choose: _____

Signature of Support and Planning Coach: _____

Date: _____

Participant: _____

Signature: _____

Date: _____

Legal Representative (if applicable): _____

Signature: _____

Date: _____

4.3 CFC Budget Amounts by Level of Need

The CFC budget amounts available to purchase services are issued annually by the department. Budget caps for waivers are calculated according to federal waiver authority for each waiver program, based on historical expenditures across the categorical populations. The UCM conducting the assessment process informs the participant of his or her available budget amount. This budget amount must be included on the plan in order for the participant and the UCM to evaluate cost effectiveness, and the likely success of the proposed plan. The person-centered service plan can include costs for services up to the annual CFC budget amount. Unexpended CFC budget funds cannot be carried over to subsequent service plan years. Unexpended CFC monthly budgets can be carried over to the following months as long as it is within the service plan year.

Reassessment may change the CFC budget. If that occurs, the UCM informs the participant of the new budget amount. If the budget is increased, the participant determines whether there are currently unmet needs and if so, revises the service plan and submits to the UCM for approval and/or reauthorization. If the budget decreases, and is less than the amount currently authorized, the participant must determine changes to services or supports within the new budget amount. The CFC service plan reflects these changes when re-submitted for UCM approval.

The universal assessment supports both the level of care determination and also establishment of needs by 'grouping'. Level 1 group is 'less than' nursing home level of care and therefore people whose needs are determined at level 1 are not eligible for CFC. Budgets by need groupings for state fiscal year 2016 are as follows:

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Need Grouping	Approximate PCA Hours 7 days per week	Budget Maximum
Level 1	Not Eligible for CFC	$1445
Level 2	4	$2104
Level 3	6	$3156
Level 4	8	$4207
Level 5	10	$5259
Level 6	11	$5818
Level 7		Prior authorization
Level 8		Prior Authorization

The funding levels on the chart above provide the basis for determining the CFC individual budget. The process for determining the individual budget is as follows:

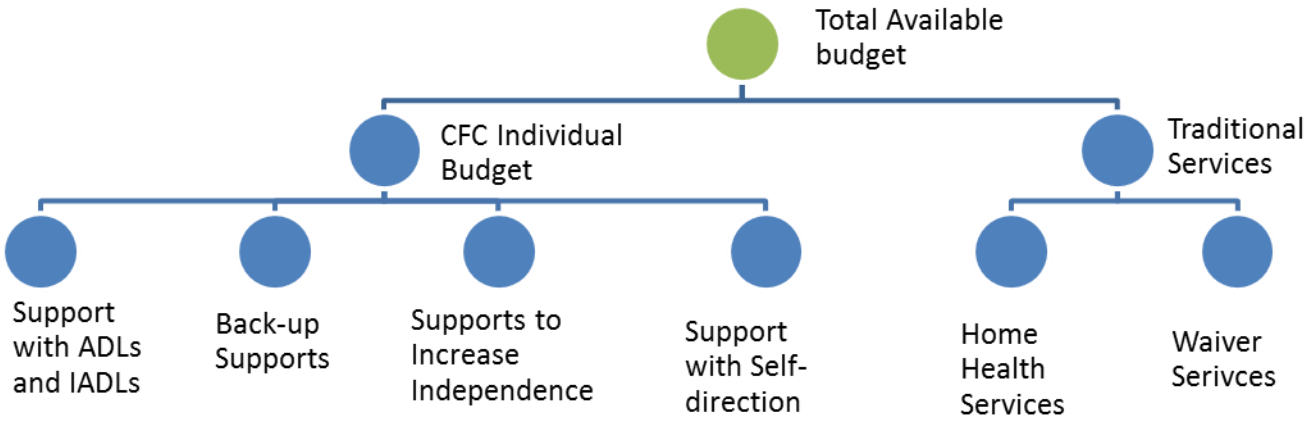
Step 1: Complete universal assessment and determine level of need.

Step 2: Subtract voluntary informal supports from total budget. The remaining budget is the total amount available.

Step 3: Discuss the following traditional services, estimate funding and if applicable, subtract from total amount available on the CFC Budget Approval document. Traditional services include:

- Emergency contingency fund for skilled nursing
- Current skilled nursing needs
- Wavier services

Step 4: Inform the participant about the remaining amount of funding (CFC individual budget). This is the amount of funding directed by the participant. Please note that if the participant selects the services of a Support and Planning Coach to assist with development of the plan, the cost associated with this service is entered in Section 2 and already obligated to a goal (develop service plan). The diagram on the following page shows the allocation between CFC individual budget and the traditional service budget.



4.4 CFC Service Plan Requirements

The Service Plan is developed by a participant and must include certain required components. The plan must identify:

- Formal and informal services and supports that meet the participant's assessed needs;
- Frequency and duration of service, the rate for the service and who will provide the service or support;
- Proposed allocation of CFC dollars between the four categories of CFC services;
- Safeguards to reasonably address and maintain the participant's health and welfare;

- Backup services, contingency plans, and emergency service to address potential situations that may arise;
- Specific provider qualifications, including training requirements established by the participant;
- Individualized Support and Planning Coach plan, as proposed by the participant, including tasks, fees, and schedule;
- Outline of plan to monitor plan implementation and effectiveness of services/supports, including desired results or outcomes, the schedule of monitoring activity, how progress is measured, and who is responsible for monitoring success;
- The participant's desired outcome or achievement with the plan in place;
- Contact information for service providers.

4.5 Allowable and Unallowable Expenditures

Allowable Expenditures	Unallowable Expenditures
Participant directed supports and services that meet one of the following four categories: A. Assistance with Activities of Daily Living (ADL), or Instrumental Activities of Daily Living (IADL) and health-related tasks through hands-on assistance, supervision, and/or cueing. B. Acquisition, maintenance, and enhancement of skills necessary for the individual to accomplish ADLs, IADLs, and health-related tasks. C. Backup systems or mechanisms to ensure continuity of services and supports D. Voluntary training on how to hire, manage or dismiss staff or on how to manage an individual budget Expenses related to the development and implementation of the community support plan.	Goods and services that shall not be purchased with the participant's budget are: • Services to people living in unqualified community housing such as licensed group homes and residential care homes [Note: Exceptions to the unqualified settings may be made on a case by case basis with supporting justification verifying how the setting meets the community setting rule.] • Services providing benefit to persons other than the participant • Services covered by Medicare, or other liable third parties including education, home based schooling, vocational services • Any fees incurred by the participant such as co-pays, attorney costs or costs related to advocate agencies, with the exception of qualifying Support and Planning Coach agencies • Insurance costs other than workman's compensation • Room and board • Home modifications that add square footage to a home • Home modifications other than to the primary residence • Expenses for travel, lodging or meals related to training the individuals or his/her representative or paid or unpaid caregivers • Vacation expenses other than the cost of direct service • Vehicle maintenance • Costs related to internet access

4.6 Applying Quality Considerations to CFC Service Plan

Program Requirements: While CFC allows the participant to design their own service plan, there are criteria for approval of such plans. Proposed services must:

- Meet the individual needs of the participant
- Assure health, safety, and welfare
- Collectively provide an alternative to institutional living
- Be the least costly alternative that reasonably meets health and safety needs
- Be for the sole benefit of the person

Personal Outcomes: For everyone participating in CFC, talking about outcomes should be part of the planning process. Envisioning desired outcomes helps a person think about what types of services they may need in order to achieve the goal. Individualized outcomes may include but not be limited to:

- Maintain community living
- Become employed
- Enhance or maintain family or community involvement
- Develop or maintain social, physical or work-related skills
- Decrease dependence on formal supports
- Acquisition, maintenance, and enhancement of skills necessary for the individual to accomplish ADLs, IADLs, and health-related tasks.
- Increase ability of unpaid family and friends to receive training and education needed to provide support
- Increase skills to hire and manage staff.

Measuring and Monitoring Plan Implementation and Results: Given the participant's stated desired results, does the plan to monitor help the participant identify needs for revision to the plan, and help demonstrate achievement of or progress toward desired outcomes or results? Does the plan include a schedule to periodically measure progress? What will be measured (indicators)? Who will do the monitoring? What steps will be taken, by whom, if the plan proves to be ineffective?

Examples:

Desired Result	**Measure**
Employment	I want to work at least 5 hours a week by summer and 10 hours a week by fall. I will demonstrate success by the following indicators: • Volunteering; • Revising my resume; • Attending networking events; • Demonstrating that I'm competitively employed by fall. If this isn't effective, I'll consider looking for internships.
Improved Health	My health is fair but will be good in 6 months. I will demonstrate success by the following indicators: • No ER visits; • No hospitalizations; I will report this in my plan and revise my plan based on what I learn. I will consider adding a health coach to my plan if this isn't effective.
Increase Independence	I will create a menu, shop and cook dinner each night for myself within a year. I will demonstrate success by the following indicators: • 50 menus stored within 'My recipe' in my computer; • Weekly shopping list and budget stored in my computer; • Dinner made from 'My recipe' If this isn't effective, I will consider additional assistive technology to help me.

The plan to monitor and periodically evaluate the effectiveness of the plan in helping the participant achieve desired results must also include what steps will be taken if the plan does not seem to be effective, cannot be implemented according to the approved service design, or if backup or emergency plans are frequently relied upon.

4.7 Reviewing the Plan

UCM agencies review each plan submitted by a CFC participant utilizing these elements and criteria:

Allowable Services	Does the plan for personal assistance include a spouse, conservator or guardian? Does the plan include items or services that are explicitly excluded as noted on page 24 of this manual?
Health and Safety: Meeting Assessed Needs, Quality of Care	Do plan components meet identified needs? Will backup and contingency plans, including risk agreement, in combination with the proposed plan, reasonably ensure the person's health and safety in the community? Are training, experience, educational, and licensing requirements outlined in the plan reasonable and adequate given assessed needs and consumer preference? Does the participant have a plan for how they will ensure that staff meet qualifications? Does the plan include adequate and reasonable informal caregiver training and other supports given the assessed needs and consumer preferences?
Participant Outcomes	Will services reasonably support the achievement of participant outcomes listed in the person's plan? Are the services considered appropriate under CFC because they are reasonably necessary to support any or all of the outcomes listed on page 25? Will the participant's monitoring schedule, activity and indicators (benchmarks), support achievement of participant's desired results?
Cost Effectiveness and Financial Accountability	Are there alternative payers for proposed services such as Medicare? Does the description of Support and Planning Coach, if any, include a clear description of what the person will buy from the Coach, at what rate and for how long?

In general, any plan submitted by a participant that contains the required documentation and that meets the above criteria, as applicable to an individual participant, should be recommended for approval by the UA. If the participant's health and safety needs change, the UCM re-evaluates the participant to determine a change in budget allocation.

4.8 Requests for exceptions to budget allocation

Requests for exceptions to budget allocations must be submitted utilizing the CFC budget exception form with supporting justification. This form is located in Appendix D and will be a downloadable form on the CFC database. This form is also used when someone is a waiver participant utilizing services as assessed under an alternative tool and seeks additional funding that includes CFC services. If the participant is also a waiver participant, the form is forwarded to the waiver unit. The waiver unit reviews the request for additional funds to ensure compliance with waiver cost caps.

- If the request for additional funds is required to meet health and safety assurances and is also within the waiver cost cap, the participant remains on the waiver and the CFC service plan along with justification is forwarded to the CFC unit.
- If the request for additional funds is not required to meet health and safety assurances, the request is denied by the waiver unit.
- If the request for additional funds is required to meet health and safety assurances and is not within the waiver cost cap, the request is forwarded to the CFC unit.
    - The CFC unit reviews the justification including level of care documentation.
    - If approved, the participant receives CFC services as long as Medicaid eligibility requirements are met.
    - The participant is disenrolled from the waiver (over cost cap) but retains services through CFC as long as the participant continues to meet Medicaid financial eligibility criteria.

4.9 Service Revisions

Participant Approval Only

The participant has a great deal of flexibility in how he or she manages their individual budget. Reallocating funds within the 4 key budget categories is permissible without review of the UCM and without approval of the Department. These changes must be submitted to the FI prior to implementation. In addition, the participant has the following flexibility but must communicate the changes to the FI prior to employing new staff or stating date of rate increases:

- Change PCAs other than hiring a spouse, legally liable relative, conservator or guardian;
- Hire additional PCAs;
- Change the days and times of services;
- Grant wage increases within allowable CFC individual budget limits;
- Pay PCAs different rates according to experience.

UCM and Participant Approval – Key elements of the plan

- A summary of assessment (My Assessment);
- The participant's desired service outcomes or results;
- How the result or outcome will be achieved;
- What training and qualifications will be required of staff;
- How the service will be monitored;
- The budget.

CFC Approval - submitted by Participant or by their Support and Planning Coach within estimated amount authorized as part of individual budget

- Transitional Budget
- Environmental Accessibility Modifications
- Assistive Technology

UCM Required Recommendation for Approval

- Update assessment based on significant change in participant need, function, or condition
- Determine new budget allocation

4.10 Health and Safety - Personal Negotiated Risk Management Plan

People take risks every day as part of life. Our ability to assume and manage risk reflects our competence, our independence, our ability and right to make choices, and our right to assess benefits and consequences of choices we make in life. A personal negotiated risk management plan is a reflection of the participant's choices that strike a balance between the recommended level of service coverage (care, supervision, and safety) and the person's desired level of independence. For example, a

participant with quadriplegia may decide that 24 hour care and supervision impinges too much on his or her feeling of living independently in an apartment, does not allow them enough time to be alone, and interferes with personal privacy, and ability to achieve restful sleep at night. The participant may choose not to have services during a 10 hour period at nighttime, even though there are personal risks that something may happen. The participant is aware of risks or consequences and has proposed a method to manage the risk. For example, an emergency alarm device is used at night, or a neighbor or friend agrees to be available in the event of an emergency. Home modifications may be part of a plan to address environmental hazards or concerns about evacuation.

Alternatively, an elderly person agrees to home modifications but does not want to utilize a walker, and has a plan to implement in the event of a fall. The participant has weighed the cost-benefit and has decided to assume a level of risk and manage it. The personal negotiated risk management plan should be documented in the CFC service plan and should be tied to the plans for backup services and community emergencies. The UCM or Support and Planning Coach can help identify potential risks or consequences as part of the support and risk management planning. Unless a participant's plan, including personal risk management, results in unaddressed health and safety issues that are so significant that *immediate harm is the likely result*, a plan should not be denied for health and safety reasons. The negotiated risk form is in Appendix C.

4.11 Back- Up Plans

The backup plan is a contingency plan that can be implemented if the primary services in the CFC service plan are disrupted. It is designed to address a variety of circumstances should they occur. A backup plan may reflect a variety of resources and should be feasible and readily implemented. It is documented in the CFC service plan along with a plan for maintaining contacts and monitoring feasibility. Activation of the backup plan is evaluated for responsiveness and effectiveness. If a backup plan is implemented frequently, the overall plan should be re-evaluated and revised.

An emergency plan is the plan that goes into effect during community-wide emergencies such as threatening weather, fires, electrical outages and other circumstances that can create safety issues or barriers to care delivery. For example, a threatening storm is approaching and warnings are issued to move to a basement area. Who will assist in moving the participant to the basement area? Is the plan feasible at all times? Who monitors and maintains the plan in case of changing situations? The emergency plan is documented in the CFC service plan with responsible persons noted and a schedule for periodic monitoring and revising this portion of the plan.

5 Services and Service Qualifications under CFC

Assistance with ADLS or IADLS

5.1 Personal Care Assistance (PCA)

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.

Shared Attendant Care

Shared personal assistance may be utilized when two participants live together and choose to have the same independent PCA provider. This shared PCA is paid 75% of the standard rate for each person. For example, if the standard rate for one person is $12.50 per hour, then the provider is paid $9.37 for each person serviced, or $18.75 per hour. This service allows a provider to 'clock-in' and 'clock out' just once when serving two people in the same residence.

Each participant must have the same provider on his or her service plan listed as a shared PCA. The duration and frequency of the shared PCA service must match on each service plan. For example, if John and Mary share a PCA for 40 hours per week, both John and Mary must have the shared PCA on each of

their plans for 40 hours per week. If John receives additional hours per week that are not shared, then those hours must be listed separately on the plan as individual PCA hours. The PCA cannot work more than 40 hours.

If the shared PCA takes Mary to the community once per month and John stays at home, then Mary must have the shared PCA also listed on her service plan as an individual PCA so that the PCA can bill at the individual rate when the participants are not together.

The shared rate can only be billed when both participants are present.

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 has the option to include the cost of Workers Compensation Coverage for their employees as part of their individual budget. The participant works with the FI to establish Workers Compensation Coverage within the approved 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.

5.2 Transitional Services (In addition to individual budget)

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.

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.

5.3 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.

5.4 Environmental Accessibility Adaptations (In addition to individual budget)

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.

5.5 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

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.

Please note that PCAs may provide this service for acquisition, maintenance, and enhancement of skill in order for the individual to accomplish ADLs, IADLs.

5.6 Health Coach: Nurse, Occupational Therapist, Physical Therapist, Speech Therapist

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.

Backup systems or mechanisms to ensure continuity of services and supports

5.7 Backup Systems

Service Definition: Each person-centered service 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 service plan.

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

Voluntary training on how to hire, manage or dismiss staff or assistance with service plan development

Service Definition: A wide range of service options that may be individualized for the participant. Options range from web based learning opportunities to 1:1 support.

5.8 Web based training options:

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. Cost for this service is not included in the CFC individual budget if it is otherwise provided by the state. The Participant may choose to receive on-line training consistent with their plan which is not free.

5.9 Support and Planning Coach

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 (web based and 1:1) is limited to an annual limit of $500 per participant without prior authorization.

5.10 Waiver / CFC Crosswalks

Elder Waiver – CFC Crosswalk		
Waiver June 30, 2015	**Waiver as amended July 1, 2015**	**CFC Service**
Personal Care self-hired	Moved to CFC	Covered
Personal Care Agency Based	Personal Care Agency Based	Not Covered
Chore Services	Chore Services	Covered
Homemaker	Homemaker	Covered
Case Management	Case Management	Administration (Assessment and QM only)
Respite	Respite	Covered
Assisted Living	Assisted Living	Not Covered
Adult Day Health	Adult Day Health	Not Covered
Companion	Companion	Covered
Adult Family	Adult Family	Not-Covered
Assistive Technology	Assistive Technology	Covered
Bill Payer	Bill Payer	Covered
Care Transition	Care Transition	Not-Covered
Chronic Disease Self-Management Program	Chronic Disease Self-Management Program	Covered
Delivered Meals	Delivered Meals	Covered
PERS	PERS	Covered
Mental Health Consultative Services	Mental Health Consultative Services	Not Covered
Independent Support Broker	Independent Support Broker	Covered
Recovery Assistant	Recovery Assistant	Covered
Fiscal Intermediary Services	Administration	Administration
Accessibility Modifications	Accessibility Modifications	Covered
Transportation	Transportation	Not-Covered

Personal Care Assistance Waiver – CFC Crosswalk		
Waiver June 30, 2015	**Waiver as amended July 1, 2015**	**CFC Service**
Personal Care	Moved to CFC	Covered
Assistive Technology	Moved to CFC	Covered
Case Management	Case Management	(Assessment and QM)
PERS	Moved to CFC	Covered
Adult Family Living	Adult Family Living	Not-Covered
Support Broker	Support Broker	Covered
Fiscal Intermediary Services	Administration	Administration

ABI II Waiver – CFC Crosswalk		
Waiver June 30, 2015	**Waiver as amended July 1, 2015**	**CFC Service**
Personal Care Self-Hired	Moved to CFC	Covered
Personal Care Agency Based	Personal Care Agency Based	Not-Covered
Chore Services	Chore Services	Covered
Homemaker	Homemaker	Covered
Home Delivered Meals	Home Delivered Meals	Covered
Case Management	Case Management	Administration (assessment and QM)
Prevocational	Prevocational	Covered
Respite	Respite	Covered
ABI Group	ABI Group	Not Covered
Adult Day Health	Adult Day Health	Not Covered
Companion	Companion	Covered
Home Adaptation	Home Adaptation	Covered
Non-Medical Transportation	Non-Medical Transportation	Not Covered
Specialized Medical Equip	Specialized Medical Equip	Covered
PERS	PERS	Covered
Independent Living Skills	Independent Living Skills	Covered
Supported Employment	Supported Employment	Covered
Substance Abuse	Substance Abuse	Covered
Consultative Services	Consultative Services	Limited to clinical, environmental, technology
Vehicle Adaptations	Vehicle Adaptations	Covered
Cognitive Behavioral Services	Cognitive Behavioral Services	Not-Covered
Community Living Support Services	Community Living Support Services	Covered
Recovery Assistant	Recovery Assistant	Covered
Fiscal Intermediary Services	Fiscal Intermediary Services	Administration
Accessibility Modifications	Accessibility Modifications	Covered
Recovery Assistant 2	Recovery Assistant 2	Not Covered

6.0 Roles and Responsibilities

6.1 Comparison of UCM role in CFC to Support and Planning Coach

The case management continuum of CFC ranges from assessment, to administrative quality management functions, to Support and Planning Coach. While these positions may all be employed by the UCM Agency, the qualifications for UCM/quality management are different from those of the Support and Planning Coach. The UCM quality management staff may not also perform Support and Planning Coach functions. Participants must be given a choice regarding where and how they purchase Support and Planning Coach services.

UCM – quality management	Support and Planning Coach
Complete Universal Assessment	Provider more detailed information about CFC services
Affirm level of care determination	Support participant in development of their service plan
Review and recommend approval of service plan	Monitor and assist with revisions to the service plan
Update assessment as a result of significant change in participant's needs, function or condition	Facilitate community access and inclusion
Offer choice of providers	Provide support for participant in the interviewing and managing process for staff
Complete annual reassessment	Assist participant with understanding and managing their individual budget
Provide participant with budget	Provide assistance with acquisition of assistive technology, if appropriate
Provide participants with alternatives to CFC so that the participant can make an informed decision	Provide assistance with accessibility modifications and submission of estimates and scope to DSS
Provide participants with resources to assist them in the development of their service plan	
Evaluate whether the participant's health and safety needs are reasonably expected to be met given the service plan and qualifications for staff	
Review and recommend estimated budgets for accessibility modifications and assistive technology	
Report Critical incidents in CFC data base or if covered under DSS waiver, report according to existing protocol	

6.2 Universal Case Management Agency Functions

As previously mentioned, while both UCM and Support and Planning Coach represent forms of case management, the UCM role is required. As such, the cost for UCM is administrative and therefore not deducted from the Participant's budget.

Required functions of the UCM agency are as follows:

- Complete UA, affirm level of care and determine if participant is eligible for CFC;
- Provide information regarding HCBS alternatives to support participant in making an informed choice about CFC;
- If the participant chooses CFC, provide him or her with their maximum budget amount and assessment summary or 'My Assessment'.
- If the participant has medical needs, determine the funding needed to support the service and subtract it from the budget;
- If the Participant is also a waiver participant, support the participant by determining how much of the budget is allocated to waiver services and subtract it from the budget;
- Provide the participant with verbal instruction and with e-learning resources to assist them in developing their plan and managing services;
- Provide participant with information about the Support and Planning Coach (reminder – Support and Planning Coach service for supporting participant with service plan development is limited to 3 hours.);
- If Participant chooses to hire a Support and Planning Coach, support participant with development of tasks for Support and Planning Coach;
- Inform Participant of requirement to submit plan to UCM within 30 days;
- Evaluate whether the participant's health and safety needs are reasonably expected to be met given the service plan including the provider training and qualifications;
- Provide feedback to the participant about the plan adjustments needed to approve, if any;
- Authorize traditional services (waiver and home health) within MMIS;
- Monitor and evaluate CFC plan, including health and safety and the adequacy of the plan as well as need for revisions at least annually;
- Review Allied reports and follow-up with participant to determine need for intervention;
- Provide technical assistance regarding service implementation, budget, and fiscal records management;
- Take corrective action if needed in order to ensure support plan implementation prior to involuntary exit from CFC;
- Investigate and report related to vulnerability or misuse of public funds;
- Report discharge summary information to the state;

6.3 Support and Planning Coach Functions and Limitation

The following is a list representing direct supports that a Support and Planning Coach may provide. The list is not inclusive.

- Facilitate development of the service plan;
- Assist with recruiting, screening, hiring, training, scheduling, monitoring and paying workers;
- Facilitate community access and inclusion;
- Provide staff training that is specific to the participant's service plan;

A Support and Planning Coach cannot:

- have any direct or indirect financial interest in the delivery of services in the plan;
- be a spouse, a guardian/conservator or a legally liable relative;
- duplicate services provided by the UCM.

7.0 Responsibilities of the Fiscal Intermediary (FI)

The FI supports the participant with self-direction. While the FI is paid with administrative dollars, the FI works for the participant. Required functions of the FI are as follows:

- Receives approved service plan from DSS;
- Meets with participant to explain his or her role as employer;
- Enrolls participant as household employer;
- Provides information about Workman's Compensation and supports participant with acquiring insurance;
- Explains to participant how to manage an individual budget;
- Completes background check on all of the participant's proposed employees;
- Verifies qualifications for Support and Planning Coach;
- Processes new employee applications and payroll for employees;
- Verifies start dates with participant before participant may receive services;
- Authorizes services for CFC agency based providers listed on the service plan;
- Sends monthly statements indicating how much of the budget is spent and how much remains;
- Receives budget revisions from participant within allowable Sections of the budget;
- Monitors budget and alerts UCM of underutilization or a significant number of timesheets rejected;
- Manages budget and disallows any requests for payment not otherwise authorized by the service plan or payments that are in excess of the approved monthly budget;
- Notifies UCM of reported hospitalizations;
- Reports fraud and abuse to the Department and to the UCM;
- Issues annual W-2 Forms to the participant's employees as well as files and pays all state and federal employer taxes on behalf of participant.
- Submits claims to MMIS.

8.0 Utilizing the Universal Assessment in coordination with waivers and Determining Budgets

The universal assessment is required for CFC services. A transition process is anticipated during which existing assessment tools and associated outcomes are honored.

8.1 Existing waiver participants who have services administratively moved to CFC

Participants in this group are reassessed utilizing the existing waiver tools until such time as the UA is required. See the chart below for how individual budgets are established for existing waiver participants.

Personal Care Assistance Waiver – CFC Crosswalk		
Waiver June 30, 2015	**Waiver as amended July 1, 2015**	**CFC Service**
Personal Care	**Moved to CFC**	Covered
Assistive Technology	**Moved to CFC**	Covered
Case Management	Case Management	(Assessment and QM)
PERS	**Moved to CFC**	Covered
Adult Family Living	Adult Family Living	Not-Covered
Support Broker	Support Broker	Covered
Fiscal Intermediary Services	Administration	Administration

For participants on the PCA waiver, 3 waiver services are now funded under CFC: Personal Care, Assistive Technology and PERS. The funding associated with these 3 services becomes the participant's CFC individual budget. The participant may choose to allocate any of this funding to other CFC services provided that the services are within the individual budget and are otherwise allowable under CFC guidance. Keep in mind, that the participant must purchase at least one service from the waiver to maintain financial coverage under the waiver.

Alternatively, if the participant is an elder only one service moved to CFC. See chart below:

Elder Waiver – CFC Crosswalk		
Waiver June 30, 2015	**Waiver as amended July 1, 2015**	**CFC Service**
Personal Care self-hired	**Moved to CFC**	Covered
Personal Care Agency Based	Personal Care Agency Based	Not Covered
Chore Services	Chore Services	Covered
Homemaker	Homemaker	Covered
Case Management	Case Management	Administration (Assessment and QM only)
Respite	Respite	Covered
Assisted Living	Assisted Living	Not Covered
Adult Day Health	Adult Day Health	Not Covered
Companion	Companion	Covered
Adult Family	Adult Family	Not-Covered
Assistive Technology	Assistive Technology	Increase/Maintain Independence
Bill Payer	Bill Payer	Covered
Care Transition	Care Transition	Not-Covered
Chronic Disease Self-Management Program	Chronic Disease Self-Management Program	Covered
Delivered Meals	Delivered Meals	Covered
PERS	PERS	Covered
Mental Health Consultative Services	Mental Health Consultative Services	Not Covered
Independent Support Broker	Independent Support Broker	Covered
Recovery Assistant	Recovery Assistant	Covered
Fiscal Intermediary Services	Administration	Administration
Accessibility Modifications	Accessibility Modifications	Covered
Transportation	Transportation	Not-Covered

For an elder participant utilizing self-hired PCA services, the self-hired service is now in CFC, therefore the participant's CFC individual budget is the annual cost of the PCA services. The expanded menu of services under the elder waiver, however, gives the participant an additional option. The participant could *elect* to move the amount of funding associated with a waiver service to any CFC covered service. Once again, the total funding for the new service plans (CFC + waiver) cannot exceed the original waiver budget. This option offers the participant increased flexibility, choice and control. As with any waiver, the participant must utilize at least one waiver service to maintain financial eligibility under the waiver.

8.2 New waiver applicants or existing waiver participants who choose CFC services

As previously stated existing assessment tools are honored during the transition as well as existing estimates of needed funding within the waiver cost cap. For DDS participants, total funding cannot exceed the DDS/DSS total allocation limit schedule. For all new waiver applicants the process as follows:

	UCM Agencies (PCA Waiver, Elder Waiver, ABI Waiver)	DMHAS	DDS
1	UCM completes waiver assessment.	DMHAS clinician completes waiver assessment.	DDS case manager completes waiver assessment.
2	UCM confirms waiver eligibility and level of care.	DMHAS clinician confirms waiver eligibility and level of care.	DDS case manager confirms waiver eligibility and level of care.
3	UCM determines budget based on waiver assessment utilizing existing waiver assessment tool.	DMHAS clinician determines budget based on waiver assessment utilizing existing waiver assessment tool.	DDS case manager determines budget based on waiver assessment utilizing existing waiver assessment tool.
4	UCM discusses HCBS options.	DMHAS clinician discusses HCBS options.	DDS case manager discusses HCBS options.
5	If participant elects CFC, UCM offers self-direction tools.	If participant elects CFC and waiver, DMHAS clinician sends CFC referral to CFC unit.	If participant elects CFC and waiver, DDS case manager sends CFC referral to CFC unit.
6	UCM and participant determine need for traditional services.	If DMHAS clinician utilized the UA, it is noted on the referral. If an alternative assessment is used, the assessment must be uploaded to the CFC web when the referral is submitted.	If DDS case manager utilized the UA, it is noted on the referral. If an alternative assessment is used, the assessment must be uploaded to the CFC web when the referral is submitted.
7	UCM subtracts traditional services from budget allocation.	DSS assigns CFC referral to UCM.	DSS assigns CFC referral to UCM.
8	UCM informs participant that they have 30 days to submit service plan to UCM.	UCM reviews alternative assessment in web or reviews UA.	UCM reviews alternative assessment in web or UA.
9	UCM submits waiver service plan, CFC service plan, and CFC referral to waiver unit.	DMHAS and UCM jointly meet with participant.	DDS case manager and UCM jointly meet with participant.
10	Waiver unit approves service plans for budget and health/safety.	DMHAS, UCM and participant discuss need for traditional services.	DDS case manager, UCM and participant discuss need for traditional services.
11	Waiver unit sends CFC service plan to CFC either through fax, paper copy or electronic scan.	DMHAS follows waiver protocol for traditional service plan.	DDS case manager follows waiver protocol for traditional service plan.

12	CFC submits CFC service plan to FI	DMHAS adds CFC individual budget allocation to waiver cost sheet to ensure participant is not over cost cap.	DDS case manager adds CFC individual budget allocation to waiver cost sheet to ensure participant is not over cost cap.
13	Waiver unit communicates with UCM regarding approval of plan.	UCM follows CFC process until review of CFC service plan is complete.	UCM follows CFC process until review of CFC service plan is complete.
14		UCM sends CFC service plan to DMHAS clinician.	UCM sends CFC service plan to DDS case manager.
15		DMHAS clinician sends total service plan package to DMHAS waiver unit for health/safety, waiver cost cap review.	DDS case manager sends total service package to DDS waiver unit for health/safety, cost cap review
16		DMHAS sends approved plans to CFC unit through the MFP/CFC web based system for budget authorization and transmittal to Allied.	DDS sends approved plans to CFC unit through the MFP/CFC web based system for budget authorization and transmittal to Allied.
17		CFC unit sends approval to UCM	CFC unit sends approval to UCM
18		DMHAS maintains established responsibilities for the waiver and the UCM maintains established responsibilities under CFC.	DDS maintains established responsibilities for the waiver and the UCM maintains established responsibilities under CFC.

This process remains the same after implementation of the UA. After implementation, however, the budget associated with the need grouping is automatically calculated and establishes the maximum amount of funding.

If the participant is a current DMHAS or DDS waiver participant who requests CFC services, the process begins with step 5.

For any CFC participant, the assessment date is the date of the waiver assessment. UCM review of existing waiver assessment is considered a reassessment.

Funding requested in addition to existing allocation during transition

Any funding requested that increases the amount of funding currently allocated to any participant is subject to the CFC prior authorization process for exceptions to budget. When the UA is fully implemented, any total budget in excess of the UA level of need grouping is subject to the prior authorization process.

9.0 Involuntary Termination of CFC Participant

Each participant who self-directs by hiring his or her own workers and managing his or her own budget has a CFC agreement describing the expectations of the participant. Termination of the participant's self-direction opportunity may be made when a participant or representative cannot adhere to the terms of the CFC Agreement. Final termination of CFC service determination is made by the CFC unit upon recommendation of the UCM.

9.1 Key terms for the participant

- participate in the development and implementation of the service planning process
- utilize funds in the individual budget only for items, goods, supports, or services identified in the participant's individual plan and authorized in the individual budget.
- actively participate in the selection and ongoing monitoring of supports and services.
- ensure that no one is a paid employee and also the guardian or legally liable relative.
- authorize payments for services provided only to the participant according to the individual plan and budget.
- enter into an agreement with the provider agency/agencies or with individual providers(s) hired.
- submit timesheets, receipts, invoices, expenditure reports, or other documentation required to the fiscal intermediary on a monthly basis or within the agreed upon timeframe.
- review expenditure reports provided by the FI on a quarterly basis and notify FI of any discrepancies.
- follow Cost Standards and Costs Guidelines for the Department for all services and support purchased with the allocation.
- get prior authorization from the Department to purchase supports, services, or goods from a party that is related to the participant through family, marriage or business association.
- seek and negotiate reasonable fares for services and reasonable costs of items, goods, or equipment, and to obtain three bids for purchases of assistive technology
- utilize Departments preferred list of vendors for home modifications
- any special equipment, furnishings, or item purchased under the CFC agreement are the property of the participant and will be transferred to the individual's new place of residence at the participant's expense or be returned to the state when the item is no longer needed.
- participate in the Department's quality review process.
- use qualified vendors enrolled by the Department where qualifications are required
- establish qualifications for PCAs and method for documenting qualifications
- ensure that each employee has completed any training required by the participant
- accept responsibility for fully reviewing criminal history background check and driver's license check and to make an informed decision regarding the hiring of the employee
- notify UCM when the participant is no longer able to meet the responsibilities for self-directed services.

The participant acknowledges that the authorization and payment for services that are not rendered could subject him/her to Medicaid fraud charges under state and federal law. Breach of any of the above requirements with or without intent may disqualify the individual from self-directing services.

9.2 Procedures Related to Involuntary Exits

When health and safety concerns arise, or fraud or misuse of funds are evident, or a fourth occurrence from the date of CFC authorization requiring corrective action (additional technical assistance) is encountered, participant may be immediately exited from CFC and returned to traditional services if available.

In the event that CFC services are terminated, traditional services are implemented as follows:

- UCM discovers unreported fraud, or fraud or misuse of funds, or a fourth event requiring corrective action occurs after three previous efforts meet the requirements for "documented" technical assistance.
- UCM sends recommendation to discontinue services to CFC unit.
- CFC renders decision within 24 hours and coordinates with waiver unit or other HCBS services to explore service options that may support the participant in the community.

9.3 Additional Technical Assistance and Support

A participant's need for additional technical assistance and support is reported to UCM agency by FI. Alternatively, assistance needs may be identified during UCM status review or reassessment. A participant may be the subject of a maltreatment report, or the participant may seek assistance to resolve problems encountered in plan implementation or service management.

While not an inclusive list, the matters below may indicate a need for additional technical assistance and support.

- Not spending enough for services needed to support health and safety without a reasonable explanation;
- A history of three months of more where the participant authorizes services in excess of what is approved in his or her plan resulting in unpaid care;
- On-going difficulty in arranging for services needed for health and safety;
- Failure to respond to notices requesting missing information from the FI;
- Not implementing the CFC service plan as approved.

Each discovery of non-compliance with CFC that requires corrective action could result in the participant receiving a CFC Notice of Technical Assistance. UCM must maintain a copy of this documentation.

UCMs may choose to provide additional assistance to a participant that does not meet the documentation requirements when successful resolution of the issue(s) seems likely. In order for an involuntary exit to occur, there must be three documented efforts that meet the formal definition of Technical Assistance and a fourth occurrence of need for corrective action before CFC services can be terminated.

Any action which triggers a fourth notice of qualifying technical assistance results in involuntary exit from the program.

UCM agency activity related to technical assistance is billed as a status payment.

9.4 Immediate Concern

Health and Safety

Any matter arising which jeopardizes the participant's health and safety may result in immediate involuntary exit. An incidence of substantiated abuse by a paid support staff, for example, may lead to involuntary exit if a backup plan cannot be implemented to assure health and safety. For this reason, it is imperative that participants have robust emergency back-up plans so that immediate jeopardy can be avoided.

Referrals to Protective Services for the Elderly or to Department of Children and Family for concerns arising about neglect rather than maltreatment follow the same process as required under state regulation.

Reported Fraud

All reports of fraud must be investigated. The UCM works with Allied to determine the facts regarding the allegation. Alleged fraud may lead to a need for technical assistance. The determining factor for technical assistance is based on the intent of the CFC participant relative to the occurrence. For example, the CFC participant's failure to examine the dates on the timesheet closely may inadvertently lead to a request for unauthorized payment. In this example, it may be reasonable to assume that the allegation of fraud is the result of error rather than intent to engage in fraudulent activity. Alternatively, if the allegation of fraud is supported by evidence that the participant is intentionally engaging in fraudulent activity, documentation to support the finding must be immediately forwarded to central office for criminal investigation.

10 Voluntary Termination of CFC services for Participant

Participants may contact the UCM to request the termination of CFC services. Participants seeking termination may choose an alternative support service subject to availability. For participants who are not eligible for waiver services or who are eligible but lack access due to waiting list considerations, home health services may be the only Medicaid option available. These participants are advised to follow existing Medicaid procedures to access these servicers. Participants who are eligible for waiver services and for whom a waiver 'slot' is available, are referred to the appropriate case management agency based on the waiver type. The UCM discusses with the individual/family all the available options and resources available and begins the process of referral to those options. Once the new option has been identified and secured, UCMs complete the form for termination of CFC services. The form is sent within 10 business days to the CFC central office.

11 Billing for CFC Services

Universal Case Management Rates: CFC only participants

Assessment: Assessment rates are consistent with rates under the competitive solicitation for elder waiver. Assessments for any participant applying for CFC (including a wavier participant) are billed utilizing the CFC procedure code.

Assessment under CFC includes:

- completion of the universal assessment;

- information regarding service options;
- discussion and tasks for Support and Planning Coach (if required);
- review and recommendation of participant service plan.

Status: Status rates are consistent with rates under competitive solicitation for elder wavier. Status payment under CFC include:

- review and documented action related to budget variance reports from FI;
- provision of technical assistance unrelated to FI reports;
- review and update of universal assessment related to a change in functional status

Reassessment: Reassessment rates are consistent with rates under competitive solicitation for elder wavier. Reassessment payments under CFC include:

- annual assessment;
- review of assessment for CFC services initiated by any entity other than the UCM agency.

Appendix A1 Notice of Action - Discontinuance

Notice of Action
Discontinuance of Service under Community First Choice Program

TO: [CFC Applicant's Name]
[CFC Applicant's Address & telephone number]

FROM: [Name of Contact Person]
[Address]

DATE SENT:

DATE OF ACTION:

The Department of Social Services (DSS) has reviewed the services you are receiving under Community First Choice (CFC), and determined that your CFC services will be **discontinued** because:

___ You are not an active recipient of Connecticut Medicaid. 42 U.S.C. § 1396n(k)(1); 42 C.F.R. § 441.510.

___ You no longer meet institutional level of care. 42 U.S.C. § 1396n(k)(1); 42 C.F.R. § 441.510(c).

___ You can no longer self-direct your care needs and/or you do not have a Representative to self-direct on your behalf. 42 U.S.C. § 1396n(k)(1)(A)(iv); 42 C.F.R. § 441.540.

___ Your proposed service plan exceeds your individual level of need budget for CFC services. 42 C.F.R. § 441.560.

___ You no longer live in a residence that meets the Home and Community Based setting standard for CFC. 42 U.S.C. § 1396n(k)(1)(A)(ii); 42 C.F.R. § 441.530.

___ You or your Legal Representative have informed us that you no longer wish to participate or are not interested in services provided through CFC.

___ Other: _____
_____[Citation(s): _____]

As of the **Date of Action** listed above, you will no longer receive services under the Community First Choice program.

This determination does not affect your eligibility for other Medicaid services.

APPEAL RIGHTS

YOU HAVE THE RIGHT TO APPEAL THIS DECISION. A description of your appeal rights and a hearing request form are enclosed.

If you do not understand this notice, or if you have any questions concerning this action, please contact Community Fist Choice Central Office at 888-992-8673.

Appendix A2 Notice of Action - Denial

Notice of Action
Denial of Participation in Community First Choice Program

TO: [CFC Applicant's Name]
[CFC Applicant's Address & telephone number]

FROM: [Name of Contact Person]
[Address]

DATE SENT:

The Department of Social Services (DSS) has reviewed your proposed service plan for Community First Choice (CFC), and determined that you are **not eligible** for CFC because:

___ You are not an active recipient of Connecticut Medicaid. 42 U.S.C. § 1396n(K)(1); 42 C.F.R. § 441.510.

___ You do not meet institutional level of care. 42 U.S.C. § 1396n(K)(1); 42 C.F.R. § 441.510(c).

___ You are **not able** to self-direct your care needs and/or do not have a Representative to self-direct on your behalf. 42 U.S.C. § 1396n(K)(iv); 42 C.F.R. § 441.540.

___ Your proposed service plan exceeds your individual level of need budget for CFC services. 42 C.F.R. § 441.560.

___ You do not live in a residence that meets the Home and Community Based setting standard for CFC. 42 U.S.C. § 1396n(K)(A)(ii); 42 C.F.R. § 441.530.

___ Other: _____
_____[Citation(s): _____]

You are not eligible to receive services under the Community First Choice program.

This determination does not affect your eligibility for other services that are covered by Medicaid.

APPEAL RIGHTS

YOU HAVE THE RIGHT TO APPEAL THIS DECISION. A description of your appeal rights and a hearing request form are enclosed.

Appendix A3 Notice of Technical Assistance

Notice of Technical Assistance and Additional Oversight

The Universal Case Manager completes this form to document a need for additional technical assistance and/or support that is beyond reasonable efforts. The participant or their legal representative must sign the form and receive a copy. The original is kept in the participant's file.

Participant: _____

Universal Case Manager: _____

Agency: _____

Date of notice and technical assistance and/or additional oversight: _____

Number of documented notices in this service plan year and date of each notice:

1 _____ 2 _____ 3 _____ 4* _____

Identification of the problem-- describe what caused the need for technical assistance and/or additional oversight: _____

_____

_____

Corrective action needed – describe what action needs to occur to correct the problem:

Timeline to accomplish the corrective action – define the timeline for the CFC participant to complete the corrective action:

Consumer and legal representative signature:

* On the 4th occurrence of the technical assistance and/or additional oversight beyond reasonable efforts, the Notice of Action – Discontinuance of Services is sent. The CFC participant is exited from CFC as of the effective date on the DSS Notice.

Appendix B 1 Community First Choice Service Budget

Name:		**Medicaid #:**	
CFC Total Budget Allocation:	**$**	**CFC Monthly Budget Allocation**	**$**

This Budget Worksheet is a guide that helps you select the services you want to receive in your home and community. Each section covers different services and supports that are covered by your budget.

Please look over the results of the "My Assessment" and speak to your family or your Support and Planning Coach about what services you may want. Details and limits on each service can be found on the Service Definition Page. Reference the Rate Sheet to figure out cost of services.

Section 1: CFC services for assistance with hands-on care/cueing/supervision

Use these hours to help with ADLs and IADLs, such as bathing, dressing, transferring, toileting, medicine management, errands, medical appointments, and household chores.

Costs of all services in this section are applied to your maximum budget.

Required service: PCA Optional services: Home Delivered Meals and Worker's Compensation.

Available Services for Hands-on Care / Cueing / Supervision	**Medicaid unit cost of Service per hour or unit**	**# of units per week**	**# of units per month (units per week X 4.43)**	**Average Monthly Cost of Service**	**Projected Annual Cost of Services**
Daily PCA	$16.32				
Live-in PCA (24 hr coverage)	$200.30				
Overnight PCA (12 hour coverage)	$144.97				
Home Delivered Meals	$4.84 single meal				
Home Delivered Meals	$8.85 double meal				

If any of your staff work greater than 25.75 hours per week, Workers Compensation Insurance is REQUIRED.

This will reduce your dollars available for PCAs but allow you to have full-time staff. The total cost of your Workers Compensation Policy is banked in your first month and you will see this reflected on your budget summary, from your FI, when you begin services.

Workers compensation (WC)	***A monthly average for a policy will range $200-$400		
		Section 1 TOTAL COST	

Section 2: CFC Services to assist you with managing your individual budget, service planning, and hiring, managing, and scheduling PCAs.

The annual costs of these services are calculated in your first month's budget and allow for flexibility of use throughout the year.

Do not count hours already authorized as one-time use, to assist with the development of the plan.

All Services are **optional.**

IF you are not interested in services in this section initial here: _____

Available Services	Rate	# of Hours per Month	Average Monthly Cost of Service	Projected Annual Cost of Service
Support and Planning Coach	Individual – rates vary, check rate sheet, then; Insert rate: _____			
	Agency: - $42.88 per hour			
Training to self-direct	Rates vary, you can set aside dollars for future use			
			Section 2 TOTAL COST	

Name of the Support and Planning Coach: _____

List any trainings you may be interested in: _____

_____

Section 3 CFC services to support backup systems

The annual costs of these services are calculated in your first month's budget and allow for flexibility of use throughout the year.

Optional services: PCA, Assistive Technology (motion monitors and so on), Personal Emergency Response System, and hardware, software, and other devices that aid in emergency response.

IF you are not interested in services offered in this section initial here: _____

If you are choosing not to use formal/paid supports, you must list your Emergency Backup Plan when PCAs call out. This could include family, friends, or neighbors providing unpaid support:

Please describe you're your Emergency Backup Plan:_____

_____

Formal Backup System and Support	**Rate**	**Monthly Cost of Service**	**Projected Annual Cost of Service**
PERS (Personal Emergency Response)	$61.86		
PCA (you can reserve dollars for emergency coverage)	$16.96		
Other Emergency Backup System			
		Section 3 TOTAL COST	

Section 4 CFC services to assist with increasing independence in health-related tasks and/or daily living tasks noted under Section 1

The annual costs of these services are calculated in your first month's budget and allow for flexibility of use throughout the year.

Optional services: Assistive Technology or Health Coaches (Registered Nurse, Physical, Occupational, and Speech therapy professionals).

Please note, you cannot use coaching services if you have these services already in the home, ordered by your doctor, for skilled care.

*PT, OT, SP Coaching require a doctors order before they can begin

IF you are not interested in services offered in this section initial here: _____

If you are budgeting for a Health Coach. Please list your Health Goals that you want your Coach to work on with you:

1._____ 2._____

Available Services	**Rate**	**Average # of units per month**	**Monthly Cost of Service**	**Projected Annual Cost of Services**
Nurse Coach	$122.80			
Physical Therapy Coach*	$134.20			
Occupational Therapy Coach*	$97.24			
Speech Therapy Coach*	$106.08			
Assistive Technology (you can reserve funds for future use)	AT is limited to $5,000 per year. You can budget up to $415.00 per month to cover cost of technology.			
			Section 4 TOTAL COST	

Appendix B 2 CFC Budget Approval Form

Name:		**Medicaid #:**	
		Date:	
Do you have someone to help you complete this form?		**YES NO**	
If yes, name of the person:		**Phone Number:**	
Total Budget Allocation:			

UNIVERSAL CARE MANAGER COMPLETES LINES A-D

A. Annual cost of ALL Wavier Services, indicate the Waiver _____	**$**
B. Annual cost of Husky Home Health Services This is the weekly skilled therapies in the home ordered by a physician (Nursing, Physical Therapy, Occupational Therapy, and Speech Therapy)	**$**
C. For individuals who used a paid Support and Planning Coach to assist with care planning, enter the authorized total, from Form 4.2	**$**
D. **SUBTRACT** the totals for A, B and C from your Total Budget Allocation. This amount is your Total CFC Annual Budget	**$**

CFC PARTICIPANT OR SUPPORT AND PLANNING COACH COMPLETES LINES E & F

E. Review the service plan budget worksheets and input the **totals** from each section. The total for all sections cannot exceed the amount in section D	Section 1 total	$	
	Section 2 total	$	
	Section 3 total	$	
	Section 4 total	$	
	Add Sections 1-4 and total → →		**$**
F. Requested One Time Expenses pending authorization, describe below. (environmental accessibility modifications and transition costs) _____ _____			**$**

Participant signature:		Date:	
Universal Case Manager approval:		Date:	
Review by DSS CO staff:		Date:	
CFC CENTRAL OFFICE STAFF ONLY: CARE PLAN EFFECTIVE DATE: _____			

Appendix C1 Community First Choice Risk Mitigation Plan

Name: Date of Completion:
Medicaid #: Name of Person Completing:

Risk Mitigation:

Area of Identified Risk:	Are Risks addressed In Plan of Care?	Strategies to Address the Risks that were Identified:
Nutrition	☐ Yes ☐ No	
Medications	☐ Yes ☐ No	
ADLs	☐ Yes ☐ No	
IADLs	☐ Yes ☐ No	
Fall Risk	☐ Yes ☐ No	
Sensory Impairment	☐ Yes ☐ No	
Skin Integrity	☐ Yes ☐ No	
Assistive Technology (AT)	☐ Yes ☐ No	
Isolation	☐ Yes ☐ No	
Other List: If necessary continue below	☐ Yes ☐ No	
History of substance abuse	☐ Yes ☐ No	

Appendix C2 Participant Risk Agreement

Risk assessment is an important part of the assessment and service planning process. This agreement serves as documentation of a conversation through which the individual or his/her legal representative have been presented with the potential risks identified though the assessment process, the source of those risks, the alternatives available to address the risks identified and an acknowledgement by the individual or his/her legal representative that the identified risks exist and the individual has agreed to assume these risks in order to return to the community.

Name of Participant/Legal Representative:

Name of Individuals involved in the risk identification and reduction discussion:

Identifying and mitigating risks

Participant's risk and choice regarding action/inaction[2]	Negative outcomes that may result[3]	Alternative measures that may be implemented by participant, agency, informal support etc[4]

The following is the plan/agreement reached to address the identified risks:

[2] Examples include: exhibited behavior or choice not to accept service or follow prescribed treatment, medication, therapy regime; history of falls, includes risk/hazard in person's environment such as side rails on bed

[3] Examples include: decline in mental/physical health, injury, asphyxiation

[4] Examples include: expand network of informal supports, education, adaptive equipment

I understand the risks identified above by the Community First Choice / Money Follows the Person case manager and the alternatives available to address the risks associated with my decisions. I agree with the plan/agreement and assume any risk that is not addressed by the services provided though the Community First Choice / Money Follows the Person program.

_____ _____

Participant/Legal Representative Date

_____ _____

Case Manager/ Social Worker Date

Appendix D Community First Choice Budget Justification

State of Connecticut
Department of Social Services
Money Follows the Person/Community/First Choice
Universal Assessment Budget Exception Form

To: Date:
From:
Agency: ☐ CCCI: ☐ NC ☐ NW ☐ Eastern
☐ AASCC ☐ SWCAA ☐ WCAAA

Consumer:
Address:

City/Town: State: CT Zip: -
Phone#: Cell#:
EMS #: DOB:
Level of Need: Current Budget: $
Budget requested: $

If after the participant has completed hers/his plan of care and upon review by the primary assessor, the plan of care, is determined not to be sufficient based on the allocated budget to ensure health and safety…the assessor may request an exception to the budget.

This must be accompanied with a concrete justification based on the participant's needs and the lack of funds allocated to provide the service/s that would meet that need.

The risk mitigation form should be completed with the participant, with the service/s on care plan and a description of the areas where more service/s dollars may be needed and the reason why. The risk mitigation should accompany this request form.

Exception to budget:

Signature of Assessor: _____ Date: _____

CO signature: _____ Date: _____

Approved: ☐ Denied: ☐

Appendix E Community First Choice Monthly Services Report

Financial Management Services

MONTHLY CFC SERVICES REPORT

Joe Employer
100 Cottage Street
East Windsor, CT 06088

Client: Joe Employer
Budget Year: 7/1/2014-6/30/2015
Calculated as of: 5/5/2015
Pay Periods Remaining: 20
Case Manager: Virginia Smith

OVERVIEW:

	Total Annual Budget Amount	Year to Date Allotment	Year to Date Expenditures	Next Month's Allotment (includes carryover)
Section 1-4 Totals (Annual Budget):	**$48,000.00**	**$11,500.00**	**$10,000.00**	**$8,700.00**

DETAIL:

Section 1: Assistance with Hands-On Care/Cueing/Supervision

	Total Annual Budget Amount	Year to Date Allotment	Year to Date Expenditures	Next Month's Allotment (includes carryover)
Attendant Care	$18,000.00	$4,500.00	$1,500.00	$4,500.00
Section 1 Totals:	**$18,000.00**	**$4,500.00**	**$1,500.00**	**$4,500.00**

Section 2: Assistance with Care Planning and Managing Your Individual Budget

	Total Annual Budget Amount	Year to Date Allotment	Year to Date Expenditures	Next Month's Allotment (includes carryover)
Planning and Support Coach	$18,000.00	$1,500.00	$4,000.00	$1,500.00
Section 2 Totals:	**$18,000.00**	**$1,500.00**	**$4,000.00**	**$1,500.00**

Section 3: Backup Systems

	Total Annual Budget Amount	Year to Date Allotment	Year to Date Expenditures	Next Month's Allotment (includes carryover)
Personal Emergency Response System	$10,000.00	$5,000.00	$4,000.00	$2,000.00
Section 3 Totals:	**$10,000.00**	**$5,000.00**	**$4,000.00**	**$2,000.00**

Section 4: Increasing Independence in Health-Related and/or Daily Living Tasks

	Total Annual Budget Amount	Year to Date Allotment	Year to Date Expenditures	Next Month's Allotment (includes carryover)
Nurse Coach	$1,000.00	$500.00	$500.00	$100.00
Speech Therapy Coach	$1,000.00	$500.00	$0.00	$600.00
Section 4 Totals:	**$2,000.00**	**$500.00**	**$500.00**	**$700.00**

Section 5: One Time Services

	Total Amount Allotted	Year to Date Expenditures	Total Amount Remaining
Environmental Modifications	$500.00	$500.00	$0.00
Section 5 Totals:	**$500.00**	**$500.00**	**$0.00**

Appendix F Hearing Request Form

HEARING REQUEST FORM

YOUR RIGHT TO A HEARING

You have the right to ask for a hearing if you do not agree with any of our decisions. A hearing is a meeting with you, your caseworker, and a Hearing Officer. The Hearing Officer will listen to the facts and decide if our decision was right or wrong.

At a hearing, you may explain why you do not agree with our decision. You may speak for yourself or have someone else, such as a friend or relative, speak for you. You may also have an attorney speak for you. You may call Legal Services at 1-800-453-3320 to ask about free legal help.

The best way to ask for a hearing is to use the HEARING REQUEST FORM.

- You have **60 days** from the date of this notice to ask for a hearing.
- Your benefits will not change if you ask for a hearing **within 10 days** of this notice. Your benefits will stay the same until the Hearing Officer decides.
- If the Hearing Officer decides our decision was right, you may have to pay us back.

KEEP THIS PAGE FOR YOUR RECORDS

YOU HAVE THE RIGHT TO MAKE A DISCRIMINATION COMPLAINT

You have the right to make a discrimination complaint if you think we have taken action against you because of your race, color, religious creed, sex, marital status, age, national origin, ancestry, criminal record, political beliefs, sexual orientation, mental retardation, mental disability, learning disability or physical disability, including but not limited to blindness.

An individual with a disability may request and receive a reasonable accommodation or special help from the department when special help is necessary to allow the individual to have an equal and meaningful opportunity to participate in the programs administered by the department.

If you asked for an accommodation or special help and we refused to provide the special help, you may make a complaint to the department's Affirmative Action Division Director or any of the agencies listed below.

You or someone representing you can write to or call one or more of these agencies to make a discrimination complaint:

Commissioner of the Department of Social Services
Attention: Affirmative Action Division Director/ADA Coordinator,
55 Farmington Avenue
Hartford, CT 06105-3730
Telephone: 1-860-424-5040 (TDD: 1-800-842-4524)

Connecticut Commission on Human Rights and Opportunities
21 Grand Street
Hartford, CT 06106
Telephone: 1-860-541-3400 (TDD: 1-860-541-3459)

US Department of Health and Human Services
Office of Civil Rights, Region 1
JFK Federal Building, Room 1875
Boston, MA. 02203
Telephone: 1-617-565-1340 (TDD: 1-617-565-1343)

US Department of Agriculture
Office of Civil Rights (Food Stamps only)
Whitten Building, Room 326-W
1400 Independence Avenue SW
Washington D.C. 20250-9410
Telephone/TDD: 1-202-720-5964

STATE OF CONNECTICUT
DEPARTMENT OF SOCIAL SERVICES

Name:_____ Client I.D.: 00

Address:_____ Worker Name:_____

_____

_____

HEARING REQUEST FORM

Use this form only if you want a hearing. Remember, before you ask for a hearing or at any time afterwards, you may call your caseworker or his/her supervisor for help in solving the problem:

1. I do not agree with the decision taken on my case. I am requesting a hearing because:

_____

_____

_____

_____

_____

_____

_____

_____

(Please use the back of this form if you need more room to write.)

2. My telephone number, including area code is: ( ) _____

3. Please check one:

☐ Under some programs, benefits may continue while the hearing decision is pending. If possible, I want my benefits to continue until the hearing decision is made. I understand that if the decision is not in my favor, I may have to pay back the benefits.

☐ I do not want my benefits continued while the Hearing Officer is deciding.

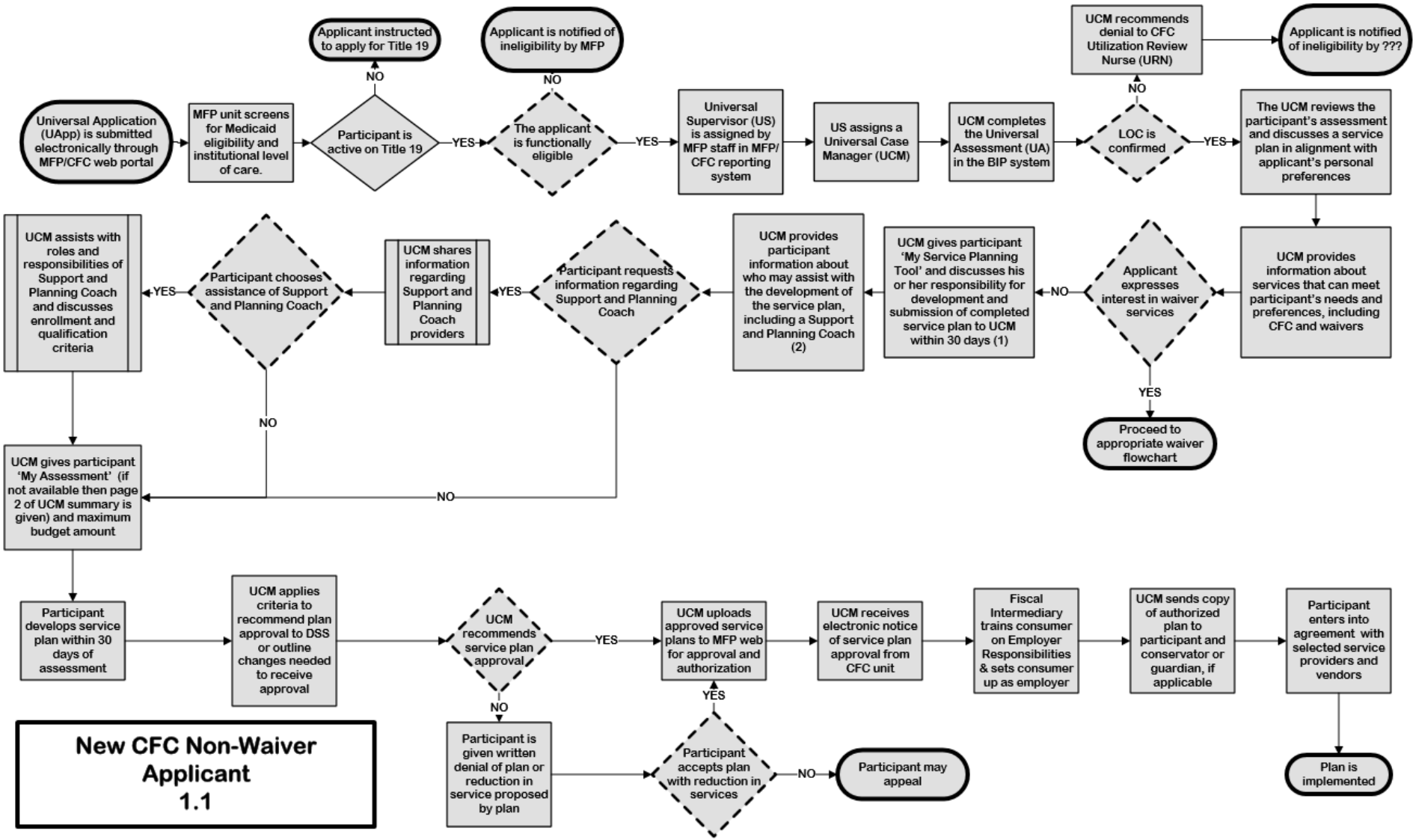
4. X_____ _____
Signature Date

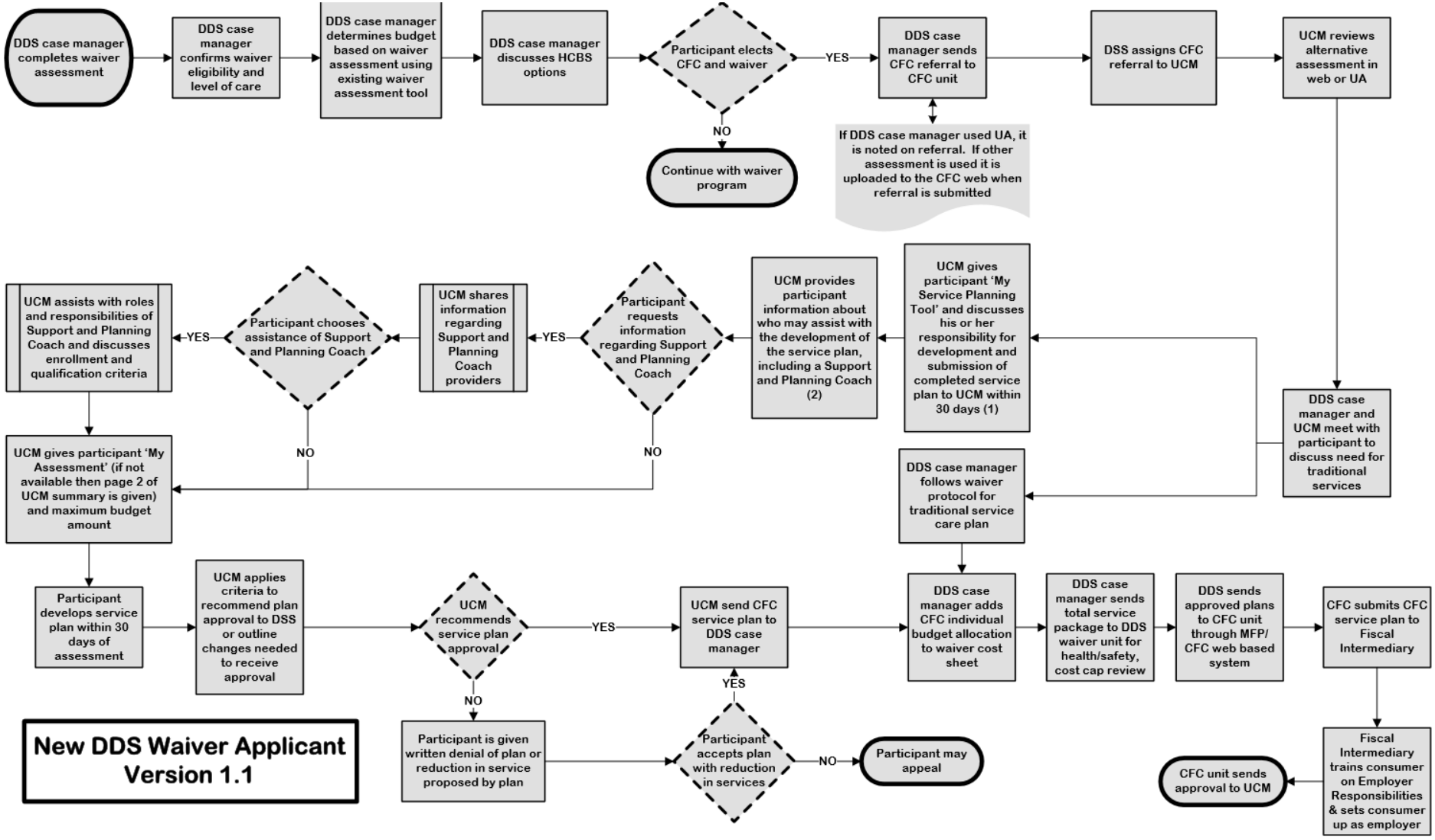
5. Mail or fax this completed request to:

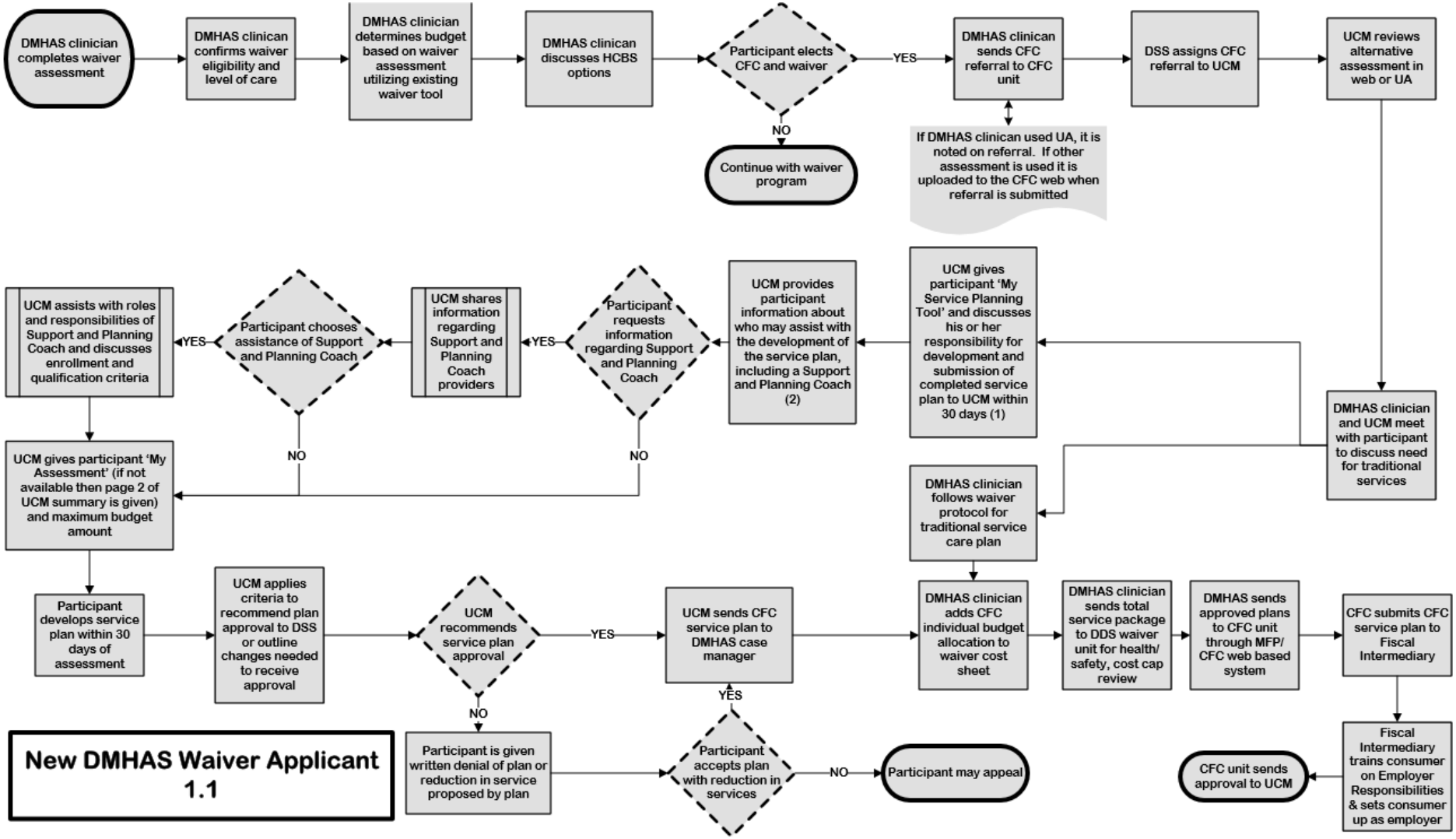
Department of Social Services
Office of Legal Counsel, Regulations and Administrative Hearings
55 Farmington Avenue
Hartford, CT 06105-3730
Fax Number: (860) 424-5729

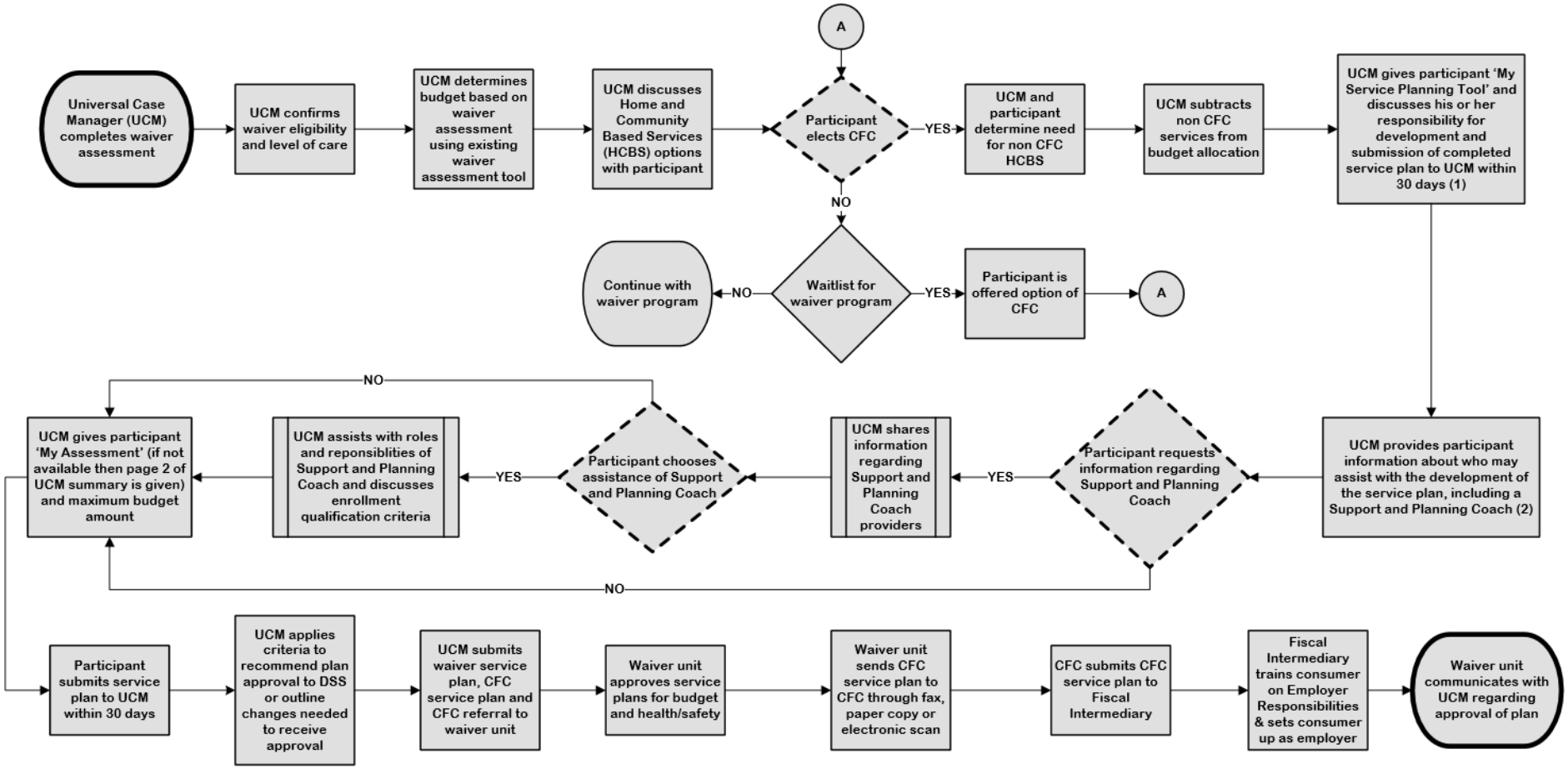
THIS INFORMATION IS AVAILABLE IN ALTERNATE FORMATS. PHONE (800) 842-1508 OR TDD/TTY (800) 842-45

Appendix G Flow Charts




DDS case manager completes waiver assessment
DDS case manager confirms waiver eligibility and level of care
DDS case manager determines budget based on waiver assessment using existing waiver assessment tool
DDS case manager discusses HCBS options
Participant elects CFC and waiver
YES
NO
Continue with waiver program
DDS case manager sends CFC referral to CFC unit
If DDS case manager used UA, it is noted on referral. If other assessment is used it is uploaded to the CFC web when referral is submitted
DSS assigns CFC referral to UCM
UCM reviews alternative assessment in web or UA
DDS case manager and UCM meet with participant to discuss need for traditional services
UCM gives participant 'My Service Planning Tool' and discusses his or her responsibility for development and submission of completed service plan to UCM within 30 days (1)
UCM provides participant information about who may assist with the development of the service plan, including a Support and Planning Coach (2)
Participant requests information regarding Support and Planning Coach
YES
NO
UCM shares information regarding Support and Planning Coach providers
Participant chooses assistance of Support and Planning Coach
YES
NO
UCM assists with roles and responsibilities of Support and Planning Coach and discusses enrollment and qualification criteria
UCM gives participant 'My Assessment' (if not available then page 2 of UCM summary is given) and maximum budget amount
DDS case manager follows waiver protocol for traditional service care plan
Participant develops service plan within 30 days of assessment
UCM applies criteria to recommend plan approval to DSS or outline changes needed to receive approval
UCM recommends service plan approval
YES
NO
UCM send CFC service plan to DDS case manager
YES
Participant is given written denial of plan or reduction in service proposed by plan
Participant accepts plan with reduction in services
NO
Participant may appeal
DDS case manager adds CFC individual budget allocation to waiver cost sheet
DDS case manager sends total service package to DDS waiver unit for health/safety, cost cap review
DDS sends approved plans to CFC unit through MFP/ CFC web based system
CFC submits CFC service plan to Fiscal Intermediary
Fiscal Intermediary trains consumer on Employer Responsibilities & sets consumer up as employer
CFC unit sends approval to UCM
New DDS Waiver Applicant Version 1.1


DMHAS clinician completes waiver assessment
DMHAS clinican confirms waiver eligibility and level of care
DMHAS clinician determines budget based on waiver assessment utilizing existing waiver tool
DMHAS clinican discusses HCBS options
Participant elects CFC and waiver
YES
NO
Continue with waiver program
DMHAS clinican sends CFC referral to CFC unit
If DMHAS clinican used UA, it is noted on referral. If other assessment is used it is uploaded to the CFC web when referral is submitted
DSS assigns CFC referral to UCM
UCM reviews alternative assessment in web or UA
DMHAS clinician and UCM meet with participant to discuss need for traditional services
UCM gives participant 'My Service Planning Tool' and discusses his or her responsibility for development and submission of completed service plan to UCM within 30 days (1)
UCM provides participant information about who may assist with the development of the service plan, including a Support and Planning Coach (2)
Participant requests information regarding Support and Planning Coach
YES
UCM shares information regarding Support and Planning Coach providers
Participant chooses assistance of Support and Planning Coach
YES
UCM assists with roles and responsibilities of Support and Planning Coach and discusses enrollment and qualification criteria
NO
NO
UCM gives participant 'My Assessment' (if not available then page 2 of UCM summary is given) and maximum budget amount
DMHAS clinician follows waiver protocol for traditional service care plan
Participant develops service plan within 30 days of assessment
UCM applies criteria to recommend plan approval to DSS or outline changes needed to receive approval
UCM recommends service plan approval
YES
NO
UCM sends CFC service plan to DMHAS case manager
YES
DMHAS clinician adds CFC individual budget allocation to waiver cost sheet
DMHAS clinician sends total service package to DDS waiver unit for health/ safety, cost cap review
DMHAS sends approved plans to CFC unit through MFP/ CFC web based system
CFC submits CFC service plan to Fiscal Intermediary
Fiscal Intermediary trains consumer on Employer Responsibilities & sets consumer up as employer
CFC unit sends approval to UCM
Participant is given written denial of plan or reduction in service proposed by plan
Participant accepts plan with reduction in services
NO
Participant may appeal
New DMHAS Waiver Applicant 1.1



New PCA, Elder or ABI Waiver Applicant
1.1