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STATE OF CONNECTICUT

REGULATION

OF

Name of Agency

Department of Social Services

Subject Matter of Regulation

Acquired Brain Injury Waiver Program

Section 1. The Regulations of Connecticut State Agencies are amended by adding sections 17b-260a-1 to 17b-260a-17, inclusive, as follows:

(NEW) Section 17b-260a-1. Purpose

The Acquired Brain Injury waiver program provides, within the limitations described in sections 17b-260a-2 to 17b-260a-17, inclusive, of the Regulations of Connecticut State Agencies a range of nonmedical, home and community-based services to eligible individuals with an ABI who, without such services, would otherwise require placement in an institutional setting. The intention of the ABI waiver program is to enable individuals with an ABI to receive services in the community at an aggregate cost of 75% of alternative institutional costs. The ABI waiver program is not an entitlement; therefore, services and access to services under the ABI waiver program may be limited, based on available funding and program capacity.

(NEW) Sec. 17b-260a-2. Scope

Sections 17b-260a-1 to 17b-260a-17, inclusive, of the Regulations of Connecticut State Agencies set forth the department's requirements for payment of services to eligible individuals through the ABI waiver program. These regulations describe the program requirements, services available and limitations under the ABI waiver program. The ABI waiver program is established pursuant to section 17b-260a of the Connecticut General Statutes and is a federal waiver program under 42 USC 1396n(c).

(NEW) Sec. 17b-260a-3. Definitions

As used in sections 17b-260a-1 to 17b-260a-17, inclusive, of the Regulations of Connecticut State Agencies:

(1) "Acquired Brain Injury" or "ABI" means the combination of focal and diffuse central nervous system dysfunctions, immediate or delayed, at the brainstem level or above. These dysfunctions may be acquired through physical trauma, oxygen deprivation, infection or a discrete incident that is toxic, surgical or vascular in nature. The term

"ABI" does not include disorders that are congenital, developmental, degenerative, associated with aging or that meet the definition of mental retardation as defined in section 1-1g of the Connecticut General Statutes;

(2) "Acquired Brain Injury Nursing Facility" or "ABI NF" means a type of nursing facility that provides specialized programs for persons with an acquired brain injury;

(3) "Acquired Brain Injury waiver program" or "ABI waiver program" or "program" or "waiver" means the program administered by the Department of Social Services, described in a federal waiver and approved by the Secretary of the United States Department of Health and Human Services pursuant to 42 USC 1396n as amended from time to time, for the provision of ABI waiver services to adults;

(4) "Acquired Brain Injury waiver services" or "ABI waiver services" means all or some the services provided to participants in the ABI waiver program;

(5) "Activities of Daily Living" or "ADLs" means activities or tasks that are essential to an individual's health, welfare and safety including, but not limited to bathing, dressing, eating, transfers, bowel and bladder care;

(6) "Agency provider" means a provider, employed by an agency, who provides services to individuals participating in the ABI waiver program;

(7) "Aggregate cap" means the total cost of the services, at any given time, for all ABI waiver program participants;

(8) "Alternative institutional care costs" means the costs of institutional care that the individual would otherwise incur, but for the support of ABI waiver services;

(9) "Applicant" means an individual who, directly or through a representative, completes an ABI waiver program application form and submits it to the department;

(10) "Assessment" means a comprehensive written evaluation conducted by nonmedical department personnel, using a standard assessment form that is used to determine whether an individual meets the level-of-care criteria to participate in the ABI waiver program;

(11) "Chronic Disease Hospital" or "CDH" means a long-term hospital having facilities, medical staff and necessary personnel for the diagnosis, care and treatment of a wide range of chronic diseases;

(12) "Cost effective" or "cost effectiveness" means the department's determination that payments for the individual's total service costs do not exceed either the individual or aggregate caps;

(13) "Department" or "DSS" means the state of Connecticut Department of Social Services;

(14) "Family member" means a person who is related to the individual by blood, adoption or marriage;

(15) "Executive functions" means the processes by which an individual plans, prioritizes, organizes, sets goals, executes strategies and monitors personal behavior;

(16) "Fiduciary agent" means the agent or agents under contract with the department that act as a fiscal intermediary responsible for paying providers for services delivered; registration of qualified providers; and providing training and outreach to providers of services under the ABI Waiver program;

(17) "Hands on care" means assistance with ADLs provided most often, but not exclusively, by home health aides. Hands on care includes the prompting and cueing necessary for an individual to perform ADLs;

(18) "Household employee" means a provider who performs chore, companion, homemaker, respite or personal care assistance services who is employed by the individual and not an agency;

(19) "Individual" means a person with an acquired brain injury who is applying for or participating in the ABI waiver program;

(20) "Individual cap" means the total cost of the individual's service plan;

(21) "Intermediate Care Facility for Mentally Retarded Persons" or "ICF-MR" means a residential facility licensed by the Connecticut Department of Developmental Services for the care and treatment of mentally retarded and developmentally disabled persons;

(22) "Intervention plan" means a document developed by a cognitive behaviorist that identifies the treatment goals and interventions for the individual and team;

(23) "Legal representative" means an attorney, guardian, conservator, or power of attorney appointed to act on the individual's behalf;

(24) "Level-of-care" means the type of facility, as determined by a DSS social worker or designated agent of the department that is needed to care for an individual if the individual were not receiving services under the ABI waiver program. The types of facilities may include, but may not be limited to: a nursing facility, ABI NF, CDH or ICF-MR;

(25) "Medical assistance program" means, any and all of the health benefit programs administered by the state of Connecticut Department of Social Services;

(26) "Nursing Facility" or "NF" means an institution, as defined in 42 USC 1396r, as amended from time to time, that participates in Connecticut's medical assistance program pursuant to the terms of a provider agreement with the department;

(27) "Other community-based services" means services provided by programs administered by the department that are not part of the ABI waiver program or services provided by programs administered by other state or local agencies that are necessary to maintain the individual in the community;

(28) "Other medical services" means services that are normally included in the department's payments to NFs, ABI NFs, CDHs and ICF-MRs, and that the individual requires, in addition to ABI waiver services, to live in the community. Other medical services include, but are not limited to: home health care, nursing services, physical therapy, speech therapy and occupational therapy;

(29) "Person-centered team" means an interdisciplinary group of people organized to assist the individual to develop and implement a service plan. The planning team consists of a DSS social worker, the individual, the legal representative (if applicable), a cognitive behaviorist, any interested family members or other relevant participants;

(30) "Private provider" means a person who provides services such as case management, cognitive behavioral programs and independent living skills training and is employed by the individual, not an agency. Private providers are not household employees;

(31) "Qualified provider" means an agency provider, household employee or private provider who meets the qualifications established by the department to provide home and community-based services under the ABI waiver program and is listed in the department's ABI provider directory;

(32) "Service plan" means an individualized written plan developed through person-centered planning that documents the medical and home and community-based services that are necessary to enable the individual to live in the community instead of an institution. The service plan includes measurable goals, objectives and documentation of total service costs;

(33) "Total service costs" means the annualized cost of ABI waiver services, other medical services, other community-based services and any lump sum payments included in an individual's service plan that are required in order for the individual to live in the community instead of an institution; and

(34) "Waiting list" means a record maintained by the department that includes the names of individuals seeking ABI waiver services and specifies the date the ABI waiver application form was received from the individual.

(New) Sec. 17b-260a-4. Eligibility and Determination of Need

(a) An individual is eligible to receive coverage for the cost of the services specified in section 17b-260a-5 of the Regulations of Connecticut State Agencies, through the department's ABI waiver program if the individual has either already been determined eligible to participate in the department's Medicaid medical assistance program and meets the additional programmatic requirements specified in subsection (d) of this section, or the individual qualifies by meeting all of the technical, financial and programmatic requirements specified in subsections (b) to (d), inclusive, of this section.

(b) The technical requirements for eligibility are as follows:

(1) All applicants for the ABI waiver program shall meet the requirements for eligibility in the department's medical assistance program that are applicable to disabled adults, as stated in the Regulations of Connecticut State Agencies and contained in the Uniform Policy Manual including, but not limited to, all regulations establishing medical assistance eligibility, requirements related to the filing of applications for assistance, verifications, redeterminations, existence of a disabling condition, citizenship status, residency, institutional status, assistance unit composition and income and asset limits.

(2) Applicants for the ABI waiver program are considered to be institutionalized for purposes of determining their eligibility for Medicaid. All medical assistance categorical eligibility rules that apply to institutionalized applicants or recipients of medical assistance apply to applicants or recipients of ABI waiver services. Specifically, without limiting the scope of this section, applicants and recipients for ABI waiver services are subject to the rules that govern eligibility including, but not limited to, the transfer of assets and the treatment of the resources and income of spouses of institutionalized applicants and recipients.

(c) The financial requirements for eligibility are as follows:

(1) An active recipient of medical assistance benefits who applies for the ABI waiver program, or an applicant who meets the technical requirements of subsections (b) and (d) of this section and who applies for the ABI waiver program, shall be found eligible if the applicant's countable income is less than 300% of the benefit amount that would be payable under the federal Supplemental Security Income program to an applicant who lives in their own home and has no income or resources.

(A) Income eligibility for ABI waiver services under this section is determined solely by reference to the applicant's countable income and does not involve consideration of the incurred medical expenses or any other liabilities that may have been incurred by the applicant.

(B) The applicant's countable income for purposes of this subsection is determined by reference to the same methodologies the department employs in determining the countable income of an institutionalized applicant for medical assistance, as noted in subsection (c)(1) of this section.

(C) Applicants who qualify for medical assistance as medically needy, but who do not qualify for ABI waiver services because their income exceeds the 300% of the Supplemental Security Income program income limit, shall receive coverage of medically necessary services to the extent such services are available generally to recipients of medical assistance, but shall not receive coverage for those services that are provided only to those individuals who are covered under this or any other federal Medicaid waiver.

(2) An individual shall not reduce their income, or fail to pursue potential sources of income, in order to obtain or retain eligibility for assistance.

(d) The programmatic requirements for eligibility are as follows:

An individual shall:

(1) Be between the ages of 18 and 64 at the time the application is completed;

(2) have an ABI, as defined in section 17b-260a-3 of the Regulations of Connecticut State Agencies;

(3) meet the criteria for one of the level-of-care categories described in subsection 17b-260a-7 (b) of the Regulations of Connecticut State Agencies;

(4) have the cognitive ability to actively participate in the development of their service plan. Participation may include, but is not limited to selection, hiring, direction and termination of providers. Absent such ability, the individual shall have a legal representative who acts on the individual's behalf to perform these tasks;

(5) lack family or community supports to meet their needs;

(6) wish to live in the community by utilizing ABI waiver services;

(7) the individual or their legal representative shall be capable of understanding and shall acknowledge that there are risks inherent in living in the community; that the individual's safety cannot be guaranteed; and that the individual accepts full responsibility if the individual chooses to live in the community, thereby absolving the department from any liability for any and all consequences that may result from this choice; and

(8) the individual or their legal representative shall acknowledge that the individual is the employer of the qualified providers and shall sign a written document accepting full responsibility as the employer of such providers.

(e) Notwithstanding subsections (a) to (d), inclusive, of this section, an individual shall not be eligible for ABI waiver program services if the individual:

(1) Fails or refuses to pursue eligibility under the department's medical assistance program;

(2) receives services under any other medical assistance waiver programs;

(3) cannot live safely in the community, even with the assistance of the ABI waiver and other community-based services;

(4) who, having received and benefited from ABI waiver services, can now continue to reside in the community without the support of ABI waiver program services;

(5) is eligible, but has a total service cost that would exceed either the individual or aggregate caps;

(6) is eligible, but has service costs that would cause the department's expenditures to exceed established funding limits;

(7) applies for ABI waiver services after the department has reached its maximum capacity of persons able to be served under the ABI waiver program;

(8) has a cognitive or behavioral dysfunction due solely to mental retardation or chronic mental illness, rather than to an ABI, as determined by a licensed medical professional;

(9) for whom, in the nonmedical opinion of the department, a service plan cannot be developed that is both cost effective or reasonably ensures the health, welfare and safety of the individual;

(10) requires inpatient care in an acute care hospital, skilled nursing facility, ABI NF, ICF-MR or who is otherwise institutionalized for a period of sixty days or more;

(11) demonstrates consistent and extreme physical, verbal, sexual

aggression toward others;

(12) demonstrates behaviors that violate the law or is contrary to community integrated living;

(13) for whom the plan of care, appropriate to the individual's health, welfare and safety, cannot be implemented due to, but not limited to:

(A) The individual's:

(i) Mental capacity;

(ii) behaviors;

(iii) refusal of services vital to health, welfare and safety;

(iv) illegal or criminal activity;

(v) threatening use of weapons or firearms for the purpose of causing harm or injury to self or others; or

(vi) compromising the safety of caregivers, staff and others in the home or community;

(B) conditions at the individual's home or grounds that constitute a hazard including, but not limited to:

(i) Illegal or criminal activity;

(ii) inappropriate maintenance of animals (number or dangerousness);

(iii) poor sanitation; or

(iv) violations of local or state fire, zoning and or housing codes that pose a risk to the health, welfare and safety of the individual or providers;

(C) provider issues, such as:

(i) Poor quality of services or care from the persons selected as providers; or

(ii) lack of availability of providers to provide services;

(D) issues pertaining to persons residing in or having regular access to the participant's home, such as:

(i) Illegal or criminal activity;

(ii) behaviors that jeopardize the safety, health and well-being of the individual or others;

(iii) exhibiting dangerous behaviors toward providers or other persons residing in the individual's home;

(iv) verbal, physical or sexual threats or actions;

(v) interfering with the receipt or delivery of services; or

(vi) other actions that interfere with the provider's access to the individual.

(f) An individual who receives services under the ABI waiver program is subject to the same rights and responsibilities as an institutionalized recipient of medical assistance including, but not limited to, those requirements relating to third party liability, securing support, recovery and liens that are applicable to institutionalized recipients who receive public assistance.

(New) Sec. 17b-260a-5. Home and Community-Based Services Available Under the ABI Waiver Program

(a) General Principles

(1) Except as set forth in subsections 17b-260a-5(b)(1) to 17b-260a-5(b)(18), inclusive, of the Regulations of Connecticut State Agencies, ABI waiver services may be provided alone or in combination with other services, in accordance with the specific needs of the individual. The ABI waiver services provided at any given time, in combination with other medical and community-based services, constitute the individual's service plan. The need for each specific ABI waiver service shall be documented in the service plan.

(2) The individual shall require a minimum of two waiver services, on at least a monthly basis, in order to be determined to need waiver services.

(3) The ABI waiver services documented in the service plan may be purchased from private providers, agency providers or household employees that meet the department's qualification standards or credentialing for the performance of such services.

(A) Except as otherwise provided in subparagraph (C) of subdivision (12) of subsection (b) of this section, the department shall not pay an individual's family members to perform any ABI waiver services.

(B) The department shall not pay the individual's conservator, power of attorney or a family member of such conservator or power of attorney, to provide ABI waiver services to the individual.

(C) Payments for ABI waiver services shall not exceed the rates, or maximum limits, the department establishes for the provision of such services.

(b) The following services and supplies may be covered under the ABI waiver program:

(1) **ABI Group Day Habilitation Services** are services and supports that foster the development, improvement or retention of skills and abilities necessary for an individual to maintain health and wellness, self-care, prepare an individual for work or community participation, or support meaningful socialization and leisure activities.

(A) This service is provided by a qualified provider in a facility-based program or appropriate community locations.

(B) Transportation to and from the individual's home to the facility or community location is not included as part of this waiver service.

(C) This service is limited to no more than 8 hours per day.

(2) **Case Management Services** are services provided to assist the individual in implementing the service plan and to assure the effective coordination, communication and cooperation among all sources of support and services to the individual. Case management services shall be purchased only if the individual is unable to coordinate their own service plan, or does not have family, a legal representative or other supportive person able and willing to act in this role. Case management services include, but are not limited to, the following:

(A) Assistance provided to the individual to identify their individual home and community-based service needs;

(B) promotion of participation in activities that may increase the individual's independence, inclusion in the community and life satisfaction;

(C) arrangement of daily living supports and services to be delivered to the individual and helping to identify and access entitlements and other possible funding sources;

(D) advocacy for the individual when necessary, to ensure the receipt of needed services; and

(E) providing and referring for crisis intervention services and monitoring, as necessary and appropriate.

(2) **Chore Services** are services needed to maintain the individual's home in a clean, sanitary and safe condition.

(A) Chore services include, but are not limited to, the following:

(i) Heavy household chores, such as washing floors, windows and walls; and
(ii) moving heavy items of furniture in order to provide safe access and egress.

(B) Chore services shall not be covered if:

(i) The individual or anyone else in the household is capable of either performing or paying for the services, or if another third party is capable of, or responsible for, providing them;

(ii) the service may be provided free of charge through friends, relatives, a caregiver, community agencies or other entity; or

(iii) in the case of rental property, condominiums or co-ops, a specific service is the responsibility of the landlord or the landlord's designee, as evidenced in the lease agreement or any other agreement.

(3) **Cognitive/Behavioral Programs** are services and interventions specifically designed to improve cognitive function and decrease the individual's behaviors that jeopardize the individual's ability to remain integrated in the community. Cognitive/behavioral services may be provided in the individual's home or, as necessary, in the community to reinforce the training in real-life situations or settings. These services include but are not limited to the following:

(A) A comprehensive assessment of cognition and behaviors;

(B) development and implementation of a structured cognitive/behavioral assessment within 30 days of the individual becoming a participant in the waiver program, as well as periodic reassessments that addresses the following:

(i) Executive functions;
(ii) attention and concentration;
(iii) information processing skills;
(iv) learning and memory;
(v) planning;
(vi) problem solving;
(vii) self-control; and
(viii) visual-spatial functioning;

(C) intervention plans shall, at a minimum, address the following areas:

(i) ADLs;
(ii) IADLs;
(iii) vocational or educational needs;

(iv) social and community inclusion in skill development;
(v) behavior management;
(vi) protective oversight and supervision; and
(vii) crisis management;

(D) assistance to providers in the implementation of interventions; and

(E) provision of ongoing or periodic supervision of the individual, family members or providers.

(F) Intervention plans shall be updated annually or as clinically indicated. Intervention plans shall include the following components:

(i) Long term goals mutually agreed upon by the individual or the individual's legal representative;
(ii) shorter term objectives to reach those goals;
(iii) strengths and challenges and how strengths are to be used in achieving goals; and
(iv) specific skills or tasks that need to be developed by the individual or the family.

(4) **Community Living Support Services** are support services that are provided to a maximum of three individuals at once, in a supervised community residential setting for either a half-day (12 hours) or a full day (24 hours).

(A) Community living support services include, but are not limited to, supervision and assistance with the following skills:

(i) Self-care;
(ii) medication management;
(iv) interpersonal communication;
(v) socialization;
(vi) sensory/motor;
(vii) mobility;
(viii) community transportation;
(ix) problem-solving;
(x) money management; and
(xi) household management.

(B) Community Living Support Services do not include assessment and training services, yet an individual may attend or participate in services that are determined by the person-centered planning team to be of benefit in providing the individual with skills and training needed to achieve

independence.

(5) **Companion Services** are services that are nonmedical, provided in accordance with a therapeutic goal.

(A) Companion services include, but are not limited to, the following:

(i) Supervision and socialization services;
(ii) assistance with or supervision of meal preparation;
(iii) assistance with laundry that is being performed by the individual; and
(iv) light housekeeping tasks that are incidental to the care.

(B) Companion services shall not entail the provision of hands on care.

(6) **Environmental Accessibility Adaptation Services** are physical changes made to the individual's home that are of direct medical or remedial benefit to the individual; that seek to ensure the health, welfare and safety of the individual; or enhance and promote greater independence, without which the individual would require institutionalization.

(A) Adaptation services include, but are not limited to, the following:

(i) Installation of ramps;
(ii) widening of doorways;
(iii) modifications to meet egress requirements;
(iv) modification of bathroom facilities; and
(v) addition of specialized electrical and plumbing devices.

(B) All adaptation services shall be provided in accordance with applicable state or local building codes.

(C) Adaptation services not covered include, but are not limited to: carpeting; central air conditioning; roof repair; and house adaptations that add to the square footage of the home.

(7) **Prevocational Services** are services designed to prepare an individual with employment-related goals for paid or unpaid employment, by providing learning and work experiences through which the individual can develop strengths and skills that contribute to employability in integrated community settings.

(A) Prevocational Services focus on teaching the concepts of taking direction, attendance, task completion, problem solving and safety, with the goal of enhancing attention span and motor skills.

(B) Prevocational services shall not be provided to an individual who is participating in a supported employment program.

(C) Individuals may be compensated at a rate not to exceed 50% of the minimum wage. The prevocational service provider or other source may provide compensation.

(D) Prevocational Service provided under the ABI Waiver may not otherwise be available under a program funded under the Rehabilitation Act of 1973, 20 USC 1401 et seq., or the Education for All Handicapped Children Act, Pub. L. No. 94-142.

(E) Transportation is included in the rate paid to the ABI Waiver prevocational provider.

(8) **Supported Employment Services** are ongoing supportive services provided to an individual who, because of their disability, needs intensive support to obtain and maintain employment at or above the minimum wage and meets personal and career goals.

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

(B) Supported employment services may not otherwise be available under a program funded under the Rehabilitation Act of 1973, 20 USC 1401 et seq., or Education for All Handicapped Children Act, Pub. L. No. 94-142.

(C) Transportation is included in the rate paid to the supported employment provider.

(9) **Homemaker Services** are general household activities including, but not limited to, meal preparation and routine household chores such as: dusting; bed making; and vacuuming. The department shall pay for homemaker services when the individual is unable to manage household activities or when the person primarily responsible is absent or unable to perform such household activities.

(10) **Home Delivered Meals** or "meals on wheels," is the preparation and delivery of 1 or 2 meals per day to an individual who is unable to prepare or obtain nourishing meals on their own, or for an individual who normally has someone who is responsible for preparing and delivering meals, but that person is temporarily absent or unable to perform this service.

(11) **Independent Living Skills Training**

(A) Independent Living Skills Training is a teaching service designed and delivered to an individual or a group to improve an individual's ability to live independently in the community and to carry out strategies developed in cognitive or behavioral programs.

(B) Supervision is not a discrete service provided under this component.

(C) Independent Living Skills Training may include, but is not limited to the following:

(i) Training in self-care;
(ii) medication management;
(iii) task completion;
(iv) interpersonal communication skills;
(v) socialization skills;
(vi) sensory/motor skills;
(vii) mobility and community transportation skills;
(viii) problem solving skills;
(ix) money management skills; and
(x) household management skills.

(D) Independent Living Skills Training is provided in the individual's home or community.

(12) **Personal Care Assistance**

(A) Personal Care Assistance is assistance with the following:

(1) Eating, bathing, dressing, personal hygiene and other activities of daily living that are performed by a qualified provider in the individual's home or community; or

(2) supervision and cueing of these activities without actual hands-on assistance.

(B) Personal care assistance is provided only if the individual's physical ability to perform activities of daily living is impaired, or if the individual's cognitive or behavioral impairments interfere with the individual's ability to perform these tasks.

(C) A member of the individual's family, except the individual's spouse, may provide personal care assistance as long as the family member meets the training requirements specified by the department.

(13) **Personal Emergency Response Systems** ("PERS")

(A) A PERS is an electronic device connected to the individual's telephone that enables an individual at high risk of institutionalization to secure help in an emergency.

(B) The PERS is available only to an individual who lives alone, or who is alone for significant parts of the day and who does not have providers, or to an individual who would otherwise require extensive routine supervision.

(14) **Respite Care**

(A) Respite care services are provided to individuals who are unable to care for themselves and the person normally performing such services is absent or in need of relief.

(B) Services shall be furnished on a short-term basis in the individual's home.

(15) **Specialized Medical Equipment and Supplies**

(A) Specialized medical equipment and supplies include, but are not limited to, the following:

(i) Devices, controls or appliances, specified in the service plan, that enable the individual to increase their ability to perform ADLs or to cognitively perceive, control or communicate in the individual's environment within the community;

(ii) items necessary for life support and those ancillary supplies and equipment that are necessary for the proper functioning of such items; and

(iii) durable and non-durable medical equipment that is not available as a covered medical service under the Medicaid program.

(B) Specialized medical equipment and supplies paid for under the ABI waiver program shall be of direct medical or remedial benefit to the individual; meet all applicable standards of manufacture, design and installation; and be in addition to any medical equipment and supplies furnished under the Medicaid State plan.

(16) **Substance Abuse Programs** are individually designed interventions to reduce or eliminate the individual's use or abuse of alcohol or drugs when such use or abuse may interfere with the individual's ability to remain in the community.

(A) Substance abuse programs shall include, but are not limited to, the following services:

(i) Performing an in-depth assessment of the relationship between the individual's use or abuse of alcohol or drugs and brain injury;
(ii) performing a learning and behavioral assessment;
(iii) developing and implementing a structured treatment plan;
(iv) providing ongoing education and training of the individual, family members and other service providers concerning support needs of the individual;
(v) developing individualized relapse strategies;
(vi) conducting periodic reassessment of the treatment plan; and
(vii) providing ongoing support to the individual.

(B) Substance abuse programs shall be provided on an outpatient basis in a congregate setting or the individual's community.

(C) The individual's structured treatment plan may include both group and individual interventions and shall reflect the use of curriculums and materials adopted from substance abuse programs designed to meet the needs of individuals with cognitive impairment.

(D) The treatment plan shall include linkages to existing community-based, self-help or support groups, such as Alcoholics Anonymous and organizations that promote and support sobriety.

(E) With the individual's consent, the substance abuse program provider shall communicate with the individual's other service providers concerning the individual's treatment regimens.

(17) **Transitional Living Services** are short-term, individualized, residential services providing support to an individual transitioning in to a community living situation. Services and supports designed to improve the individual's skills and ability to live in the community. Services include: assessment; communication and interpersonal skills; socialization; sensory/motor skills; mobility and community transportation skills; problem solving skills; money management and skills necessary to maintain a household. The intent of transitional living services is to "step-down" from a higher level of care. Services may be provided up to 24 hours per day.

(A) Transitional living services shall be provided only when the individual is unable to be supported in a permanent residence and is in need of intensive clinical interventions provided by this service.

(B) Transitional living services may be provided only once and are expected to meet all of the ABI waiver services and support needs of the individual.

(C) Prior to discharge from transitional living services, the provider shall work with the individual and the DSS social worker to develop a community living plan of care. Upon discharge, other ABI purchasable services shall become available to the individual in accordance with the revised service plan.

(D) ABI waiver funds shall not be used to pay for the room and board component of transitional living services.

(E) Transitional living services cannot be provided with any services except, case management, environmental modifications, specialized medical equipment and vehicle modifications.

(18) **Transportation Services**

(A) Transportation services shall be available under the ABI Waiver Program for the purpose of transporting individuals to ABI waiver services as set forth in the service plan.

(B) Transportation services shall not be provided when friends, family, neighbors or community agencies are able to provide transportation free of charge.

(C) All reasonable alternatives shall be explored and exhausted prior to receiving approval for transportation services.

(D) Transportation services may be provided when the transportation needed does not qualify as medical transportation under 42 CFR §440.170(a).

(19) **Vehicle modification services** are alterations made to a vehicle when such alterations are necessary improve the individual's independence and so that the individual may avoid institutionalization.

(A) The vehicle shall be the individual's primary means of transportation. The vehicle shall be owned by the individual; a relative with whom the individual lives or has consistent and ongoing contact; or a non-relative who provides primary long-term support to the individual and is not a paid provider of such services.

(B) All modifications and adaptations shall be provided in accordance with applicable federal and state vehicle codes.

(NEW) **Sec. 17b-260a-6. Services Not Covered Under the ABI Waiver**

(1) The department shall not pay for any services that are not set forth in section 17a-260a-5 of the Regulations of Connecticut State Agencies, including, but not limited to:

(1) Basic needs such as food, shelter, clothing, utilities, routine transportation and personal incidental expenses;
(2) medical services already covered under the department's medical assistance program including, but not limited to: hospital care; physician's fees; and prescription drugs;
(3) services not listed in the individual's service plan;
(4) services not provided in accordance with the terms of the approved service plan, including, but not limited to, the number of hours specified in the plan;
(5) services not performed by the designated provider listed in the service plan;
(6) services billed for an amount that exceeds the department's approved rate and maximum limit for such service;
(7) services billed by a single household employee or private provider, alone or in combination with other services, in excess of 25.75 hours per week, except as otherwise provided in section 17b-260a-5 (E)(12) of the Regulations of Connecticut State Agencies;
(8) for scheduled hours that a provider did not keep;
(9) for transportation of the provider to and from the individual's home;
(10) chore services, companion services, homemaker services, personal care assistance and transportation services when the provider performed such services free of charge before the individual became eligible for the ABI waiver program; or
(11) any services billed for dates during which the participant is an inpatient at a hospital, skilled nursing facility or other institution.

(NEW) **Sec. 17b-260a-7. Assessment and Development of a Cost-Effective Service Plan**

(a) The department shall conduct an initial level-of-care assessment following the receipt of the individual's application to determine whether the individual meets one of the level-of-care criteria described in this section and the requirements described in section 17b-260a-4 of the Regulations of Connecticut State Agencies.

(b) The level-of-care assessment is based upon information obtained from the individual; medical reports from the individual's physician, including a neuropsychologist; and any other clinical personnel who are familiar with the individual's case and history. The individual shall meet one of the following levels-of-care in order to qualify for services under the ABI Waiver:

(1) Category I - The individual is considered to require care in a nursing facility if the individual resides in such a facility, or has impaired cognition and, due to physical or cognitive deficits, requires physical assistance, supervision or cueing with two or more ADLs, including, but not limited to, eating, bathing, dressing, toileting and transferring;

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

(3) Category III - The individual is considered to require care in an ICF-MR if the individual resides in such a facility, or has impaired cognition, an ABI that occurred before the age of 22 and, due to physical deficits, requires physical assistance, with two or more ADLs; or

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

(c) If the individual meets the one of the level-of-care criteria in subsection (b) of this section, the department, in conjunction with the person-centered team, shall develop a cost-effective service plan.

(d) An individual who meets the level-of–care-requirements for more than one of the categories described in subsection (b) of this section shall be served at the lower level-of-care.

(e) The department shall reevaluate the level-of-care required by an individual at least once every twelve months or more frequently when necessary.

(NEW) **Sec. 17b-260a-8. Determining the Cost Effectiveness of the Service Plan**

(a) In order to determine the cost effectiveness of the individual's service plan, the department shall:

(1) Obtain the annualized alternative institutionalized care costs for the individual. For each level-of-care listed in subsection (b) of section 17a-260a-7 of the Regulations of Connecticut State Agencies, the alternative institutional care cost is equal to the state's weighted average cost for the specified facility type, as annually developed and published by the

department, minus the average applied income;

(2) determine the annualized cost of the individual's total service plan by totaling the 12-month cost of each covered service, described in subdivisions (A) to (C), inclusive, of this subsection, which may be provided to the individual, based on the department's established rates for such services.

(A) Determine the annualized cost of the waiver services, included under section 17b-260a-5 of the Regulations of Connecticut State Agencies, to be provided to the individual under the proposed service plan;

(B) determine the annualized cost of other medical services, as specified under section 17b-260a-3(27), provided in the individual's home that the individual may require in order to live in the community, by multiplying the expected frequency of utilization of these services by the Medicaid rates established by the department for such services; and

(C) determine the annualized cost of any community-based services that the individual may require in order to live in the community.

(3) Add the annualized cost of the waiver services, other home-based medical services and community based services to obtain the individual's total service costs.

(4) Compare the individual's total service costs to the individual and aggregate caps.

(b) Individual and Aggregate Caps

(1) The individual cap is equal to 200% of the individual's alternative institutional care costs. The aggregate cap is equal to 75% of the alternative institutional care costs for the entire waiver population.

(2) Two hundred per cent of the individual's alternative institutional care costs shall equal the maximum dollar amount available to fund the service plan. However, since no single plan may cause the aggregate cap to exceed 75%, every effort shall be made to provide services below the maximum dollar amount level, in the most cost-effective manner possible. In addition, the department may not exceed the funding limitations established in the approved waiver when determining whether an individual can be accepted into the program.

(c) The department shall not approve a plan that exceeds the individual or the aggregate caps as defined in this regulation.

(NEW) **Sec. 17b-260a-9. Individual's Responsibilities**

(a) The individual or, if applicable, the individual's legal representative and the person-centered team, shall collaborate and participate in the service plan development process and select qualified providers to deliver the services specified in the service plan.

(b) An individual whose gross income exceeds 200% of the federal poverty level shall be required to contribute toward the cost of services rendered under the waiver. The amount contributed shall be calculated according to section 5045 of the Uniform Policy Manual.

(c) The individual shall agree to pay the portion of their income calculated to be contributed toward their cost of care, directly to the department's fiduciary agent and the department shall deduct this same amount from its payment to the provider. This agreement shall be documented in the individual's service plan.

(d) The individual is the employer of household employees and private providers who are not employed by an agency. As the employer of these providers, the individual shall have free choice of all qualified providers of each service included in the individual's service plan and shall be responsible for:

(1) Selection of providers;
(2) supervision of the services that are provided in accordance with the service plan;
(3) notifying the department if they are dissatisfied with an agency provider or with the quality of the services performed by an agency provider and select a different provider; and
(4) if necessary, termination of the employment of a household employee or a private provider not otherwise employed by an agency.

(e) In accordance with section 31-284 of the Connecticut General Statutes, the individual shall obtain and maintain worker's compensation services for single providers who are employees under the definition provided in section 31-275(9)(B) of the Connecticut General Statutes.

(f) The individual shall provide documentation to the department to verify that worker's compensation insurance has been obtained and shall remain

in effect for at least one year from the date the personal care assistant begins providing personal care assistance services to the individual. Personal care assistance services provided more than 25.75 hours per week shall not be covered without the submission of such documentation.

(NEW) Sec. 17b-260a-10. Department Responsibilities

The department shall:

(a) Inform individuals of any feasible alternatives available under the ABI waiver program and offer individuals the choice of either institutional or home and community-based services;

(b) provide social work services to individuals that include, but are not limited to, the following:

(1) An assessment of the individual's eligibility for the ABI waiver program;

(2) coordination and development of a service plan designed to deinstitutionalize or divert the individual from institutional placement;

(3) assistance with implementation of the approved service plan by coordinating services provided to the individual;

(4) review with the individual, on a regular basis, the effectiveness of the service plan and make appropriate and cost-effective revisions to the plan, as required, based on achievement of the expected outcomes, the individual's degree of satisfaction with the services and providers, the individual's changing capabilities and the ongoing availability of community-based services;

(5) complete a formal review of the service plan with the individual at least once every 12 months;

(6) initiating a reassessment of the individual's level-of-care every 12 months from the date of the initial service plan;

(7) maintaining records for at least 5 years; and

(8) initiating a re-assessment of the service plan when the individual has experienced a significant improvement or decline in the individual's ability to function in the community.

(c) advise the individual of their right to an administrative hearing if they are aggrieved by the department's decision with respect to the individual's application or eligibility for the ABI waiver;

(d) maintain a waiting list of individuals who are ineligible for ABI services for reasons listed in section 17b-260a-4(d) of the Regulations of Connecticut State Agencies;

(e) establish provider qualifications and, through its fiduciary agent, establish and maintain a directory of qualified providers;

(f) establish payment rates for all services offered under the waiver program;

(g) pay for approved ABI waiver services delivered by qualified providers through its fiduciary agent, on behalf of the individual; and

(h) determine within 45-days of application the individual's financial eligibility for the program, and complete, as expeditiously as possible, the level-of-care assessment and development of a cost-effective service plan.

(NEW) **Sec. 17b-260a-11. Provider Responsibilities**

(a) General Provider Responsibilities

(1) All household employees, private providers or agency shall report any arrest of a provider to the department within 10 business days. The failure of the household employee, private provider or agency to report such arrest may result in termination of the provider agreement.

(2) The department may deny payment of services performed by any household employee, private provider or agency provider who does not meet the department's qualifications as set forth in this section.

(3) Any household employee, private provider or agency provider may be suspended from participation in the program if the provider accepted payment for services that were never provided to the individual client or otherwise violates the rules, regulations, standards or laws governing the program in accordance with sections 17-83k-1 to 17-82k-7, inclusive, of the Regulations of Connecticut State Agencies.

(4) All providers are required to report to the department an occurrence involving an individual that results in a physical injury to or by the individual that requires a physician's treatment or an admission to a hospital; results in someone's death; requires emergency mental health treatment for the consumer; or requires the intervention of law enforcement. Critical incident reports shall be made in accordance with the manner, format and time frame set forth in the provider agreement or as directed by the DSS Manager or the individual's designee.

(5) Agency providers shall have policies in place regarding the provision of language services and should not rely on patients' friends, family or other "ad hoc" interpreters.

(6) Individuals who apply to become a qualified provider under the ABI Waiver program are required to complete a state and federal criminal background check and include, with their submitted Provider Directory Application, the fee to pay for the processing of the application. The fee shall be submitted in the amount, form and manner as set forth in the Provider Directory Application that is in effect at the time the application is submitted.

(7) The commissioner shall have the discretion to refuse to list an individual in the Provider Directory, remove an individual's name from the Provider Directory or refuse payments to a household employee if the household employee performing the services has been convicted in this state or any other state of a felony, as defined in section 53a-25 of the Connecticut General Statutes; involving forgery under sections 53a-138 and 53a-139 of the Connecticut General Statutes; involving robbery under section 53a-133 of the Connecticut General Statutes; involving larceny under sections, 53a-119, 53a-122, 53a-123, and 53a-124 of the Connecticut General Statutes; involving vendor fraud under 53a-290 and 53a-296 the Connecticut General Statutes; involving cruelty to persons under section 53-20 of the Connecticut General Statutes; involving sexual assault under sections 53a-70, 53a-70a, 53a-70b, 53a-71, 53a-72a, 53a-72b, 53a-73a of the Connecticut General Statutes; involving assault under section 53a-59 and 53a-59a of the Connecticut General Statutes; or involving the abuse of elderly, blind, disabled or mentally retarded persons under sections 53a-320 and 53a-323 of the Connecticut General Statutes.

(b) Agency Providers

(1) Agencies seeking application to become a qualified provider or that are currently a qualified provider under the ABI Waiver program are required to ensure that all staff, volunteers, interns or other person employed by, supervised by or representing the agency who may have direct contact with individuals receiving ABI Waiver funding, that the agency meet and maintain all criminal background standards as set forth in subsection (a)(6) of this section.

(2) Provider agencies shall deliver training to staff members regarding the provision of services that are person-centered and culturally competent.

(3) Provider agencies shall have policies and procedures in place regarding employee standards of conduct. These policies and procedures shall include the following topics, but are not limited to:

(A) Person-centered provision of services;

(B) respect of participant's rights, including privacy and self-determination;

(C) neglect, abuse and harassment of participants;

(D) the provision of services while using, or under the influence of drugs or alcohol;

(E) confidentiality of all participant information collected, used or maintained; and

(F) critical incident reporting requirements.

(NEW) **Sec. 17b-260a-12. Provider Participation**

(a) In order to participate in the ABI Waiver program and receive payment from the department, provider shall:

(1) Enroll with the department or its agent and have on file a valid provider agreement;

(2) Meet and maintain applicable programmatic credentialing criteria and federal and state licensing, certification and accreditation requirements;

(3) Comply with all Medicaid documentation and other requirements, including but not limited to, those in the provider agreement;

(4) Maintain good standing within State of Connecticut (e.g., no fraud, loss of contract for cause, or suspension for any state of Connecticut funded program within past 5 years);

(5) Deliver and bill for services that are outlined in the participant's service plan; and

(6) Comply with the stipulations outlined in any corrective action plans implemented.

(b) If the department has reason to believe that a provider is a threat to the health of a waiver participant, the department may summarily suspend the provider agreement.

(c) The commissioner shall have the discretion to refuse provider participation to persons who have been convicted in this state or any other state of a felony, as defined in section 53a-25 of the Connecticut General Statutes.

(NEW) **Sec. 17b-260a-13. Corrective Action**

(a) If a provider is out of compliance with sections 17b-260a-11 to 17b-260a-17 of the Regulations of Connecticut State Agencies or provider agreement, the department shall have the discretion to implement a corrective action plan. Failure to develop or meet the requirements of the corrective action plan shall result in termination or suspension of the provider agreement.

(1) The provider shall, reply to, and cooperate in arranging compliance with, a program or fiscal audit or program violation exception that a state or federal audit or review discovers.

(2) The provider shall cooperate fully with the department or its agent, prepare and send to the department a written plan of correction or response to any adverse findings.

(3) The provider shall correct all deficiencies in the manner and times required by the department.

(4) The provider shall report any arrests of agency employees or themself within 10 business days and provide status updates periodically at the request of the department.

(NEW) **Sec. 17b-260a-14. Fiscal responsibility**

(a) For purposes of this section

(1) "Fraud" means an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or herself or some other person. It includes any act that constitutes fraud under applicable federal or state law.

(2) "Abuse" means practices that are inconsistent with generally accepted fiscal or business practices and result in unnecessary cost to the ABI Waiver program.

(a) The provider agrees that it shall not engage in or commit fraud or abuse including, but not limited to:

(1) Billing for services not rendered;

(2) billing for services not in the service plan;

(3) billing for services not medically necessary;

(4) inappropriate or lack of documentation to support services billed;

(5) billing for services for ABI Waiver participants who are institutionalized during the dates of billed service provision; or

(6) violating Medicaid policies, procedures, rules, regulations or statutes.

(NEW) **Sec.17b-260a-15. Quality Assurance**

(1) All providers shall submit program data in a form that is set forth by the department.

(2) Agency providers shall complete random checks of staff.

(3) Agency providers shall establish a quality assurance plan at the time of application.

(NEW) **Sec. 17b-260a-16. Client Documentation and Provider Reporting**

(a) Providers are required to retain records to document services submitted for Medicaid reimbursement for at least five years from the date the service or item was provided. Documentation shall include the following:

(1) Individual's name and the signature of the individual or their legal representative;

(2) provider's name and signature;

(3) dates of service;

(4) start time for each visit;

(5) end time for each visit; and

(6) a brief description of duties performed.

(b) Upon written request presented to the provider, the department or its authorized agent may be given immediate access to, and permitted to review and copy any and all records and documentation used to support claims billed to Medicaid.

(c) For purposes of subsection (b) of this section, "immediate access" means access
to records at the time the written request is presented to the provider.

(d) The provider shall submit monthly reports and written updates on the individual's progress in a form that is set forth by the department.

(e) The failure of a provider to comply with subsections (a) to (e), inclusive, of this section, may result in the nonpayment of the services.

(NEW) **Sec. 17b-260a-17. Provider Termination or De-Qualification**

Providers shall remain in good standing. Failure to comply with the aforementioned provider requirements or to remediate, within prescribed timeframes as set forth in provider agreement or required by the DSS ABI Waiver manager or designee, any requirements herein may result in the suspension or termination of the provider's service contract, removal from the Provider Directory, or disqualification as a provider.