Sec. 17b-342-2. Services covered under the connecticut home care program for elders

The following services are available to elders who are determined eligible for the Connecticut Home Care Program either under the criteria for the Medicaid Waiver portion or the state-funded portion of the program. These services are also covered under fee-for-service and the assisted living services component of the program. The amount of services available or allowed shall be based on the category of service or service package level assessed in accordance with sections 17b-342-1 to section 17b-342-3, inclusive, of the Regulations of Connecticut State Agencies and shall be documented in the approved plan of care.

(a) **Care Management Services**

(1) Description

Care management services are only authorized through department-contracted access agencies or department designee. Care management services include those activities that involve implementation, coordination, monitoring and reassessment of care managed cases. Care management is a client-centered service that respects clients' rights, values and preferences. The care manager assists the client in coordinating all types of assistance to meet the individual's needs, monitoring the quality of services provided and using resources efficiently.

(2) Provider Participation

All providers reimbursed for care management services shall be access agencies as defined in section 17b-342-1(b)(1) of the Regulations of Connecticut State Agencies or ALSAs as defined in section 17b-342-1(b)(3) of the Regulations of Connecticut State Agencies and shall meet all provider enrollment requirements. This provision is not meant to restrict home health and other providers from providing such services to the extent required or authorized under their license. However, only department-contracted access agencies or ALSAs may receive reimbursement for this activity as a distinct service. The requirement for providers to be access agencies shall not prohibit the department from using its own staff to provide care management services in accordance with section 17b-342-2(b) of the Regulations of Connecticut State Agencies.

(3) Services Covered

(A) When authorized, the department shall reimburse the access agency or ALSA for care management services which include contacts with the clients, family, members of their informal support networks or service providers, as deemed necessary. The care manager shall monitor clients of the Connecticut Home Care Program who receive ongoing care management by an access agency or ALSA as follows:

(i) Making contact at least monthly with the client, family or provider by telephone or by a home visit, depending upon the client's needs;

(ii) making home visits to the client as needed and at least every six months to determine the appropriateness of the service plan and to assess changes in the client's condition;

(iii) conducting a formal reassessment of the client's health, functional and financial status and service needs every twelve months, utilizing a standardized assessment tool;

(iv) responding to changes in client needs as they occur by making appropriate changes in the type, frequency, cost or provider of services needed for the client to remain safely in

the community within the limitations of service availability. This includes ongoing reassessment as needed to assure appropriateness of the plan of care, continued financial eligibility, category of service and quality of care; and

(v) providing information and service referral or access to appropriate resources on a 24 hour per day basis, including responding to emergencies.

(B) Care management services may be delivered in the person's home, in the community, in a community agency or other non-institutional settings as appropriate.

(4) Need for Service

(A) For the Connecticut Home Care Program, the need for ongoing care management services by an access agency is identified in conjunction with establishment of eligibility for the program. Upon completion of an assessment and development of a plan of care, the access agency shall confirm the risk of institutionalization and shall further establish that:

(i) The person can be appropriately served in the community without the creation of an unacceptable risk to the person or others;

(ii) the person chooses to remain in the community rather than be admitted to a nursing facility;

(iii) as specified in the person's plan of care, the total state administered funds of home care services specified in the client's plan of care do not exceed the limits set forth in section 17b-342-3(c) of the Regulations of Connecticut State Agencies;

(iv) the client has been informed of the assisted living services component and offered participation if feasible; and

(v) a review to determine if there is an ongoing need for care-management has been done and the client has been advised of the self-directed care option, if appropriate.

(B) For the Connecticut Home Care Program, ongoing care management services by an access agency may be suspended for a client who meets the following criteria:

(i) The client's functional and cognitive status have been determined to be stable (this can include the presence of chronic health problems if the conditions are under control and do not require involvement by an access agency);

(ii) the department determines that the person or the caregiver is able to assume responsibility for coordinating and monitoring services; or

(iii) the client is determined appropriate for the self-directed care or assisted living services component under the program.

(5) Authorization Process

(A) Care management services shall be included as part of the written plan of care and authorized by the department in order to be reimbursed under the Connecticut Home Care Program.

(B) When care management services by an access agency have been suspended, the client may continue to receive other home care services through the Connecticut Home Care Program. The department shall require renewals of orders for such home care services annually and complete annual redeterminations of eligibility for the program in order to continue services. If the client's condition becomes unstable and the client continues to reside in the community, the department may reinstate ongoing monitoring by an access agency including, but not limited to, transferring the client from the self-directed or the assisted living service component of the program to the access agency with services

provided through fee-for-service, if feasible and allowed under the program.

(6) Limitations

In order to receive payment for care management services under the Connecticut Home Care Program, the access agency shall be in compliance with all terms of its contract with the department and in addition shall assure that home care service providers meet standards of quality as established in section 17b-342-2(b) to section 17b-342-2(o), inclusive, of the Regulations of Connecticut State Agencies and have documented such compliance to the access agency. The department shall not reimburse for care management services:

(A) Provided prior to completion of the assessment and development of an approved plan of care;

(B) provided while the elderly person is in a hospital, nursing facility or out of the state;

(C) provided to clients who are authorized for self-directed care;

(D) provided to clients who are program participants under the assisted living service component; or

(E) provided to clients who have been determined ineligible for program participation by the department and the access agency has been notified of such decision.

(b) **Adult Day Health Services**

(1) Description

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

(2) Provider Participation

In order to receive payment for adult day health services provided under the Connecticut Home Care Program, an adult day health provider shall:

(A) Meet all applicable federal, state and local requirements including zoning, licensing, sanitation, fire and safety requirements;

(B) provide, at a minimum, nursing consultation services, social work services, nutritionally balanced meals to meet specialized dietary needs as prescribed by health care personnel, personal care services, recreational therapy and transportation services for individuals to and from their homes;

(C) provide adequate personnel to operate the program, including:

(i) A full-time program administrator;

(ii) nursing consultation during the full operating day by a Registered Nurse (RN) licensed in the state of Connecticut; and

(iii) the direct care staff-to-participant ratio shall be a minimum of one to seven. Staffing shall be adequate to meet the needs of the client base. Volunteers shall be included in the ratio only when they conform to the same standards and requirements as paid staff.

(3) Adult Day Health Facility Requirements

(A) In order to be a provider of services to department clients, any facility located and operating within the State of Connecticut or located and operating outside the state of Connecticut, in a bordering state, shall be certified by the Connecticut Association of Adult Day Centers Incorporated, its successor agency or a department designee.

(B) A facility (center) located and operating outside the State of Connecticut in a bordering state shall be licensed or certified by its respective state and comply at all times with all pertinent licensure or certification requirements in addition to the approved standards for certification by the department.

(C) Certified facilities (centers) shall be in compliance with all applicable requirements in order to continue providing services to department clients. The failure to comply with any applicable requirements shall be grounds for the termination of its certification and participation as a department service provider.

(4) Services Covered and Limitations

(A) Payment for adult day services under the rate for a medical model is limited to providers which demonstrate to the department their ability to meet the following additional requirements:

(i) A program nurse shall be available on site for not less than fifty percent of each operating day;

(ii) the program nurse shall be a registered nurse, except that a program nurse may be a licensed practical nurse if the program is located in a hospital or long term care facility licensed by the Department of Public Health, with ready access to a registered nurse from such hospital or long term care facility or the program nurse is supervised by a registered nurse who can be reached by telephone at any time during the operating day and who can be called to the center if needed within one half hour of the request. The program nurse is responsible for administering medications as needed and assuring that the participant's nursing services are coordinated with other services provided in the adult day health center, health and social services currently received at home or provided by existing community health agencies and personal physicians;

(iii) additional personal care services shall be provided as specified in the individual plan of care, including but not limited to, bathing and transferring;

(iv) ongoing training shall be available to the staff on a regular basis including, but not limited to, orientation to key specialty areas such as physical therapy, occupational therapy, speech therapy and training in techniques for recognizing when to arrange or refer clients for such services; and

(v) individual therapeutic and rehabilitation services shall be coordinated by the center as specified in the individual plan of care including, but not limited to, physical therapy, occupational therapy and speech therapy. The center shall have the capacity to provide such services on site; this requirement shall not preclude the provider of adult day health services from also arranging to provide therapeutic and rehabilitation services at other locations in order to meet needs of individual clients.

(B) Payment for adult day services shall include the costs of transportation, meals and all other required services except for individual therapeutic and rehabilitation services.

(C) For participants in the assisted living service component, adult day services are included as part of the monthly rate. A separate reimbursement for this service is not

authorized. The assisted living service agency may arrange for adult day health services and reimburse the adult day service provider from their all-inclusive rate.

(c) **Assisted Living Services**

(1) Description

Assisted living services are a special combination of housing, supportive services, core services, personalized assistance and health care designed to respond to the individual needs of those who require assistance with activities of daily living and instrumental activities of daily living. These services are necessary to enable the eligible clients to remain independent longer, thereby avoiding unnecessary or early transfer to a higher level-of-care facility.

(2) Provider participation

Assisted living services can be offered through an assisted living service package mechanism, provided by an ALSA licensed by the State of Connecticut Department of Public Health and enrolled as a performing provider with the department. Assisted living services shall be offered to eligible clients approved for participation in the following MRCs as defined in section 19-13-D105 of the Regulations of Connecticut State Agencies: State-funded congregates, housing and urban development facilities, private facilities and demonstration projects.

(3) Services covered and limitations

(A) Assisted living services are provided through a personal-assisted-living services package based on the needs of the eligible person. The negotiated per diem reimbursement represents the all-inclusive payment rate for the allowable personal care and core services.

(1) Personal care services include, but are not limited to, hands-on assistance with daily activities, including but not limited to, dressing, grooming, bathing, using the toilet, transferring, walking and eating. Personal care services may also include personal laundry and changing bed linens in conjunction with incontinence care or other needs which necessitate such assistance more than once per week. Some or all of the personal care services may be offered through an adult day center but, since the components of the adult day services are included in the payment to the ALSA, the adult day center shall be reimbursed by the ALSA through a sub-contract.

(2) "Core services" means the services described in section 19-13-D105 subsection (c)(3) of the Regulations of Connecticut State Agencies.

(3) The ALSA shall determine the assisted living services package appropriate for each client participating in the assisted living service component of the program from the following service levels:

(i) SP-1 Occasional personal care service-1 to 3.75 hours per week of personal services plus nursing visits as needed;

(ii) SP-2 Limited personal care service- 4 to 8.75 hours per week of personal care services plus nursing visits as needed;

(iii) SP-3 Moderate personal care service- 9 to 14.75 hours per week of personal care services plus nursing visits as needed; or

(iv) SP-4 Extensive personal care services- 15 to 25 hours per week of personal care services plus nursing visits as needed.

(B) Additional basic core services such as housekeeping, laundry and meal preparation beyond the level provided by the MRC under its core services package are allowed. The

additional core services can be provided by the agency or the MRC facility. If the MRC is to perform the core services, the MRC must enter into a contract with the ALSA for the purposes of performing the core services. The ALSA shall reimburse the MRC facility for the additional core services rendered by the MRC. The additional core services shall be only to those clients that are determined to need the services regardless of whether or not they are determined eligible to receive personal assistance services.

(C) The licensed assisted living services are a substitute for Medicaid and state-funded nursing and home health aide services for individuals with chronic, stable conditions. Assisted living services shall not be offered in conjunction with services provided under traditional fee-for-service.

(D) Skilled home health services are covered by Medicare for acute needs, often post hospitalization, and may be covered by Medicare in limited circumstances for individuals in MRC facilities. Such services shall be covered under Medicaid only for persons who are not eligible for Medicare benefits. Home health services, which do not meet the Medicare criteria for skilled services, are included in the payment for assisted living services under the program. Clients determined to need skilled nursing services which are not covered by Medicare and cannot be provided through the assisted living services package shall be transferred by the access agency into the fee–for-service component of the program, if allowed and feasible under the program.

The department may allow the ALSA to provide assisted living services for these clients in combination with Medicare and any of the assisted living service packages. The department shall not pay for duplicative services already covered under Medicare or another source of payment.

(E) The only additional services and charges authorized are personal emergency response system services and mental health counseling services. The department will not reimburse the ALSA for services provided under the waiver program or for home health or skilled nursing services that are provided under Medicaid. The Medicaid waiver client will continue to be eligible to receive the other traditional Medicaid benefits permitted under the department's medical assistance program policy.

(F) The nursing visits shall be provided on an as-needed basis to the client. The ALSA shall provide the nursing visits as indicated on the client's plan of care and in the assigned assisted living service package level.

(G) The ALSA may change a client's service level package at any time, provided proper justification and documentation is recorded in the client's record.

(H) The ALSA shall have their reimbursement by the department adjusted if the department determines that the client has to pay a client's mandatory contribution of service. The ALSA is responsible for the collection of the client's contribution towards their care.

(I) The ALSA shall act in good faith regarding the determination of the service needs of the client and shall document justification of the needs accordingly to assure non-duplication of services and proper billing to the department.

(J) When Medicare coverage is determined appropriate for a client due to the need for skilled care, the ALSA shall not seek approval or payment for these additional services from the department. Medicare is to be the payer source for these services. If there is no Medicare coverage, then the ALSA shall determine what type of nursing needs the client requires. If

the personal care needs involve maintenance, such as ambulatory needs, then these are services that are to be incorporated in the duties of the ALSA home health aide. The ALSA shall not seek additional approval or payment for these services since these types of services are included in the service level package rate.

(K) Physical therapy is not a covered service under the Medicaid waiver or state-funded components of the assisted living services program.

(L) If the client is no longer eligible for program participation, then the MRC facility determines if the individual can remain a resident at the facility.

(d) **Chore Services**

(1) Description

Chore services include the performance of heavy indoor work, outdoor work or household tasks for elders who are unable to do these tasks for themselves because of frailty or other conditions. These services are necessary to maintain and promote a healthy and safe environment for elders in their own homes.

(2) Provider Participation

Chore service providers are not licensed or regulated and shall be provided by a person who is not a relative of the service recipient. Chore service providers shall demonstrate the ability to meet the needs of the individual seeking services. The department or the access agency shall ensure that the services provided qualify as chore services and are not services which should be provided by a licensed provider of home health services.

(3) Services Covered and Limitations

When an individual requires one-time only unique or specialized services in order to maintain a healthy and safe home environment, the Connecticut Home Care Program shall pay for highly skilled chore services which include, but are not limited to:

(A) Extraordinarily heavy cleaning where the work required is beyond the heavy cleaning normally performed by chore services;

(B) electrical repairs or installation;

(C) plumbing repairs;

(D) minor home repairs; and

(E) extermination.

(e) **Companion Services**

(1) Description

Companion services are home-based supervision and monitoring activities which assist or instruct an individual in maintaining a safe environment, when the person is unable to maintain a safe environment or when the person primarily responsible for monitoring and supervising is absent or unable to perform such activities.

(2) Provider Participation

(A) In order to provide companion services and receive reimbursement from the Connecticut Home Care Program, a companion shall be at least eighteen (18) years of age, be of good health, have the ability to read, write and follow instructions, be able to report changes in a person's condition or needs to the department, the access agency, or the agency or organization that contracted the persons to perform such functions and shall maintain confidentiality and complete required record-keeping of the employer or contractor of services.

(B) Companion services are not licensed or regulated and shall be provided by a person hired by an agency or organization. Certain relatives, as defined in section 17b-342-1(b)(29) of the Regulations of Connecticut State Agencies, cannot be providers of services. Providers shall demonstrate the ability to meet the needs of the service recipient. The access agency or a department designee shall also ensure that the services provided are appropriate for companion services and are not services which should be provided by a licensed provider of home health services.

(C) Companion service agencies or organizations shall abide by the standards and requirements as described in the performing provider agreement and sub-contract with the department or any authorized entity.

(D) Any homemaker-companion agency must register with the Department of Consumer Protection pursuant to sections 20-671 to 20-680, inclusive, of the Connecticut General Statutes.

(3) Services Covered and Limitations

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

(A) Escorting an individual to recreational activities or the necessary medical, dental or business appointments;

(B) reading to or for an individual;

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

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

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

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

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

(f) **Adult Family Living**

(1) Description

Adult family living services provide an individual with continuous monitoring, supervision, coordination of daily living and management of overall health and welfare. These services are provided on a 24-hour basis in a private non-related family residence, when necessary to prevent or delay institutionalization.

(2) Provider Participation

For purposes of obtaining reimbursement under the Connecticut Home Care Program, the adult family living provider shall meet the following conditions:

(A) There shall be an individual designated to meet the specific needs of an adult family living client and that individual shall:

(i) Be at least eighteen (18) years of age, be of good health, have the ability to read, write and follow instructions, be able to report changes in a person's condition or needs to the sponsor of the foster care program or access agency or department designee, maintain confidentiality and complete required record-keeping of the employer or contractor of services;

(ii) not be the service recipient's relative, as defined in section 17b-342-1(b)(29) of the Regulations of the Connecticut State Agencies; and

(iii) be able to provide the individual with necessary supervision and assistance with management of overall health and activities of daily living.

(B) The family shall document that its income is adequate to meet the needs of the family;

(C) An adult family living provider shall not provide services to more than three (3) elderly persons at the same time; and

(D) Adult family living shall be provided in a living arrangement which conforms to applicable local and state building, health and safety codes and ordinances and meets the individual's needs for privacy.

(3) Services Covered and Limitations

The services provided to the individual shall include, but not be limited to, the following activities:

(A) Escorting an individual to recreational activities and to medical, dental or business appointments;

(B) reading to or for an individual;

(C) supervising or performing household tasks such as meal preparation, laundry and simple chores;

(D) supervising or monitoring an individual during the performance of activities of daily living such as eating, dressing and personal hygiene;

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

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

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

(H) reporting changes in an individual's needs or condition to a sponsor of the adult family living program or the care manager.

(4) Non-Reimbursable Services

Separate room and board charges are non-reimbursable services through the program. The client may be required to make payments directly to the adult family provider for room and board and meals.

(5) Meals

(A) Meals in the adult family living setting shall:

(i) Be nutritionally balanced and at least three (3) times daily;

(ii) include snacks and fluids as appropriate to meet the participant's needs; and

(iii) be adapted to modified diets if prescribed by a physician.

(6) Meals on wheels, homemaker services, companion services and chores services are not allowed.

(7) Additional allowable services

Attendance at an adult day center, personal emergency response system, mental health counseling and other benefits, if such services are deemed appropriate and are allowed within the program policy.

(g) **Home Delivered Meals**

(1) Description

Home delivered meals, or "meals on wheels," include the preparation and delivery of one or two meals for persons who are unable to prepare or obtain nourishing meals on their own.

(2) Provider Participation

Reimbursement for home delivered meals shall be available under the Connecticut Home Care Program only to providers which provide meals that meet a minimum of one-third of the current daily recommended dietary allowance and requirements as established by the Food and Nutrition Board of the National Academy of Sciences National Research Council.

All "meals on wheels" providers shall provide their menus to the department, contracted agencies or department designee for review and approval. Quality assurance and quality control shall be performed by the department's contracted providers to ensure that the "meals on wheels" service providers are in compliance with the dietary requirements and the requirements for the preparation and storage and delivery of food based on the department policies for the elderly nutrition program and Title (III) of the Older American's Act.

(3) Service Covered and Limitations

Payment under the Connecticut Home Care Program is not available for more than two meals a day.

(4) Meals must be delivered at the client's place of residence and must be provided directly to the client or to an authorized person. If the client is attending an adult day center, the meal may be left at the center but the meal cannot be counted as part of the meals that the center is to provide to the client. The adult day center shall ensure that the client ordered meals are stored at an adequate temperature and the client takes the meal home.

(h) **Home Health Services**

(1) Description

Home health services include the same medical procedures that are included in the definition of home health services under the Medicaid program.

(2) Provider Participation

In order to receive payment from the Connecticut Home Care Program, providers of home health services shall be enrolled as home health providers under the Medicaid program and be licensed with the state Department of Public Health.

(3) Services Covered and Limitations

Home health services provided under the Connecticut Home Care Program shall be covered to the same extent as they are under the Medicaid program.

(i) **Homemaker Services**

(1) Description

Homemaker services are general household management activities provided in the home to assist or instruct an individual in managing a household when the elder is unable to manage the home or when the individual primarily responsible is absent or unable to perform such management activities. These services are provided on a part-time or intermittent basis.

(2) Provider Participation

(A) Homemaker services shall be provided by an individual that is at least eighteen (18) years of age, in good health, has the ability to read, write and follow instructions, is able to report changes in a persons' condition or needs to the department, access agency and the agency or organization that hired the service providers. Service providers shall demonstrate the ability to meet the needs of the individual service recipient and, when money

management is involved, to protect the individual's financial interests. The homemaker service agency, the department or the access agency shall ensure that the services provided are appropriate for homemaker services and are not services which should be provided by a licensed provider of home health services or a professional financial advisor.

(B) Certain relatives, as defined in section 17b-342-1(b)(29)of the Regulations of the Connecticut State Agencies, are not allowed to provide homemaker services to program clients.

(C) Homemaker services shall only be provided through a homemaker service provider agency enrolled with the department and subcontracted with a department-contracted access agency or department designee.

(D) The homemaker service provider agency shall ensure that the individuals hired to perform the task of homemaker services meet all requirements set forth in subdivision (2)(A) of this subsection.

(E) The homemaker services shall be performed only for the benefit of the client and not for other members of the household.

(3) Services Covered and Limitations

Homemaker services include, but are not limited to:

(A) Changing linens;

(B) communication of health or other problems (neglect or abuse) to supervisor;

(C) correspondence, including written communications of a business or social nature;

(D) dishwashing;

(E) light housecleaning;

(F) laundry;

(G) meal planning and preparation;

(H) mending limited to repair of an individual's clothing;

(I) money management by bonded personnel, limited to check writing and balancing, bank deposits, paying bills and budgeting for the purpose of daily household expenses and personal needs, not including long term financial planning or investment advice;

(J) shopping; and

(K) transportation.

(j) **Laundry Services**

(1) Description

Laundry Service is designed to serve frail elders who have no other means of having laundry cleaned and shall be arranged by the contracted access agency or department designee.

(2) Provider Participation

Laundry Service is ordinarily to be provided by a commercial laundry company or by a provider of adult day health services.

(3) Services Covered and Limitations

The service is limited to one bag of laundry (up to 10 lbs.) every two weeks per client, except in cases where the case manager determines that a higher amount is necessary, such as when a client is incontinent. Two times in a 12-month period, an additional amount of laundry service may be provided per client. This additional service is limited to blankets, bedspreads and small rugs weighing no more than 20 pounds. Dry cleaning is not included

in laundry services.

(4) Laundry services shall not be available to clients that are receiving homemaker services, to clients whose family caregivers are providing the service, to participants in the assisted living service component of the program or residing in any managed residential communities.

(k) **Mental Health Counseling Services**

(1) Description

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

(2) Provider Participation

For purposes of receiving reimbursement under the Connecticut Home Care Program, a mental health counseling provider shall be a licensed clinical social worker as defined in section 20-195m of the Connecticut General Statutes, and shall have experience and training in providing mental health services to the elderly, or a social worker who holds a masters degree from an accredited school of social work, or an individual who has a masters degree in counseling, psychology or psychiatric nursing and has experience in providing mental health services to the elderly.

Service providers are not allowed to provide mental health counseling to relatives, as defined in section 17-342-1(b)(29)of the Regulations of Connecticut State Agencies.

(3) Services Covered and Limitations

The department shall pay for mental health services conforming to accepted methods of diagnosis and treatment, including:

(A) Mental health evaluation and assessment;

(B) individual counseling;

(C) group counseling; and

(D) family counseling.

(*l*) **Minor Home Modification Services**

(1) Description

Minor home modifications, also known as environmental accessible adaptations to the home or place of residence of the client, are services available, if required by the individual's plan of care, that are necessary to ensure the health, welfare and safety of the individual and to enhance independence in their home without which, the individual would require institutionalization.

(2) Provider participation

The vendor or contractor shall be registered with the state Department of Consumer Protection to do business in the state of Connecticut. The vendor or contractor shall show evidence of a valid home improvement registration and evidence of worker's compensation, if applicable, and liability insurance, at the time they provide an estimate for the job to the access agency.

The vendor or contractor shall meet any additional requirements as established by the department.

(3) Services covered and limitations

(A) Services may include, but are not limited to, the installation of handrails and grab bars in the tub area, widening of doorways and installation of ramps and stair-glides, if deemed feasible and appropriate.

(B) The vendor or contractor shall provide all services, materials and labor that are necessary to complete the project/minor home modifications as indicated in the agreement with the department-contracted access agency.

(C) All services shall be provided in accordance with applicable state and local building codes.

(D) Excluded services are those adaptations or improvements to the home which are of general utility and are not of direct medical or remedial benefit to the individual including, but not limited to, carpeting, roof repair and central air conditioning. Adaptations, which add to the total square footage of the home, are excluded from this service.

(E) Availability of services is contingent on appropriations of funds for services for both the Medicaid waiver and state-funded components under the program. No waiting list shall be maintained for services. Once the appropriated funds are exhausted, the access agency and department staff will be notified and no further requests for services will be taken. However, the access agencies and the department staff shall maintain a listing of those clients that can benefit from services if funds are made available.

(F) Review and approval of the service from the access agency shall include clients who are active and residing in a community setting that may include rental property, such as an apartment, or a private home. Clients must provide justification and documentation for the need and the cost related to the project. The department will provide a written decision to the request.

The access agency shall ensure that the client or client representative obtains written permission from the owner of the property, if the client is not the legal owner. This written permission must be obtained even if the property owner is a relative or friend of the client.

(G) The contractor or vendor and access agency shall ensure that the funding approved is used for the project approved. If the work is not completed, the contractor or vendor shall not be paid. Before payment is issued, the access agency shall verify that the work was completed as described in the work or project specifications.

If, after approval of a request for work on the property and prior to the commencement of the work, the client dies, enters a nursing facility, is hospitalized or institutionalized, moves out of state, moves in with a relative or friend or moves into another type of community setting, then the work shall not be done. In the event that the client is living with a family member or friend, is hospitalized or institutionalized, or in a nursing facility on a temporary basis, approval for the work shall be placed on hold until the client returns home.

(m) **Personal Emergency Response System Services**

(1) Description

A Personal Emergency Response System (PERS) service is an in-home, 24-hour electronic alarm system activated by a signal to a central switchboard.

(2) Provider Participation

For purposes of receiving reimbursement from the Connecticut Home Care Program,

providers of a PERS shall adhere to the following requirements:

(A) Provide trained emergency response staff on a 24-hour basis;

(B) have quality control of equipment;

(C) provide service recipient instruction and training;

(D) assure emergency power failure backup and other safety features;

(E) conduct a monthly test of each system to assure proper operation;

(F) recruit and train community based responders in service provision; and

(G) provide an electronic means of activating a response system to emergency medical and psychiatric services, police or social support systems.

(3) Services Covered and Limitations

(A) PERS enables a high risk individual to secure immediate help in the event of a medical, physical, emotional or environmental emergency. These services are provided on a 24-hour basis when necessary to prevent or delay institutionalization of an individual.

(B) PERS services are provided through local hospitals or emergency response centers that provide 24-hour coverage.

(C) PERS is not allowed in those managed residential care facilities that offer PERS as part of the service package.

(D) PERS is not allowed for clients who enter a nursing facility as permanent placement, move out of state or are temporarily out of state.

(E) PERS providers shall be a legitimate vendor or contractor and be registered with the state Department of Consumer Protection.

(F) PERS providers shall meet all applicable requirements as described in subsections (m)(2) and (m)(3) of this section in order to be a provider of service to department clients.

(n) **Respite Care Services**

(1) Description

Respite care services provide short-term relief from the continuous care of an elderly individual for the individual's family or other primary caregiver.

(2) Provider Participation

Providers of respite care services shall meet one of the following qualifications to receive reimbursement from the Connecticut Home Care Program:

(A) In-Home Respite Care Provider

An in-home respite care provider is an individual who has received training as well as has experience in providing home care for elderly persons. In-home providers of respite care shall include, but not be limited to, companions, homemakers, home health aides and other home health care personnel; or

(B) Out-of-Home Respite Care Provider

An out-of-home respite care provider is an organized facility licensed, certified or otherwise operating under the guidelines of other State agencies to provide respite care appropriately as defined in sections 17b-342-1 to 17b-342-5, inclusive of the Regulations of Connecticut State Agencies. Out-of-home providers may include, but are not limited to, rest homes with nursing supervision, chronic and convalescent nursing facilities, adult day care centers, homes for the aged or elderly foster care providers. Respite services provided in a licensed facility are limited to thirty (30) days per year per recipient.

(3) Services Covered and Limitations

The primary purposes of respite care services are to reduce the stress on the family members or other primary caregivers in order to assure that the client can continue to receive such necessary support; to allow the caregiver to meet other family needs; or to provide care during temporary absence of the primary caregiver.

(o) **Transportation Services**

(1) Description

Transportation services provide access to medical services, social services, community services and appropriate social or recreational facilities that are essential to help some individuals avoid institutionalization by enabling these individuals to retain their role as community members.

(2) Provider Participation

(A) In order to receive payment from the Connecticut Home Care Program, all commercial transportation providers shall be regulated carriers and meet all applicable state and federal permit and licensure requirements and vehicle registration requirements. Commercial transportation providers shall also meet all applicable Medicaid program enrollment requirements.

(B) There are no enrollment requirements for private transportation. Private transportation is defined as transportation by a vehicle owned by a volunteer organization, or a private individual, provided the vehicle is not used for commercial carriage.

(3) Services Covered and Limitations

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

(B) Transportation services may be provided by taxi, livery, bus, invalid coach, volunteer organization or individuals. They shall be reimbursed when they are necessary to provide access to needed community based services or community activities as specified in the approved plan of care.

(C) Transportation services are not allowed for the purpose of attending an adult day health center or for program clients that are participants in the assisted living component of the program and who reside in certain managed care residential facilities.

(Effective July 8, 1998; Amended September 3, 2010)