Agency
Department of Social Services

Subject
Child Care Subsidy Programs

Inclusive Sections
§§ 17b-3-1—17b-3-6

CONTENTS

Sec. 17b-3-1—17b-3-6. Repealed

Child Care Subsidy Programs

Sec. 17b-3-1—17b-3-6. Repealed

Repealed July 10, 2001.

Agency
Department of Social Services

Subject
Community-Based Services

Inclusive Sections
§§ 17b-4(a)-1—17b-4(a)-6

CONTENTS

Sec. 17b-4(a)-1. Definitions
Sec. 17b-4(a)-2. Conditions and standards of eligibility
Sec. 17b-4(a)-3. Application and determination of eligibility
Sec. 17b-4(a)-4. Payments for services
Sec. 17b-4(a)-5. Recovery of direct services overpayments
Sec. 17b-4(a)-6. Fair hearings

Community-Based Services

Sec. 17b-4(a)-1. Definitions

As used in Sections 17b-4 (a)-1 through 17b-4 (a)-6, inclusive, as follows:

(a) "Adult" means a person with a disability between the ages of 18–64 years.

(b) "Administrative Overpayment" is an overpayment caused by the Department's incorrect action or failure to act within the appropriate time limits.

(c) "Applicant" means any person who has submitted to the Department a completed and signed application form for Community-Based Services for families and adults.

(d) "Assets" means all personal property and resources including, but not limited to, cash, bank accounts, stocks, bonds, credit union shares, mortgage notes, real estate, automobiles, cash value of life insurance, assignments of interest in estates or causes of action.

(e) "Commissioner" means the Commissioner of the Department of Social Services or a designee.

(f) "Community-Based Services" means the following services:

(1) Adult Day Care Services – day care in a center for adults provided for a scheduled number of hours per week. Elements of this service are directed toward meeting supervision, health maintenance and restoration needs of participants.

(2) Adult Companion Service – home-based supervision and monitoring activities which assist and/or instruct an adult in maintaining a safe environment, including escorting adults to medical or other appointments or recreational activities, supervising and/or assisting with activities of adult daily living, and reminding individuals to take self-administered medications.

(3) Home-Delivered Meals – the preparation and delivery of meals for adults who are unable to prepare or obtain nourishing meals on their own.

(4) Case Management – the implementation, coordination and monitoring by a department social worker of a community-based plan of care developed as a result of a comprehensive client needs assessment completed by the Department.

(5) Chore Service – the performance of heavy indoor work, outdoor work or household tasks that are necessary to maintain and promote a healthy and safe environment for recipients in their own homes.

(6) Case Work – duties performed by a social worker dealing with problems of a particular case.

(7) Homemaker Services – general household management activities provided in the home on a part-time, intermittent, or full-time basis as determined by a department social worker to assist and/or instruct the recipient in managing a household.

(8) Temporary Foster Care – the placement of minor child(ren), for a period of up to 90 days, in an approved foster home or with relatives when parents or a legal guardian are out of the home due to illness or other factors beyond their control.

(9) Social Work Services – assessment and evaluation of need by a Department social worker including service planning, contracting, counseling, case work, advocacy for the

recipient, and crisis intervention when appropriate.

(10) Teaching Homemaker – a trained provider who assists and/or instructs a parent in child development, household management, shopping, meal planning, meal preparation and family household finances.

(11) Personal Emergency Response System – a 24 hour electronic alarm system placed in an adult's home that enables him or her to obtain immediate help in case of an emergency.

(g) "Department" means the Department of Social Services.

(h) "Excess Income" means the amount by which the gross income exceeds the Title XIX medical assistance level for Region A as established annually by the Department of Social Services (DSS).

(i) "Emergency Need" is a situation in which a physical and/or mental impairment prevents an individual from meeting needs of adult daily living, where there is no legally liable relative able to perform these duties or a non-legally liable relative or friend willing and able to perform these duties without compensation and lack of service would result in serious physical and/or mental deterioration.

(j) "Family" means related individuals living together as one economic unit which may include one or more child(ren) under the age of 18.

(k) "Good Cause" means that a person was prevented from informing the Department of changes in their circumstances which would affect their eligibility for Community-Based Services due to personal illness, death in the immediate family, severe weather, or other catastrophic events beyond the control of the recipient or other responsible members of the recipient's household.

(*l*) "Grant Reduction Recoupment" is a method of recoupment in which the Department reduces the recipient's monthly grant.

(m) "Income"

(1) "Earned income" means any compensation payable by an employer to an employee and includes wages, salaries, commissions, bonuses, and tips, as well as earnings from self-employment or contractual agreements.

(2) "Other income" may include, but is not limited to, pensions, annuities, dividends, interest, rental income, estate or trust income, royalties, social security minus any Medicare deduction or supplemental security income, unemployment compensation, workers' compensation, alimony, child support, recurring voluntary cash contributions, and cash assistance from federal, state, or municipal programs.

(n) "Installment Recoupment" is a method of recoupment in which the recipient makes monthly installment payments to the Department.

(o) "Legally liable relative" means either a spouse or a parent of a child under the age of 18.

(p) "Lump-sum Recoupment" is a method of recoupment in which the recipient makes payment to the Department of the entire amount of the overpayment in one payment.

(q) "Overpayment" is the amount of financial assistance paid to or on behalf of the recipient in excess of the amount to which the unit is properly entitled.

(r) "Person with a disability" means an adult between the ages of 18 and 64 who, due to a physical and/or mental condition lacks the ability to meet his or her own needs, and may, as determined by a Department social worker, require institutional placement if not provided with significant supportive services.

(s) "Recipient" means a person who has been determined eligible by the Department for Community-Based Services for families and adults and who has been notified of the effective date of such service and/or service payment.

(t) "Recoupment" is a process by which the Department recovers an overpayment from the recipient or service provider.

(u) "Relative" means blood relatives and their spouses, relatives of half-blood and their spouses, and relatives whose relationship with the recipient is based on legal adoption.

(v) "Risk of Institutionalization" means the probability that a person will have to be institutionalized within 60 days if services to prevent severe mental and/or physical deterioration are either withheld or withdrawn.

(w) "Service Provider" means one who provides Community-Based Services but does not include:

(1) legally liable relatives or

(2) other relatives who are members of the recipient's household unless they have suffered a demonstrable loss of income as a result of providing such services.

(x) "Service provider agency" is an organization that employs persons to provide Community-Based Services and for whom a rate of reimbursement has been approved by the Commissioner.

(Effective November 30, 1995)

Sec. 17b-4(a)-2. Conditions and standards of eligibility

(a) **Eligible families:**

(1) In order to be eligible for any services, families must reside in Connecticut and meet the income guidelines in subsection (d) of this section.

(2) Eligible families may receive social work and case management services in appropriate circumstances including, but not limited to, homelessness, child rearing problems, pending eviction and family violence.

(3) Eligible families may receive paid community based services when the supervising relative is temporarily incapacitated or unable to manage the household and children are in need of temporary foster care, homemaker services or the supervising relative is in need of a teaching homemaker. Additionally, paid services may also be provided if the supervising relative is a person with a disability.

(b) **Eligible adults**

(1) In order to be eligible for any services, the adult must reside in Connecticut, be between the ages of 18 and 64, be a person with a disability as defined in Section 17b-4 (a)-1 and meet the income guidelines as defined in subsection (d) of this section.

(2) Eligible adults may receive social work and case management services in appropriate

circumstances including, but not limited to, homelessness, pending eviction, and inappropriate institutionalization.

(3) Eligible adults with disabilities may receive paid community based services if such services, as part of the overall case plan, are provided in order to maintain the individual in the community.

(c) Medical need for Community-Based Services will be determined by the Department as follows:

(1) The adult applicant for paid services shall document the medical basis of his or her need, and the Department will review all documentation submitted to determine its sufficiency. Medical data may include a statement from a medical doctor, therapist or other appropriate health care professional stating that services are necessary to allow the applicant to remain in the community. The incapacitated supervising relative of a family shall also document medical need when applying for paid services.

(2) The Department social worker shall assess the case to determine the impact of the disability on the individual and/or the family, and how this directly affects their ability to meet needs.

(3) A Department social worker shall determine whether services provided or paid for by the Department can adequately meet the need.

(4) The Department may authorize Community-Based Services for families and adults when the social worker's assessment indicates that a need for services exists due to an individual's disability, appropriate medical data confirms this assessment, and fiscal information verifies that there is financial eligibility.

No service plan shall be established unless the client has a need which can specifically be met by a Community-Based Service as defined in Section 17b-4 (a)-1.

If an applicant is eligible for or receiving comparable services from another agency, such applicant shall be considered ineligible for the same Community-Based Services through the Department.

(d) **Income**

(1) In determining an applicant's eligibility, or a recipient's continuing eligibility, the following income of the applicant/recipient and any legally liable relative shall be counted:

(A) All gross monthly earned income, based on the most recent 13 weeks, minus:

(i) Non-personal work expenses such as: union dues (if mandatory), tools, materials, uniforms or other special protective clothing necessary for the job if they are not furnished or paid for by the employer.

(ii) Personal work expenses such as: withholding tax based upon the maximum number of dependents to which the applicant is entitled, FICA, group life insurance, health insurance, and a mandatory retirement plan.

(B) The gross monthly amount of all other income, including any cash assistance from federal, state, or municipal assistance programs not otherwise excluded as income by federal or state law, and including the gross amount of social security benefits, minus any Medicare deductions.

(2) A person shall be eligible for services when earned and other income of his or family as determined in accordance with this subsection and based on family size, does not exceed Title XIX Medical Assistance levels for Region A as established annually by the Department of Social Services (DSS).

(e) **Spend Down:**

(1) Applicants and recipients who have excess income shall be eligible if the excess income is less than the authorized payment for Community Based Services, and the excess income is applied to the cost of Community Based Services.

(2) Excess income which is already being applied to medical expenses for the purpose of qualifying the applicant/recipient for Title XIX medical assistance shall not be considered available for community based services.

(f) **Assets**

(1) Total assets of applicants and recipients and any legally liable relatives shall be considered in determining eligibility with the exception of real property used as the primary residence, any medical or remedial appliance or device, prepaid funerals or a vehicle essential for transportation.

(2) Assets shall not have been disposed of or transferred for less than reasonable consideration or fair value, or for the purposes of qualifying for services, within a period of 30 months prior to the date of application.

(3) Total assets of applicants and recipients and any legally liable relatives minus the exclusions set forth in subdivision (1) of this subsection shall not exceed the asset limits established by the Department of Health and Human Services through the Social Security Administration for the Supplemental Security Income Program.

(g) **Grandfathered Cases:**

(1) Recipients of Community-Based Services at the time that the legislation transferred new intake to the State Department on Aging in 1990 were grandfathered as are those clients who turned 60 between July 1, 1990 and June 30, 1991 and will continue to receive services provided that their need for Community-Based Services continues to exist, and all the eligibility requirements other than age are met.

(2) Community-Based Services for Families and Adult recipients who were receiving service payments in excess of $650.00 per month prior to July 1, 1984, and who continue to satisfy the eligibility standards, shall not be subject to subsection (d) of Section 17b-4 (a)-4, whicn establishes a maximum payment of $650.00 per month.

(Effective November 30, 1995)

Sec. 17b-4(a)-3. Application and determination of eligibility

(a) An applicant is responsible for providing all social, medical, and financial information necessary to establish eligibility. Staff assigned by the Commissioner may assist applicants in completing applications.

(b) A determination of eligibility by the Department shall be made no later than 60 days following the receipt by the Department of the completed application. A notice of action

shall be mailed to the applicant.

(c) Staff assigned by the Commissioner, with the assistance of the applicant, shall assess the applicant's needs, determine what needs are unmet, and develop an appropriate plan for Community-Based Services within established cost limits.

(d) Applicants and recipients shall report any changes in circumstances affecting eligibility to the Department within 10 days.

(e) Program eligibility for paid and unpaid services shall be reviewed at least once per year. Eligibility will be reviewed more frequently in cases where service needs are of short term.

(Effective November 30, 1995)

Sec. 17b-4(a)-4. Payments for services

(a) Community-Based Services for Families and Adults is not an entitlement program. Payments for services shall be contingent upon the availability of funds. The Commissioner may take whatever steps are necessary to ensure that expenditures do not exceed the amount of funds available.

(b) Should the Department be unable to provide payments for services to all current recipients due to a shortage of funds, the steps that the Department may take include the following:

(1) Denial of new applications for Community-Based Services as well as the denial of additional services for current recipients.

(2) A pro rata reduction in payments to all recipients until such time as sufficient funds are available. Thirty days written notice shall be given to all recipients stating that payment levels for Community-Based Services shall be reduced, the reasons for the reduction, and the date such reductions shall take effect. Unless the recipient believes that the calculation of the payment is incorrect, there shall be no appeal for this decision.

(3) Highest priority for payment may be given to those individuals at immediate risk of institutionalization, recipients who have emergency needs, and children in need of temporary foster care.

(c) There shall be no payment for any Community-Based Services for Families and Adults not authorized by the Commissioner or a designee, nor shall there be payment for any such service incurred, or paid for, by the recipient prior to the date of payment authorization.

The date of authorization is the effective date appearing on the authorization form.

(d) The maximum payment, per recipient, for Community-Based Services shall not exceed $650.00 per month.

(e) Payment will be authorized for the applicant or recipient if the expense is not payable through third party coverage.

(f) Prior to a reduction or discontinuance of a Community-Based Service for Families and Adults payment, a recipient shall be given ten days' written notice of such proposed change except in cases of reductions in accordance with subsection (b) (2) of this Section.

The notice shall advise the recipient of the change and his right to a fair hearing in accordance with Sections 17-603 and 17-604 of the Connecticut General Statutes.

(g) **FICA, FUTA, UC Payments**

Payments for Community-Based Services shall be for the gross amount of the service payment as authorized by the Commissioner with no deductions for Social Security (FICA), Federal Unemployment Tax (FUTA), or State Unemployment Compensation (UC) payments.

The recipient of services shall be responsible for payment of the appropriate amount of FICA, FUTA, and UC.

Responsibility for FICA, FUTA and UC accounts currently established and maintained by the Department, may be transferred to the recipient of services. No such transfer shall be made until recipients are given reasonable notice of such change.

(Effective November 30, 1995)

Sec. 17b-4(a)-5. Recovery of direct services overpayments

(a) Recipients, service providers, and service provider agencies are obligated to reimburse the Department for any overpayment received whether directly, or on behalf of a recipient.

(b) The Commissioner may waive recoupment of an overpayment up to the limit of statutory authority pursuant to Connecticut General Statutes Section 3-7 if in his judgment the imposition of recoupment measures would place the recipient at significant risk of institutionalization, would place the recipient's family in a crisis situation or is not in the best interest of the State.

(c) Prior to the Department initiating any recoupment process, the recipient, service provider, or service provider agency shall be notified of the amount of the overpayment, the reason the overpayment occurred, the time period covered by the overpayment, and the proposed method for recovering the overpayment.

(d) **Method of Recoupment:**

(1) The Department will attempt to recover overpayments from recipients, former recipients, service providers, or service provider agencies by the lump-sum recoupment method.

(2) If the individual who owes the overpayment is unable to make a lump sum repayment, the Department will attempt to recover the money through the installment recoupment method. Active recipients and providers may agree to the grant reduction recoupment method in lieu of installment recoupment.

(3) In cases where the individual who owes the overpayment fails or refuses to make a lump sum payment, sign an installment agreement, or comply with the provisions of an installment agreement, the Department may invoke the grant reduction recoupment method by reducing each subsequent payment made to or on behalf of a recipient by up to 25% of the total amount owed until such overpayment is recovered.

(4) Service provider agencies that fail or refuse to repay overpayments may have the

amount which is owed recouped from any other payments to which they are entitled on behalf of any other client.
(5) When there is failure to agree to an appropriate repayment plan, the Commissioner shall take whatever action he deems appropriate to recover such overpayment.

(Effective November 30, 1995)

Sec. 17b-4(a)-6. Fair hearings
A person aggrieved by any action or inaction of the Department may request a fair hearing in accordance with Connecticut General Statutes Sections 17-603 and 17-604 as same may be amended. The Department of Social Services' fair hearing procedures are governed by applicable provisions of the Uniform Administrative Procedure Act and the Department's separate fair hearing regulations.

(Effective November 30, 1995)

Agency
Department of Social Services

Subject
Uniform Policy Manual

Section
§ 17b-10-1

CONTENTS

Sec. 17b-10-1. Uniform policy manual

Uniform Policy Manual

Sec. 17b-10-1. Uniform policy manual

Pursuant to section 17b-10 of the Connecticut General Statutes, the Department of Social Services has prepared, and routinely updates, a state eligibility Policy Manual containing all departmental policy regulations and substantive procedures which affect the rights or procedures available to the public. In particular, the Policy Manual outlines the policies and procedures used by the department to implement and enforce federal and state laws for all of the programs which it administers.

The Policy Manual was adopted pursuant to the applicable provisions of the Uniform Administrative Procedure Act and any amendment to, or repeal of, the regulatory provisions contained therein would also be subject to UAPA procedural requirements. However, in accordance with Conn. Gen. Stat. 4-173 (c), the full text will not be published herein. Instead, the following list of sections from the Table of Contents for the Policy Manual has been reproduced in order to assist persons interested in seeking further information with respect to the regulations:

Rights and Responsibilities	1000
The Eligibility Process	1500
Assistance Unit Composition	2000
Categorical Eligibility Requirements	2500
Technical Eligibility Requirements	3000
Procedural Eligibility Requirements	3500
Treatment of Assets	4000
Standards of Assistance	4500
Treatment of Income	5000
Income Eligibility	5500
Calculation of Benefits	6000
Benefits Issuance	6500
Benefit Error	7000
Recovery	7500
Special Programs	8000
Special Benefits	9000

A copy of the Policy Manual is available at the Connecticut Department of Social Services, Office of Legal Affairs, 25 Sigourney Street, Hartford, CT 06106.

(Effective December 21, 1990; Amended May 27, 1992; Amended June 23, 1992; Amended July 29, 1992; Amended August 26, 1992; Amended October 6, 1992; Amended October 27, 1992; Amended February 8, 1993; Amended March 3, 1993; Amended March 25, 1993; Amended May 10, 1993; Amended July 7, 1993; Amended July 20, 1993; Amended July 27, 1993; Amended Au-

gust 23, 1993; Amended October 26, 1993; Amended November 22, 1993; Amended December 29, 1993; Amended February 1, 1994; Amended February 22, 1994; Amended March 23, 1994; Amended April 26, 1994; Amended May 23, 1994; Amended June 28, 1994; Amended September 28, 1994; Amended October 25, 1994; Amended March 23, 1995; Amended April 26, 1995; Amended May 18, 1995; Amended August 21, 1995; Amended October 25, 1995; Transferred from § 17-3f-1, January 31, 1996; Amended March 29, 1996; Amended July 24, 1996; Amended April 1, 1997; Amended September 4, 1997; Amended October 7, 1997; Amended December 24, 1997; Amended February 4, 1998; Amended May 8, 1998; Amended February 9, 1999; Amended September 23, 1999; Amended October 8, 1999; Amended February 9, 2000; Amended June 6, 2000; Amended November 7, 2000; Amended February 13, 2001; Amended November 5, 2001; Amended November 7, 2001; Amended December 10, 2001; Amended January 3, 2002; Amended January 4, 2002; Amended February 7, 2002; Amended May 6, 2002; Amended September 17, 2002; Amended November 6, 2002; Amended February 11, 2003; Amended March 11, 2003; Amended March 14, 2003; Amended June 11, 2003; Amended July 29, 2003; Amended September 10, 2003; Amended December 10, 2003; Amended February 10, 2004; Amended March 4, 2004; Amended March 31, 2004; Amended May 24, 2004; Amended July 9, 2004; Amended August 19, 2004; Amended August 23, 2004; Amended August 26, 2004; Amended September 8, 2004; Amended September 9, 2004; Amended October 14, 2004; Amended November 9, 2004; Amended December 14, 2004; Amended February 8, 2005; Amended February 9, 2005; Amended March 3, 2005; Amended April 4, 2005; Amended May 2, 2005; Amended May 26, 2005; Amended June 8, 2005; Amended June 13, 2005; Amended July 15, 2005; Amended July 21, 2005; Amended August 9, 2005; Amended August 11, 2005; Amended August 31, 2005; Amended September 1, 2005; Amended September 9, 2005; Amended September 14, 2005; Amended October 12, 2005; Amended November 9, 2005; Amended December 7, 2005; Amended January 5, 2006; Amended March 9, 2006; Amended April 10, 2006; Amended May 9, 2006; Amended June 14, 2006; Amended July 11, 2006; Amended August 3, 2006; Amended August 7, 2006; Amended August 23, 2006; Amended October 5, 2006; Amended December 6, 2006; Amended December 15, 2006; Amended February 7, 2007; Amended March 7, 2007; Amended June 4, 2007; Amended August 6, 2007; Amended October 11, 2007; Amended December 28, 2007; Amended January 31, 2008; Amended April 7, 2008; Amended July 7, 2008; Amended July 29, 2008; Amended July 31, 2008; Amended September 4, 2008; Amended October 9, 2008; Amended December 5, 2008; Amended January 7, 2009; Amended February 11, 2009; Amended April 8, 2009; Amended August 12, 2009; Amended September 4, 2009; Amended November 9, 2009; Amended May 10, 2010; Amended June 1, 2010; Amended July 6, 2010; Amended October 8, 2010; Amended November 5, 2010; Amended March 3, 2011; Amended March 31, 2011; Amended June 8, 2011; Amended July 11, 2011; Amended June 5, 2012; Amended July 2, 2012; Amended December 28, 2012)

Agency
Department of Social Services

Subject
Hospital-based Acknowledgment of Paternity

Inclusive Sections
§§ 17b-27-1—17b-27-8

CONTENTS

Sec. 17b-27-1. Definitions
Sec. 17b-27-2. Protocol requirement
Sec. 17b-27-3. Informational materials
Sec. 17b-27-4. Forms and notices
Sec. 17b-27-5. Consultation
Sec. 17b-27-6. Affirmation and acknowledgment opportunity
Sec. 17b-27-7. Filing
Sec. 17b-27-8. Repealed

Hospital-based Acknowledgment of Paternity

Sec. 17b-27-1. Definitions

As used in sections 17b-27-1 through 17b-27-7, inclusive:

(1) "Acknowledgment of paternity" means the form prescribed by the Department of Public Health for the purpose of establishing the legal paternity of a child born to unmarried parents, as provided in subsection (a) of section 46b-172 of the Connecticut General Statutes. The acknowledgment of paternity includes the affirmation of paternity, the waiver, and the notice of rights and responsibilities.

(2) "Affirmation of paternity" means the signed and sworn portion of the acknowledgment of paternity in which the mother names the biological father of her child and consents to such acknowledgment of paternity.

(3) "Birthing institution" means a hospital that has an obstetric care unit or provides obstetric services, or a birthing center associated with a hospital.

(4) "Commissioner" means the commissioner of the Department of Social Services, a designee, or authorized representative.

(5) "Department" means the Department of Social Services or any bureau, division, or agency of the Department of Social Services.

(6) "Notice of rights and responsibilities" means the portion of the acknowledgment of paternity that contains the written notice to the mother and the putative father of the alternatives to, the legal consequences of, and the rights and responsibilities that arise from signing such acknowledgment, including the right to rescind the acknowledgment, as required by subdivision (a) (1) of Section 46b-172 of the Connecticut General Statutes.

(7) "Protocol" means the standards and procedures established by a birthing institution to comply with Sections 17b-27-1 to 17b-27-7, inclusive, of the Regulations of Connecticut State Agencies.

(8) "Waiver" means the portion of the acknowledgment of paternity that is signed and sworn to by the putative father wherein such father voluntarily acknowledges that he is the biological father of the child, accepts the obligation to support such child, and waives his rights to a trial, a lawyer to represent him, and a genetic test to determine paternity.

(Effective August 21, 1995; Amended June 8, 1998)

Sec. 17b-27-2. Protocol requirement

(a) **In general**

Each birthing institution shall develop and follow a protocol for the voluntary acknowledgment of paternity during the period immediately before or after the birth of a child to an unmarried woman in such institution.

(b) **Submittal**

The protocol developed under subsection (a) of this section shall be in writing and submitted to the commissioner. An amended protocol document shall be submitted no later than 60 days after the adoption of a significant change to an existing protocol.

(c) **Required components**

The written protocol submitted in accordance with subsection (b) of this section shall specify, at a minimum, how, when, and by whom each of the following services shall be provided:

(1) distribution of the informational materials specified in section 17b-27-3 of the Regulations of Connecticut State Agencies to the mother and the putative father;

(2) provision of the forms and notices specified in section 17b-27-4 of the Regulations of Connecticut State Agencies to the mother and the putative father;

(3) consultation regarding paternity establishment as required by section 17b-27-5 of the Regulations of Connecticut State Agencies;

(4) provision of an opportunity for the mother and the father to sign an acknowledgment of paternity, as provided in section 17b-27-6 of the Regulations of Connecticut State Agencies, in the birthing institution in the presence of a notary public; and

(5) forwarding of the completed acknowledgment of paternity to the paternity registry, as provided in section 17b-27-7 of the Regulations of Connecticut State Agencies.

(Effective August 21, 1995; Amended June 8, 1998)

Sec. 17b-27-3. Informational materials

The birthing institution shall distribute to both the mother and the putative father, if he is present in such institution, written informational materials about paternity establishment. Such materials shall include, but not be limited to, those developed by the department and provided to such birthing institutions specifically for the operation of the hospital-based acknowledgment of paternity program. The department shall provide such informational materials to any birthing institution upon request.

(Effective August 21, 1995; Amended June 8, 1998)

Sec. 17b-27-4. Forms and notices

The birthing institution shall provide to both the mother and the putative father, if he is present in such institution, the forms and notices necessary to voluntarily affirm and acknowledge paternity, respectively. The department shall provide such forms and notices to any birthing institution upon request. All of the required forms and notices are included in the acknowledgment of paternity form prescribed by the Department of Public Health pursuant to subdivision (a) (3) of Section 46b-172 of the Connecticut General Statutes.

(Effective August 21, 1995; Amended June 8, 1998)

Sec. 17b-27-5. Consultation

The birthing institution shall provide to both the mother and the putative father, if he is present in such institution, the opportunity to speak with staff, either by telephone or in person, who are trained to clarify information and answer questions about paternity establishment.

(Effective August 21, 1995; Amended June 8, 1998)

Sec. 17b-27-6. Affirmation and acknowledgment opportunity

(a) **In general**

The requirements of this section shall be satisfied if the birthing institution provides the required services, including notarization, prior to the mother's discharge, if practicable, or, if not practicable, within 10 calendar days thereafter.

(b) **Affirmation procedure**

The birthing institution shall provide to each unmarried mother the opportunity to voluntarily sign an affirmation of paternity in such institution. The birthing institution shall provide an oral and written notice of rights and responsibilities to the mother before the mother signs an affirmation of paternity. The mother's sworn signature on the affirmation of paternity shall be sufficient to ensure that she is informed, competent to understand and agree to an affirmation of paternity, and that such affirmation is voluntary and free from coercion.

(c) **Acknowledgment procedure**

The birthing institution shall provide to each putative father the opportunity to voluntarily sign an acknowledgment of paternity in such institution. The birthing institution shall provide an oral and written notice of rights and responsibilities to such father before the father signs an acknowledgment of paternity. The father's sworn signature on the waiver shall be sufficient to ensure that he is informed, competent to understand and agree to an acknowledgment of paternity, and that such acknowledgment is voluntary and free from coercion.

(Effective August 21, 1995; Amended June 8, 1998; Amended May 24, 2004)

Sec. 17b-27-7. Filing

The birthing institution shall promptly forward the acknowledgment of paternity completed in accordance with section 17b-27-6 of the Regulations of Connecticut State Agencies to the paternity registry established and maintained by the Department of Public Health in accordance with section 19a-42a of the Connecticut General Statutes.

(Effective August 21, 1995; Amended June 8, 1998; Amended July 10, 2000)

Sec. 17b-27-8. Repealed

Repealed June 8, 1998.

Agency
Department of Social Services

Subject
Electronic Health Records Incentive Program

Inclusive Sections
§§ 17b-34-1—17b-34-9

CONTENTS

Sec. 17b-34-1. Scope
Sec. 17b-34-2. Definitions
Sec. 17b-34-3. General Requirements for Participation
Sec. 17b-34-4. Incentive Payment Requirements for Eligible Professionals
Sec. 17b-34-5. Incentive Payment Requirements for Eligible Hospitals
Sec. 17b-34-6. Methodology for Determining Patient Volume
Sec. 17b-34-7. Incentive Payments
Sec. 17b-34-8. Initial Review and Right to Request an Administrative Hearing
Sec. 17b-34-9. Audits and Documentation

Electronic Health Records Incentive Program

Sec. 17b-34-1. Scope

The department distributes Electronic Health Record Incentive Program payments to eligible providers who meet the criteria set forth in 42 CFR 495.2 to 42 CFR 495.10, inclusive, and 42 CFR 495.300 to 42 CFR 495.370, inclusive. Eligible providers include: Physicians, nurse practitioners, certified nurse-midwives, dentists, physician assistants, acute care hospitals and children's hospitals. Eligible providers shall meet applicable federal and state requirements, including licensure and scope of practice requirements.

(Effective January 13, 2013)

Sec. 17b-34-2. Definitions

Unless otherwise defined in this section, the definitions provided in 42 CFR 495.4 and 42 CFR 495.302 apply to sections 17b-34-1 to 17b-34-9, inclusive, of the Regulations of Connecticut State Agencies. As used in sections 17b-34-1 to 17b-34-9, inclusive, of the Regulations of Connecticut State Agencies:

(1) "Adopt, implement or upgrade" or "AIU" means one or more of the following:

(A) Acquire, purchase or install a certified EHR system;

(B) install or commence use of a certified EHR system and have started one of the following: A training program for the certified EHR system; data entry of patient demographic and administrative data into the EHR; or establishment of data exchange agreements and a relationship between the provider's certified EHR system and health information exchanges or other providers including, but not limited to, laboratories and pharmacies;

(C) expand available functionality of certified EHR technology capable of meeting meaningful use requirements at a practice site, including staffing, maintenance and training; or

(D) upgrade from existing EHR technology to certified EHR technology, including, but not limited to, upgrades to the addition of clinical decision support, e-prescribing functionality and computerized physician order entry;

(2) "Certified electronic health record" or "certified EHR" means EHR technology certified in accordance with the EHR certification criteria of the Office of the National Coordinator for Health Information Technology;

(3) "CMS" means the Centers for Medicare and Medicaid Services;

(4) "Commissioner" means the Commissioner of Social Services or the commissioner's designee;

(5) "Department" means the Department of Social Services or its agent;

(6) "Electronic health record" or "EHR" means a systematic collection of electronic health information on individual patients in a digital format that includes a range of data in comprehensive or summary form, such as: Demographics; medical history; medication; medication allergies; immunization status; laboratory test results; radiology images; vital signs; and personal statistics such as age, weight and billing information;

(7) "Electronic Health Record Incentive Program" or "EHR Incentive Program" means the incentive program established pursuant to section 17b-34 of the Connecticut General Statues and authorized by 42 USC 1396b(a)(3)(F) and 42 USC 1396b(t), that enables providers to receive funding from the department to promote AIU and meaningful use;

(8) "Eligible hospital" means a children's hospital or an acute care hospital, as such terms are defined in 42 CFR 495.302;

(9) "Eligible professional" or "EP" means a professional as described in 42 CFR 495.304(b) to 42 CFR 495.304(d), inclusive;

(10) "Hospital-based EP" means an EP who furnishes ninety percent or more of the EP's covered professional services in a hospital setting as measured by data in the calendar year preceding the payment year;

(11) "Hospital setting" means a site of service that is identified by the codes used in Health Insurance Portability and Accountability Act standard transactions as an inpatient hospital or emergency room setting;

(12) "Meaningful use" means use of certified EHR in a meaningful manner, including, but not limited to: E-prescribing; the use of certified EHR technology for electronic exchange of health information to improve quality of health care; or the use of certified EHR technology to submit clinical quality and other measures;

(13) "Medicaid" means the program operated by the department pursuant to section 17b-261 of the Connecticut General Statutes and authorized by Title XIX of the Social Security Act;

(14) "Patient volume" means the minimum participation threshold that is estimated using the methodology in 42 CFR 495.306(c);

(15) "Pediatrician" means a physician whose practice is comprised of at least ninety percent of patients age 18 and under, and who:

(A) Holds board certification by the American Board of Pediatrics in pediatrics or a pediatric subspecialty;

(B) in the opinion of the department has training or experience comparable to that required for board certification by the American Board of Pediatrics in pediatrics or a pediatric subspecialty;

(C) holds board certification by the American Board of Medical Specialties in any specialty recognized by such board and serves a pediatric patient population; or

(D) in the opinion of the department provides what is generally accepted to be specialty care to a pediatric patient population;

(16) "Physician" means a person licensed pursuant to section 20-13 of the Connecticut General Statutes; and

(17) "Provider" means a provider enrolled in Medicaid.

(Effective January 13, 2013)

Sec. 17b-34-3. General Requirements for Participation

To be eligible for participation in the EHR Incentive Program, a provider shall:

(1) Be an EP or an eligible hospital but not a hospital-based EP;

(2) comply with sections 17b-34-1 to 17b-34-9, inclusive, of the Regulations of Connecticut State Agencies;

(3) meet all applicable requirements of 42 CFR 495.304;

(4) be enrolled in Medicaid with a valid provider enrollment agreement on file with the department and comply with all of the department's Medicaid requirements, including, but not limited to, sections 17b-262-522 to 17b-262-532, inclusive, of the Regulations of Connecticut State Agencies;

(5) not have any current sanctions that temporarily or permanently bar the provider from participation in the Medicare program or any state's Medicaid program;

(6) demonstrate, in a manner specified by the department, that the provider:

(A) For the first payment year, is adopting, implementing or upgrading an EHR system; and

(B) for the second and subsequent payment years, satisfies the meaningful use criteria applicable to the provider under 42 CFR 495.6;

(7) comply with all requirements in 42 CFR 495.310 regarding limitations on provider participation in more than one EHR incentive program; and

(8) comply with all other applicable requirements in 42 CFR 495, Subparts A and D, including 42 CFR 495.304.

(Effective January 13, 2013)

Sec. 17b-34-4. Incentive Payment Requirements for Eligible Professionals

In addition to meeting the requirements of section 17b-34-3 of the Regulations of Connecticut State Agencies, an EP shall meet the following requirements in order to be eligible to participate in the EHR Incentive Program:

(1) Comply with all applicable requirements of 42 CFR 440, be licensed pursuant to Title 20 of the Connecticut General Statutes and act within the EP's scope of practice under state law.

(2) Except for the first payment year as provided in subdivision (3) of this section, satisfy the requirements for meaningful use, as follows:

(A) Unless otherwise provided in 42 CFR 495.6(a), an EP shall meet: (i) All of the objectives and associated measures in 42 CFR 495.6(d), (ii) five objectives of the EP's choice from the objectives in 42 CFR 495.6(e) and (iii) if applicable, the criteria in 42 CFR 495.6(h); and

(B) as provided in 42 CFR 495.8(a), an EP shall attest, in a manner specified by the department, that the EP satisfies each of the applicable objectives and associated measures required pursuant to 42 CFR 495.6(a).

(3) In the first payment year only, an EP may either satisfy the requirements for meaningful use provided in subdivision (2) of this section or the EP may demonstrate that the EP has adopted, implemented or upgraded an EHR system during the payment year by attesting that:

(A) The EP has adopted, implemented or upgraded certified EHR technology; and

(B) the EP meets the applicable patient volume requirements in 42 CFR 495.304.

(4) Except as otherwise provided in subdivision (3) of this section, for program years one through six, an EP shall attest not more than ninety days after the close of each program calendar year that the EP has met the requirements for meaningful use of certified EHR technology, as follows:

(A) In program calendar years one and two, the EP shall attest to meeting the objectives and associated measures of meaningful use criteria in subdivision (2) of this section for any continuous ninety-day period within such program calendar year; and

(B) in program calendar years three through six, the EP shall attest to meeting the objectives and associated measures of meaningful use criteria in subdivision (2) of this section for the entirety of each program calendar year.

(5) An EP shall submit the information described in 42 CFR 495.10 to the department in the manner specified by CMS.

(Effective January 13, 2013)

Sec. 17b-34-5. Incentive Payment Requirements for Eligible Hospitals

In addition to meeting the requirements of section 17b-34-3 of the Regulations of Connecticut State Agencies, an eligible hospital shall meet the following requirements in order to be eligible to participate in the EHR Incentive Program:

(1) Hold a valid license issued by the Department of Public Health and comply with all applicable state statutes and regulations.

(2) Except for the first payment year as provided in subdivision (3) of this section, satisfy the requirements for meaningful use, as follows:

(A) Unless otherwise provided in 42 CFR 495.6(b), an eligible hospital shall meet: (i) All of the objectives and associated measures of the criteria in 42 CFR 495.6(f); (ii) five objectives of the eligible hospital’s choice, from the objectives in 42 CFR 495.6(g); and (iii) if applicable, the criteria in 42 CFR 495.6(i); and

(B) as provided in 42 CFR 495.8(b), an eligible hospital shall attest, in a manner specified by the department, that the eligible hospital satisfies each of the objectives and associated measures required pursuant to 42 CFR 495.6(b).

(3) In the first payment year only, an eligible hospital may either satisfy the requirements for meaningful use provided in subdivision (2) of this section or demonstrate that it has adopted, implemented or upgraded an EHR system during the payment year by attesting to the criteria in section 17b-34-4(c) of the Regulations of Connecticut State Agencies.

(4) Except as otherwise provided in subdivision (3) of this section, for program years one through six, an eligible hospital shall attest not more than 90 days after the close of each program federal fiscal year that it has met meaningful use of certified EHR technology, as follows:

(A) To be considered a meaningful EHR user in program federal fiscal years one and two, an eligible hospital shall attest to meeting the objectives and associated measures of

meaningful use criteria in subdivision (2) of this section for any continuous ninety-day period within the program federal fiscal year; and

(B) to be considered a meaningful EHR user in program federal fiscal years three through six, an eligible hospital shall attest to meeting the objectives and associated measures of meaningful use criteria in subdivision (2) of this section for each program federal fiscal year in its entirety.

(5) An eligible hospital shall submit the information described in 42 CFR 495.10 to the department in the manner specified by CMS.

(Effective January 13, 2013)

Sec. 17b-34-6. Methodology for Determining Patient Volume

(a) Each EP and eligible hospital shall, on an annual basis, meet the applicable patient volume requirements of 42 CFR 495.304 using the methodology in 42 CFR 495.306(c).

(b) Only an EP who is a pediatrician as defined in section 17b-34-2 of the Regulations of Connecticut State Agencies may use the reduced minimum Medicaid patient volume requirement for participation in the EHR Incentive Program pursuant to 42 CFR 495.304(c). Such pediatrician shall comply with applicable requirements of 42 CFR 495.310.

(Effective January 13, 2013)

Sec. 17b-34-7. Incentive Payments

To receive incentive payments, an EP or eligible hospital shall meet the applicable requirements under 42 CFR 495.314. The department shall make incentive payments to each eligible Medicaid provider in accordance with 42 CFR 495.308, 42 CFR 495.310 and sections 17b-34-1 to 17b-34-9, inclusive, of the Regulations of Connecticut State Agencies.

(Effective January 13, 2013)

Sec. 17b-34-8. Initial Review and Right to Request an Administrative Hearing

(a) A provider aggrieved by a decision concerning only the issues set forth in 42 CFR 495.370(a) or section 17b-34(c) of the Connecticut General Statutes may request an initial review of the department's determination, and such review shall occur only if the department receives the provider's written request for an initial review, together with any supporting documents or data, not more than thirty days after the provider received the department's determination.

(b) An individual other than the person who made the department's determination shall conduct the initial review. The individual who conducts the initial review shall issue a written decision to the provider not more than thirty days after the department receives the request for initial review.

(c) If the provider is aggrieved by the outcome of the initial review, the provider may request an administrative hearing in writing to the commissioner, together with a detailed written description of all items of aggrievement, not more than fourteen days after the date the written initial review decision was issued.

(d) The department shall conduct an administrative hearing requested pursuant to subsection (c) of this section in accordance with chapter 54 of the Connecticut General Statutes.

(Effective January 13, 2013)

Sec. 17b-34-9. Audits and Documentation

(a) The department may access all relevant records and documentation and take any other appropriate quality assurance measures it deems necessary to verify provider attestations or conduct pre-payment or post-payment audits to assure compliance with the provisions of sections 17b-34-1 to 17b-34-9, inclusive, of the Regulations of Connecticut State Agencies and other regulatory and statutory requirements. The department may disallow or recover any amounts paid or pending to the provider for which required documentation is not maintained or not provided to the department upon request.

(b) For purposes of documenting AIU, the provider shall make available to the department all relevant documents, including, but not limited to, one or more of the following documents, as directed by the department:

(1) Contract;
(2) software license;
(3) receipt or evidence of cost;
(4) purchase order;
(5) evidence of cost or contract for training; or
(6) payroll record demonstrating hiring of staff to assist with the implementation.

(c) After conducting an audit, if the department finds that the provider was not eligible for payments made to the provider, the department may disallow and recover those funds. The provider shall promptly repay all disallowed funds to the department not more than forty-five days after receiving notice of the disallowance. In addition to taking any other lawful actions, the department may also offset such funds against current or future payments that the department otherwise would have made to the provider.

(d) A provider aggrieved by a decision in a final written audit conducted under this section may request a written review from the department. The provider shall request such review in writing and not later than thirty days after the department's final audit report was issued, together with a detailed written description of each specific item of aggrievement. The scope of the review shall not include or consider facts or circumstances outside of the audit and the final written audit report. An individual other than a person who conducted the audit or made the department's final audit determination shall conduct the review. At the discretion of the person presiding over the review, the person may make informal inquiries to the provider or the department; accept written statements from the provider and the department; and hold an informal conference with the department and the provider for the purpose of fact finding, accepting oral statements, or hearing witness testimony, after giving appropriate notice thereof to the provider and the department. After completing the final review, the person presiding over the review shall issue a final written decision

regarding what, if any action will be taken, including, but not limited to, revising the final written audit or any other action within the scope of the department's authority.

(Effective January 13, 2013)

Agency
Department of Social Services

Subject
The General Assistance Policy Manual

Section
§ 17b-78-44

CONTENTS

Sec. 17b-78-44. The general assistance policy manual

The General Assistance Policy Manual

The provisions of Section 17b-78-44, which implements Public Act 97-2 of the June 18th Special Session, shall include Sections 17b-78-11 through 17b-78-43 of the Regulations of Connecticut State Agencies (the General Assistance Policy Manual).

For purposes of clarity, this Section shall incorporate the provisions of Public Acts 95-194, 95-351, 96-209 and 96-268. Except as specifically noted in the text of this Section, all towns are required to administer the General Assistance program in accordance with regulations enacted herein as Section 17b-78-44.

Sec. 17b-78-44. The general assistance policy manual

The text of these regulations will not be published herein in accordance with the provisions of Section 4-173 of the Connecticut General Statutes. Copies of this regulation are available at the Department of Social Services. Interested members of the public may obtain a copy by writing to the General Assistance Unit, Department of Social Services, 25 Sigourney St., Hartford, CT 06106. Telephone (860) 424-5382 or toll free 1-800-842-2159.

(Transferred from § 17-3a-11 through 17-3a-42.1, February 10, 1998; Amended February 10, 1998)

Agency
Department of Social Services

Subject
Requirements for Providing Financial Incentive for the Reporting of Vendor Fraud

Inclusive Sections
§§ 17b-102-01—17b-102-04

CONTENTS

Requirements for Payment for Reporting Vendor Fraud

Scope

Sec. 17b-102-01. Definitions
Sec. 17b-102-02. Eligibility
Sec. 17b-102-03. Payment
Sec. 17b-102-04. Payment limitations

Requirements for Providing Financial Incentive for the Reporting of Vendor Fraud

Requirements for Payment for Reporting Vendor Fraud

Scope

Sections 17b-102-01 to 17b-102-04, inclusive, set forth the Department of Social Services requirements for providing a financial incentive for the reporting of vendor fraud in any program under the jurisdiction of the Department of Social Services.

Sec. 17b-102-01. Definitions

For the purposes of sections 17b-102-01 to 17b-102-04, inclusive, the following definitions shall apply:

(1) "Commissioner" means the chief executive officer of the department appointed pursuant to subsection (a) of section 17b-1 of the general statutes.

(2) "Department" means the Department of Social Services or its agent.

(3) "Fraud" means, with intent to defraud the department or a program under the jurisdiction of the department by:

(A) presenting for payment any false claim for goods or services performed;

(B) or accepting payment for goods or services performed, which exceeds either the amounts due for goods or services performed, or the amounts authorized by law for the cost of such goods or services;

(C) or soliciting to perform services for or sell goods to any beneficiary, knowing that such beneficiary is not in need of such goods or services;

(D) or selling goods to or performing services for any beneficiary without prior authorization by the department, when prior authorization is required by said department for the buying of such goods or the performance of any service;

(E) or accepting from any person or source other than the state an additional compensation in excess of the amount authorized by law.

(4) "Vendor" means the definition contained in section 17-83k-1 of the Regulations of Connecticut State Agencies.

(Adopted effective April 2, 1998)

Sec. 17b-102-02. Eligibility

Payment of a financial incentive shall be provided to any person reporting vendor fraud in connection with any program under the jurisdiction of the department subject to the payment conditions and limitations which apply to this financial incentive pursuant to section 17b-102 of the general statutes and section 17b-102-01 to 17b-102-04, inclusive, of the Regulations of Connecticut State Agencies.

(Adopted effective April 2, 1998)

Sec. 17b-102-03. Payment

(a) The commissioner shall be the sole determiner of whether the person is entitled to

the financial incentive.

(b) The payment shall not exceed 15% of the amounts recovered by the state that are directly attributed to the person's report.

(c) The commissioner shall be the sole determiner of the amount of the incentive.

(Adopted effective April 2, 1998)

Sec. 17b-102-04. Payment limitations

(a) The department shall pay a financial incentive when:

(1) the person reporting has not materially participated in or benefited from any of the fraudulent activity being reported; and

(2) a direct correlation exists between the information reported and amounts recovered by the state as a result of such report; and

(3) the person reporting submits a claim for the financial incentive, in writing, on a form specified by the department and files it within six months from the date of when the vendor fraud was first reported;

(b) The department shall not pay a financial incentive when:

(1) the person reporting requests anonymity; or

(2) a claim is made regarding a case where the department or other state or federal agency has initiated an audit, investigation or similar proceedings prior to the person reporting the fraud; or

(3) the person reporting or a member of his immediate family is employed in a job which requires auditing, investigation or enforcement involving the programs under the jurisdiction of the department.

(Adopted effective April 2, 1998)

Agency
Department of Social Services

Subject
Safety Net Services Account

Section
§ 17b-112f-1

CONTENTS

Sec. 17b-112f-1. Safety net services account. Regulations

Safety Net Services Account

Sec. 17b-112f-1. Safety net services account. Regulations

(a) All moneys deposited in the Safety net services account shall be used to provide assistance to individuals receiving Safety net services pursuant to Section 17b-112e of the Connecticut General Statutes.

(b) All moneys deposited in the Safety net services account shall be used for the following purposes:

(1) Payment for food, shelter, clothing and employment assistance to individuals receiving Safety net services;

(2) Payment for eviction prevention;

(3) Payment for the purposes specified in subdivisions (3) and (4) of subsection (b) of Section 17b-112e of the Connecticut General Statutes, to the extent funds are available.

(c) There shall be no direct cash payments made to individuals enrolled in Safety net.

(d) Payments shall be made either through vendor or voucher payment.

(Adopted effective January 5, 2001)

Agency

Department of Social Services

Subject

Title IV-D Child Support Enforcement Program

Inclusive Sections

§§ 17b-179(a)-1—17b-179(a)-4

CONTENTS

Sec. 17b-179(a)-1. Definitions for the Title IV-D program
Sec. 17b-179(a)-2. Publication of names of delinquent obligors
Sec. 17b-179(a)-3. Recovery of misapplied child support payments
Sec. 17b-179(a)-4. Cooperation with the child support program

Title IV-D Child Support Enforcement Program

Sec. 17b-179(a)-1. Definitions for the Title IV-D program

As used in sections 17b-179(a)-1 through 17b-179(a)-4, inclusive; 17b-179(b)-1; 17b-179(b)-2; 17b-179(f)-1; 17b-179(i)-1; 17b-179(m)-1 through 17b-179(m)-13, inclusive; 52-362d-1 through 52-362d-5, inclusive; and 52-362e-1 through 52-362e-3, inclusive:

(1) "AGO" means the Connecticut Attorney General's office, or any assistant attorney general within such office who is responsible for performing any IV-D function in accordance with the cooperative agreement between the department and such office.

(2) "Assistance case" means one in which the recipient of IV-D services is receiving benefits under the TFA or foster care programs, or the federal waiver granted under section 1115 of the Social Security Act.

(3) "BCSE" means the Bureau of Child Support Enforcement established within the department by section 17b-179 of the Connecticut General Statutes as the IV-D agency for the State of Connecticut.

(4) "Case record" means the automated and paper files of BCSE and its cooperating agencies relating to a particular child support enforcement case, which shall include all information and documents pertaining to the case, as well as all relevant facts, dates, actions taken, contacts made, and results in the case.

(5) "CCSES" means the Connecticut Child Support Enforcement System, the automated system used by BCSE and its cooperating agencies to collect and distribute child support and maintain related records.

(6) "Commissioner" means the commissioner of the Department of Social Services, a designee, or authorized representative.

(7) "Cooperating agency" means any Connecticut state agency under cooperative or purchase of service agreement with BCSE to provide IV-D services or perform IV-D functions as specified in federal or state statutes or regulations.

(8) "Custodial party" means the individual who has physical custody of a child, or, in foster care cases, the Commissioner of the Department of Children and Families.

(9) "Department" means the Department of Social Services or any bureau, division, or agency of the Department of Social Services.

(10) "FPLS" means the Federal Parent Locator Service operated by OCSE.

(11) "IV-D" means the child support enforcement program mandated by Title IV-D of the federal Social Security Act and implementing OCSE regulations, as implemented in Connecticut under section 17b-179 of the Connecticut General Statutes and related statutes and regulations.

(12) "IV-D agency" means the single and separate organizational unit within state government that has the responsibility for administering or supervising the administration of the IV-D state plan.

(13) "Location" means information concerning the physical whereabouts of the noncustodial parent, the noncustodial parent's employer(s), and other sources of income or assets, as appropriate, which is sufficient and necessary to take the next appropriate action

in a case.

(14) "Non-assistance case" means one in which the recipient of IV-D services applied for such services, is a Medicaid recipient, or is receiving continuation of services following discontinuance of an assistance or Medicaid case.

(15) "Noncustodial parent" means the parent who does not have physical custody of the child receiving IV-D services.

(16) "OCSE" means the federal Office of Child Support Enforcement within the Department of Health and Human Services, Administration for Children and Families.

(17) "SED" means the Support Enforcement Division within the Connecticut Judicial Branch, an agency under cooperative agreement with BCSE to assist in administering the IV-D program for the State of Connecticut.

(18) "SPLS" means the State Parent Locator Service operated by BCSE.

(19) "Support order" means a judgment, decree, or order, whether temporary, final, or subject to modification, issued by a court or an administrative agency of competent jurisdiction, for the support and maintenance of a child, including a child who has attained the age of majority under the law of the issuing state, or of the parent with whom the child is living, which provides for monetary support, health care, arrearages, or reimbursement, and which may include related costs and fees, interest and penalties, income withholding, attorneys' fees, and other relief.

(20) "TFA" means the Temporary Family Assistance program established under section 17b-112 of the Connecticut General Statutes.

(21) "UIFSA" means the Uniform Interstate Family Support Act, model legislation approved and recommended for enactment in all the states by the National Conference of Commissioners on Uniform State Laws and adopted in Connecticut as sections 46b-212 to 46b-213v, inclusive, of the Connecticut General Statutes.

(Effective July 31, 1995; Amended June 8, 1998; Amended July 10, 2000)

Sec. 17b-179(a)-2. Publication of names of delinquent obligors

(a) **Definitions**

The definitions in sections 17b-179(a)-1 and 52-362d-1 of the Regulations of Connecticut State Agencies shall apply to this section.

(b) **Developing a pre-publication list**

The department may develop a pre-publication list consisting of randomly selected obligors whose cases meet the following criteria.

(1) IV-D case

The obligor's case is subject to the Title IV-D state plan.

(2) Court order

The obligor's overdue support accrued under a court order to pay current and/or past-due support

(3) CCSES obligation

The IV-D obligation has been monitored through CCSES for at least 180 days prior to

development of the pre-publication list.

(4) Duration of non-payment

The obligor made no payments on any CCSES obligations within 180 days immediately preceding the development of the pre-publication list. For the purpose of this subdivision, collections received as a result of any of the following actions shall not be considered as payments made by the obligor:

(A) release of a lien on the obligor's property in accordance with section 52-362d-2 of the Regulations of Connecticut State Agencies;

(B) withholding of an obligor's lottery winnings in accordance with section 52-362d-4 of the Regulations of Connecticut State Agencies;

(C) seizure of financial assets in accordance with section 52-362d-5 of the Regulations of Connecticut State Agencies;

(D) withholding of an obligor's federal income tax refund in accordance with section 52-362e-2 of the Regulations of Connecticut State Agencies; or

(E) withholding of an obligor's state income tax refund in accordance with section 52-362e-3 of the Regulations of Connecticut State Agencies.

(5) Overdue support amount

The obligor's total overdue support on all CCSES obligations for a single case is at least $5,000.

(6) Custodial party's address

The custodial party's address, according to CCSES records, is known and valid.

(c) **Obtaining the custodial party's consent**

The name of the delinquent obligor shall not be publicized without the signed written consent of the custodial party. BCSE shall use the following procedures to obtain the custodial party's consent.

(1) Identify custodial parties

BCSE shall identify the custodial parties associated with the obligors included on the pre-publication list developed in accordance with subsection (b) of this section.

(2) Mail consent request

BCSE shall prepare and mail to the custodial parties identified in subdivision (1) of this subsection a letter requesting such parties' consent to publication of the name of the delinquent obligor. The letter shall:

(A) cite the regulatory authority governing the proposed publicity;

(B) state the department's intent to publicize the obligor's name and other information, as provided in subdivision (g) (1) of this section, provided all requirements of this section are met, including the department's receipt within 30 days of a signed custodial party consent document;

(C) identify the delinquent obligor, the information the department intends to publicize, and the method or methods of publication that may be used;

(D) state the overdue support amount and the date of last payment;

(E) request the custodial party's consent to such publicity, and explain that the custodial

party is not required to provide such consent as a condition of receiving IV-D services, and that the granting of consent does not ensure publication;

(F) explain the conditions under which consent may be withdrawn; and

(G) request a recent photograph of the obligor, if available, and a physical description of the obligor, if the custodial party consents to the proposed publicity.

(3) Consent documentation

The request for consent letter shall be accompanied by a consent document and a self-addressed return envelope. If a signed consent document is not received within 30 days of the request, BCSE shall delete the obligor from the pre-publication list.

(4) Withdrawal of consent

The custodial party may withdraw consent in writing at any time. If consent is withdrawn within 60 days of the signing of the consent document, BCSE shall exclude the obligor's name from the publication list. If consent is withdrawn later than 60 days after the signing of the consent document, BCSE shall exclude or delete the obligor's name from the publication list, or cease publicizing the obligor's name, only if administratively feasible.

(d) **Notifying obligors**

The department shall notify the obligor of the proposed publication and provide an opportunity for the obligor to challenge such publication at a fair hearing held by the department. BCSE shall use the following procedures to notify the obligor.

(1) Compile notice list

BCSE shall compile a notice list of the delinquent obligors with respect to whom the department has received the consent of the custodial party pursuant to subsection (c) of this section.

(2) Mail notice

BCSE shall prepare and mail to the delinquent obligors identified in subdivision (1) of this subsection, at their last known address as reflected in the department's records, a notice of intent to publicize the obligor's name. The notice shall:

(A) state the regulatory authority governing the proposed publicity;

(B) state the department's intent to publicize the obligor's name and other information, as provided in subdivision (g) (1) of this section;

(C) state the overdue support amount and the date of last payment;

(D) list the defenses available to the obligor to challenge the proposed action, as specified in subsection (e) of this section; and

(E) inform the obligor of the method and timeframe for requesting a fair hearing.

(e) **Providing a fair hearing**

The department shall provide a fair hearing, in accordance with section 17b-60 of the Connecticut General Statutes, to any obligor who challenges the publication of his name under this section, provided the request is made within 60 days of the mailing date of the notice of intent in accordance with subsection (d) of this section. The obligor's available defenses shall include, but not be limited to, the following:

(1) Mistaken identity

The obligor is not the individual identified by the department as a non-payer of child support.

(2) No court order

There is no child support order against the alleged obligor.

(3) Overdue support less than $5,000

The obligor's total overdue support on the case is less than $5,000 on the date of the notice issued under subsection (d) of this section.

(4) Inability to pay

During the 180 days of non-payment monitored by CCSES and used as the basis for development of the pre-publication list, the obligor was unable to pay any amount on the court order(s) for any of the following reasons:

(A) The obligor was receiving a federal, state, or local public assistance grant.

(B) The obligor was disabled as defined in section 2530.05 of the department's Uniform Policy Manual, or incapacitated as defined in section 8530.10 of the department's Uniform Policy Manual.

(C) The obligor was incarcerated.

(D) The obligor was institutionalized.

(E) The income of the obligor was such that application of the child support guidelines, section 46b-215a-2 of the Regulations of Connecticut State Agencies, would have resulted in a recommended support amount of zero.

(f) **Compiling the publication list**

BCSE may compile a publication list which shall be based on the following criteria:

(1) Fair hearing opportunity

The list shall be limited to those obligors who fail to request a fair hearing within 60 days after the mailing date of the notice of intent or who receive an adverse fair hearing decision and fail to appeal such decision to the superior court in a timely manner.

(2) Obligor not receiving assistance

The list shall be limited to obligors who are not current recipients of public assistance from the State of Connecticut or public assistance from the town of the obligor's residence in this state, if known.

(3) Custodial party's request

The department may consider, in the compilation of any initial or amended publication list, the custodial party's request to publicize the name of an obligor who is the noncustodial parent in his or her IV-D case provided:

(A) the obligor's name was included on the pre-publication list developed in accordance with subsection (b) of this section or otherwise selected by the department on the basis of non-payment of child support, and

(B) all requirements other than those included in subsection (b) of this section are met.

(g) **Publicizing names**

Publicizing the names of the obligors included on the publication list compiled in accordance with subsection (f) of this section may proceed as follows:

(1) Data publicized

The data to be publicized shall include, but not be limited to, the following:

(A) the obligor's name and date of birth;

(B) the obligor's town of residence, and street address, if known;

(C) the total amount of overdue support as of a date certain; and

(D) the date of last payment.

The department may, in its discretion, also publicize the obligor's photograph and physical description.

(2) Publication methods

The department may use any publication methods, subject to available appropriations. The methods may include, but shall not be limited to, the following:

(A) news releases and advertisements;

(B) radio and television public service announcements;

(C) utility and cable television bill inserts;

(D) billboards;

(E) posters;

(F) transit advertising;

(G) radio and television public affairs shows; and

(H) other state IV-D agencies.

(Effective August 3, 1995; Amended June 8, 1998)

Sec. 17b-179(a)-3. Recovery of misapplied child support payments

(a) **Definitions**

(1) The definitions of "BCSE", "CCSES", "cooperating agency", "custodial party", "department", "IV-D", "non-assistance case", and "SED" in section 17b-179(a)-1 of the Regulations of Connecticut State Agencies and the definitions of "fair hearing", "obligor", and "past-due support" in section 52-362d-1 of the Regulations of Connecticut State Agencies shall apply to this section.

(2) As used in this section:

(A) "Child support collection" means child and spousal support received from an obligor by BCSE, SED, or the state disbursement unit, as defined in subdivision (a)(3) of section 17b-179(m)-6 of the Regulations of Connecticut State Agencies, pursuant to operation of the IV-D program or the state disbursement unit.

(B) "Misapplied payment" means a child support collection or refund posted to the account of the wrong obligor or obligee, or the amount of which exceeds that due the obligor or obligee.

(C) "Misapplied payment recipient" means the custodial party in a non-assistance IV-D case or a case in which payments are directed to the state disbursement unit pursuant to subsection (p) of section 52-362 of the Connecticut General Statutes, to whose account a misapplied payment has been posted or an obligor who has received a misapplied payment in the form of a refund.

(D) "Repayment agreement" means a document signed by the misapplied payment recipient which shall state the amount of the misapplied payment, the repayment schedule established in accordance with subdivision (d)(2) of this section, and a statement that failure to abide by such schedule shall result in the establishment of a wrong account posting.

(E) "Wrong account posting" means a CCSES entry that results in the automatic interception of all or a part of any future child support collections made in behalf of the misapplied payment recipient for the purpose of repayment of such misapplied payment.

(b) **Notice of misapplied payment**

BCSE shall provide written notice to the misapplied payment recipient which notice shall contain, at a minimum, the following information:

(1) the alleged amount of the misapplied payment;

(2) a demand for repayment;

(3) a description of the available methods for repayment;

(4) a statement of the department's intent to establish a wrong account posting or make a referral to the Department of Administrative Services if such recipient fails or refuses to cooperate in the voluntary repayment of the misapplied payment;

(5) a statement of such recipient's right to request a fair hearing, and the method and timeframe for doing so; and

(6) a list of possible reasons for requesting a fair hearing.

(c) **Right to a fair hearing**

An individual who receives notice of a misapplied payment shall have the right to a fair hearing. Reasons for requesting a hearing, and defenses which may be raised at a hearing, include, but are not limited to, the following:

(1) the individual who received the notice is not the person identified as having received the misapplied payment;

(2) the alleged amount of the misapplied payment is incorrect; and

(3) the misapplied payment was not received.

(d) **Recovery methods**

BCSE, a cooperating agency, or the State Disbursement Unit shall attempt to recover a misapplied payment from the misapplied payment recipient using the methods described in this subsection.

(1) Lump sum recovery

Recovery by lump sum repayment equal to the full amount of the misapplied payment shall be attempted first.

(2) Repayment agreement

(A) In general

If the misapplied payment recipient fails or refuses to repay the full amount of such payment in one lump sum, such recipient shall be given an opportunity to sign a repayment agreement. Such repayment agreement shall specify either the establishment of a wrong account posting or regular installment payments in the amount specified in subparagraph (B) in this subdivision.

(B) Amount

The amount of the installment payments shall be not less than three percent (3%) but not more than ten percent (10%) of the sum of the amounts described in subparagraphs (B) (i) and (B) (ii) of this subdivision. The following factors shall be considered in determining the appropriate percentage: the total liquid assets available to the misapplied payment recipient, shelter costs relative to such recipient's household income, unreimbursable medical expenses, and support or alimony payments regularly made by such recipient.

(i) The first amount is "net income" as defined in subdivision (15) of section 46b-215a-1 of the Regulations of Connecticut State Agencies.

(ii) The second amount is the average periodic payment, as determined over the preceding thirteen week or three month period, of any current or past-due child support received by the misapplied payment recipient.

(C) Exception

The installment payment may exceed the amounts specified in subparagraph (B) of this subdivision at the sole option of the misapplied payment recipient.

(3) Wrong account posting

BCSE shall establish a wrong account posting pursuant to the terms of a repayment agreement or in the case of any individual who fails to respond to the notice of misapplied payment, or fails or refuses to abide by the terms of a repayment agreement. The wrong account posting shall be established no earlier than 60 days after the mailing date of the notice of misapplied payment.

(4) Referral to the Department of Administrative Services

(A) Agreement and purpose

Referral under this subdivision shall be made to the Department of Administrative Services, Collection Services Business Center, for the purpose of debt collection or Governor's cancellation, as appropriate, provided an agreement is reached in accordance with subdivision (a) (4) of section 4a-12 of the Connecticut General Statutes.

(B) Referral criteria

Cases referred under this subdivision shall be limited to those in which the misapplied payment recipient has failed or refused to repay the misapplied payment and in whose case either (i) or (ii) applies:

(i) No payments have been applied to the wrong account posting for a period of at least six months.

(ii) The establishment of a wrong account posting is inappropriate.

(Effective November 27, 1996; Amended June 8, 1998; Amended May 24, 2004)

Sec. 17b-179(a)-4. Cooperation with the child support program

(a) **Definitions**

(1) The definitions of "BCSE", "cooperating agency", "department", and "IV-D agency" in section 17b-179(a)-1 of the Regulations of Connecticut State Agencies shall apply to this section.

(2) As used in this section:

(A) “Child” means one for whom TFA, Medicaid, SAGA or child care assistance has been applied or received;

(B) “Child care assistance” means a subsidy for child care expenses authorized under the child care assistance program in accordance with sections 17b-749-01 to 17b-749-23, inclusive, of the Regulations of Connecticut State Agencies;

(C) “Client” means an applicant or recipient of TFA, Medicaid, SAGA or child care assistance;

(D) “Medicaid” means the medical assistance program funded under Title XIX of the Social Security Act;

(E) “SAGA” means the State Administered General Assistance program established under section 17b-111 of the Connecticut General Statutes; and

(F) “TFA” means the Temporary Family Assistance program for cash assistance to families funded under the Temporary Assistance to Needy Families block grant.

(b) **Cooperation requirements**

(1) In general

Except as provided in subsection (c) of this section, each client shall be required to cooperate in good faith with the department in the following efforts on behalf of each child for whom assistance is applied or received:

(A) locating the child’s noncustodial parent;

(B) establishing the child’s legal paternity;

(C) establishing, modifying, or enforcing a monetary support order; and

(D) establishing, modifying, or enforcing a medical support order.

Cooperation for the purposes of this section shall include the activities described in subdivisions (2) through (5) of this subsection.

(2) Providing information

The activity required under this subdivision is providing the department with information with respect to the noncustodial parent of each child. The purpose of gathering this information is to enable the department to confirm the identity of the noncustodial parent and to locate such parent for service of process. The minimum information required is described in the following subparagraphs.

(A) Name

The first or given name and the last or surname of the noncustodial parent shall be required.

(B) Social security number

The information required under this subparagraph is the social security number of the noncustodial parent, if available. If unavailable, the client shall provide either the information required under subparagraph (C) or the information required under two of the subparagraphs (D) to (I), inclusive of this subdivision.

(C) Current or former employer

The information required under this subparagraph is the name and location of a current

or former employer of the noncustodial parent. Such information shall be provided with sufficient specificity to enable the department to contact the employer by mail or telephone.

(D) Date and place of birth

The information required under this subparagraph is the exact date and the town and state or foreign country of the birth of the noncustodial parent. If such information is not provided, an approximate age and all of the information listed in one of the following items (i)-(iii) may be substituted.

(i) mother's and father's full names and, if still living, their address(es),

(ii) make, model, and approximate year of any motor vehicle owned, or

(iii) license plate number of any motor vehicle owned.

(E) Schools attended

The information required under this subparagraph is the name, the town, and the state of any secondary or postsecondary educational institution attended by the noncustodial parent and the year or years of attendance.

(F) Trade or profession

The information required under this subparagraph is all of the information specified in at least one of the following items (i)-(ii):

(i) the name and location or telephone number of any union or trade association of which the noncustodial parent is currently or was within the last five years a member, or

(ii) the name of any licensed profession or occupation in which the noncustodial parent is currently or was within the last five years engaged, and the jurisdiction in which the noncustodial parent is currently or was within the last five years licensed.

(G) Arrest or incarceration

The information required under this subparagraph is all of the information specified in at least one of the following items (i)-(ii):

(i) the approximate date and the town and state of any arrest of the noncustodial parent within the last five years, or

(ii) the approximate dates and the name and state of the correctional institution in which the noncustodial parent was incarcerated within the last five years.

(H) Military service

The information required under this subparagraph is the branch and the approximate dates of any military service of the noncustodial parent.

(I) Other information

The information required under this subparagraph is any other information which can be verified by the department and could reasonably be expected to lead to the determination of the parent's social security number.

(3) Assisting in court actions and other proceedings

The client shall assist in court actions and other proceedings as necessary to establish the paternity of, or to establish, modify, or enforce a medical or monetary support order for, any child receiving assistance by participating in the following activities:

(A) appearing as a witness in court, before a family support magistrate, or at a fair

hearing;

(B) assisting an attorney representing the interests of the IV-D agency in the preparation or conduct of a court action;

(C) appearing at interviews as requested by a representative of the department or a cooperating agency; and

(D) providing the department or a cooperating agency with information or documentation in addition to that specifically identified in subdivision (2) of this subsection to the extent it is known to, possessed by, or reasonably obtainable by such client.

(4) Submitting to genetic tests

The client shall submit to genetic tests and shall submit the child to genetic tests pursuant to an order of a court or family support magistrate or as required by the IV-D agency pursuant to subsection (a) of section 46b-168a of the Connecticut General Statutes and section 46b-168a-1 of the regulations of Connecticut State Agencies.

(5) Turning over support payments

A recipient of TFA only, not medicaid, SAGA, or child care assistance, shall turn over to the department any support payments received directly from the noncustodial parent for a child receiving such assistance. Any such payment that is not turned over shall result in an overpayment.

(c) **Exemptions from cooperation requirements**

(1) Domestic violence

A client who is a past or present victim of domestic violence, as defined in section 17b-112a of the Connecticut General Statutes, or who is at risk of further domestic violence shall be exempt from all cooperation requirements of subsection (b) of this section provided the department determines that fulfilling such requirements would result in the inability or increased difficulty of such client to escape or prevent such domestic violence.

(2) Deceitful noncustodial parent

A client shall be exempt from providing information under subdivision (2) of subsection (b) of this section to the extent such client provides evidence and the department determines that the noncustodial parent was deceitful concerning such information and the required information is unavailable to the client.

(3) Mental impairment

A client shall be exempt from providing information under subdivision (2) of subsection (b) of this section if the department determines that such client suffers from a permanent or temporary mental illness or disability which impairs memory or otherwise impedes the client's ability to obtain such information.

(4) Other good faith reason

A client shall be exempt from providing information under subdivision (2) of subsection (b) of this section if the department determines that such client has any other good faith reason for not being able to provide such information.

(5) Exceptional circumstances

A client shall be excused from discrete acts such as but not limited to the keeping of

scheduled appointments as required under subdivisions (3) and (4) of subsection (b) of this section, but shall not be exempt from otherwise cooperating under such subdivisions, if such client demonstrates and the department determines that a good faith effort was made to cooperate and that circumstances beyond the client's control prevented cooperation.

(6) Documentation

A client who is claiming an exemption under subdivisions (1) through (4), inclusive of this subsection shall be required to submit a sworn statement describing the circumstances justifying the claimed exemption. The department shall inform such client of the following potential penalties prior to requesting such statement:

(A) penalties for false statement under sections 53a-157b and 17b-97 of the Connecticut General Statutes,

(B) penalties for larceny under sections 53a-122 and 53a-123 of the Connecticut General Statutes, and

(C) penalties for perjury under federal law.

(d) **Cooperation determination by the department**

(1) General rule

BCSE shall make all cooperation determinations pursuant to this section, except as provided in subdivision (2) of this subsection.

(2) Exceptions

(A) Minimum information obtained

BCSE shall not be required to make a determination of cooperation where the minimum information required under subdivision (2) of subsection (b) of this section is provided by the client at application or redetermination.

(B) Domestic violence claimed

Exemption determinations on the basis of a claim of domestic violence pursuant to subdivision (1) of subsection (c) of this section shall be made by departmental staff who are not assigned to BCSE.

(Adopted effective December 24, 1997; Amended June 8, 1998; Amended July 10, 2000; Amended May 24, 2004)

Agency
Department of Social Services

Subject
Child Support and Arrearage Guidelines

Inclusive Sections
§§ 17b-179(b)-1—17b-179(b)-2

CONTENTS

Sec. 17b-179(b)-1. Use of child support and arrearage guidelines
Sec. 17b-179(b)-2. Redirection of support payments

Child Support and Arrearage Guidelines

Sec. 17b-179(b)-1. Use of child support and arrearage guidelines

In all IV-D cases, current child support and arrearage obligations shall be computed in accordance with the child support and arrearage guidelines promulgated by Connecticut's Commission for Child Support Guidelines, as required by Section 46b-215b of the Connecticut General Statutes. Such guidelines, and any updates, are incorporated herein by reference as though fully set forth herein.

(Effective July 31, 1995; Amended June 8, 1998)

Sec. 17b-179(b)-2. Redirection of support payments

(a) **Payment to the state**

Upon the establishment of a IV-D case, BCSE shall take appropriate CCSES and other actions to redirect all payments under pre-existing support orders to the State of Connecticut acting by and through the IV-D agency. When an order is redirected, BCSE shall notify the obligee and shall mail promptly to the obligor a notice informing him or her of such actions, which notice shall provide

(1) an explanation of the basis for such actions;

(2) information on the terms of the support order;

(3) instructions for making payments to the state disbursement unit, as defined in subdivision (a) (3) of Section 17b-179(m)-6 of the Regulations of Connecticut State Agencies;

(4) a summary of the remedies for noncompliance with the support order;

(5) notice of the obligor's right to a hearing prior to imposition of any sanction, the right to appointment of an attorney to represent him or her prior to incarceration for contempt in the case of indigency, the right to request a review of the support order, and the right to petition the court for a modification of such order; and

(6) the address and telephone number of the individual or agency to contact if the obligor has any questions about the notice or disputes any information about the support order.

(b) **Distribution to the custodial relative**

Payments redirected to the state acting by and through the IV-D agency under subsection (a) of this section shall continue to be made to the state disbursement unit for as long as IV-D services are being provided. Upon the discontinuance of cases in which support rights have been assigned to the state in accordance with section 17b-77 of the Connecticut General Statutes, current child support payments shall be distributed to the custodial party of record on the date of discontinuance, for the benefit of the children named in the support order.

(Effective July 31, 1995; Amended June 8, 1998)

Agency
Department of Social Services

Subject
Title IV-D Child Support Enforcement Program

Section
§ 17b-179(f)-1

CONTENTS

Sec. 17b-179(f)-1. Referrals to the federal parent locator service

Title IV-D Child Support Enforcement Program

Sec. 17b-179(f)-1. Referrals to the federal parent locator service

(a) **Definitions**

As used in this section:

(1) "Authorized person" means the Office of the State's Attorney; the Office of the U.S. Attorney; a family relations counselor of the Family Division of the Superior Court; or the Department of Public Safety, Division of State Police, Missing Persons Unit.

(2) "Custody or visitation determination" means a judgment, decree, or other order of a court of competent jurisdiction providing for custody or visitation of a child, and includes permanent and temporary orders, and initial orders and modifications.

(3) "Parental kidnapping" means the unlawful taking or restraint of a child by a parent.

(b) **SPLS established**

There is established within BCSE a central SPLS with sole responsibility, under subsection (f) of section 17b-179 of the Connecticut General Statutes, to make referrals to the FPLS in accordance with this section and in compliance with applicable federal regulations.

(c) **SPLS functions**

(1) Accept requests to use the FPLS

The SPLS shall only accept requests to use the FPLS from:

(A) BCSE or an agency under cooperative agreement with BCSE or the department which has the duty under such agreement to seek to recover any amounts owed as child and spousal support;

(B) a court or agency thereof that has authority to issue a support order or to serve as the initiating court in an action to seek an order against a noncustodial parent for the support and maintenance of a child;

(C) the resident parent, legal guardian, attorney, or agent of a child who is not receiving TFA, without regard to the existence of a court order against a noncustodial parent who has a duty to support and maintain any such child; or

(D) an authorized person, for the sole purpose of making or enforcing a child custody or visitation determination, or investigating or prosecuting a parental kidnapping case.

(2) Access FPLS

The SPLS shall:

(A) enter the required data into the FPLS automated system within five working days of receipt of a proper referral and

(B) forward information received from the FPLS to the requesting agency or individual within five working days from the date the information is received.

(3) Access other states' SPLS

When a request is made to access another state's SPLS, the SPLS shall, in addition to the efforts of subdivision (2) of this subsection:

(A) send a referral to such other state within five working days of receipt of a proper referral and

(B) forward information received from the other state within five working days of receipt of any information received.

(4) Protect information

(A) In general

Except as provided in subparagraph (B) in this subdivision, any information obtained by the SPLS shall be used and disclosed only in connection with the administration of the IV-D program.

(B) Parental kidnapping and child custody cases

BCSE and the SPLS shall:

(i) restrict access to any information obtained in a parental kidnapping or child custody case to such persons whose duties or responsibilities require access;

(ii) send information obtained from the FPLS only to the requester of such information, and make no other use of the information; and

(iii) destroy any confidential records or information related to the request after the information is sent to the requester.

(d) **Processing fees**

A processing fee shall be charged by BCSE in accordance with this subsection to all applicants for location services who are not receiving any other IV-D services. All such fees shall be paid in advance to the commissioner, and shall be nonrefundable even if no information is found.

(1) Location-only cases

The fee for the location of a noncustodial parent when location is the only service requested shall be $10.00 for the basic service, plus $4.00 additional if the noncustodial parent's social security number is not provided by the applicant.

(2) Parental kidnapping and child custody cases

The fee for the location of a noncustodial parent or child in a parental kidnapping or child custody case shall be $20.00 for the basic service, plus $4.00 additional if the noncustodial parent's social security number is not provided by the applicant.

(Effective July 31, 1995; Amended June 8, 1998)

Agency
Department of Social Services

Subject
Title IV-D Child Support Enforcement Program

Section
§ 17b-179(i)-1

CONTENTS

Sec. 17b-179(i)-1. Application fee for non-assistance cases

Title IV-D Child Support Enforcement Program

Sec. 17b-179(i)-1. Application fee for non-assistance cases

Individuals who request IV-D services and are not at the time of the request receiving TFA, foster care, or medicaid assistance from the state, or continuing IV-D services pursuant to such programs, shall be charged an application fee in the amount of $1.00, which shall be paid by the state.

(Effective July 31, 1995; Amended June 8, 1998; Amended May 24, 2004)

Agency
Department of Social Services

Subject
Title IV-D Child Support Enforcement Program

Inclusive Sections
§§ 17b-179(m)-1—17b-179(m)-13

CONTENTS

Sec. 17b-179(m)-1. Intake and establishment of cases
Sec. 17b-179(m)-2. Location of noncustodial parents
Sec. 17b-179(m)-3. Service of process
Sec. 17b-179(m)-4. Establishment of paternity
Sec. 17b-179(m)-5. Establishment of support orders
Sec. 17b-179(m)-6. Collection of support payments
Sec. 17b-179(m)-7. Medical support
Sec. 17b-179(m)-8. Review and modification
Sec. 17b-179(m)-9. Enforcement of support orders
Sec. 17b-179(m)-10. Provision of services in interstate IV-D cases
Sec. 17b-179(m)-11. Administration
Sec. 17b-179(m)-12. Case closure
Sec. 17b-179(m)-13. Substantial compliance

Title IV-D Child Support Enforcement Program

Sec. 17b-179(m)-1. Intake and establishment of cases

(a) **Assistance and Medicaid cases**

(1) Required activities

In assistance and Medicaid cases, BCSE shall, except as provided in subdivision (2) in this subsection:

(A) ensure the availability of at intake or provide to the recipient within 5 working days of referral from the appropriate referral source, information describing available services, the individual's rights and responsibilities, and the state's fees, cost recovery, and distribution policies;

(B) within 5 working days of receipt of referral from the appropriate referral source, open a IV-D case by establishing a case record; and

(C) within 20 calendar days of receipt of referral from the appropriate referral source, based on an assessment of the case to determine necessary action,

(i) solicit necessary and relevant information from the custodial party and other relevant sources and initiate verification of information, if appropriate; and

(ii) if there is inadequate location information to proceed with the case, request additional information from the custodial party or refer the case to the SPLS for further location attempts.

(2) Domestic violence exemption

(A) Request

Upon receiving notice that a client, as defined in subparagraph (a)(2)(B) of section 17b-179(a)-4 of the Regulations of Connecticut State Agencies, has requested an exemption from cooperation requirements on the basis of a claim of domestic violence pursuant to section 17b-112a of the Connecticut General Statutes, BCSE shall suspend all activities to establish paternity or establish, modify, or enforce a child or medical support order until notified of a final determination pursuant to subparagraph (d)(2)(B) of section 17b-179(a)-4 of the Regulations of Connecticut State Agencies.

(B) Determination

BCSE shall not undertake to establish paternity or establish, modify, or enforce a child or medical support order for any client who is determined exempt from cooperation requirements pursuant to subdivision (c)(1) of section 17b-179(a)-4 of the Regulations of Connecticut State Agencies.

(b) **Non-assistance cases**

In non-assistance cases, BCSE shall:

(1) provide an application for IV-D services to any individual who requests the application or any IV-D service

(A) on the day of the request if the request is made in person or

(B) within 5 working days if the request is in writing or by telephone;

(2) provide with each application information describing available services, the individual's rights and responsibilities, and the state's fees, cost recovery, and distribution

policies;
(3) accept a completed application as filed on the day it and the application fee are received; and
(4) within 20 calendar days of the filing of an application, based on an assessment of the case to determine necessary action:
(A) open a IV-D case by establishing a case record;
(B) solicit necessary and relevant information from the applicant and other relevant sources and initiate verification of information, if appropriate; and
(C) if there is inadequate location information to proceed with the case, request additional information from the applicant or refer the case to the SPLS for further location attempts.
(c) **Continuation of services**
Upon receiving notice from the department that a final determination to discontinue an assistance or Medicaid case has been made, BCSE shall:
(1) continue to provide all appropriate IV-D services without an application or application fee, provided the IV-D case has not been closed;
(2) redirect all future current support collections to the family;
(3) determine the amount of any IV-D collections which must be refunded to the custodial party;
(4) transfer to the custodial party's non-assistance accounts any assigned support amounts which exceed the amount of unreimbursed assistance paid to the family; and
(5) mail a notice to the custodial party informing him or her of the available child support services and his or her rights with respect thereto, any applicable fees, how any support collections will be distributed, and that all appropriate IV-D services will continue to be provided unless the custodial party requests case closure in accordance with section 17b-179(m)-12 of the Regulations of Connecticut State Agencies.

(Effective July 31, 1995; Amended June 8, 1998; Amended July 10, 2000)

Sec. 17b-179(m)-2. Location of noncustodial parents
(a) **Responsible agencies**
(1) BCSE
BCSE shall be responsible for location pursuant to the intake process in all IV-D cases, including those in which there is a pre-existing support order which has not already been established on CCSES. Such responsibility shall remain with BCSE until the noncustodial parent is located and an enforceable order is established.
(2) SED
SED shall be responsible for location in all IV-D cases after the establishment of an enforceable order even if such order should subsequently become unenforceable or the noncustodial parent's whereabouts become unknown.
(b) **General requirement**
The responsible agency as specified in subsection (a) shall attempt to locate all noncustodial parents or sources of income and/or assets when location is necessary to take

other necessary action in a case.

(c) **Sources to be accessed**

When location is necessary, the responsible agency shall use the following location sources, as appropriate:

(1) the FPLS and interstate location networks;

(2) state and local officials and employees administering public assistance, general assistance, medical assistance, food stamps, and social services;

(3) relatives and friends of the noncustodial parent;

(4) current or past employers;

(5) the local telephone company;

(6) the U.S. Postal Service;

(7) financial references;

(8) unions;

(9) fraternal organizations;

(10) police, parole, probation, and criminal records;

(11) state labor department;

(12) motor vehicle department; and

(13) any other sources described in Section 17b-137 of the Connecticut General Statutes.

(d) **Processing times**

(1) Local sources

Within 30 calendar days of determining that location is necessary, the responsible agency shall access all appropriate location sources other than the SPLS, the FPLS, and interstate location networks; and either locate the noncustodial parent or a source of income or assets, or refer the case to the SPLS for further location attempts.

(2) All sources

Within 75 calendar days of determining that location is necessary, the responsible agency shall access all appropriate location sources including the SPLS, the FPLS, and interstate location networks; and ensure that location information is sufficient to take the next appropriate action in a case.

(e) **Repeated location attempts**

(1) When required

The responsible agency shall repeat location attempts in cases in which previous attempts have failed, but adequate identifying and other information exists to meet requirements for submittal for location, on the earlier of

(A) quarterly or

(B) immediately upon receipt of new information which may aid in location.

(2) Required sources

Quarterly attempts shall be limited to currently available automated sources and shall include accessing state labor department files.

(3) Time standards

Repeated attempts because of new information which may aid in location shall meet the

time standards in subsection (d).

(Effective July 31, 1995; Amended June 8, 1998)

Sec. 17b-179(m)-3. Service of process

(a) **Responsible agencies**

(1) AGO

The AGO shall be responsible for meeting the requirements of this section in actions for the legal determination of paternity in all IV-D cases, provided that the AGO shall refer cases in which repeated attempts to serve process are required under subdivision (b) (2) of this section to BCSE for location efforts, and shall repeat such attempts when the alleged father is located and the case is returned to the AGO by BCSE.

(2) BCSE

BCSE shall be responsible for meeting the requirements of this section in actions for the establishment of court-ordered support (exclusive of paternity actions) in all IV-D cases.

(3) SED

SED shall be responsible for meeting the requirements of this section in actions for the enforcement and modification of court-ordered support in all IV-D cases.

(b) **General requirement**

When service of process is necessary for the establishment, modification, or enforcement of court-ordered support, the responsible agency, as specified in subsection (a), shall ensure that diligent efforts to serve process are

(1) undertaken initially, and

(2) repeated at least quarterly in cases in which previous efforts have failed, but adequate identifying and other information exists to attempt service of process.

(c) **Diligent efforts**

Diligent efforts to serve process upon a noncustodial parent shall include the following:

(1) at least one attempt to serve process in hand, and

(2) if that fails, service at the verified abode of the noncustodial parent, and

(3) if that fails, by service on the employer of the noncustodial parent, if known, in accordance with subsection (f) of section 52-57 of the Connecticut General Statutes.

(d) **Documentation**

Diligent efforts, as required by this section, shall be documented in the case record, and the responsible agency, as specified in subsection (a), shall obtain such documentation from a sheriff or other party authorized to make the service whenever the agency arranges for such other party to make service.

(Effective July 31, 1995; Amended June 8, 1998)

Sec. 17b-179(m)-4. Establishment of paternity

(a) **BCSE functions**

BCSE shall:

(1) identify and use laboratories which perform, at reasonable cost, legally and medically

acceptable genetic tests which tend to identify the father or exclude the alleged father. BCSE shall make available a list of such laboratories to SED, the Attorney General's Office (AGO), family support magistrates, and the public upon request.

(2) in all IV-D cases in which paternity of a child has not been established, within 30 calendar days of locating the alleged father:

(A) establish legal paternity by obtaining an acknowledgment of paternity, or, if that fails,

(B) refer the case to the AGO for establishment of paternity and a support order by court action.

(b) **AGO functions**

The AGO shall, within 60 calendar days of receipt of a referral for paternity and support action from BCSE,

(1) file a verified paternity petition, refer the case to an authorized party for service of process, and complete service of process to establish paternity and support, or

(2) document unsuccessful attempts to serve process, despite diligent efforts to do so, in accordance with section 17b-179(m)-3.

(c) **Expedited process**

Cases requiring service under this section shall be completed, from the date of service of process to the date on which paternity and a support order are established or the court action is dismissed, within the following timeframes:

(1) 75% within 6 months and

(2) 90% within 12 months.

(Effective September 26, 1996; Amended June 8, 1998)

Sec. 17b-179(m)-5. Establishment of support orders

(a) **Initial activity**

In all intrastate IV-D cases in which a support order does not already exist, BCSE shall, within 90 calendar days of locating the alleged father or noncustodial parent, either:

(1) establish a support order by obtaining a child support agreement and, if necessary, an acknowledgment of paternity, or

(2) obtain the AGO's approval of the documents necessary to commence proceedings to establish a support order, and either:

(A) complete service of process of such documents, or

(B) document unsuccessful attempts to serve process, despite diligent efforts to do so.

(b) **Initiating income withholding**

(1) AGO functions

The AGO shall, when an immediate order for withholding is issued by a court or family support magistrate against a nonappearing obligor, attempt service by certified mail of the notice required by subsection (b) of section 52-362 of the Connecticut General Statutes.

(2) BCSE functions

Except as provided in subdivision (1) of this subsection, BCSE shall take the actions

required in subsection (b) of section 17b-179(m)-9 to initiate an income withholding order upon the establishment of an initial support order or the redirection of a pre-existing order to the State of Connecticut.

(c) **Review in the case of dismissal**

If the court or family support magistrate dismisses a petition for a support order without prejudice, BCSE shall, in consultation with the AGO, examine the reasons for dismissal at the time of dismissal and determine when it would be appropriate to seek an order in the future, and schedule a review for that time.

(d) **Expedited process**

Cases requiring service under this section shall be completed, from the date of service of process to the date on which a support order is established or the court action is dismissed, within the following timeframes:

(1) 75% within 6 months and

(2) 90% within 12 months.

(Effective September 26, 1996; Amended June 8, 1998)

Sec. 17b-179(m)-6. Collection of support payments

(a) **Definitions**

As used in this section:

(1) "Deposit" means credit to an account owned by the State of Connecticut.

(2) "Post" means credit to the correct obligor's account in CCSES.

(3) "State Disbursement Unit" means the entity under contract with the department to provide comprehensive collection and disbursement services for the Connecticut IV-D program.

(b) **Time standards**

The department shall take steps to ensure that the State Disbursement Unit:

(1) deposits all IV-D support collections within 24 hours of receipt and

(2) transmits to the department the necessary posting data for at least 95% of such collections within 24 hours of receipt.

(Effective July 31, 1995; Amended June 8, 1998)

Sec. 17b-179(m)-7. Medical support

(a) **BCSE functions**

BCSE shall:

(1) attempt to establish a medical support order, either solely in appropriate Medicaid-only cases, or in conjunction with efforts to establish a monetary order in any IV-D case, if there is no existing monetary support order;

(2) coordinate the collection of information concerning the noncustodial parent's health insurance policy or plan and transmit the necessary information to the appropriate unit within the department for cases receiving medical assistance;

(3) recommend to the court to include employment related or other group health

insurance in support orders;
(4) inform individuals who are not receiving financial or medical assistance that medical support enforcement services are available to them; and
(5) enter medical insurance information on CCSES within 10 calendar days from the date that an order is entered, or from the date when the obligor secures health insurance under the order.
(b) **SED functions**
SED shall:
(1) attempt to establish medical support through the modification process if a monetary support order already exists;
(2) assist BCSE in obtaining and maintaining basic medical support information on child support obligors;
(3) recommend to the court to include employment related or other group health insurance in support orders;
(4) take the steps necessary to enforce the health coverage required by a court or administrative order by ensuring that the obligor secure and maintain the health coverage as ordered;
(5) transfer notice of a health insurance coverage requirement, in accordance with subsection (e) of section 38a-497a of the Connecticut General Statutes, to the obligor's new employer when an obligor changes employment; and
(6) enter medical insurance information on CCSES within 10 calendar days from the date that an order is modified, or from the date when the obligor secures health insurance under the order.

(Effective July 31, 1995; Amended June 8, 1998; Amended July 10, 2000)

Sec. 17b-179(m)-8. Review and modification
SED shall perform the following functions with respect to the review and modification of support orders in IV-D cases.
(a) **Review**
Review the orders in all IV-D cases in accordance with subdivision (s) (4) of Section 46b-231 of the Connecticut General Statutes and in compliance with applicable federal regulations. The review shall include a determination of the appropriateness of a motion for modification as well as the application of appropriate enforcement remedies.
(b) **Modification**
SED shall prepare, serve, and be available for testifying at court on motions for modification for all orders identified pursuant to subsection (a), herein, as appropriate for modification. All types of modifications, including, but not limited to, the following shall be the responsibility of SED:
(1) upward and downward modifications due to increased or decreased income of either party or other change in financial circumstances causing a 15% or more deviation from the child support guidelines;

(2) addition or removal of a child resulting from emancipation, changed household residence, consolidation or modification of orders after a paternity acknowledgment or adjudication, or a child born after divorce;

(3) establishment of a current support order if only an arrearage order or a medical support order exists;

(4) addition of a health insurance coverage requirement to an existing financial support order;

(5) change of unallocated order when the children now reside with different custodial parties; and

(6) custody modifications, payee changes, and motions to add party plaintiff when ordered by the court during enforcement or modification proceedings.

(Effective July 31, 1995; Amended June 8, 1998; Amended July 10, 2000)

Sec. 17b-179(m)-9. Enforcement of support orders

(a) **In general**

(1) Use of CCSES

The CCSES automated enforcement module shall be maintained by SED and shall be used in all IV-D cases to monitor compliance with support orders. Cases of noncompliance shall be identified by CCSES on the date the obligor fails to make payments in an amount equal to the support payable for one month.

(2) Required actions

Support orders in IV-D cases shall be enforced as follows:

(A) Income withholding

Income withholding shall be initiated in accordance with subsection (b) of this section.

(B) Income tax refund withholding

(i) Federal

All IV-D cases which satisfy the criteria set forth in section 52-362e-2 of the Regulations of Connecticut State Agencies shall be submitted in accordance with such section once a year for federal income tax refund withholding.

(ii) State

All IV-D cases which satisfy the criteria set forth in section 52-362e-3 of the Regulations of Connecticut State Agencies shall be submitted in accordance with such section once a year for state income tax refund withholding.

(C) Other enforcement actions

Except as otherwise provided in this section, SED shall be responsible for taking the actions required by this subparagraph. Enforcement actions other than income withholding and income tax refund withholding shall be taken as follows:

(i) Service of process not required

If service of process is not required, the action shall be taken within 30 calendar days of the later of the date the delinquency or other support-related noncompliance is identified, or the noncustodial parent is located.

(ii) Service of process required

If service of process is required, the action shall be taken within 60 calendar days of the date the delinquency or other support-related noncompliance is identified, or the noncustodial parent is located. If service of process cannot be made, diligent efforts to serve process, as described in section 17b-179(m)-3 of the Regulations of Connecticut State Agencies, shall be made and documented within the specified time period.

(D) Review when attempts fail

In cases in which enforcement attempts have been unsuccessful, the agency responsible for taking the particular enforcement action shall examine, at the time an attempt to enforce fails, the reason the attempt failed and determine when it would be appropriate to take an enforcement action in the future, and review the case at that time.

(3) Communication and referral

BCSE shall assist SED in the enforcement of IV-D support orders by:

(A) referring to SED all persons requesting the enforcement of support orders which have already been established on CCSES;

(B) assisting SED in communicating with IV-D agencies in other jurisdictions regarding the collection and enforcement of support orders;

(C) notifying SED within five working days of any changes in the status of an assistance or Medicaid case affecting the child support obligation; and

(D) providing SED with any new information on the obligor that becomes available to BCSE, including but not limited to address, employer, unemployment compensation intercept data, and increased wages.

(4) Motions to add party plaintiff

BCSE shall take the necessary steps to prepare a motion to add party plaintiff in situations where the state and the custodial party applying for IV-D services for the child were not parties to the original court action.

(5) Fatherhood initiative

SED shall, within existing resources, provide information regarding work activity and education programs to noncustodial parents when appropriate. SED shall also make recommendations to the family support magistrate that certain noncustodial parents participate in work activities and education programs when brought before the court. SED shall monitor cases for compliance when the family support magistrate issues an order to participate in work activities and education programs.

(b) **Income withholding**

(1) General provisions

(A) Responsible agency

Except as otherwise provided, BCSE shall be responsible for the procedures in this subsection pursuant to the establishment of an initial support order or the initiation of withholding on the basis of a pre-existing support order not already on CCSES, provided the obligor's income source is known at the time the order is established or the withholding is initiated. SED shall be responsible for such procedures in all other IV-D cases.

(B) Termination of withholding

BCSE shall examine CCSES reports to identify all cases in which

(i) a payment is received,

(ii) there is no longer a current support order,

(iii) all arrearages have been satisfied, and

(iv) income withholding is still in effect.

BCSE shall notify SED of all cases so identified, and SED shall promptly notify the obligor's employer or other payer of income to terminate withholding.

(C) Refunds

SED shall identify all IV-D cases in which amounts have been improperly withheld, and promptly prepare and refer to BCSE a request for refund of such amounts. BCSE shall promptly process such requests.

(D) Reporting requirements

All support orders issued or modified in IV-D cases shall include a provision requiring the obligor to keep the IV-D agency informed of:

(i) the name and address of his or her current employer,

(ii) whether the obligor has access to health insurance coverage at reasonable cost and, if so,

(iii) the health insurance policy information.

(E) Unemployment compensation

SED shall review on a monthly basis computer printouts of unemployment compensation recipients to determine if an income withholding order should be served on the labor department commissioner.

(F) Action on new hire reporting information

SED shall review information received through the new hire reporting process pursuant to section 31-254 of the Connecticut General Statutes and take the necessary action to establish, transfer or enforce an income withholding order pursuant to section 52-362 of the Connecticut General Statutes.

(2) Immediate withholding

All support orders issued or modified in IV-D cases shall include an order for immediate income withholding, regardless of any arrearage, except where:

(A) a party demonstrates, and the court or family support magistrate finds, that there is good cause not to require immediate withholding, or

(B) the parties reach a written agreement which provides for an alternative arrangement.

For the purposes of this subparagraph, "written agreement" means a written alternative arrangement signed by all parties, approved by the IV-D agency, and reviewed and entered in the record by the court or family support magistrate.

(3) Initiated withholding

This subdivision applies in all IV-D cases not subject to an order for immediate income withholding, including cases subject to a finding of good cause or to a written agreement, as provided in subdivision (2) of this subsection.

(A) When obligor subject to withholding

The income, as defined in subdivision (a)(5) of section 52-362 of the Connecticut General Statutes, of the obligor shall become subject to withholding on the date on which the payments the obligor has failed to make under a support order are at least equal to the support payable for one month or, if earlier, and without regard to any arrearage, on the earlier of:

(i) the date on which the obligor requests that withholding begin, provided a voluntary wage deduction is executed and approved in accordance with section 52-362c of the Connecticut General Statutes, or

(ii) the date on which the custodial party requests that withholding begin, provided such request is in writing and the procedures in subparagraph (B) of this subdivision are followed.

(B) Issuance of withholding order

The responsible agency shall issue an income withholding order as provided in subsection (e) of section 52-362 of the Connecticut General Statutes when the obligor becomes subject to withholding in accordance with subparagraph (a) of this subdivision. The order for withholding shall include all provisions required by section 52-362 of the Connecticut General Statutes and applicable federal law and regulations.

(C) Notice to obligor

The responsible agency shall serve notice of the withholding issued under subparagraph (B) of this subdivision promptly in accordance with subsection (h) of section 52-362 of the Connecticut General Statutes. Such notice shall comply in all respects with the provisions of subsection (c) of section 52-362 of the Connecticut General Statutes, and shall be accompanied by a copy of the withholding order.

(D) Hearing

A hearing shall be held in accordance with subsection (d) of section 52-362 of the Connecticut General Statutes if the obligor contests the withholding in response to the notice served in accordance with subparagraph (C) of this subdivision. When a hearing is requested, the responsible agency shall notify the employer or other payer of income that the withholding order is stayed under said subsection until the claim or motion is decided by the court or a family support magistrate.

(4) Processing times

(A) Immediate withholding

In the case of an immediate withholding order under subdivision (2) of this subsection, the responsible agency shall use CCSES to send the withholding order to the employer within two business days of the date the support order is entered if the employer is known on that date or, if the employer is unknown on that date, within two business days of locating the employer.

(B) Initiated withholding

In the case of initiated withholding pursuant to subdivision (3) of this subsection, the responsible agency shall use CCSES to send the withholding order to the employer within two business days of the date the obligor becomes subject to withholding if the employer

is known on that date or, if the employer is unknown on that date, within two business days of locating the employer.

(5) Interstate withholding

(A) Initiating cases

Within 20 calendar days of a determination that an obligor has earnings subject to income withholding in another jurisdiction and, if appropriate, receipt of any information necessary to carry out the withholding, SED shall follow the procedure set forth in section 52-362f of the Connecticut General Statutes to request interstate withholding.

(B) Responding cases

SED shall, in addition to any other requirements set forth in section 52-362f of the Connecticut General Statutes, upon filing a foreign support order as provided in subsection (d) of section 52-362f of the Connecticut General Statutes, proceed as provided in section 46b-213k of the Connecticut General Statutes.

(c) **Administrative enforcement functions**

(1) BCSE functions

BCSE shall meet the requirements of this subdivision in all IV-D cases.

(A) Liens

Liens shall be placed in accordance with section 52-362d-2 of the Regulations of Connecticut State Agencies.

(B) Reporting overdue support to consumer reporting agencies

Overdue support information shall be reported to consumer reporting agencies in accordance with section 52-362d-3 of the Regulations of Connecticut State Agencies.

(C) Withholding of lottery winnings

Lottery winnings shall be withheld in accordance with section 52-362d-4 of the Regulations of Connecticut State Agencies.

(D) Seizure of financial assets

Financial assets shall be seized in accordance with section 52-362d-5 of the Regulations of Connecticut State Agencies, as provided in subsection (e) of section 52-362d of the Connecticut General Statutes.

(E) State and federal income tax refund withholding

State and federal income tax refunds shall be withheld in accordance with sections 52-362e-1 through 52-362e-3 of the Regulations of Connecticut State Agencies. Information concerning modifications, deletions and state payments relative to certified cases shall be submitted in a timely manner to the appropriate agency.

(F) Federal administrative enforcement certifications

Cases appropriate for passport denial, revocation, restriction or limitation, and cases appropriate for administrative offset of federal payments shall be certified to the appropriate federal agency in accordance with applicable federal law. Information concerning modifications, deletions and state payments relative to certified cases shall be submitted in a timely manner to the appropriate agency.

(G) Fair hearings

When a fair hearing in cases not yet referred to SED, or in cases involving recoupment or seizure of financial assets, is requested by a IV-D obligor,

(i) A hearing summary shall be prepared and

(ii) Appropriate personnel shall attend and participate in the fair hearing.

Testimony regarding the procedures followed by BCSE to establish support orders or to calculate arrearages shall be provided at fair hearings for which SED is responsible when requested by the hearing officer.

(H) Capias mittimus

Capias mittimus orders shall be served in accordance with the order of the court or family support magistrate.

(I) IRS full collection

Applications for IRS full collection services shall be submitted to OCSE within 30 days of receipt from SED, provided such applications are properly completed and adequately documented, and the fee has been paid.

(J) Fraudulent transfers

BCSE shall, in any case in which it determines that a child support obligor has made a transfer of income or property that is fraudulent as to the state or the recipient of IV-D services under chapter 923a of the Connecticut General Statutes,

(i) seek to avoid such transfer under section 52-552h of the Connecticut General Statutes or

(ii) obtain a settlement in the best interests of the state or such recipient.

(2) SED functions

SED shall meet the requirements of this subdivision in all IV-D cases.

(A) Account audit

An audit of an obligor's account shall be performed upon the obligor's request.

(B) Fair hearings

When a fair hearing on matters other than recoupment or seizure of financial assets is requested by a IV-D obligor,

(i) a hearing summary shall be prepared and

(ii) appropriate personnel shall attend and participate in the fair hearing.

(C) Liens and fraudulent transfers

(i) A determination shall be made, when enforcing or modifying an order, whether the obligor owns real or personal property which can be encumbered for the purpose of securing any past-due support or may have made a transfer of any such property that is fraudulent as to the state or the recipient of IV-D services under chapter 923a of the general statutes.

(ii) Cases identified in step (i) shall be referred to BCSE within fifteen days for appropriate action.

(D) Record maintenance

CCSES and manual records related to the enforcement functions described in this section shall be maintained.

(E) IRS full collection

(i) Applications for IRS full collection services shall be prepared in IV-D cases in which other legal remedies have been exhausted.

(ii) The appropriate fee shall be collected and forwarded with the application to BCSE.

(iii) Appropriate cases in which SED cannot identify assets sufficient for requesting full collection services shall be referred to BCSE for obtaining information subject to disclosure by the IRS.

(Effective September 26, 1996; Amended June 8, 1998; Amended July 10, 2000; Amended May 24, 2004)

Sec. 17b-179(m)-10. Provision of services in interstate IV-D cases

(a) **Central registry**

(1) Definition

"Central registry" means a single centralized office within or under cooperative agreement with the IV-D agency which is responsible for receiving, distributing, and responding to automated and manual inquiries on all incoming interstate IV-D cases, including UIFSA petitions and requests for income withholding.

(2) Functions

There shall be a central registry located within SED which shall:

(A) within 10 working days of receipt of an interstate IV-D case from an initiating state,

(i) review submitted documentation for completeness,

(ii) forward the case to either the SPLS or the appropriate local office of SED for processing,

(iii) acknowledge receipt of the case and ensure that any missing documentation has been requested from the initiating state, and

(iv) inform the IV-D agency in the initiating state where the case was sent for action;

(B) if the documentation received with a case is inadequate and cannot be remedied by the central registry without the assistance of the initiating state, forward the case to the appropriate agency for any action which can be taken pending receipt of necessary documentation from the initiating state; and

(C) respond to inquiries from other states within 5 working days of receipt of the request for a case status review.

(b) **Responding state functions**

When Connecticut is the responding state, SED shall:

(1) serve as the support enforcement agency under UIFSA and provide any necessary services within the applicable timeframes for the given services which shall include paternity and support obligation establishment, in conjunction with the AGO, enforcement of court orders, and collection and monitoring of support payments;

(2) perform clerical, administrative and other non-judicial functions on behalf of the family support magistrate division pursuant to UIFSA;

(3) maintain a registry of support orders of the Family Support Magistrate Division;

(4) maintain a registry of paternity judgments of other states, which registry shall include

both paternity acknowledgments and adjudications;
(5) serve as the state information agency under UIFSA;
(6) provide timely notice to the parties and the IV-D agency in the initiating state of:
(A) Hearings to establish or modify a support order,
(B) Hearings to contest the registration of a support or income withholding order, and
(C) Hearings to contest the direct filing of an income withholding order from another state with a Connecticut employer;
(7) Provide a copy of any support order established or modified, or a notice of determination that there should be no change in the amount of the support order, within 14 days of issuance, to each party and the state case registry;
(8) Provide the petitioner within 5 days, excluding weekends and holidays with:
(A) copies of written notice from an initiating, responding or registering tribunal,
(B) copies of written communication from the respondent or respondent's attorney, and
(C) notice if jurisdiction over the respondent cannot be obtained;
(9) within 10 working days of receipt of new information on a case, notify the IV-D agency in the initiating state by submitting an updated form;
(10) within 75 calendar days of receipt of a standardized interstate Child Support Enforcement Transmittal and documentation from the central registry:
(A) provide location services in accordance with section 17b-179(m)-2 of the Regulations of Connecticut State Agencies if the request is for location services or the form or documentation does not include adequate location information on the noncustodial parent,
(B) if unable to proceed with the case because of inadequate documentation, notify the IV-D agency in the initiating state of the necessary additions or corrections to the form or documentation, and
(C) if the documentation received with a case is inadequate and cannot be remedied by SED without the assistance of the initiating state, process the interstate IV-D case to the extent possible pending necessary action by the initiating state;
(11) within 10 working days of locating the noncustodial parent in a different jurisdiction within the state, forward the form and documentation to the appropriate jurisdiction and notify the initiating state and central registry of its action;
(12) within 10 working days of locating the noncustodial parent in a different state:
(A) return the form and documentation, including the new location, to the initiating state, or, if directed by the initiating state, forward the form and documentation to the central registry in the state where the noncustodial parent has been located, and
(B) notify the central registry where the case has been sent;
(13) If a petition or comparable pleading is received by an inappropriate tribunal of this state, promptly forward the pleadings and the accompanying documents to an appropriate tribunal in this state or another state and notify the petitioner by first class mail where and when the pleading was sent;
(14) Accept and process international requests for child support services from any foreign jurisdiction that has enacted a law or established procedures for issuance and enforcement

of support orders which are substantially similar to UIFSA, the Uniform Reciprocal Enforcement of Support Act, or the Revised Uniform Reciprocal Enforcement of Support Act;

(15) notify the central registry in the initiating state when a case is closed; and

(16) coordinate genetic testing arrangements with the initiating court.

(c) **Initiating state functions**

When Connecticut is the initiating state, SED shall perform the functions assigned to it under UIFSA. SED shall also accept and process requests from BCSE for child support services in foreign nations that have enacted a law or established procedures for issuance and enforcement of support orders which are substantially similar to UIFSA, the Uniform Reciprocal Enforcement of Support Act, or the Revised Uniform Reciprocal Enforcement of Support Act. SED shall also perform the following additional functions specified in this subsection.

(1) Establishment

In cases requiring the establishment of paternity where the putative father resides out of or is absent from the state, BCSE shall first attempt to establish legal paternity in accordance with section 17b-179(m)-4 of the Regulations of Connecticut State Agencies, to the extent provided in section 46b-160 of the Connecticut General Statutes, before proceeding under this section. In other cases when Connecticut is the initiating state, BCSE shall, in cases requiring the establishment of a support order through the UIFSA petition process:

(A) complete all required forms for the interstate referral package and refer to the responding state's central registry within 20 calendar days of determining that the noncustodial parent is in another state;

(B) provide the petitioner within five days, excluding weekends and holidays with:

(i) copies of written notice from an initiating, responding or registering tribunal,

(ii) copies of written communication from the respondent or the respondent's attorney, and

(iii) notice if jurisdiction over the respondent cannot be obtained;

(C) provide the IV-D agency or central registry in the responding state any requested additional information or notify the responding state when the information will be provided within 30 calendar days of receipt of the request for information by submitting an updated form and any necessary additional documentation;

(D) notify the IV-D agency in the responding state within 10 working days of receipt of new information on a case by submitting an updated form and any necessary additional documentation;

(E) coordinate genetic testing arrangements when ordered by the responding court; and

(F) provide a copy of any support order established or modified, or a notice of determination that there should be no change in the amount of the support order, within 14 days of issuance, to each party and the state case registry.

(2) Enforcement

(A) Responsible agency

BCSE shall perform the functions in this subdivision if it determines, pursuant to the intake process, that there is a pre-existing support order which has not already been established on CCSES. SED shall perform such functions if BCSE determines that there is a pre-existing support order which has already been established on CCSES.

When BCSE performs the functions in this subdivision, it shall also, where required for the remedy chosen, complete all forms for the interstate referral package and forward the completed package along with all required documentation, such as financial affidavits and certified copies of court orders, to the responding state's central registry within 20 calendar days of determining that the noncustodial parent is in another state.

(B) Initiate remedy

The responsible agency shall obtain sufficient information and documentation to determine the appropriate remedy, depending on the noncustodial parent's income source, and initiate such remedy as follows:

(i) income withholding served on resident agent if the noncustodial parent is employed by a company doing business in Connecticut,

(ii) direct income withholding if the noncustodial parent is employed by a company in another state with the UIFSA direct withholding provision;

(iii) interstate income withholding or request for enforcement of responding state's own local order if the noncustodial parent is employed by a company not doing business in Connecticut and direct income withholding is not appropriate,

(iv) involuntary military allotment if the noncustodial parent is in active military service,

(v) withholding served on designated agent if the noncustodial parent is employed by the federal government,

(vi) registration of order or request for enforcement of responding state's own local order if the noncustodial parent is self-employed or his or her income source is unknown, or

(vii) UIFSA petition to establish a support order if there are no orders entitled to recognition under UIFSA.

(C) Provide information

The responsible agency shall provide the IV-D agency or central registry in the responding state any requested additional information or notify the responding state when the information will be provided within 30 calendar days of receipt of the request for information by submitting an updated form and any necessary additional documentation.

(D) Update information

The responsible agency shall notify the IV-D agency in the responding state within 10 working days of receipt of new information on a case by submitting an updated form and any necessary additional documentation.

(E) Notify petitioner

The responsible agency shall provide the petitioner within five days, excluding weekends and holidays with:

(i) copies of written notice from an initiating, responding or registering tribunal,

(ii) copies of written communication from the respondent or the respondent's attorney,

and
(iii) notice if jurisdiction over the respondent cannot be obtained.
(F) Coordinate genetic testing
The responsible agency shall coordinate genetic testing arrangements when ordered by the responding court.
(G) Provide copy of order
The responsible agency shall provide a copy of any support order established or modified, or a notice of determination that there should be no change in the amount of the support order, within 14 days of issuance, to each party and the State Case Registry.
(H) Update CCSES
The responsible agency shall update CCSES upon completion of the responding state action.

(Effective July 31, 1995; Amended June 8, 1998; Amended July 10, 2000)

Sec. 17b-179(m)-11. Administration
(a) **BCSE or department functions**
BCSE, the department, or an entity under contract with the department shall perform the following administrative functions.
(1) Federal reports
Prepare the federal reports required by OCSE for the IV-D program.
(2) Fair hearings
Provide obligors aggrieved by an alleged action or inaction with an opportunity for a fair hearing on matters concerning the withholding of state and federal income tax refunds; placement of liens on real or personal property; reporting overdue support to consumer reporting agencies; withholding of lottery winnings; SED determinations not to pursue motions for modification; certifications for passport denial, revocation, restriction or limitation, and administrative offset of federal payments; and seizure of financial assets.
(3) Oversight
Ensure that the functions delegated to cooperating agencies pursuant to the IV-D state plan are being carried out properly, efficiently and effectively.
(4) CCSES reports
Provide existing reports, and create and provide new reports, that are appropriate and necessary for the administration of the Connecticut IV-D program based on information contained in CCSES.
(5) Labor department cooperative agreement
Maintain a cooperative agreement with the state labor department that defines procedures for serving income withholding orders on the labor commissioner against the unemployment compensation benefits of child support obligors. The cooperative agreement shall also provide for payment of the labor department's costs by the IV-D program.
(6) Access to automated databases
Ensure access by SED to the automated databases of the departments of labor, motor

vehicles, correction, and others as available, through CCSES.

(7) Automated interface

Arrange for and maintain an automated interface capability between CCSES and the department's Eligibility Management System for referral and information exchange in assistance and Medicaid cases.

(8) Bad checks

Receive IV-D support checks which have been charged back and returned by financial institutions, establish a bad check recovery disposition on CCSES, and return the original charged back check to the payer with appropriate notification and instructions.

(9) Returned checks

Receive IV-D support checks returned by the post office as undeliverable and remail such checks to a more recent valid address if one appears on CCSES. If a more recent valid address does not appear on CCSES, void such checks and invalidate the custodial party's address on CCSES using a unique code.

(10) Refunds

Process all refund requests and respond to all inquiries concerning such refunds other than those related to the preparation of the request itself.

(11) Recovery of retained direct support

Recover child support payments received directly and retained by custodial parties.

(12) Recovery of misapplied child support payments

Recover misapplied child support payments in accordance with section 17b-179(a)-3 of the Regulations of Connecticut State Agencies.

(13) Resolution of inquiries and complaints

Assist in the resolution of inquiries and complaints.

(14) Administrative enforcement inquiries

Accept and respond to initial telephone inquiries regarding the administrative enforcement mechanisms for which BCSE is responsible under subsection (c) of section 17b-179(m)-9 of the Regulations of Connecticut State Agencies.

(15) IV-D management forum

Establish a forum for the cooperating agencies at the managerial level to maintain open communications between the primary agencies involved in the administration of the IV-D program for the State of Connecticut. Such forum shall hold regular meetings for the purpose of identifying and resolving any functional issues not otherwise adequately addressed, maintaining a clear and unified vision of the aims and policies of the IV-D program, and planning for the implementation of any new federal or state requirements.

(b) **SED functions**

SED shall perform the following administrative functions.

(1) Interstate correspondence

Cooperate with BCSE in responding to any requests for information or services received from IV-D agencies in other jurisdictions.

(2) Financial statements

Submit to BCSE for the purpose of federal financial participation a quarterly statement of costs incurred in the performance of its responsibilities under the IV-D state plan no later than twenty days from the last day of each quarter, in accordance with an agreed cost allocation plan and the annual personnel plan consisting of the number of positions by job classification and a budget for the cost of services provided. Indirect costs shall be submitted annually no later than the second quarter of the state fiscal year, and calculated utilizing the statewide cost allocation plan and the standard indirect cost rate.

(3) Statistical reports

Submit monthly statistical reports to BCSE as required for the implementation of the IV-D state plan, subject to the availability of staffing and electronic data processing resources.

(4) Oversight

Assist BCSE in its monitoring responsibilities in accordance with the self-assessment plan issued by BCSE pursuant to federal IV-D program requirements to ensure that the IV-D agency remains in compliance with federal regulations and OCSE audit guidelines.

(5) Record retention

Retain all records for cases closed for a minimum of three years from the date of closure.

(6) Bad checks

Assist BCSE in the recovery of bad checks issued to the State of Connecticut in non-assistance cases when a payer fails to provide restitution to the department. SED assistance shall be limited to notifying the court of the existence of a bad check in the automated enforcement process and remitting any recovery to BCSE for proper credit.

(7) Refund requests

Investigate and prepare requests for refunds of child support monies to obligors and custodial parties, and refer such requests to the department for processing. Respond to inquiries concerning such refunds that are related to the preparation of the request itself. Refer to the department or the State Disbursement Unit, as appropriate, cases associated with problems resulting from operator error or systemic failure for completing the refund request.

(8) Resolution of inquiries and complaints

Maintain a unit of judicial branch employees referred to as the child support information and problem resolution unit whose responsibilities shall include: responding to requests for child support program information, responding to questions and inquiries related to the child support enforcement program, and resolving case-related problems that require extensive, detailed research or time.

(9) Payment processing

(A) Transfer child support payments or other funds received by SED field offices to the State Disbursement Unit by electronic fund transfer, check or other automated process when appropriate. Such transfers shall be made in accordance with state and federal laws and regulations.

(B) Prepare and fax to the State Disbursement Unit a transmittal, which contains the appropriate detail, related to each payment received by SED and transferred to the State

Disbursement Unit.

(C) Notify the State Disbursement Unit of misapplied or missing payments that are discovered by SED and document such payments in CCSES or on an appropriate form to ensure resolution.

(D) Assist the State Disbursement Unit in the resolution of non-disbursed funds due to a "not valid address" indicator in CCSES.

(E) Assist the State Disbursement Unit in the resolution of returned checks (not deliverable by the post office) by performing the following activities, as resources permit:

(i) locate activities as appropriate,

(ii) case closure,

(iii) termination of income withholding, if appropriate, and

(iv) notifying BCSE of action taken.

(F) Assist the State Disbursement Unit in contacting employers who are not in compliance with an income withholding order.

(10) Non-IV-D cases

(A) Process income withholding order forms from non-IV-D litigants or their attorneys.

(B) Enter the required information for non-IV-D cases in the state case registry.

(Effective July 31, 1995; Amended June 8, 1998; Amended July 10, 2000)

Sec. 17b-179(m)-12. Case closure

BCSE, in pre-obligation cases, and SED, in obligation cases, shall close cases in accordance with this section. The agency responsible for case closure shall also be responsible for verifying the circumstances justifying closure.

(a) **Criteria**

In order to be eligible for closure, a IV-D case must meet at least one of the following criteria:

(1) There is no longer a current support order and arrearages are under $150 if owed to the state, under $500 if owed to the custodial party, or unenforceable under state law.

(2) The noncustodial parent or putative father is deceased and no further action, including a levy against the estate, can be taken.

(3) Paternity cannot be established because:

(A) the child is at least 18 years old and action to establish paternity is barred by section 46b-160 of the Connecticut General Statutes,

(B) a genetic test or a court or administrative process has excluded the putative father and no other putative father can be identified,

(C) the department has determined that it would not be in the best interests of the child to establish paternity in a case involving incest or forcible rape, or in any case where legal proceedings for adoption are pending, or

(D) The identity of the biological father is unknown and cannot be identified after diligent efforts, including at least one interview by the IV-D agency with the recipient of services.

(4) The noncustodial parent's location is unknown, and BCSE or a cooperating agency has made diligent efforts using multiple sources, in accordance with section 17b-179(m)-2 of the Regulations of Connecticut State Agencies, all of which have been unsuccessful, to locate the noncustodial parent:

(A) Over a three-year period when there is sufficient information to initiate an automated locate effort, or

(B) Over a one-year period when there is not sufficient information to initiate an automated locate effort.

(5) The noncustodial parent cannot pay support for the duration of the child's minority because the parent has been institutionalized in a psychiatric facility, is incarcerated with no chance for parole, or has a medically verified total and permanent disability with no evidence of support potential, and no income or assets available which could be levied or attached for support.

(6) The noncustodial parent is a citizen of, and lives in, a foreign country, does not work for the federal government or a company with headquarters or offices in the United States, and has no reachable domestic income or assets; and Connecticut has been unable to establish reciprocity with such country.

(7) In a non-assistance case,

(A) BCSE or SED is unable to contact the recipient of services within a 60 calendar day period despite an attempt by at least one letter sent by first class mail to the recipient's last known address, or

(B) BCSE or SED documents the circumstances of the recipient of services noncooperation and an action by the recipient of services is essential for the next step in providing IV-D services.

(8) BCSE or SED documents failure by the initiating state to take an action which is essential for the next step in providing services.

(9) BCSE has provided location-only services as requested pursuant to section 17b-179(f)-1 of the Regulations of Connecticut State Agencies.

(10) The non-assistance recipient of services requests closure of a case in writing and there is no assignment to the state of medical support or arrearages which accrued under a support order.

(11) The client has been determined exempt from cooperation requirements in accordance with subsection (c) of section 17b-179(a)-4 of the Regulations of Connecticut State Agencies and the department has determined that support enforcement may not proceed without risk of harm to the child or custodial party.

(b) **Notice of closure**

In cases meeting the criteria in subdivisions (1) through (8) of subsection (a) of this section, BCSE, in pre-obligation cases, and SED, in obligation cases, shall notify the recipient of services, or in an interstate case meeting the criteria for closure under subdivision (a)(8) of this section, the initiating state, in writing 60 calendar days prior to closure of the state's intent to close the case. The case shall be kept open if the recipient of

services or the initiating state supplies information in response to the notice which could lead to the establishment of paternity or a support order or enforcement of an order or, in the instance of subparagraph (a)(7)(A) of this section, if contact is reestablished with the recipient of services. If the case is closed, the former recipient of services may request at a later date that the case be reopened if there is a change in circumstances which could lead to the establishment of paternity or a support order or enforcement of an order by completing a new application for IV-D services and paying any applicable application fee in accordance with section 17b-179(i)-1 of the Regulations of Connecticut State Agencies.

(c) **Retention of case records**

BCSE and cooperating agencies shall retain all records for cases closed pursuant to this section for a minimum of three years.

(Effective July 31, 1995; Amended June 8, 1998; Amended July 10, 2000)

Sec. 17b-179(m)-13. Substantial compliance

(a) **Definition**

(1) 90% standard

Substantial compliance with the standards established in

(A) subparagraph (a)(1)(A) and subdivisions (b)(1) through (b)(3) of section 17b-179(m)-1, and

(B) section 17b-179(m)-12

shall be defined as achievement of the given standard in at least 90% of the cases requiring the action regulated by such standard.

(2) 75% standard

Except as provided in subsection (c) of section 17b-179(m)-4 and subsection (d) of section 17b-179(m)-5 of the Regulations of Connecticut State Agencies, substantial compliance with the standards established in sections 17b-179(m)-1 (exclusive of those subject to the standard established in subdivision (1) of this subsection) through 17b-179(m)-11, inclusive, shall be defined as achievement of the given standard in at least 75% of the cases requiring the action regulated by such standard.

(b) **How determined**

Substantial compliance shall be determined separately for each case activity described in sections 17b-179 (m)-1 through 17b-179 (m)-12, to the extent of the monitoring capabilities of CCSES.

(c) **Notice of deficiency**

The department may issue a notice of deficiency to any cooperating agency determined to be not in substantial compliance with any of sections 17b-179 (m)-1 through 17b-179 (m)-12. The notice shall identify the specific deficiencies and how they were determined, and shall specify the date by which a corrective action plan shall be submitted.

(d) **Corrective action plan**

(1) Submittal

Any agency to which a notice of deficiency has been issued shall prepare, in consultation

with the director of BCSE and any other appropriate department officials, a corrective action plan detailing the steps such agency will take to achieve compliance. The plan shall be submitted to the department within 45 calendar days of the issuance date of the notice of deficiency.

(2) Review

The department shall review a cooperating agency's corrective action plan within 90 calendar days of its submittal date. The results of such review shall be reported to the cooperating agency within 30 calendar days.

(3) Implementation

The department shall review a cooperating agency's implementation of any corrective action plan a minimum of 180 calendar days from the date of approval of such plan. The results of such review shall be reported to the cooperating agency within 30 calendar days. Any deficiencies remaining at the time of the review shall be noted in the annual report of BCSE to the judiciary and human services committees of the general assembly, as required by subsection (n) of section 17b-179 of the Connecticut General Statutes.

(Effective September 26, 1996; Amended July 10, 2000)

Agency
Department of Social Services

Subject
Title IV-D Child Support Enforcement Program

Inclusive Sections
§§ 17b-179b-1—17b-179b-4

CONTENTS

Sec. 17b-179b-1. Definitions
Sec. 17b-179b-2. Parenthood Program requirements
Sec. 17b-179b-3. Arrearage adjustment program for Parenthood Program participants
Sec. 17b-179b-4. Arrearage liquidation

Title IV-D Child Support Enforcement Program

Sec. 17b-179b-1. Definitions

As used in sections 17b-179b-1 through 17b-179b-4, inclusive, of the Regulations of Connecticut State Agencies:

(1) "Arrearage" means either one or a combination of (A) court ordered current support payments which have become due and payable and remain unpaid; and (B) support due for past periods that has been found owing by a court of competent jurisdiction, whether or not presently payable;

(2) "Arrearage adjustment" means a reduction, by the Department of Social Services or any bureau, division, or agency of the department, or agency under cooperative or purchase of service agreement therewith, of the total arrearage owed as of the first day of the qualifying year by a noncustodial parent to the State in a child support case in accordance with sections 17b-179b-1 to 17b-179b-4, inclusive, of the Regulations of Connecticut State Agencies, and includes an equivalent reduction of the amount of unreimbursed assistance;

(3) "Arrearage adjustment program" means the system of scheduled arrearage adjustments prescribed by sections 17b-179b-1 to 17b-179b-4, inclusive, of the Regulations of Connecticut State Agencies for the purpose of encouraging the positive involvement of noncustodial parents in the lives of their children and encouraging noncustodial parents to make regular support payments;

(4) "Child support case" means one in which the Department of Social Services or any bureau, division, or agency of the department, or agency under cooperative or purchase of service agreement therewith, is providing child support enforcement services under Title IV-D of the federal Social Security Act;

(5) "Current child support obligation" means a court ordered amount for the ongoing support of a child, and does not include payments on an arrearage;

(6) "Custodial party" means the individual who has primary physical custody of a child, or, in foster care cases, the Commissioner of the Department of Children and Families;

(7) "Domestic violence" means (A) physical acts that result in or are threatened to result in physical or bodily injury; (B) sexual abuse; (C) sexual activity involving a child in the home; (D) forced participation in nonconsensual sexual acts or activities; (E) threats of or attempts at physical or sexual abuse; (F) mental abuse; or (G) neglect or deprivation of medical care;

(8) "Parenthood Program" means any project, site or program that meets the requirements of section 17b-179b-2 of the Regulations of Connecticut State Agencies, and shall include the research and demonstration projects established under subsection (d) of section 1 of Public Act 99-193;

(9) "Noncustodial parent" means the parent who does not have primary physical custody of a child;

(10) "Obligor" means the individual required to make payments under a current child support or arrearage obligation;

(11) "Qualifying year" means the twelve-month period beginning with the date a

noncustodial parent enters into a voluntary agreement to participate in the arrearage adjustment program;

(12) "Starting arrearage" means the total arrearage owed, as of the first day of the qualifying year, to the State of Connecticut by a noncustodial parent or obligor in a child support case; and

(13) "Unreimbursed assistance" means the portion that has not been repaid to the State of Connecticut of the total assistance provided under the aid to families with dependent children, state-administered general assistance or temporary family assistance programs to or in behalf of either parent, such parent's spouse, or such parent's child; such portion being the subject of the State's claim under section 17b-93 of the Connecticut General Statutes.

(Adopted effective May 24, 2004)

Sec. 17b-179b-2. Parenthood Program requirements

(a) **In general**

(1) Certification

Participants in a Parenthood Program shall be eligible for an arrearage adjustment under section 17b-179b-3 of the Regulations of Connecticut State Agencies only if such program is designated initially and certified annually by the Commissioner of Social Services as a participating program that provides services that promote the positive involvement and interaction of noncustodial parents with their children.

(2) Exception

Notwithstanding subdivision (1) of this subsection, the research and demonstration projects established under subsection (d) of section 1 of Public Act 99-193 shall not require certification to participate in the arrearage adjustment program.

(b) **Program components**

A Parenthood Program seeking designation or certification as a participating program under subsection (a) of this section shall demonstrate to the satisfaction of the Commissioner of Social Services that such program provides a minimum curriculum of at least twenty-four hours of programming over an eight week period, and a plan of service to assist male or female noncustodial parents to identify and resolve problems, build healthy relationships with their children, and establish or strengthen collaborative co-parenting alliances with the custodial party. To meet these requirements, a participating program shall provide services directly and by referral in at least the following areas:

(1) education, training and employment placement;
(2) parenting education and services to strengthen the parent-child relationship;
(3) counseling, support and self-help;
(4) legal assistance and court advocacy;
(5) mental health and substance abuse services;
(6) housing;
(7) transportation;
(8) domestic violence services;

(9) conflict resolution and anger management;
(10) mentoring;
(11) relationship and co-parenting mediation; and
(12) pregnancy prevention.
(c) **Administrative requirements**
(1) In general
A Parenthood Program seeking designation or certification as a participating program under subsection (a) of this section shall demonstrate to the satisfaction of the Commissioner of Social Services that such program has and will use the forms and procedures prescribed by such commissioner to administer the provisions of sections 17b-179b-1 to 17b-179b-4, inclusive, of the Regulations of Connecticut State Agencies.
(2) Voluntary agreement
The voluntary agreement required under subdivision (4) of subsection (a) of section 17b-179b-3 of the Regulations of Connecticut State Agencies shall, at a minimum:
(A) state the rights and responsibilities of the noncustodial parent or obligor under the arrearage adjustment program;
(B) clearly define the activities required for participation in the arrearage adjustment program;
(C) specify the outcomes expected from successful participation in the arrearage adjustment program; and
(D) state the total arrearage amount that may be subject to adjustment.

(Adopted effective May 24, 2004)

Sec. 17b-179b-3. Arrearage adjustment program for Parenthood Program participants

(a) **Eligibility for program**
A noncustodial parent or obligor shall be eligible for the arrearage adjustment program for Parenthood Program participants if the Department of Social Services determines, based on information provided by a participating program or otherwise available to the department, that the requirements of this subsection are met. The requirements of this subsection may be met retroactively in the case of participants in programs that were established under subsection (d) of section 1 of Public Act 99-193 as research and demonstration projects or funded under the federal Temporary Assistance for Needy Families block grant.
(1) The noncustodial parent begins and continues to make regular current support payments after non-payment of support for a year or more. For the purpose of this subdivision, such support payments shall not include recoveries of past-due or overdue support pursuant to child support enforcement actions taken by the State of Connecticut under sections 52-362d-2, 52-362d-4, 52-362d-5, 52-362e-2, or 52-362e-3 of the Regulations of Connecticut State Agencies;
(2) The noncustodial parent or obligor is participating and making satisfactory progress in a Parenthood Program, as demonstrated by quantifiable achievements that facilitate

positive involvement with the child or the participant's ability to provide support, such as (A) signing a paternity acknowledgment, (B) signing a voluntary support agreement, (C) signing a co-parenting or mediation agreement, (D) attending one or more child development classes or (E) registering with the Department of Labor for skills training;

(3) The noncustodial parent meets program goals for appropriate involvement and interaction with the child or children and (A) has an active child support case where an arrearage is owed to the State of Connecticut and there is a current payment due to the custodial party or (B) is an obligor who now resides with the child or children to whom support is owed;

(4) The noncustodial parent or obligor applies for an arrearage adjustment and enters annually into a voluntary agreement with the Commissioner of Social Services or such commissioner's designee that complies with subdivision (2) of subsection (c) of section 17b-179b-2 of the Regulations of Connecticut State Agencies; and

(5) The noncustodial parent or obligor has no felony convictions, as known or reported to the Department of Social Services or attested by such parent or obligor, during the year for which an adjustment is requested.

(b) **Adjustment amounts**

(1) Qualifying Year

(A) Completes Parenthood Program

A noncustodial parent or obligor who successfully completes a Parenthood Program shall receive a one-time arrearage adjustment in the qualifying year of five percent of the starting arrearage.

(B) Pays support or lives with child

(i) A noncustodial parent or obligor who, during the qualifying year, receives an adjustment under subparagraph (A) of this subdivision shall be eligible to claim an arrearage adjustment in accordance with the following "Arrearage Adjustment Table – Qualifying Year" if such parent or obligor:

(I) pays the full amount of the current child support obligation due to the custodial party,

(II) resides with the child and documents substantial contributions for support of the child or is the primary caregiver for the child, provided the custodial party acknowledges or consents in writing to such arrangement and there is no evidence of domestic violence for the qualifying year, or

(III) becomes the custodial party and resides with the child, in which case the acknowledgment or consent of the other parent shall not be required.

ARREARAGE ADJUSTMENT TABLE QUALIFYING YEAR	
If the obligor meets the criteria under paragraphs (I), (II), or (III) for the following number of months during the qualifying year:	*the arrearage adjustment shall be in the following percentage of the starting arrearage:*
12	20%
11	15%
10	10%

(ii) The arrearage adjustment specified under subclause (i) of this subparagraph may be granted on the basis of criterion (I) of said subclause exclusively, criterion (II) of said subclause exclusively, criterion (III) of said subclause exclusively, or on the basis of any combination of such criteria, provided at least one criterion is satisfied during the period specified in the "Arrearage Adjustment Table".

(iii) A noncustodial parent or obligor who is denied an arrearage adjustment on the basis of only an allegation of domestic violence shall be entitled to a desk review of the denial by the Commissioner of Social Services or such commissioner's designee.

(C) Maintains steady employment

A noncustodial parent or obligor who receives an adjustment under subparagraph (B) of this subdivision and maintains employment for an average of at least one hundred twenty hours per month during the qualifying year shall receive an additional arrearage adjustment of five percent of the starting arrearage to be added to the percentages specified in subparagraph (B) of this subdivision.

(2) Subsequent years

(A) Pays support or lives with child

(i) A noncustodial parent or obligor who received an adjustment for the immediately preceding year shall be eligible to claim an additional arrearage adjustment in accordance with the following "Arrearage Adjustment Table – Subsequent Years" if, during a subsequent year, such parent or obligor:

(I) pays the full amount of the current child support obligation due to the custodial party,

(II) resides with the child and documents substantial contributions for support of the child or is primary caregiver for the child, provided the custodial party acknowledges or consents in writing to such arrangement and there is no evidence of domestic violence for the qualifying year, or

(III) becomes the custodial party and resides with the child, in which case the acknowledgment or consent of the other parent shall not be required.

ARREARAGE ADJUSTMENT TABLE - SUBSEQUENT YEARS				
If the obligor meets the criteria under paragraphs (I), (II), or (III) for the following number of months during the subsequent year:	*the arrearage adjustment shall be in the following percentages of the starting arrearage in the indicated subsequent years:*			
	first . . .	*second . . .*	*third . . .*	*all additional . . .*
12	15%	10%	10%	10%
11	10%	5%	5%	0%
10	5%	0%	0%	0%

(ii) The arrearage adjustment specified under subclause (i) of this subparagraph may be granted on the basis of criterion (I) of said subclause exclusively, criterion (II) of said subclause exclusively, criterion (III) of said subclause exclusively, or on the basis of any combination of such criteria, provided at least one criterion is satisfied during the period specified in the "Arrearage Adjustment Table".

(iii) A noncustodial parent or obligor who is denied an arrearage adjustment on the basis of only an allegation of domestic violence shall be entitled to a desk review of the denial by the Commissioner of Social Services or such commissioner's designee.

(iv) A noncustodial parent or obligor who signs a voluntary agreement to participate in the arrearage adjustment program and who fails to qualify for a scheduled adjustment without good cause shall be eligible to receive a future adjustment only if such parent or obligor signs a new voluntary agreement. In such cases, any future adjustments shall be in the amounts prescribed in this subdivision for subsequent years, and not in the amounts prescribed in subdivision (1) of this subsection for the qualifying year.

(B) Maintains steady employment

A noncustodial parent or obligor who receives an adjustment under subparagraph (A) of this subdivision and, during the subsequent year, as compared to the preceding year:

(i) maintains employment for a greater average number of hours per month,

(ii) increases earnings, or

(iii) enhances employability through education or training

shall receive an additional arrearage adjustment of five percent of the starting arrearage to be added to the percentages specified in subparagraph (A) of this subdivision.

(Adopted effective May 24, 2004)

Sec. 17b-179b-4. Arrearage liquidation

(a) **Definitions**

As used in this section:

(1) "Arrearage liquidation" means an arrearage adjustment, as defined in section 17b-179b-1 of the Regulations of Connecticut State Agencies, of one hundred percent in accordance with this section based on a lump sum payment by the noncustodial parent of a

specified percentage of the existing arrearage;

(2) "Liquidation percentage" means the portion of a noncustodial parent's total arrearage that may be accepted by the Commissioner of Social Services in full satisfaction of the support arrearage owed to the State of Connecticut.

(b) **Eligibility**

A noncustodial parent or obligor shall be eligible for arrearage liquidation of state-owed arrearages if the requirements of this subsection are met.

(1) State-owed arrearage

There is an arrearage owed to the State in a child support case that would take the obligor at least five years to pay in full at the rate of payment calculated in accordance with the Arrearage Guidelines established in section 46b-215a-4a of the Regulations of Connecticut State Agencies.

(2) Obligations to custodial party

(A) Current support

If there is a current child support obligation payable to the custodial party:

(i) payments shall be current, or

(ii) any payments owed to the custodial party shall be paid prior to or at the time of the arrearage liquidation.

(B) Arrearage

Any arrearage payable to the custodial party shall be paid in full prior to or at the time of the arrearage liquidation.

(c) **Liquidation percentage**

The liquidation percentage for State-owed arrearages shall be determined with reference to the following "Arrearage Liquidation Table", to be used in conjunction with the liquidation percentage factors set forth in subsection (d) of this section:

ARREARAGE LIQUIDATION TABLE		
If it would take the obligor the following number of years to pay the arrearage in full:	*the liquidation percentage shall be . . .*	
	at least . . .	*but no more than . . .*
5	70%	85%
6	68%	83%
7	66%	81%
8	64%	79%
9	62%	77%
10	60%	75%
11	58%	73%
12	56%	71%

ARREARAGE LIQUIDATION TABLE		
If it would take the obligor the following number of years to pay the arrearage in full:	*the liquidation percentage shall be . . .*	
	at least . . .	*but no more than . . .*
13	54%	69%
14	52%	67%
15	50%	65%
16	48%	63%
17	46%	61%
18	44%	59%
19	42%	57%
20 or more	40%	55%

(d) **Liquidation percentage factors**

(1) Specific

The applicable liquidation percentage shall be reduced by three percent from the higher percentage listed in the table set forth in subsection (c) of this section for each of the following factors:

(A) The obligor is presently living with the child or has made regular support payments for the past three months.

(B) The obligor has paid at least twenty-five percent of the child's college or private secondary school tuition for one semester.

(C) The obligor has satisfactorily completed a Parenthood Program, as defined in section 17b-179b-1 of the Regulations of Connecticut State Agencies.

(D) The obligor was not present at a court hearing held to determine the obligor's initial arrearage, and the court used a standard other than the obligor's actual past ability to pay to determine at least six months of such arrearage.

(E) At least six months of the obligor's arrearage accrued while the obligor was incarcerated or unemployed.

(F) The obligor has received a disability determination from the federal Social Security Administration.

(2) Non-specific

If full payment of the arrearage would take twenty years or more, the applicable liquidation percentage shall be reduced by the following percentages from the higher percentage listed in the table set forth in subsection (c) of this section:

(A) Three percent if full payment of the arrearage at the guidelines rate would take twenty-five years or more.

(B) Six percent if full payment of the arrearage at the guidelines rate would take thirty years or more.

(C) Nine percent if full payment of the arrearage at the guidelines rate would take thirty-five years or more.

(D) Twelve percent if full payment of the arrearage at the guidelines rate would take forty years or more.

(3) Limitation

The combined percentage reductions applied pursuant to subdivisions (1) and (2) of this subsection shall not reduce the applicable liquidation percentage below the lower percentage listed in the table set forth in subsection (c) of this section.

(Adopted effective May 24, 2004)

Agency
Department of Social Services

Subject
Requirements for Payments of Services Provided under the State Administered General Assistance Program

Inclusive Sections
§§ 17b-192-1—17b-192-12

CONTENTS

Sec. 17b-192-1. Scope (Repealed)
Sec. 17b-192-2. Definitions (Repealed)
Sec. 17b-192-3. Administration of the SAGA medical program (Repealed)
Sec. 17b-192-4. Responsibilities of the ASO (Repealed)
Sec. 17b-192-5. Provider network (Repealed)
Sec. 17b-192-6. Services covered and limitations (Repealed)
Sec. 17b-192-7. Service management (Repealed)
Sec. 17b-192-8. Billing and payment procedures (Repealed)
Sec. 17b-192-9. Payment for hospitals (Repealed)
Sec. 17b-192-10. Payment rates for providers (Repealed)
Sec. 17b-192-11. Documentation (Repealed)
Sec. 17b-192-12. Grievance and administrative hearing process (Repealed)

Requirements for Payments of Services Provided under the State Administered General Assistance Program

Sec. 17b-192-1. Scope (Repealed)

Repealed June 11, 2014.

(Adopted effective October 12, 2005; Repealed June 11, 2014)

Notes: For 2014 repeal, see Sec. 54 of Public Act 14-187. (June 11, 2014)

Sec. 17b-192-2. Definitions (Repealed)

Repealed June 11, 2014.

(Adopted effective October 12, 2005; Repealed June 11, 2014)

Notes: For 2014 repeal, see Sec. 54 of Public Act 14-187. (June 11, 2014)

Sec. 17b-192-3. Administration of the SAGA medical program (Repealed)

Repealed June 11, 2014.

(Adopted effective October 12, 2005; Repealed June 11, 2014)

Notes: For 2014 repeal, see Sec. 54 of Public Act 14-187. (June 11, 2014)

Sec. 17b-192-4. Responsibilities of the ASO (Repealed)

Repealed June 11, 2014.

(Adopted effective October 12, 2005; Repealed June 11, 2014)

Notes: For 2014 repeal, see Sec. 54 of Public Act 14-187. (June 11, 2014)

Sec. 17b-192-5. Provider network (Repealed)

Repealed June 11, 2014.

(Adopted effective October 12, 2005; Repealed June 11, 2014)

Notes: For 2014 repeal, see Sec. 54 of Public Act 14-187. (June 11, 2014)

Sec. 17b-192-6. Services covered and limitations (Repealed)

Repealed June 11, 2014.

(Adopted effective October 12, 2005; Repealed June 11, 2014)

Notes: For 2014 repeal, see Sec. 54 of Public Act 14-187. (June 11, 2014)

Sec. 17b-192-7. Service management (Repealed)

Repealed June 11, 2014.

(Adopted effective October 12, 2005; Repealed June 11, 2014)

Notes: For 2014 repeal, see Sec. 54 of Public Act 14-187. (June 11, 2014)

Sec. 17b-192-8. Billing and payment procedures (Repealed)

Repealed June 11, 2014.

(Adopted effective October 12, 2005; Repealed June 11, 2014)

Notes: For 2014 repeal, see Sec. 54 of Public Act 14-187. (June 11, 2014)

Sec. 17b-192-9. Payment for hospitals (Repealed)

Repealed June 11, 2014.

(Adopted effective October 12, 2005; Repealed June 11, 2014)

Notes: For 2014 repeal, see Sec. 54 of Public Act 14-187. (June 11, 2014)

Sec. 17b-192-10. Payment rates for providers (Repealed)

Repealed June 11, 2014.

(Adopted effective October 12, 2005; Repealed June 11, 2014)

Notes: For 2014 repeal, see Sec. 54 of Public Act 14-187. (June 11, 2014)

Sec. 17b-192-11. Documentation (Repealed)

Repealed June 11, 2014.

(Adopted effective October 12, 2005; Repealed June 11, 2014)

Notes: For 2014 repeal, see Sec. 54 of Public Act 14-187. (June 11, 2014)

Sec. 17b-192-12. Grievance and administrative hearing process (Repealed)

Repealed June 11, 2014.

(Adopted effective October 12, 2005; Repealed June 11, 2014)

Notes: For 2014 repeal, see Sec. 54 of Public Act 14-187. (June 11, 2014)

Agency
Department of Social Services

Subject
Requirements for Payment of Home Health Agencies

Inclusive Sections
§§ 17b-262-1—17b-262-966

CONTENTS

Sec. 17b-262-1. Scope
Sec. 17b-262-2. Definitions
Sec. 17b-262-3. Provider participation
Sec. 17b-262-4. Eligibility
Sec. 17b-262-5. Policy
Sec. 17b-262-6. Designation of service area
Sec. 17b-262-7. Refusal to serve
Sec. 17b-262-8. Legitimate non-discriminatory reason
Sec. 17b-262-9. Sanctions
Sec. 17b-262-10—17b-262-201. Reserved

Requirements for the Reimbursement of Early Intervention Services to Children Age Birth to Three Years with Developmental Delays

Sec. 17b-262-202—17b-262-211. Repealed
Sec. 17b-262-212. Reserved

Requirements for Payment of School Based Child Health Services

Sec. 17b-262-213. Scope
Sec. 17b-262-214. Definitions
Sec. 17b-262-215. Provider participation
Sec. 17b-262-216. Eligibility
Sec. 17b-262-217. Need for services
Sec. 17b-262-218. Services covered
Sec. 17b-262-219. Limitations
Sec. 17b-262-220. Documentation and record retention requirements
Sec. 17b-262-221. Billing requirements
Sec. 17b-262-222. Establishment of rates
Sec. 17b-262-223. Audit/compliance review
Sec. 17b-262-224—17b-262-298. Reserved

Requirements for Payment of Services Provided by Intermediate Care Facilities for the Mentally Retarded (ICFs/MR)

Sec. 17b-262-299. Scope
Sec. 17b-262-300. Definitions
Sec. 17b-262-301. Provider participation
Sec. 17b-262-302. Eligibility
Sec. 17b-262-303. Services covered and limitations
Sec. 17b-262-304. Need for services and authorization process
Sec. 17b-262-305. Client's bill of rights
Sec. 17b-262-306. Bed reserve for hospitalization
Sec. 17b-262-307. Bed reserve for home leave
Sec. 17b-262-308. Applied income
Sec. 17b-262-309. Billing and payment procedures
Sec. 17b-262-310. Rates
Sec. 17b-262-311. Documentation
Sec. 17b-262-312—17b-262-336. Reserved

Requirements for Payment of Physicians' Services

Sec. 17b-262-337. Scope
Sec. 17b-262-338. Definitions
Sec. 17b-262-339. Provider participation
Sec. 17b-262-340. Eligibility
Sec. 17b-262-341. Services covered and limitations
Sec. 17b-262-342. Services not covered
Sec. 17b-262-343. Need for service
Sec. 17b-262-344. Prior authorization
Sec. 17b-262-345. Billing procedures
Sec. 17b-262-346. Payment
Sec. 17b-262-347. Payment rate
Sec. 17b-262-348. Payment limitations
Sec. 17b-262-349. Documentation and audit requirements
Sec. 17b-262-350—17b-262-439. Reserved
Sec. 17b-262-440—17b-262-449. Repealed
Sec. 17b-262-450—17b-262-451. Reserved

Requirements for Payment of Psychiatrists' Services

Sec. 17b-262-452. Scope
Sec. 17b-262-453. Definitions
Sec. 17b-262-454. Provider participation

Sec. 17b-262-455. Eligibility
Sec. 17b-262-456. Services covered and limitations
Sec. 17b-262-457. Need for service
Sec. 17b-262-458. Prior authorization
Sec. 17b-262-459. Billing procedures
Sec. 17b-262-460. Payment
Sec. 17b-262-461. Payment rate
Sec. 17b-262-462. Payment limitations
Sec. 17b-262-463. Documentation
Sec. 17b-262-464—17b-262-466. Reserved

Requirements for Payment of Psychologists' Services

Sec. 17b-262-467. Scope
Sec. 17b-262-468. Definitions
Sec. 17b-262-469. Provider participation
Sec. 17b-262-470. Eligibility
Sec. 17b-262-471. Services covered and limitations
Sec. 17b-262-472. Services not covered
Sec. 17b-262-473. Need for service and authorization process
Sec. 17b-262-474. Billing procedures
Sec. 17b-262-475. Payment
Sec. 17b-262-476. Payment rate
Sec. 17b-262-477. Payment limitations
Sec. 17b-262-478. Documentation
Sec. 17b-262-479—17b-262-492. Reserved

Requirements for Client Copayment on Prescription Drugs, Over-The-Counter Drugs, and Refills Under the Medical Assistance Program

Sec. 17b-262-493. Scope
Sec. 17b-262-494. Definitions
Sec. 17b-262-495. Services requiring a copayment
Sec. 17b-262-496. Copayment exclusions
Sec. 17b-262-497. Copayment responsibilities
Sec. 17b-262-498. Copayment rate

Requirements for Payment of Inpatient Psychiatric Hospital Services

Sec. 17b-262-499. Scope
Sec. 17b-262-500. Definitions
Sec. 17b-262-501. Provider participation
Sec. 17b-262-502. Eligibility

Sec. 17b-262-503. Services covered
Sec. 17b-262-504. Services not covered
Sec. 17b-262-505. Certification of need review requirements for inpatient psychiatric services for a client under age twenty-one in a psychiatric hospital
Sec. 17b-262-506. Individual plan of care requirements for inpatient psychiatric services for a client under age twenty-one in a psychiatric hospital
Sec. 17b-262-507. Individual plan of care for a client age sixty-five or over in a psychiatric hospital
Sec. 17b-262-508. Utilization review program for inpatient psychiatric services for clients under age twenty-one or age sixty-five or over
Sec. 17b-262-509. Billing procedures
Sec. 17b-262-510. Documentation and record retention
Sec. 17b-262-511. Reserved

Requirements for Payment to Independent Radiology and Ultrasound Centers

Sec. 17b-262-512. Scope
Sec. 17b-262-513. Definitions
Sec. 17b-262-514. Provider participation
Sec. 17b-262-515. Eligibility
Sec. 17b-262-516. Services covered
Sec. 17b-262-517. Need for service and authorization process
Sec. 17b-262-518. Billing procedures
Sec. 17b-262-519. Payment rate and limitations
Sec. 17b-262-520. Documentation
Sec. 17b-262-521. Reserved

Requirements for Provider Participation in the Connecticut Medical Assistance Program

Sec. 17b-262-522. Scope
Sec. 17b-262-523. Definitions
Sec. 17b-262-524. Provider participation
Sec. 17b-262-525. Termination or suspension of provider agreement
Sec. 17b-262-526. General provider requirements
Sec. 17b-262-527. Need for goods or services
Sec. 17b-262-528. Prior authorization
Sec. 17b-262-529. Billing procedures
Sec. 17b-262-530. Payment rates

Sec. 17b-262-531. Payment limitations
Sec. 17b-262-532. Payment for out-of-state goods or services
Sec. 17b-262-533. Sums paid in excess of the authorized schedules of payment or for other reasons of ineligibility for payment
Sec. 17b-262-534. Reserved

Requirements for Payment of Chiropractic Services

Sec. 17b-262-535. Scope
Sec. 17b-262-536. Definitions
Sec. 17b-262-537. Provider participation
Sec. 17b-262-538. Eligibility
Sec. 17b-262-539. Services covered and limitations
Sec. 17b-262-540. Services not covered
Sec. 17b-262-541. Need for service
Sec. 17b-262-542. Prior authorization
Sec. 17b-262-543. Billing procedures
Sec. 17b-262-544. Payment
Sec. 17b-262-545. Documentation
Sec. 17b-262-546. Reserved

Requirements for Payment of Natureopathic Services

Sec. 17b-262-547. Scope
Sec. 17b-262-548. Definitions
Sec. 17b-262-549. Provider participation
Sec. 17b-262-550. Eligibility
Sec. 17b-262-551. Services covered and limitations
Sec. 17b-262-552. Services not covered
Sec. 17b-262-553. Need for service
Sec. 17b-262-554. Prior authorization
Sec. 17b-262-555. Billing procedures
Sec. 17b-262-556. Payment
Sec. 17b-262-557. Documentation
Sec. 17b-262-558. Reserved

Requirements for Payment of Vision Care Services

Sec. 17b-262-559. Scope
Sec. 17b-262-560. Definitions
Sec. 17b-262-561. Provider participation
Sec. 17b-262-562. Eligibility

Sec. 17b-262-563. Services covered and limitations
Sec. 17b-262-564. Services not covered
Sec. 17b-262-565. Need for service
Sec. 17b-262-566. Early periodic screening, diagnostic and treatment services
Sec. 17b-262-567. Billing procedures
Sec. 17b-262-568. Payment
Sec. 17b-262-569. Payment rate
Sec. 17b-262-570. Payment limitations
Sec. 17b-262-571. Documentation
Sec. 17b-262-572. Reserved

Requirements for Payment of Nurse-Midwifery Services

Sec. 17b-262-573. Scope
Sec. 17b-262-574. Definitions
Sec. 17b-262-575. Provider participation
Sec. 17b-262-576. Eligibility
Sec. 17b-262-577. Services covered and limitations
Sec. 17b-262-578. Services not covered
Sec. 17b-262-579. Need for service
Sec. 17b-262-580. Prior authorization
Sec. 17b-262-581. Billing procedures
Sec. 17b-262-582. Payment
Sec. 17b-262-583. Payment rate
Sec. 17b-262-584. Payment limitations
Sec. 17b-262-585. Documentation
Sec. 17b-262-586. Reserved

Requirements for Payment of Personal Care Assistance Services for Adults

Sec. 17b-262-587. Purpose and scope
Sec. 17b-262-588. Definitions
Sec. 17b-262-589. Eligibility and determination of need
Sec. 17b-262-590. Application process
Sec. 17b-262-591. Waiting list
Sec. 17b-262-592. Limitations
Sec. 17b-262-593. Services covered
Sec. 17b-262-594. Determining the cost effectiveness of the service plan
Sec. 17b-262-595. Payment

Sec. 17b-262-596. Personal care assistant qualifications
Sec. 17b-262-596a. Fair hearings
Sec. 17b-262-596b. Repealed

Requirements for Payment for Early Intervention Services to Children Age Birth to Three Years with Developmental Delays

Sec. 17b-262-597. Scope
Sec. 17b-262-598. Definitions
Sec. 17b-262-599. Provider participation
Sec. 17b-262-600. Eligibility
Sec. 17b-262-601. Services covered and limitations
Sec. 17b-262-602. Billing procedures
Sec. 17b-262-603. Payment
Sec. 17b-262-604. Documentation requirements
Sec. 17b-262-605. Audit and record retention
Sec. 17b-262-606. Reserved

Requirements for Payment of Nurse Practitioner Services

Sec. 17b-262-607. Scope
Sec. 17b-262-608. Definitions
Sec. 17b-262-609. Provider participation
Sec. 17b-262-610. Eligibility
Sec. 17b-262-611. Services covered and limitations
Sec. 17b-262-612. Services not covered
Sec. 17b-262-613. Need for service
Sec. 17b-262-614. Prior authorization
Sec. 17b-262-615. Billing procedures
Sec. 17b-262-616. Payment
Sec. 17b-262-617. Payment rate and limitations
Sec. 17b-262-618. Documentation

Requirements for Payment of Podiatric Services

Sec. 17b-262-619. Scope
Sec. 17b-262-620. Definitions
Sec. 17b-262-621. Provider participation
Sec. 17b-262-622. Eligibility
Sec. 17b-262-623. Services covered and limitations
Sec. 17b-262-624. Services not covered
Sec. 17b-262-625. Need for service
Sec. 17b-262-626. Prior authorization

Sec. 17b-262-627. Billing procedures
Sec. 17b-262-628. Payment
Sec. 17b-262-629. Documentation and audit requirements

Requirements for Payment of Services Provided by Independent Licensed Audiologists, Physical Therapists, Occupational Therapists and Speech Pathologists

Sec. 17b-262-630. Scope
Sec. 17b-262-631. Definitions
Sec. 17b-262-632. Provider participation
Sec. 17b-262-633. Eligibility
Sec. 17b-262-634. Services covered and limitations
Sec. 17b-262-635. Need for service
Sec. 17b-262-636. Prior authorization
Sec. 17b-262-637. Billing procedures
Sec. 17b-262-638. Payment
Sec. 17b-262-639. Payment rates
Sec. 17b-262-640. Documentation

Requirements for Payment of Laboratory Services

Sec. 17b-262-641. Scope
Sec. 17b-262-642. Definitions
Sec. 17b-262-643. Provider participation
Sec. 17b-262-644. Eligibility
Sec. 17b-262-645. Services covered and limitations
Sec. 17b-262-646. Need for service
Sec. 17b-262-647. Prior authorization
Sec. 17b-262-648. Billing procedures
Sec. 17b-262-649. Payment
Sec. 17b-262-650. Documentation

Requirements for Payment of Dialysis Services

Sec. 17b-262-651. Scope
Sec. 17b-262-652. Definitions
Sec. 17b-262-653. Provider participation
Sec. 17b-262-654. Eligibility
Sec. 17b-262-655. Services covered and limitations
Sec. 17b-262-656. Need for service and authorization process
Sec. 17b-262-657. Billing procedures
Sec. 17b-262-658. Payment
Sec. 17b-262-659. Payment rate

Sec. 17b-262-660. Documentation
Sec. 17b-262-661—17b-262-671. Reserved

Requirements for Payment of Durable Medical Equipment

Sec. 17b-262-672. Scope
Sec. 17b-262-673. Definitions
Sec. 17b-262-674. Provider participation
Sec. 17b-262-675. Eligibility
Sec. 17b-262-676. Services covered and limitations
Sec. 17b-262-677. Services not covered
Sec. 17b-262-678. Prior authorization
Sec. 17b-262-679. Billing procedure
Sec. 17b-262-680. Payment limitations
Sec. 17b-262-681. Documentation
Sec. 17b-262-682. Other
Sec. 17b-262-683. Reserved

Requirements for Payment Under the Connecticut Pharmaceutical Assistance Contract to the Elderly and the Disabled (ConnPACE)

Sec. 17b-262-684. Scope
Sec. 17b-262-685. Definitions
Sec. 17b-262-686. Provider participation
Sec. 17b-262-687. Eligibility
Sec. 17b-262-688. Services covered and limitations
Sec. 17b-262-689. Services not covered
Sec. 17b-262-690. Payment rate
Sec. 17b-262-691. Documentation
Sec. 17b-262-692. Manufacturer rebate program

Requirements for Payment of Public Health Dental Hygienist Services

Sec. 17b-262-693. Scope
Sec. 17b-262-694. Definitions
Sec. 17b-262-695. Provider participation
Sec. 17b-262-696. Eligibility
Sec. 17b-262-697. Services covered and limitations
Sec. 17b-262-698. Services not covered
Sec. 17b-262-699. Payment rate and billing procedure
Sec. 17b-262-700. Documentation

Requirements for Payment of Nursing Facilities

Sec. 17b-262-701. Scope
Sec. 17b-262-702. Definitions
Sec. 17b-262-703. Provider participation
Sec. 17b-262-704. Eligibility
Sec. 17b-262-705. Services covered and limitations
Sec. 17b-262-706. Service limitations
Sec. 17b-262-707. Need for service and authorization process
Sec. 17b-262-708. Applied income
Sec. 17b-262-709. Billing and payment procedures
Sec. 17b-262-710. Rates
Sec. 17b-262-711. Documentation

Requirements for Payment for Medical and Surgical Supplies

Sec. 17b-262-712. Scope
Sec. 17b-262-713. Definitions
Sec. 17b-262-714. Provider participation
Sec. 17b-262-715. Eligibility
Sec. 17b-262-716. Supplies covered and limitations
Sec. 17b-262-717. Supplies not covered
Sec. 17b-262-718. Prior authorization
Sec. 17b-262-719. Billing procedure
Sec. 17b-262-720. Payment limitations
Sec. 17b-262-721. Documentation
Sec. 17b-262-722. Other
Sec. 17b-262-723. Reserved

Requirements for Payment of Home Health Care Services

Sec. 17b-262-724. Scope
Sec. 17b-262-725. Definitions
Sec. 17b-262-726. Provider participation
Sec. 17b-262-727. Eligibility
Sec. 17b-262-728. Services covered and limitations
Sec. 17b-262-729. Services not covered
Sec. 17b-262-730. Cost effectiveness test
Sec. 17b-262-731. Need for service
Sec. 17b-262-732. Prior authorization
Sec. 17b-262-733. Billing procedures
Sec. 17b-262-734. Payment

Sec. 17b-262-735. Documentation

Requirements for Payment to Providers of Orthotic and Prosthetic Devices

Sec. 17b-262-736. Scope
Sec. 17b-262-737. Definitions
Sec. 17b-262-738. Provider participation
Sec. 17b-262-739. Eligibility
Sec. 17b-262-740. Services covered and limitations
Sec. 17b-262-741. Goods and services not covered
Sec. 17b-262-742. Prior authorization
Sec. 17b-262-743. Billing procedure
Sec. 17b-262-744. Payment limitations
Sec. 17b-262-745. Documentation
Sec. 17b-262-746. Other

Requirements for Payment of Services Provided by Private Non-Medical Institutions

Sec. 17b-262-747. Scope
Sec. 17b-262-748. Definitions
Sec. 17b-262-749. Provider and billing provider requirements
Sec. 17b-262-750. Eligibility
Sec. 17b-262-751. Need for services
Sec. 17b-262-752. Covered services
Sec. 17b-262-753. Limitations
Sec. 17b-262-754. Documentation and record retention requirements
Sec. 17b-262-755. Billing requirements
Sec. 17b-262-756. Payment
Sec. 17b-262-757. Audit and compliance review

Requirements for Payment of Mental Health Rehabilitation Services for Adults Provided by Private Non-Medical Institutions

Sec. 17b-262-758. Scope
Sec. 17b-262-759. Definitions
Sec. 17b-262-760. Provider participation
Sec. 17b-262-761. Eligibility
Sec. 17b-262-762. Need for services
Sec. 17b-262-763. Covered services
Sec. 17b-262-764. Limitations
Sec. 17b-262-765. Prior authorization
Sec. 17b-262-766. Documentation and record retention requirements

Sec. 17b-262-767. Billing requirements
Sec. 17b-262-768. Payment
Sec. 17b-262-769. Audit and compliance review
Sec. 17b-262-770. Scope
Sec. 17b-262-771. Definitions
Sec. 17b-262-772. Provider participation
Sec. 17b-262-773. Establishment and dissemination of written policies
Sec. 17b-262-774—17b-262-778. Reserved

Payment to Chronic Disease Hospitals

Sec. 17b-262-779. Scope
Sec. 17b-262-780. Definitions
Sec. 17b-262-781. Provider participation
Sec. 17b-262-782. Eligibility
Sec. 17b-262-783. Need for service
Sec. 17b-262-784. Services covered
Sec. 17b-262-785. Service limitations
Sec. 17b-262-786. Services not covered
Sec. 17b-262-787. Authorization process
Sec. 17b-262-788. Applied income
Sec. 17b-262-789. Billing and payment procedures
Sec. 17b-262-790. Rates
Sec. 17b-262-791. Documentation
Sec. 17b-262-792. Scope
Sec. 17b-262-793. Definitions
Sec. 17b-262-794. Provider participation
Sec. 17b-262-795. Need for service
Sec. 17b-262-796. Eligibility
Sec. 17b-262-797. Services covered and limitations
Sec. 17b-262-798. Goods and services not covered
Sec. 17b-262-799. Payment and payment limitations
Sec. 17b-262-800. Prior authorization
Sec. 17b-262-801. Billing procedure
Sec. 17b-262-802. Documentation
Sec. 17b-262-803. Other

Requirements for Payment of Services Provided by Psychiatric Residential Treatment Facilities Providers

Sec. 17b-262-804. Scope

Sec. 17b-262-805. Definitions
Sec. 17b-262-806. Provider participation
Sec. 17b-262-807. Eligibility
Sec. 17b-262-808. Services covered
Sec. 17b-262-809. Services not covered
Sec. 17b-262-810. Certification of need requirements
Sec. 17b-262-811. Individual plan of care requirements
Sec. 17b-262-812. Utilization review program
Sec. 17b-262-813. Billing procedures
Sec. 17b-262-814. Documentation and record retention
Sec. 17b-262-815. Payment
Sec. 17b-262-816. Audit and compliance review
Sec. 17b-262-817—17b-262-828. Reserved

Requirements for Payment of Hospice

Sec. 17b-262-829. Scope
Sec. 17b-262-830. Definitions
Sec. 17b-262-831. Provider participation
Sec. 17b-262-832. Eligibility
Sec. 17b-262-833. Refusal to serve
Sec. 17b-262-834. Certification of terminal illness
Sec. 17b-262-835. Plan of care
Sec. 17b-262-836. Election of hospice
Sec. 17b-262-837. Discharge from hospice
Sec. 17b-262-838. Services covered
Sec. 17b-262-839. Coordination of hospice and waiver services
Sec. 17b-262-840. Volunteers
Sec. 17b-262-841. Service limitations
Sec. 17b-262-842. Services not covered
Sec. 17b-262-843. Prior authorization
Sec. 17b-262-844. Billing procedures
Sec. 17b-262-845. Payment
Sec. 17b-262-846. Payment limitations
Sec. 17b-262-847. Review process
Sec. 17b-262-848. Documentation

Requirements for Payment of Rehabilitation Services for Individuals Under Age 21 with Behavioral Health Disorders

Sec. 17b-262-849. Scope

Sec. 17b-262-850. Definitions
Sec. 17b-262-851. Provider participation
Sec. 17b-262-852. Eligibility
Sec. 17b-262-853. Need for services
Sec. 17b-262-854. Covered services
Sec. 17b-262-855. Coverage limitations
Sec. 17b-262-856. Non-billable activities
Sec. 17b-262-857. Authorization
Sec. 17b-262-858. Documentation and record retention requirements
Sec. 17b-262-859. Billing requirements
Sec. 17b-262-860. Payment
Sec. 17b-262-861. Audit and compliance reviews

Requirements for Payment of Services Provided by Licensed Behavioral Health Clinicians in Independent Practice

Sec. 17b-262-912. Scope
Sec. 17b-262-913. Definitions
Sec. 17b-262-914. Provider participation
Sec. 17b-262-915. Eligibility
Sec. 17b-262-916. Services covered
Sec. 17b-262-917. Service limitations
Sec. 17b-262-918. Services not covered
Sec. 17b-262-919. Need for service and treatment plan
Sec. 17b-262-920. Prior authorization and registration
Sec. 17b-262-921. Billing procedures
Sec. 17b-262-922. Payment
Sec. 17b-262-923. Payment rate
Sec. 17b-262-924. Payment limitations
Sec. 17b-262-925. Documentation

Requirements for Payment to Birth Centers

Sec. 17b-262-956. Scope
Sec. 17b-262-957. Definitions
Sec. 17b-262-958. Provider participation
Sec. 17b-262-959. Need for service
Sec. 17b-262-960. Eligibility
Sec. 17b-262-961. Services covered and limitations
Sec. 17b-262-962. Payment and payment limitations
Sec. 17b-262-963. Prior authorization

Sec. 17b-262-964. Billing procedure
Sec. 17b-262-965. Documentation
Sec. 17b-262-966. Reserved

Requirements for Payment of Home Health Agencies

Sec. 17b-262-1. Scope

Sections 17b-262-2 to 17b-262-9 inclusive set forth the requirements for payment of Home Health services provided to individuals who are determined eligible to receive services under Connecticut's Medical Assistance Program pursuant to Section 17b-262 of the Connecticut General Statutes.

(Effective June 4, 1996)

Sec. 17b-262-2. Definitions

For the purpose of Sections 17b-262-1 through 17b-262-9 the following definitions apply:

(1) **"Commissioner"** means the Commissioner of the department of social services, or his representative.

(2) **"Department"** means the State of Connecticut department of social services, or its agent.

(3) **"Home"** means the recipient's place of residence which includes a boarding home or Home for the Aged. Home does not include a hospital, Skilled Nursing Facility, Intermediate Care Facility, or Intermediate Care Facility for the Mentally Retarded.

(4) **"Home Health Care Agency"** means the definition contained in subsection (d) of section 19a-490 of the Connecticut General Statutes (CGS).

(5) **"Home Health Provider"** means any home health care agency licensed by the Department of Public Health and who also meets the requirements for participation in Medicare. Providers shall also meet all departmental enrollment requirements.

(6) **"Refusal to Serve"** shall mean a refusal to accept a new client, a termination of service to an existing client, or an interruption of service to an existing client which lasts longer than 48 hours.

(7) **"Service Area"** means those cities or towns designated by zip codes on forms provided by the department.

(8) **"Suspension of Service"** shall mean an interruption of service to an existing client which lasts 48 hours or less.

(Effective June 4, 1996)

Sec. 17b-262-3. Provider participation

In order to receive payment from the department for home health services, all Home Health Care Agencies shall be licensed by the Department of Public Health and shall meet the requirements for participation in Medicare. [Home Health Care Agency Licensure Regulations: Public Health Code Sections 19-13-D66 to D79 Inclusive and Federal Regulation: Sections 42 (Code of Federal Regulations) 440.70 and 42 (Code of Federal Regulations) 441.15]. Providers shall also meet all departmental enrollment requirements.

(Effective June 4, 1996)

Sec. 17b-262-4. Eligibility

Payment for home health services is available to all persons eligible for Medicaid subject to the conditions and limitations which apply to these services.

(Effective June 4, 1996)

Sec. 17b-262-5. Policy

No home health care agency enrolled as a Medicaid provider shall select a service area, or refuse to serve any person, based on the geographical location of the service to be provided unless the home health care agency has a legitimate, nondiscriminatory reason for its choice of service area or its refusal to serve. Referrals for service made to Medicaid enrolled home health care agencies shall not be refused if the patient's home is located within the home health care agency's designated service area. Any and all home health care agency refusals to serve shall be documented and based upon objective, legitimate, non-discriminatory reason(s). Upon receipt of a complaint of discriminatory action by a home health care agency, the home health care agency's proof of legitimate non-discriminatory purpose shall be evaluated to determine that it is not pretextual.

(Effective June 4, 1996)

Sec. 17b-262-6. Designation of service area

(a) All home health care agencies shall designate their service area by identifying the zip codes of the areas which they serve on a form to be provided by the department. All changes in that service area shall be reported to the department on an annual basis. The designated service area shall not be smaller than that reported to the Department of Public Health. If an agency serves any zip code within a town or municipality, the agency shall serve all zip codes within such town.

(b) The department shall timely evaluate all such designations, and changes in designations, to determine that the service area has not been chosen in a pattern which suggests an intent to avoid, or has the effect of avoiding, areas with a high concentration of minority residents, based on census data and other objective information. If the department determines that the choice of service area is designed to or has the effect of avoiding areas with a high concentration of minority residents, the agency shall be notified in writing of such determination and shall be required, within ten days, to provide written justification of its choice of service area based upon legitimate non-discriminatory reasons in accordance with subsection 17b-262-8, Legitimate Non-Discriminatory Reason.

(Effective June 4, 1996)

Sec. 17b-262-7. Refusal to serve

(a) All home health care agencies shall record each and every written or oral refusal to serve and suspension of service, including but not limited to discharges, including the date, the name and address of the patient or the reason why the name and address is unavailable, the reason for the refusal to serve, and identifying the support for this reason.

(b) If the stated reason for the refusal to serve is that there is an immediate danger to the health and safety of the home health care agency's personnel, the home health care agency shall, within 48 hours of the refusal to serve or discharge:

(1) Complete a form to be provided by the department detailing the timely, objective and substantial evidence on which the refusal to serve is based, the reasonable efforts taken to protect the home health care agency personnel, the geographic area covered by the refusal to serve, and the actual or expected duration of the refusal to serve;

(2) If the name and address of the client are known, send the client written notice of the refusal to serve in a form prescribed by the department, which notice shall include the reason for the refusal to serve, the timely, objective and substantial evidence on which the refusal to serve is based, the length of time during which service shall be refused, the right of the client to file a complaint with the department; and informing the client of his or her right to seek legal advice if he or she feels his or her rights have been violated; and

(3) Send the department a copy of the form with a copy of the notice to the client attached.

If the department determines that the agency has failed to comply with these requirements, the home health care agency shall be notified in writing of such determination, and shall be required, within ten days of receipt of the notice, to submit, in writing, justification for its failure to comply based on legitimate nondiscriminatory reasons in accordance with section 17b-262-8.

(c) The department shall review and monitor all forms prepared by home health care agencies pursuant to subsection (b) of section 17b-262-7, Refusal to Serve, to determine that the refusal to serve does not evidence a pattern which suggests an intent to avoid, or have the effect of avoiding, areas with a high concentration of minority residents, based on census data and other objective information. If the department determines that such a pattern exists, the home health care agency shall be notified of such determination, and shall be required, within ten days, to submit, in writing, justification for his refusals to serve based on legitimate non-discriminatory reasons in accordance with section 17b-262-8.

(d) The department shall conduct random inspections to ensure compliance with record-keeping requirements.

(e) The department shall respond to all complaints of refusal to serve by conducting a full investigation into the circumstances of the particular case, including but not limited to inspection of the home health care agency's records regarding refusals to serve.

(f) The department shall, in its discretion, conduct investigations into any refusals to serve or discharges which it determines warrant investigation, even in the absence of a specific complaint.

(g) If the department determines that a home health care agency has refused to serve a person located within its designated service areas, the agency shall be notified in writing of such determination and shall be required, within ten days, to submit, in writing, justification for its refusal to serve based upon legitimate non-discriminatory reasons in accordance with section 17b-262-8.

(h) All suspensions of service shall be justified by timely, objective and substantial evidence, and oral or written notice of the suspension shall be given to the client.

(Effective June 4, 1996)

Sec. 17b-262-8. Legitimate non-discriminatory reason

(a) In any case in which a home health care agency is required to provide written justification based upon legitimate non-discriminatory reasons in accordance with this section, the home health care agency shall be afforded an opportunity to demonstrate, and shall have the burden of demonstrating, that it had a legitimate, nondiscriminatory reason for its actions, including but not limited to:

(1) The patient's non-compliance with the plan of care;

(2) Lack of staff qualified for the client's particular medical needs; and

(3) Immediate danger to the health or safety of home health care agency personnel.

(b) Immediate danger to the health or safety of home health care agency personnel shall not constitute a legitimate, non-discriminatory reason unless:

(1) There is timely, substantial and objective evidence demonstrating that the provider has a well-founded belief that there is an immediate danger to the health or safety of home health care agency personnel in providing services at the particular time and location at which the home health care services were requested, or in accessing such location, which prevents the agency from delivering services;

(2) All reasonable efforts to protect the home health care agency personnel have been made prior to refusing service, including but not limited to the use of escorts, coordination with community patrols, and coordination with public and housing authority law enforcement;

(3) The refusal to serve covers an area no larger than necessary to avoid the immediate danger to the health and safety of the home health care agency personnel; and

(4) The refusal to serve is limited in duration so as to be no longer than necessary to avoid the immediate danger to the health or safety of the home health care agency personnel.

(c) Proof of a legitimate non-discriminatory reason, including immediate danger to the health and safety of home health care agency personnel, shall be documented in writing and be based on timely, objective and substantial evidence. Such proof may include, but not be limited to, records maintained pursuant to Department of Public Health's regulations. Proof of immediate danger to the health and safety of home health care agency personnel, such as documented observation of significant drug dealing, criminal gang activity or threatening use of weapons or police department reports of ongoing criminal activity, shall relate to the particular location in question, or the means of access to that location.

(d) All proof of legitimate non-discriminatory purpose submitted pursuant to subsection (c) of section 17b-262-8, Legitimate Non-Discriminatory Reason, shall be investigated and evaluated by the department to ensure that they are not pretextual. For purposes of this section, an allegedly legitimate non-discriminatory purpose is pretextual when:

(1) The home health care agency is unable to offer timely, substantial and objective proof

of its alleged legitimate non-discriminatory purpose; or

(2) Timely, substantial and objective evidence exists which demonstrates that there were alternative, neutral means of accomplishing the alleged purpose and that the home health care agency knew or should have known of the existence of such alternative, neutral means.

The department shall issue its findings and recommendations in writing at the conclusion of its investigation.

(e) If the home health care agency is unable to demonstrate a legitimate nondiscriminatory purpose, or if the department finds an alleged legitimate non-discriminatory purpose to be pretextual, the department shall issue a notice of violation and refer the case to the U.S. Department of Health and Human Services Office of Civil Rights.

(Effective June 4, 1996)

Sec. 17b-262-9. Sanctions

If the department determines, in accordance with sections 17b-262-1 through 17b-262-9, that these regulations have been violated, the department shall provide the home health care agency a written notice of violation stating the basis of the department's determination and the sanctions to be imposed. Such sanctions may include any of the following, alone or in combination:

(a) Termination of provider agreement;
(b) Monitoring and/or reporting requirements;
(c) Public Notice; and
(d) Such other and further sanctions as the department deems appropriate.

(Effective June 4, 1996)

Sec. 17b-262-10—17b-262-201. Reserved

Requirements for the Reimbursement of Early Intervention Services to Children Age Birth to Three Years with Developmental Delays

Sec. 17b-262-202—17b-262-211. Repealed

Repealed August 28, 1998.

Sec. 17b-262-212. Reserved

Requirements for Payment of School Based Child Health Services

Sec. 17b-262-213. Scope

Sections 17b-262-213 to 17b-262-224 inclusive set forth the requirements for payment of school based child health services provided by or on behalf of Local Educational Agencies (LEAs) under section 10-76d of the Connecticut General Statutes (CGS), and Part B of the Individuals with Disabilities Education Act (IDEA) 20 U.S.C section 1411 et seq., to children determined eligible to receive such services under Connecticut's Medical

Assistance Program pursuant to section 17b-262 of the CGS.

(Effective January 31, 1996; Amended May 10, 2000)

Sec. 17b-262-214. Definitions

For purposes of section 17b-262-213 through 17b-262-224 the following definitions shall apply:

(1) **"Allied Health Professional"** means an individual who is licensed or certified by the Department of Public Health (DPH) or the SDE to provide school based child health services as defined within the context of this regulation.

(2) **"Child"** means an individual as defined in subsection (e) of section 10-76a of the Connecticut General Statutes (CGS).

(3) **"Children Requiring Special Education"** means an individual as defined in subsection (e) of section 10-76a of the CGS.

(4) **"Department"** means the State of Connecticut Department of Social Services (DSS) or its designated agent.

(5) **"Diagnostic Services"** means those services as defined in the Code of Federal Regulations (CFR) under 42 CFR, Part 440, subsection (a) of section 440.130, as amended from time to time.

(6) **"Individualized Education Program (IEP)"** means the ongoing plan of treatment services as defined in section 10-76d-11 of the Regulations of Connecticut State Agencies, and Part B of IDEA, as amended from time to time.

(7) **"Evaluation"** is the process defined under section 10-76d-9 of the Regulations of Connecticut State Agencies.

(8) **"Licensed Practitioner of the Healing Arts"** means those practitioners as defined in section 20-1 of the CGS.

(9) **"Local Educational Agencies" or "Board of Education"** means local or regional boards of education as defined in subsection (b) of section 10-76a-1 of the Regulations of Connecticut State Agencies and in Part B of IDEA, as amended from time to time.

(10) **"Medical Appropriateness/Medically Appropriate"** means health care that is provided in a timely manner and meets professionally recognized standards of acceptable medical care; is delivered in the appropriate setting; and is the least costly of multiple, equally- effective, alternative treatments or diagnostic modalities.

(11) **"Medically Necessary"** means medical care provided to correct or diminish the adverse affects of a medical condition, assist an individual in attaining or maintaining an optimal level of well being, diagnose a condition or prevent a medical condition from occurring.

(12) **"Planning and Placement Team"** means the definition contained in subsection (p) of section 10-76a-1 of the Regulations of Connecticut State Agencies.

(13) **"Provider"** means the local educational agencies or boards of education that participate in the medicaid program as providers of school based child health ("SBCH") services.

(14) **"Qualified SBCH Service Providers"** include but, are not limited to: licensed physician, licensed osteopath, licensed optometrist, licensed chiropractor, licensed naturopath, licensed audiologist, speech therapy assistants working under the direction of licensed speech pathologists, licensed speech pathologist, licensed advanced practice registered nurse (APRN), licensed registered nurse (RN), licensed physician assistant, licensed practical nurse (LPN), licensed psychologist, certified family and marital counselors, SDE certified school psychologist, SDE certified school social worker, DPH certified independent social worker, DPH certified substance abuse counselor, DPH certified marital and family therapist, SDE certified school counselor, SDE certified guidance counselor, licensed occupational therapist, licensed occupational therapy assistant, licensed physical therapist, physical therapist assistant meeting requirements of section 20-66 of the CGS, licensed respiratory care practitioner and licensed optometrist.

(15) **"Rehabilitative Services"** are those services as defined under 42 CFR, Part 440, subsection (d) of section 440.130, as amended from time to time.

(16) **"School Based Child Health Services"** are those diagnostic and rehabilitative treatment services which are medically necessary and appropriate and which meet the needs of children as provided in accordance with Part B of IDEA, as amended from time to time, and section 10-76d of the CGS and supporting regulations, and are recommended in writing by a licensed practitioner of the healing arts within each respective practitioner's scope of practice as defined under state law in accordance with 42 CFR, Part 440, subsections (a) and (d) of section 440.130, as amended from time to time.

(17) **"Triennial Reevaluation"** is the process of reevaluation at least once every three years as described under section 10-76d-9 of the Regulations of Connecticut State Agencies.

(18) **"Type of Placement"** means, for the purposes of this regulation, the type of setting in which the child receives special education services. These settings include, but are not limited to: in-district, out-of-district public residential, out-of-district private residential, out-of-district public day and out-of-district private day.

(Effective January 31, 1996; Amended May 10, 2000)

Sec. 17b-262-215. Provider participation

In order to participate in the Connecticut Medical Assistance Program and provide SBCH Services eligible for Medicaid reimbursement from the Department, the provider shall meet the following requirements:

(1) Enroll with the Department, and have on file, a valid provider agreement. This agreement shall be updated annually in order to continue billing the Department for services.

(2) Ensure that all professionals employed by or under contract arrangements with a LEA to provide school based child health services meet all applicable federal and state licensing and certification requirements.

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

(4) Follow all laws, rules, regulations, policies and amendments which govern Medicaid

reimbursement for services provided pursuant to Part B of IDEA, as amended from time to time, and section 10-76 of the CGS, and which are specified by the federal government and the State of Connecticut.

(Effective January 31, 1996; Amended May 10, 2000)

Sec. 17b-262-216. Eligibility

Medicaid funding is available for SBCH Services under section 17b-262-218 below on behalf of all children who are Medicaid recipients.

(Effective January 31, 1996; Amended May 10, 2000)

Sec. 17b-262-217. Need for services

Medicaid shall reimburse for SBCH Services provided the following requirements are met:

(a) The diagnostic and evaluation services recommended by the PPT and a licensed practitioner of the healing arts in the initial evaluation or triennial reevaluation of the child are supported by reports containing recommendations by licensed or certified practitioners within the scope of their practice as defined by state law.

(b) The ongoing treatment services, as recommended by the PPT and a licensed practitioner of the healing arts, are specified in the child's IEP on file with the respective LEA. The IEP shall include, either in the IEP document itself or in an attachment to the IEP, but is not limited to:

(1) applicable medical diagnoses in a format acceptable to the department;

(2) anticipated treatment goals;

(3) a description of the type, amount, frequency and duration of the services to be furnished;

(4) identification of the type(s) of service providers(s); and

(5) signature(s) of licensed practitioner(s) of the healing arts, within their scope of practice as defined by state law, recommending the plan of medical services.

(Effective January 31, 1996; Amended May 10, 2000)

Sec. 17b-262-218. Services covered

The Department shall pay for the following services:

(a) **Audiology**

Audiology services include, but are not limited to: (1) identification of children with hearing loss; (2) determination of the range, nature and degree of hearing loss, including referral for medical or other professional attention for the treatment of hearing; (3) provision of treatment activities, such as language habilitation, auditory training, speech reading (lip reading), hearing evaluation and speech conservation; (4) creation and administration of programs for the prevention of hearing loss; (5) counseling and guidance of children, parents and teachers regarding hearing loss; and (6) determination of the child's need for individual or group amplification, selecting and fitting an appropriate aid and evaluating the

effectiveness of amplification, provided that these services are within the scope of practice set forth in subsection (3) of section 20-408 of the CGS.

(b) **Clinical Diagnostic Laboratory Services**

Clinical diagnostic laboratory services means services recommended by the PPT such as simple diagnostic tests and procedures performed in the school. These services include, but are not limited to: (1) blood sugar by a finger stick, (2) urine dipstick and (3) hematocrit.

(c) **Durable Medical Equipment, Other Medical Supplies and Devices**

Durable medical equipment means the purchase or rental of medically necessary and appropriate assistive devices such as: (1) augmentative communication device; (2) crouch screen voice synthesizer; (3) prone stander; (4) corner chair; (5) wheelchair; (6) crutches; (7) walkers; (8) auditory trainers; and (9) suctioning machines. Other medical supplies and devices means supplies and devices necessary, and incidental to, IEP related services.

(d) **Medical Services**

Medical services means medical diagnostic and evaluative services recommended by the PPT to determine the child's medically related disability as approved by the licensed practitioner of the healing arts as defined in section 20-1 of the CGS and provided by the qualified SBCH service provider.

(e) **Medical Transportation**

Medical transportation means the transportation of a child identified as requiring special education and related services to sites of medically appropriate and necessary services. This includes the cost of staff required to accompany the child, as prescribed in the IEP, in order to transport the child to and from school and other sites of medically appropriate and necessary services.

(f) **Mental Health Services (Psychological & Counseling Services)**

Mental health services means diagnostic and treatment services involving mental, emotional or behavioral problems and disturbances and dysfunctions, or the diagnosis and treatment of substance abuse. These services include, but are not limited to: (1) mental health evaluations; (2) psychological testing such as the (A) administering of psychological tests and other assessment procedures; (B) interpreting of assessment results; (C) obtaining, integrating and interpreting of information about child behavior and conditions related to learning; (D) planning and managing of a program of psychological services including psychological counseling for children and parents; and (3) counseling services such as individual, group or marital and family counseling or psychotherapy for the treatment of a mental, emotional, behavioral or substance abuse condition to alleviate the condition and encourage growth and development, as performed by qualified SBCH providers, provided these services are within the scope of practice set forth in subsection (a) of section 20-74o, section 20-187a, subsections (a) and (b) of section 20-195, subsection (a) of section 20-195a, subsection (a) of section 20-195m, and subsection (b) of section 20-195q of the CGS, and sections 10-145d-555 through 10-145d-566, inclusive, of the Regulations of Connecticut State Agencies.

(g) **Nursing Services**

Nursing services include, but are not limited to: (1) health assessment and development of individualized health care plans; (2) nursing procedures including suctioning, tracheostomy care, catherterization, toileting, ostomy management and care; (3) monitoring of health status, for example, monitoring of shunt functioning or respiratory status; and individual health counseling and instruction and emergency interventions, provided that these services are within the scope of practice set forth in subsections (a), (b) and (c) of section 20-87a of the CGS.

(h) **Occupational Therapy**

Occupational therapy services means those services as defined in subsection (1) of section 20-74a of the CGS.

(i) **Physical Therapy**

Physical therapy services means those services as defined in subsection (2) of section 20-66 of the CGS.

(j) **Respiratory Care Services**

Respiratory care services means those services as defined in subsection (b) of section 20-162n of the CGS.

(k) **Speech/Language**

Speech pathology services include, but are not limited to: (1) identification of children with speech and language impairments; (2) diagnosis and appraisal of specific speech and language impairments; (3) referrals for medical or other professional attention necessary for the treatment of speech or language impairments; (4) provision of speech or language services for the treatment or prevention of communicated impairments; and (5) counseling or guidance of parents, children and teachers regarding speech and language impairments, provided that these services are within the scope of practice set forth in subsection (1) of section 20-408 of the CGS and sections 10-145d-543 through 10-145d-546, inclusive, of the Regulations of Connecticut State Agencies.

(*l*) **Optometric Services**

Optometric services include, but are not limited to: (1) assessment for visual acuity, color blindness, near vision and strabismus; and (2) diagnosis of abnormalities related to the eye and optic nerves, provided that these services are within the scope of practice set forth in subsection (2) of section 20-127 of the CGS.

(Effective January 31, 1996; Amended May 10, 2000)

Sec. 17b-262-219. Limitations

(a) No payments shall be made by Medicaid:

(1) directly to health professionals or organizations under contract to a LEA for medically appropriate and necessary services covered under section 17b-262-218 above;

(2) for services of an unproven, experimental, cosmetic or research nature or for any diagnostic, therapeutic or treatment procedures in excess of those deemed medically appropriate and necessary by the Department to treat the child's condition;

(3) for any immunizations, biological products and other products or examinations and

laboratory tests for preventable diseases available free of charge from the Department of Public Health;

(4) for speech services involving non-diagnostic, non-therapeutic, routine, repetitive and reinforced procedures or services for the child's general good and welfare (e.g., the practicing of word drills which are not planned and performed or supervised by a licensed speech pathologist);

(5) for services which are provided free of charge to all students such as routine screenings; or

(6) for cancelled visits or appointments not kept.

(b) Services may be provided to an individual until the end of the school year in which a student reaches twenty-one (21) years of age.

(Effective January 31, 1996; Amended May 10, 2000)

Sec. 17b-262-220. Documentation and record retention requirements

(a) A permanent service record documenting each SBCH Service provided to each medicaid eligible child shall be maintained by the LEA at which the child is enrolled at the time of service. The permanent service record shall include, but is not limited to:

(1) the written evaluation and the results of any diagnostic tests;

(2) the diagnosis(ses), in a manner acceptable to the Department;

(3) the IEP signed by a licensed practitioner of the healing arts in a manner acceptable to the Department; and

(4) the actual service delivery record including: the type of service; the date of the service; the units of service; the name and discipline of the person performing services and, for persons affiliated with an organization under contract to the LEA, the name of the organization; the signature of the individual performing the service; and progress notes signed by a licensed or certified allied health professional who performed or supervised the services within the scope of his or her practice under state law.

(b) The Local Educational Agency (LEA) shall maintain a current record of the applicable licenses or certificates of practice of all licensed or certified persons performing SBCH Services.

(c) The Local Educational Agency (LEA) shall maintain all supporting records of costs reported for SBCH Services.

(d) All records shall be maintained for at least six (6) years.

(Effective January 31, 1996; Amended May 10, 2000)

Sec. 17b-262-221. Billing requirements

(a) All SBCH Services performed on behalf of Medicaid-eligible children shall be recorded on the required claim forms for the SBCH provider and submitted to the Department in accordance with the billing instructions provided by the Department.

(b) All claims submitted to the Department for payment of services covered under section 17b-262-218 above shall be substantiated by documentation in the eligible child's permanent

service record pursuant to section 17b-262-220 above.

(Effective January 31, 1996; Amended May 10, 2000)

Sec. 17b-262-222. Establishment of rates

(a) The Department shall establish payment rates for three (3) types of service specific to type of placement for SBCH Services:

(1) a per month per child unit rate for SBCH treatment services, specific to type of placement;

(2) a rate for initial evaluations and triennial reevaluations, specific to type of placement; and

(3) a rate for Durable Medical Equipment, Other Medical Supplies and Devices. Rates shall be determined based upon annual cost and utilization filings made on forms prescribed by the Commissioner of the Department, except that for the July 1, 1999 through June 30, 2000 rate period, such rates shall be determined based upon the July 1, 1996 through June 30, 1997 cost reports inflated by the increase in the consumer price index (urban-all items). Rates shall be based on cost and utilization data for all children referred for special educational services. The Commissioner may establish interim rates for the billing periods.

(b) On an annual basis, except for the July 1, 1999 through June 30, 2000 period, the participating local educational agencies (LEA), shall provide to the Commissioner of the Department of Social Services, for all Medicaid eligible and non-Medicaid eligible children receiving SBCH services through such agencies, the following information and supporting documentation including, but not limited to:

(1) the average monthly unduplicated count of children receiving initial evaluations for special education services by type of placement;

(2) the costs of providing initial evaluations for special education services by type of placement;

(3) the average monthly unduplicated count of children receiving triennial reevaluations and diagnostic testing for special education services by type of placement;

(4) the costs of providing triennial reevaluations and diagnostic testing for special education services by type of placement;

(5) the average monthly unduplicated count of children receiving ongoing special education-related health treatment services independent of initial evaluations and triennial reevaluations by type of placement; and

(6) the costs of providing ongoing special education-related health treatment services independent of initial evaluations and triennial reevaluations by type of placement.

(c) Cost and utilization data provided to the Department by the State Department of Education shall be audited in accordance with Generally Accepted Government Auditing Standards (GAGAS).

Cost and utilization data shall be maintained for a minimum of six (6) years from the billing period by the LEA.

(Effective January 31, 1996; Amended May 10, 2000)

Sec. 17b-262-223. Audit/compliance review

All supporting accounting and business records, statistical data, the child's permanent service record and all other records relating to the provision of SBCH Services paid for by the Department shall be subject to audit or compliance review by authorized personnel. If an audit discloses discrepancies in the accuracy or allowability of actual direct or indirect costs or statistical data as submitted for each state fiscal year by the Department of Education and its LEAs, the Department's rates for said period shall be subject to adjustment. All documentation shall be made available to authorized personnel upon request in accordance with 42 CFR, Part 431. SDE shall take full responsibility for any Medicaid claims disallowed due to inadequate documentation by any LEA or failure to comply with requirements set forth in statute or regulations.

(Effective January 31, 1996; Amended May 10, 2000)

Sec. 17b-262-224—17b-262-298. Reserved

Requirements for Payment of Services Provided by Intermediate Care Facilities for the Mentally Retarded (ICFs/MR)

Sec. 17b-262-299. Scope

Sections 17b-262-299 to 17b-262-311, inclusive, of the Regulations of Connecticut State Agencies set forth the requirements for payment of services provided by Intermediate Care Facilities for the Mentally Retarded to clients eligible to receive such services under Medicaid pursuant to section 17b-262 of the Connecticut General Statutes.

(Adopted effective October 1, 2001)

Sec. 17b-262-300. Definitions

As used in sections 17b-262-299 to 17b-262-311, inclusive, of the Regulations of Connecticut State Agencies the following definitions shall apply:

(1) "Active treatment" means the treatment as described in 42 CFR 483.440(a), as amended from time to time;

(2) "Applied income" means the amount of income that each client receiving ICF/MR services is expected to pay each month toward the cost of his or her care, calculated according to the DSS Uniform Policy Manual, section 5045.20;

(3) "Client" means a person eligible for services under the Connecticut Medicaid program;

(4) "DMR" means the Department of Mental Retardation or its agent;

(5) "DPH" means the Department of Public Health or its agent;

(6) "Department" or "DSS" means the Department of Social Services or its agent;

(7) "Discharge" means the movement of a client out of an ICF/MR;

(8) "Home leave" means an overnight absence from the ICF/MR for any reason other than admission to a hospital. It is taken at the discretion of the client;

(9) "Hospital" means a general hospital, special hospital or chronic disease hospital as

defined in section 19-13-D1(b) of the Regulations of Connecticut State Agencies;

(10) “Interdisciplinary team” or “IDT” means a group of persons, as described in 42 CFR 483.440(c)(2), as amended from time to time;

(11) “Intermediate care facility for the mentally retarded” or “ICF/MR” means a residential facility for the mentally retarded licensed pursuant to section 17a-227 of the Connecticut General Statutes and certified and enrolled to participate in Medicaid as an intermediate care facility for the mentally retarded pursuant to 42 CFR 442.101, as amended from time to time;

(12) “Medical appropriateness” or “medically appropriate” means health care that is provided in a timely manner and meets professionally recognized standards of acceptable medical care; is delivered in the appropriate medical setting; and, is the least costly of multiple, equally-effective, alternate treatments or diagnostic modalities;

(13) “Medicaid” means the program operated by the Department of Social Services pursuant to section 17b-260 of the Connecticut General Statutes and authorized by Title XIX of the Social Security Act;

(14) “Medical necessity” or “medically necessary” means health care provided to correct or diminish the adverse effects of a medical condition or mental illness; to assist a client in attaining or maintaining an optimal level of health; to diagnose a condition; or to prevent a medical condition from occurring;

(15) “Objective information” means an estimate of the client’s projected length of hospital stay obtained by the ICF/MR from a hospital staff person. This prognosis may be obtained from the client’s record or the overall plan of service (OPS) or given by a physician or other health professional under his or her direction or by another qualified professional such as a social worker or discharge planner;

(16) “Overall plan of services” or “OPS” means a document that specifies a strategy to guide the delivery of services to a client for up to one year. It is the document required for a client that meets the federal requirements for a plan of care as outlined in 42 CFR 456.380, as amended from time to time, and an individual program plan as outlined in 42 CFR 483.440, as amended from time to time; and

(17) “Provider” means an ICF/MR that is enrolled in the Medicaid program.

(Adopted effective October 1, 2001)

Sec. 17b-262-301. Provider participation

In order to enroll in Medicaid and receive payment from the department, providers shall comply with sections 17b-262-522 to 17b-262-533, inclusive, of the Regulations of Connecticut State Agencies and be certified, in accordance with federal regulations, to participate in the Medicaid program.

(Adopted effective October 1, 2001)

Sec. 17b-262-302. Eligibility

Payment to Intermediate Care Facilities for the Mentally Retarded is available on behalf

of all clients who are determined to be in need of ICF/MR care by the Department of Mental Retardation and the Department of Social Services, subject to the conditions and limitations set forth in sections 17b-262-299 to 17b-262-311, inclusive, of the Regulations of Connecticut State Agencies. Clients shall be receiving active treatment as described in 42 CFR 483.440(a), as amended from time to time.

(Adopted effective October 1, 2001)

Sec. 17b-262-303. Services covered and limitations

(a) **Services Covered**

(1) The department shall pay an all-inclusive per diem rate, computed in accordance with section 17b-340 of the Connecticut General Statutes and sections 17-311-1 to 17-311-120, inclusive, of the Regulations of Connecticut State Agencies, to the ICF/MR for each client. This rate represents an inclusive payment for all services and items that are required to be provided by the facility as a condition for participation as an ICF/MR, including but not necessarily limited to the following:

(A) services provided by qualified staff engaged by the ICF/MR, as described in 42 CFR 483.430, as amended from time to time;

(B) active treatment services as described in 42 CFR 483.440, as amended from time to time;

(C) client behavior and facility practice as described in 42 CFR 483.450, as amended from time to time;

(D) health care services as described in 42 CFR 483.460, as amended from time to time;

(E) physical environment management as described in 42 CFR 483.470, as amended from time to time;

(F) dietetic services as described in 42 CFR 483.480, as amended from time to time;

(G) routine personal hygiene items as defined in 42 CFR 483.10(c)(8)(i)(E), as amended from time to time;

(H) over the counter medications except insulin;

(I) durable medical equipment, except for those items listed in section 17b-262-676(a)(2) of the Regulations of Connecticut State Agencies where Medicaid payment is available directly to the supplier of durable medical equipment if the item is medically necessary;

(J) supplies used in the routine care of the client that are included on the department's medical and surgical fee schedule including:

(i) antiseptics and solutions;

(ii) bandages and dressing supplies;

(iii) catheters and urinary incontinent supplies;

(iv) diabetic supplies;

(v) diapers and underpads;

(vi) compression, burns and specialized medical garments;

(vii) ostomy supplies;

(viii) respiratory and tracheotomy supplies;

(ix) enteral and parenteral supplies; and
(x) miscellaneous supplies;
(K) services related to the provision or arrangement for provision of customized wheelchairs that are the responsibility of the ICF/MR as described in subsections 17-134d-46(m) and (n) of the Regulations of Connecticut State Agencies; and
(L) transportation services necessary to transport a client to and from any service included in the per diem rate as described in this section.
(2) The department shall pay to reserve a bed in an ICF/MR for a client during a temporary absence in a hospital as described in section 17b-262-306 of the Regulations of Connecticut State Agencies.
(3) The department shall pay to reserve a bed in an ICF/MR for home leave in accordance with section 17b-262-307 of the Regulations of Connecticut State Agencies.
(b) **Limitations**
(1) The department shall not pay for anything of an unproven, experimental or research nature or for services in excess of those deemed medically necessary by the department to treat the client's condition or for services not directly related to the client's diagnosis, symptoms or medical history.
(2) The department shall pay for the date of admission and not for the date of discharge. Exceptions to this are:
(A) the department shall pay for the date of death when the client dies in the ICF/MR. If the client dies while in the hospital or on home leave, the date of death is paid as a reserve bed day, provided all other bed reservation requirements as described in sections 17b-262-306 and 17b-262-307 of the Regulations of Connecticut State Agencies are met; and
(B) in the case of a client admitted and discharged on the same day, payment is authorized for one day of care.

(Adopted effective October 1, 2001)

Sec. 17b-262-304. Need for services and authorization process
(a) The decision to admit and the subsequent admission to a facility must be made by the Department of Mental Retardation or the admitting ICF/MR in conjunction with the client's interdisciplinary team, subject to review by DSS.
(b) DSS shall evaluate and approve in writing the client's need for ICF/MR services ordered by the physician, as described in 42 CFR 456.372, as amended from time to time.
(c) In order for DSS to pay for ICF/MR services, the ICF/MR shall document the need for the admission by all of the following:
(1) certification of the need for care by a physician as described in 42 CFR 456.360(a), as amended from time to time;
(2) medical, psychological and social evaluations as described in 42 CFR 456.370, as amended from time to time;
(3) an admissions review as described in 42 CFR 483.440(b), as amended from time to time;

(4) exploration of alternative services as described in 42 CFR 456.371, as amended from time to time;

(5) an OPS; and

(6) a written report of each evaluation and OPS entered in the client's record, as described in 42 CFR 456.381, as amended from time to time.

(7) DSS written approval of the client's need for ICF/MR services in accordance with 42 CFR 456.372, as amended from time to time.

(d) Beginning no later than six months after admission, or earlier if indicated at the time of admission, the ICF/MR shall document the need for continued stay by all of the following:

(1) recertification of need for care as described in 42 CFR 456.360(b), as amended from to time, on forms prescribed by DSS;

(2) exploration of alternative services as described in 42 CFR 456.371, as amended from time to time;

(3) a continued stay review process in accordance with 42 CFR 456.431 to 42 CFR 456.438, inclusive, as amended from time to time;

(4) a review of the OPS as described in 42 CFR 456.380(c), as amended from time to time; and

(5) monitoring of the program plan as described in 42 CFR 483.440(f), as amended from time to time.

(Adopted effective October 1, 2001)

Sec. 17b-262-305. Client's bill of rights

(a) An ICF/MR shall protect and promote the rights of each client as described in 42 CFR 483.420, as amended from time to time.

(b) Requirements for the administration of the patient's personal allowance shall be in accordance with sections 17-2-140 to 17-2-145, inclusive, of the Regulations of Connecticut State Agencies.

(Adopted effective October 1, 2001)

Sec. 17b-262-306. Bed reserve for hospitalization

(a) DSS shall pay to reserve a bed in an ICF/MR for a client during a temporary absence in a hospital for up to fifteen (15) days in accordance with subsection (e) of this section.

(b) The ICF/MR shall inform the client and guardian or other responsible person, upon admission to the ICF/MR and upon transfer of a client to the hospital, that the bed of a client shall be reserved if the conditions outlined in this section are met.

(c) The ICF/MR shall reserve the bed of any client who is absent from the ICF/MR due to hospitalization unless the ICF/MR has obtained objective information from the hospital that the client shall not return to the ICF/MR within the fifteen day period, including the day of admission, to the hospital.

(d) The ICF/MR shall not make the reserved bed available for use by any other person.

(e) DSS shall reimburse an ICF/MR at the per diem Connecticut Medicaid program rate of the ICF/MR for each day that the ICF/MR reserves the bed of a client in accordance with the following conditions:

(1) an ICF/MR shall be reimbursed for reserving the bed of a client who is hospitalized for a maximum of seven (7) days including the admission date of hospitalization, if on the date of admission the ICF/MR documents that it contacted the hospital and the hospital failed to provide objective information confirming that the person would be unable to return to the ICF/MR within fifteen (15) days of the date of hospitalization;

(2) the ICF/MR shall be reimbursed for a maximum of eight (8) additional days provided on or before the seventh day, but not before the third day of the hospitalization of a client, the ICF/MR contacts the hospital for an update on the client's status and the ICF/MR documents in the client's file that the information obtained through the contact does not indicate that the client shall be unable to return to the ICF/MR within fifteen (15) days of the hospital admission;

(3) documentation of the hospital contact described in subdivisions (1) and (2) of this subsection shall include the date of the contact, the hospital representative's name, the source of the information and the estimated length of stay;

(4) if at any time the ICF/MR is provided with information from the hospital that the client shall not return to the ICF/MR within fifteen (15) days of the hospital admission, the ICF/MR is not eligible to receive reimbursement for reserving the client's bed for any days after such information is received, including the day the information is received; and

(5) for the purposes of determining the beginning of the bed reservation period, admission to the hospital shall mean the time at which the client, on recommendation of a physician, is formally admitted as an inpatient to the hospital. When a client is transferred to the hospital and is not formally admitted, it shall not be considered a discharge, regardless of the length of the stay. It shall be considered a discharge from the ICF/MR only when the client is formally admitted by the hospital. Any other hospital stay, whether in the emergency room or otherwise shall be considered an outpatient visit.

(f) If the client's hospitalization exceeds the period of time that an ICF/MR is required to reserve the client's bed, the ICF/MR:

(1) shall provide the client the first available bed at the time notice is received of the client's discharge from the hospital;

(2) shall grant the client priority admission over applicants for new admission to the ICF/MR; and

(3) may charge a fee to reserve the bed if the client, his or her family or responsible party wishes to pay to reserve the bed. For hospital leave beyond fifteen (15) days per hospital admission, the facility shall reserve the bed as long as payment is available. The fee shall not exceed the per diem Connecticut Medicaid program rate for that bed.

(Adopted effective October 1, 2001)

Sec. 17b-262-307. Bed reserve for home leave

(a) DSS shall pay to reserve a bed in an ICF/MR for a client during a temporary absence for home leave for up to thirty-six (36) days per calendar year. The ICF/MR shall not make the reserved bed available for use by any other person.

(b) The ICF/MR shall inform the client and guardian or other responsible person upon admission to the facility, that a bed shall be reserved for home leave if the conditions outlined in subsection (d) of this section are met.

(c) The ICF/MR shall reserve a client's bed for up to thirty-six (36) days per calendar year. No facility shall require, or request, a client to provide payment for authorized home leave.

(d) DSS shall reimburse an ICF/MR at the per diem Connecticut Medicaid program rate of the facility for each day that the facility reserves the bed in accordance with the following conditions:

(1) the client has not used more than thirty-six (36) days of home leave during the calendar year;

(2) the facility has not refused to take the client back during or upon completion of the authorized home leave. If so, no payment shall be made for the entire home leave; and

(3) the client has not failed to return to the ICF/MR. If the client has not returned, the liability for payment to the ICF/MR shall terminate on the date the ICF/MR is notified that the client will not be returning.

(e) If the client has used more than thirty-six (36) days of home leave in a calendar year the facility shall not be required to reserve the bed; however, the ICF/MR:

(1) shall provide the client the first bed available after notice is received that the client wishes to return;

(2) shall grant the client priority admission over applicants for new admission to the ICF/MR; and

(3) may charge a fee to reserve the bed if the client, his or her family or responsible party wishes to pay to reserve the bed. For home leave beyond thirty-six (36) days per calendar year, the facility shall reserve the bed as long as payment is available. The fee shall not exceed the per diem Connecticut Medicaid program rate for that bed.

(f) The ICF/MR shall document in the client's medical record:

(1) the contact person;

(2) the duration of the absence;

(3) the client's condition before leaving, and upon returning, to the facility; and

(4) the dates of home leave.

(g) The medical record does not need to be closed nor does the client need to be readmitted after home leave.

(Adopted effective October 1, 2001)

Sec. 17b-262-308. Applied income

(a) DSS is responsible for calculating the applied income. DSS shall notify the ICF/MR

of the amount of any applied income that the facility is responsible for collecting. Applied income shall be deducted from what otherwise would have been the DSS monthly payment to the ICF/MR on behalf of the client.

(b) The ICF/MR shall notify DSS of any errors in the amount of applied income processed against the claim using the form specified by DSS. Payment adjustments resulting from retroactive applied income corrections shall be processed periodically.

(c) In any month that a client returns to the community or dies, and the cost of care is less than the applied income, the department shall adjust the applied income as follows: the applied income shall equal the number of days that the client was in the ICF/MR multiplied by the per diem rate.

(d) Applied income shall not be pro rated. It shall be used to cover the cost of care until it is expended.

(Adopted effective October 1, 2001)

Sec. 17b-262-309. Billing and payment procedures

(a) The ICF/MR shall submit claims to the department as described in section 17b-262-529 of the Regulations of Connecticut State Agencies and the billing instructions specific to ICFs/MR.

(b) The ICF/MR shall:

(1) complete the daily admission and discharge forms in accordance with DSS instructions;

(2) notify the DSS caseworker if the ICF/MR is aware that the ICF/MR client's asset level exceeds the established resource limit. The report shall be made on the form specified by DSS.

(3) notify the convalescent payment unit of DSS of any and all credits due DSS on the form specified by DSS.

(Adopted effective October 1, 2001)

Sec. 17b-262-310. Rates

The per diem rates for an ICF/MR shall be determined annually, pursuant to section 17b-340 of the Connecticut general statutes and sections 17-311-1 to 17-311-120, inclusive, of the Regulations of Connecticut State Agencies. DSS shall reimburse the ICF/MR at the per diem rate minus the applied income.

(Adopted effective October 1, 2001)

Sec. 17b-262-311. Documentation

(a) The ICF/MR shall maintain all documentation required for rate setting purposes for a minimum of 10 years pursuant to section 17-311-56 of the Regulations of Connecticut State Agencies, including all documentation required to support the billing for bed reserve days described in subsection (e)(4) of this section. This documentation shall be subject to review by the department.

(b) The ICF/MR shall maintain all other documentation required by this section for at least five (5) years or longer as required by statute or regulation, and shall be subject to review by authorized department personnel. In the event of a dispute concerning a service provided, the ICF/MR shall maintain all documentation until the end of the dispute, for five (5) years, or for the length of time required by statute or regulation, whichever is longest.

(c) Failure to maintain all required documentation shall result in the disallowance and recovery by the department of any amounts paid to the ICF/MR for which the required documentation is not maintained and provided to the department upon request. Documentation requirements are described in detail in the Provider Agreement for ICFs/MR and sections 17b-262-522 to 17b-262-533, inclusive, of the Regulations of Connecticut State Agencies.

(d) An ICF/MR shall maintain fiscal and medical records to fully disclose services and goods rendered or delivered to Medicaid residents. Records shall be maintained in accordance with the department's Provider Agreement for ICFs/MR.

(e) Required documentation shall include:

(1) all reports, evaluations, certifications, reviews and approvals documenting the need for admission as described in subsection 17b-262-304(b) of the Regulations of Connecticut State Agencies;

(2) all certifications and reviews documenting the need for continued stay as described in subsection 17b-262-304(c) of the Regulations of Connecticut State Agencies;

(3) all admission and discharge forms required by DSS; and

(4) all documentation required to support the ICF's/MR billing for and the DSS payment of bed reserve days as described in sections 17b-262-306 and 17b-262-307 of the Regulations of Connecticut State Agencies.

(f) Providers shall maintain all medical records pursuant to sections 17a-227-17 and 17a-227-18 of the Regulations of Connecticut State Agencies.

(Adopted effective October 1, 2001)

Sec. 17b-262-312—17b-262-336. Reserved

Requirements for Payment of Physicians' Services

Sec. 17b-262-337. Scope

Sections 17b-262-337 through 17b-262-349, inclusive, set forth the Department of Social Services requirements for payment of accepted methods of treatment performed by or under the supervision of licensed physicians for clients who are determined eligible to receive services under Connecticut's Medicaid Program pursuant to section 17b-261 of the Connecticut General Statutes.

(Adopted effective May 11, 1998; Amended January 31, 2008)

Sec. 17b-262-338. Definitions

As used in sections 17b-262-337 through 17b-262-349, inclusive, of the Regulations of

Connecticut State Agencies:

(1) "Acute" means symptoms that are severe and have rapid onset and a short course;

(2) "Admission" means the formal acceptance by a hospital of a client who is to receive health care services while lodged in an area of the hospital reserved for continuous nursing services;

(3) "Allied Health Professional" or "AHP" means a licensed individual who is qualified by special training, education, skills, and experience in health care and treatment and shall include: psychologists, social workers, nurses, nurse midwives, physician assistants, professional counselors, marital and family therapists, alcohol and drug counselors, physical therapists, occupational therapists, speech therapists, audiologists and respiratory care practitioners as defined in title 20 of the Connecticut General Statutes;

(4) "Border provider" means a provider located in a state bordering Connecticut, in an area that allows it to generally serve Connecticut residents, and that is enrolled as and treated as a Connecticut Medical Assistance Program provider. Such providers are certified, accredited, or licensed by the applicable agency in their state and are deemed border providers by the department on a case-by-case basis;

(5) "Child" means a person who is under twenty-one years of age;

(6) "Chronic disease hospital" means "chronic disease hospital" as defined in section 19-13-D1 of the Regulations of Connecticut State Agencies;

(7) "Client" means a person eligible for goods or services under the department's Medicaid program;

(8) "Commissioner" means the Commissioner of Social Services appointed pursuant to subsection (a) of section 17b-1 of the Connecticut General Statutes;

(9) "Consultation" means those services rendered by a physician whose opinion or advice is requested by the client's physician or agency in the evaluation or treatment of the client's illness;

(10) "Department" means the Department of Social Services or its agent;

(11) "Early and Periodic Screening, Diagnostic and Treatment services" means the services provided in accordance with section 1905(r) of the Social Security Act, as amended from time to time;

(12) "Emergency" means a medical condition, including labor and delivery, manifesting itself by acute symptoms of sufficient severity, including severe pain, such that the absence of immediate medical attention could reasonably be expected to result in placing the client's health in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part;

(13) "Family planning services" means any medically approved diagnostic procedure, treatment, counseling, drug, supply, or device which is prescribed or furnished by a provider to individuals of childbearing age for the purpose of enabling such individuals to freely plan the number and spacing of their children;

(14) "Fees" means the payments for services, treatments, and drugs administered by physicians which shall be established by the commissioner and contained in the

department's fee schedules;

(15) "General hospital" means "general hospital" as defined in section 17-134d-80 of the Regulations of Connecticut State Agencies;

(16) "Home" means the client's place of residence, which includes a boarding home, community living arrangement, or residential care home. Home does not include facilities such as hospitals, chronic disease hospitals, nursing facilities, intermediate care facilities for the mentally retarded (ICF/MR), or other facilities that are paid an all inclusive rate directly by Medicaid for the care of the client;

(17) "Hysterectomy "means "hysterectomy" as defined in 42 CFR 441.251;

(18) "Informed consent" means "informed consent" as defined in 42 CFR 441.257;

(19) "Intermediate care facility for the mentally retarded" or "ICF/MR" means a residential facility for persons with mental retardation licensed pursuant to section 17a-227 of the Connecticut General Statutes and certified to participate in the Medicaid program as an intermediate care facility for the mentally retarded;

(20) "Institutionalized individual" means an "institutionalized individual" as defined in 42 CFR 441.251;

(21) "Legend Device" means "legend device" as defined in section 20-571 of the Connecticut General Statutes;

(22) "Legend Drug" means "legend drug" as defined in section 20-571 of the Connecticut General Statutes;

(23) "Medical appropriateness" or "Medically appropriate" means health care that is provided in a timely manner and meets professionally recognized standards of acceptable medical care; is delivered in the appropriate setting; and is the least costly of multiple, equally-effective alternative treatments or diagnostic modalities;

(24) "Medicaid" means the program operated by the Department of Social Services pursuant to section 17b-260 of the Connecticut General Statutes and authorized by Title XIX of the Social Security Act;

(25) "Medical necessity" or "medically necessary" means health care provided to correct or diminish the adverse effects of a medical condition or mental illness; to assist an individual in attaining or maintaining an optimal level of health; to diagnose a condition; or to prevent a medical condition from occurring;

(26) "Medical record" means "medical record" as defined in section 19a-14-40 of the Regulations of Connecticut State Agencies;

(27) "Mentally incompetent individual" means a "mentally incompetent individual" as defined in 42 CFR 441.251;

(28) "Nursing facility" means a "nursing facility" as defined in 42 USC 1396r(a);

(29) "Out of state provider" means a provider that is located outside Connecticut and is not a border provider;

(30) "Panel or Profile Tests" means certain multiple tests performed on a single specimen or material derived from the human body which are related to a condition, disorder or family of disorders, which when combined mathematically or otherwise, comprise a finished

identifiable laboratory study or studies;
(31) "Physician" means a person licensed pursuant to section 20-10 of the Connecticut General Statutes;
(32) "Physicians' services" means services provided:
(A) by a physician within the scope of practice as defined by state law; or
(B) by an AHP within the scope of practice of the AHP as defined by state law;
(33) "Prior authorization" means approval for the provision of a service or the delivery of goods from the department before the provider actually provides the service or delivers the goods;
(34) "Provider" means a licensed physician or physician group enrolled in the Medicaid program, or an AHP acting within their scope of practice;
(35) "Quality of care" means the evaluation of medical care to determine if it meets the professionally recognized standards of acceptable medical care for the condition and the client under treatment;
(36) "Sterilization" means "sterilization" as defined in 42 CFR 441.251;
(37) "Under the supervision" means that the physician shall assume professional responsibility for the service performed by the AHP;
(38) "Usual and customary charge" means the amount that the provider charges for the service or procedure in the majority of non-Medicaid cases. If the provider varies the charges so that no one amount is charged in the majority of cases, "usual and customary charge" shall be defined as the median charge. Token charges for charity patients and other exceptional charges are to be excluded; and
(39) "Utilization review" means "utilization review" as defined in section 17-134d-80 of the Regulations of Connecticut State Agencies.

(Adopted effective May 11, 1998; Amended January 31, 2008)

Sec. 17b-262-339. Provider participation

In order to enroll in Medicaid and receive payment from the department, providers shall meet and maintain all departmental enrollment requirements as described in sections 17b-262-522 to 17b-262-533, inclusive, of the Regulations of Connecticut State Agencies.

(Adopted effective May 11, 1998; Amended January 31, 2008)

Sec. 17b-262-340. Eligibility

Payment for provider's services shall be available on behalf of all persons eligible for Medicaid subject to the conditions and limitations that apply to these services.

(Adopted effective January 31, 2008)

Sec. 17b-262-341. Services covered and limitations

The department shall pay providers:
(1) only for those procedures listed in the department's fee schedule for providers that are medically necessary and medically appropriate to treat the client's condition;

(2) for provider services provided in an office, a general hospital, the client's home, a chronic disease hospital, nursing facility, icf/mr or other medical care facility;

(3) for laboratory services provided by a provider in compliance with the provisions of the Clinical Laboratory Improvement Amendments (CLIA) of 1988;

(4) for medical and surgical supplies used by a provider in the course of treatment of a client;

(5) for drugs and devices administered by a provider;

(6) for a second opinion for surgery when requested voluntarily by the client or when required by the department. The department shall pay for a second opinion according to the established fees for consultation;

(7) for family planning, abortion and hysterectomy services as described in section 17b-262-348(s) of the Regulations of Connecticut State Agencies;

(8) for Early and Periodic Screening, Diagnostic and Treatment services, including treatment services which are indicated following screening not otherwise covered, provided that prior authorization is obtained;

(9) for surgical services necessary to treat morbid obesity when another medical illness is caused by, or is aggravated by, the obesity. Such illnesses shall include illnesses of the endocrine system or the cardio-pulmonary system, or physical trauma associated with the orthopedic system. For the purposes of this section, "morbid obesity" means "morbid obesity" as defined by the International Classification of Diseases (ICD), as amended from time to time;

(10) for family planning services for clients of childbearing age, including minors who can be considered sexually active, and who desire the services;

(11) for sterilization for clients who are at least 21 years of age at the time of informed consent; and

(12) for a hysterectomy performed during a period of retroactive eligibility as described in 42 CFR 441.255(e).

(Adopted effective January 31, 2008)

Sec. 17b-262-342. Services not covered

The department shall not pay for the following:

(1) transsexual surgery or for a procedure which is performed as part of the process of preparing an individual for transsexual surgery, such as hormone therapy and electrolysis;

(2) immunizations, biological products and other products available to providers free of charge;

(3) examinations and laboratory tests for preventable diseases which are furnished free of charge;

(4) information or services provided to a client by a provider over the telephone;

(5) cosmetic surgery;

(6) an office visit for the sole purpose of the client obtaining a prescription where the need for the prescription has already been determined;

(7) cancelled services and appointments not kept;

(8) services provided in a general hospital if the department determines the admission does not, or retrospectively did not, fit the department's utilization review requirements as set forth in section 17-134d-80 of the Regulations of Connecticut State Agencies;

(9) infertility treatment;

(10) sterilizations performed on mentally incompetent individuals or institutionalized individuals;

(11) more than one visit per day to the same physician by a client; and

(12) services to treat obesity other than those described in section 17b-262-341(9) of the Regulations of Connecticut State Agencies; and

(13) any procedures or services of an unproven, educational, social, research, experimental or cosmetic nature; for any diagnostic, therapeutic or treatment services in excess of those deemed medically necessary and medically appropriate by the department to treat the client's condition; or for services not directly related to the client's diagnosis, symptoms or medical history.

(Adopted effective January 31, 2008)

Sec. 17b-262-343. Need for service

Payment for an initial office visit and continuing services which the department deems medically necessary, in relation to the diagnosis for which care is required, is available provided that:

(a) the services are within the scope of the provider's practice, and

(b) the services are made part of the client's medical record.

(Adopted effective January 31, 2008)

Sec. 17b-262-344. Prior authorization

(a) Prior authorization, on forms and in the manner specified by the department, is required in order for payment to be available for the following provider services:

(1) electrolysis epilation;

(2) physical therapy services in excess of two visits per calendar week per client per provider;

(3) physical therapy services in excess of nine visits per calendar year per client per provider, when the therapy being prescribed is for the treatment of:

(A) all mental disorders, including diagnoses related to mental retardation and specific delays in development covered by the International Classification of Diseases (ICD), as amended from time to time;

(B) musculoskeletal system disorders of the spine covered by the ICD, as amended from time to time; and

(C) symptoms related to nutrition, metabolism, and development covered by the ICD, as amended from time to time;

(4) reconstructive surgery, including breast reconstruction following mastectomy;

(5) plastic surgery;

(6) transplant procedures; and

(7) Early and Periodic Screening, Diagnostic and Treatment services that are identified during a periodic screening as medically necessary and which are not payable pursuant to the existing physician fee schedule.

(b) Prior authorization is required for payment of all hospital admissions as required and described in section 17-134d-80 of the Regulations of Connecticut State Agencies.

(c) The department shall make payment available only if the procedure or course of treatment authorized shall be initiated not later than six months of the date of authorization.

(d) The initial authorization period shall be for a period not to exceed six months.

(e) If prior authorization is needed beyond the initial authorization period, requests for continued treatment beyond the initial authorization period shall be considered for up to an additional six-month period per request.

(f) Except in emergency situations, prior authorization shall be received before services are rendered.

(g) In an emergency situation that occurs after working hours or on a weekend or holiday, the provider shall secure verbal approval on the next working day for the services provided. This applies only to those services that normally require prior authorization.

(h) In order to receive payment from the department a provider shall comply with all prior authorization requirements. The department in its sole discretion determines what information is necessary in order to approve a prior authorization request. Prior authorization does not, however, guarantee payment unless all other requirements for payment are met.

(Adopted effective January 31, 2008)

Sec. 17b-262-345. Billing procedures

(a) Claims from providers shall be submitted on the department's designated form or electronically transmitted to the department's fiscal agent and shall include all information required by the department to process the claim for payment.

(b) The amount billed to the department shall represent the provider's usual and customary charge for the services delivered.

(c) When a client is referred to a provider for consultation, the consultant provider shall include the referring practitioner's name.

(d) When billing for anesthesia services, anesthesiologists shall include the name of the primary surgeon on the bill.

(e) Laboratory services performed in the provider's office shall be payable to the provider and shall be billed as separate line items. When a provider refers a client to a private laboratory for services, the laboratory shall bill directly and no laboratory charge shall be paid to the provider.

(f) when services are provided by more than one member of a group, the authorization request shall be submitted prior to billing as described in the billing instructions in the

provider manual.

(Adopted effective January 31, 2008)

Sec. 17b-262-346. Payment

(a) Fees shall be the same for in state, border and out-of-state providers.

(b) Payment shall be made at the lowest of:

(1) the provider's usual and customary charge;

(2) the lowest Medicare rate;

(3) the amount in the applicable fee schedule as published by the department pursuant to section 4-67c of the Connecticut General Statutes; or

(4) the amount billed by the provider.

(c) Notwithstanding the provisions of the regulations of connecticut state agencies or any provisions of the department's Medical Services Policy, the department shall not pay any provider under sections 17b-262-337 through 17b-262-349, inclusive, of the Regulations of Connecticut State Agencies for a client seen at a freestanding clinic enrolled in Medicaid. Only the clinic may bill for such services. As an exception to the foregoing, a provider may bill for covered services for a client seen at an outpatient dialysis clinic or at an outpatient surgical facility. A provider who is enrolled with medicaid at a location separate from the clinic may bill the department for clients seen at the separate practice location.

(d) The department shall not pay interns or residents for their services nor shall the department pay for assistant surgeons in general or chronic disease hospitals staffed by interns and residents, unless the procedure is significantly complicated, open heart surgery for example, so as to justify a full surgeon acting as an assistant. If the surgery is performed by a resident or intern and the supervising surgeon assists, only the assistant's fee shall be paid to the surgeon. The regular surgical fee shall not be paid.

(e) If a resident or intern performs the surgery and the supervising surgeon is not present while the procedure is performed, no fee shall be paid to the surgeon even when the surgeon is on call.

(Adopted effective January 31, 2008)

Sec. 17b-262-347. Payment rate

The department shall establish and may periodically update the fees for covered physician services as promulgated in the department's fee schedule pursuant to section 4-67c of the Connecticut General Statutes.

(Adopted effective January 31, 2008)

Sec. 17b-262-348. Payment limitations

(a) The fees listed in the department's fee schedule shall be payable only when the services are performed by or under the supervision of a provider.

(b) The department shall pay the fee for an initial visit by a provider in an office, home,

ICF/MR or nursing facility only once per client. Initial visits refer to the provider's first contact with the client and reflect higher fees for the additional time required for setting up records and developing past history. The only exception to this is when the provider-client relationship has been discontinued for three or more years and is then reinstated.

(c) The department shall pay non-hospital based providers for evaluation and management services provided to the provider's private practice clients in the emergency room.

(d) Payment for physician fees are available only when the opinions and advice of a physician consultant are requested by another physician or other appropriate source. The consultant's opinion and any services that were ordered or performed must be documented in the patient's medical record and communicated by written report to the requesting physician or other appropriate source. In a consultation, the referring provider carries out the plan of care. In a referral, a second provider provides direct service to the client.

(e) If a client is referred to a provider for treatment of a condition that the referring provider does not usually treat, the department shall pay the treating provider the fee for an office visit rather than the fee for a consultation.

(f) When the consultant provider assumes the continuing care of the client, any subsequent service shall be paid according to the fee listed for the procedure.

(g) If a client's medical condition necessitates the concurrent services and skills of two or more providers, each provider shall be entitled to the listed fee for the service that he or she provides.

(h) When a provider examines a Medicaid applicant for the purpose of substantiating whether a medical condition exists that would enable the department to determine eligibility for Medicaid disability, the department shall pay only for the tests required to establish eligibility as requested by the department. No other procedures shall be paid.

(i) **Surgery**

(1) When a claim is submitted by a provider for multiple surgical procedures performed on the same date of service, the department shall pay for the primary surgical procedure the full Medicaid allowed amount. the department shall pay for additional surgical procedures performed on that day at 50% of the Medicaid allowed amount.

(2) When an assistant surgeon, in addition to staff provided by the general or chronic disease hospital, is required, the amount payable by the department to the assistant surgeon shall be 20% of the listed fee for surgery.

(3) Fees for related evaluation and management encounters on the same day of surgery are not payable.

(4) The listed fees for all surgical procedures include the surgery and typical postoperative follow-up care while in the general or chronic disease hospital. Followup visits after a client is discharged from the general or chronic disease hospital shall be payable as office visits.

(5) The listed fees for surgery on the musculoskeletal system shall include payment for the application of the first cast or traction device.

(j) **Anesthesia**

(1) The listed fees for anesthesia services include pre- and post-operative visits, the administration of the anesthetic and the administration of fluids and blood incident to the anesthesia or surgery.

(2) The listed fees for anesthesia services shall be used only when the anesthesia is administered by or under the supervision of a licensed provider who remains in constant attendance during the procedure for the sole purpose of rendering anesthesia services.

(3) No payment shall be made for local infiltration or digital block administered by the operating surgeon.

(k) **Radiology**

(1) The listed fees for all diagnostic radiology procedures, including nuclear medicine, magnetic resonance imaging, computerized axial tomography and diagnostic ultrasound, shall include consultation and a written report to the referring provider.

(2) The listed fees for all diagnostic radiology procedures shall apply only when the provider's own equipment is being used. If the equipment used to perform the procedure is owned directly or indirectly by the general or chronic disease hospital or a related entity, or if a hospital includes the operating expenses of the equipment in its cost reports, the provider shall not be paid for the technical component of the listed fee.

(*l*) **Radiotherapy**

(1) The provider fee for radiological treatment of malignancies shall include one-year follow-up care unless otherwise specified.

(2) The provider fee for treatment of nonmalignant conditions shall include followup care ninety days from the end of treatment unless otherwise specified.

(3) The provider fee for treatment shall include the concomitant office visits, but does not include surgical, radiological or laboratory procedures performed on the same day.

(4) The fees listed for therapeutic procedures involving the use of radium and radioisotopes shall not include the radioactive drug used or preliminary and followup diagnostic tests. Radioactive drugs may be billed separately.

(5) The fees listed for diagnostic procedures involving the use of radium and radioisotopes shall not include the radioactive drugs used. Radioactive drugs may be billed separately.

(m) **Laboratory**

(1) The following routine laboratory tests shall be included in the physician fee for an office visit and shall not be billed on the same date of service: urinalysis without microscopy, hemoglobin determination and urine glucose determination.

(2) No payment shall be made for tests which are provided free of charge.

(3) Payment shall be made for panel or profile tests according to the fees listed in the department's fee schedule for panel tests and not according to the fee for each separate test included in the panel or profile.

(n) **Drugs**

(1) The department shall pay the actual acquisition costs for oral medications incident

to an office visit as billed by the provider.

(2) The department shall pay for legend drugs and legend devices administered by the provider based on a fee schedule determined by the department.

(3) No payment shall be made for drugs provided free of charge.

(o) **Newborn Care**

(1) The provider fee for routine care of a normal newborn infant in the general hospital includes history and examination of the infant, initiation of diagnostic and treatment programs, preparation of hospital records, history and physical examination of the baby and conferences with the parents. Subsequent hospital care for evaluation and management of a normal newborn is paid per day.

(2) When a newborn requires other than routine care following delivery, the provider shall bill for the appropriate critical care. The department shall not pay both the critical care and the routine or subsequent newborn care for the same child.

(3) Newborn resuscitation may be billed in addition to billing for routine care of a newborn or billing for critical care.

(p) **Payment for assessments and subsequent care for clients in a nursing facility, ICF/MR and chronic disease hospital**

(1) The department shall make payments available to providers for evaluation and management only when performed in the facility.

(2) The annual assessment is limited to one per client per year.

(q) **Allergy Procedures**

Providers shall bill for follow-up visits which include intracutaneous tests only if subsequent visits require testing. If follow-up visits do not include testing, regular office visit codes for established clients shall be billed.

(r) **Admission to a General Hospital**

Payment for services provided by the admitting provider in a general hospital shall not be made available if it is determined by the department's utilization review program, either prospectively or retrospectively, that the admission did not fulfill the accepted professional criteria for medical necessity, medical appropriateness, appropriateness of setting or quality of care. Specific requirements are described in section 17-134d-80 of the Regulations of Connecticut State Agencies.

(s) **Family planning, abortion and hysterectomy**

(1) The department shall pay the provider for sterilization only if the client has given his or her informed consent in accordance with the requirements in 42 CFR 441.250 through 441.259, inclusive, as amended from time to time.

(2) The department shall pay for hysterectomies and related laboratory and hospital services that are medically necessary and medically appropriate only if the physician or physician's representative has obtained:

(A) a consent form in accordance with 42 CFR 441.251 through cfr 441.259 inclusive, as amended from time to time, or

(B) a physician's certification in accordance with 42 CFR 441.255(d), as amended from

time to time.

(3) The department shall pay physicians for all abortions that a physician certifies as medically necessary and medically appropriate whether or not the woman's life would be endangered by carrying the fetus to term and whether or not the pregnancy is the result of rape or incest. For the purposes of abortion coverage and payment, a physician determines medical necessity.

(4) the provider shall maintain all forms required by section 19a-116-1 of the Regulations of Connecticut State Agencies and section 19a-601 of the Connecticut General Statutes.

(Adopted effective January 31, 2008)

Sec. 17b-262-349. Documentation and audit requirements

(a) Providers shall maintain a specific record for all services received for each client eligible for Medicaid payment including, but not limited to: name, address, birth date, Medicaid identification number, pertinent diagnostic information, a current treatment plan and treatment notes signed by the provider, documentation of services provided and the dates the services were provided.

(b) All required documentation shall be maintained in its original form for at least five years or longer by the provider in accordance with statute or regulation subject to review by authorized department personnel. In the event of a dispute concerning a service provided, documentation shall be maintained until the end of the dispute, five years or the length of time required by statute or regulation whichever is longest.

(c) Failure to maintain all required documentation shall result in the disallowance and recovery by the department of any amounts paid to the provider for which the required documentation is not maintained and not provided to the department upon request.

(d) The department retains the right to audit any and all relevant records and documentation and to take any other appropriate quality assurance measures it deems necessary to assure compliance with these and other regulatory and statutory requirements.

(Adopted effective January 31, 2008)

Sec. 17b-262-350—17b-262-439. Reserved

Sec. 17b-262-440—17b-262-449. Repealed

Repealed January 31, 2008.

Sec. 17b-262-450—17b-262-451. Reserved

Requirements for Payment of Psychiatrists' Services

Sec. 17b-262-452. Scope

Sections 17b-262-452 through 17b-262-463 inclusive set forth the Department of Social Services requirements for payment of: (a) medical and clinical services provided by licensed psychiatrists in private or group practice, and (b) clinical procedures performed by allied

health professionals in the employ of the psychiatrist in private or group practice for clients who are determined eligible to receive services under Connecticut's Medical Assistance Program pursuant to section 17b-262 of the Connecticut General Statutes (CGS).

(Adopted effective May 11, 1998)

Sec. 17b-262-453. Definitions

For the purposes of sections 17b-262-452 through 17b-262-463 the following definitions shall apply:

(1) "Acute" means having rapid onset, severe symptoms, and a short course.

(2) "Acute Care" means medical care needed for an illness, episode, or injury which requires short-term, intense care, and hospitalization for a short period of time.

(3) "Allied Health Professional (AHP)" means a professional or paraprofessional individual who is qualified by special training, education, skills, and experience in mental health care and treatment and shall include, but is not limited to: psychologists, social workers, psychiatric nurses, and other qualified therapists.

(4) "By or Under the Supervision" means the psychiatrist shall assume professional responsibility for the service performed by the allied health professional, overseeing or participating in the work of the allied health professional including, but not limited to:

(A) availability of the psychiatrist to the allied health professional in person and within five minutes;

(B) availability of the psychiatrist on a regularly scheduled basis to review the practice, charts, and records of the allied health professional and to support the allied health professional in the performance of services; and

(C) a predetermined plan for emergency situations, including the designation of an alternate psychiatrist in the absence of the regular psychiatrist.

(5) "Client" means a person eligible for goods or services under the department's Medical Assistance Program.

(6) "Commissioner" means the Commissioner of Social Services appointed pursuant to subsection (a) of section 17b-1 of the Connecticut General Statutes.

(7) "Consultation" means those services rendered by a psychiatrist whose opinion or advice is requested by another physician or an agency in the evaluation and treatment of a client's illness.

(8) "Department" means the Department of Social Services or its agent.

(9) "Emergency" means a medical condition, including labor and delivery, manifesting itself by acute symptoms of sufficient severity, including severe pain, such that the absence of immediate medical attention could reasonably be expected to result in placing the client's health in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part.

(10) "Estimated Acquisition Cost (EAC)" means the department's best estimate of the price generally and currently paid by providers for a drug marketed or sold by a particular manufacturer.

(11) "HealthTrack Services" means the services described in subsection (r) of section 1905 of the Social Security Act.

(12) "HealthTrack Special Services" means medically necessary and medically appropriate health care, diagnostic services, treatment, or other measures necessary to correct or ameliorate disabilities and physical and mental illnesses and conditions discovered as a result of a periodic comprehensive health screening or interperiodic encounter. Such services are provided in accordance with subdivision (5) of subsection (r) of section 1905 of the Social Security Act, and are:

(A) services not covered under the State Plan or contained in a fee schedule published by the department; or

(B) services covered under the State Plan and contained in a fee schedule published by the department which exceed the limit on the amount of services established by the department that are contained in regulation.

(13) "Home" means the client's place of residence which includes a boarding home or home for the aged. Home does not include a hospital or long-term care facility; long-term care facility includes a nursing facility, chronic disease hospital, and intermediate care facility for the mentally retarded (ICF/MR).

(14) "Interperiodic Encounter" means any medically necessary visit to a Connecticut Medical Assistance provider, other than for the purpose of performing a periodic comprehensive health screening. Such encounters include, but are not limited to, physician's office visits, clinic visits, and other primary care visits.

(15) "Legend Drug" means the definition contained in section 20-571 of the Connecticut General Statutes.

(16) "Licensed Practitioner of the Healing Arts" means a professional person providing health care pursuant to a license issued by the Department of Public Health (DPH).

(17) "Long-Term Care Facility" means a medical institution which provides, at a minimum, skilled nursing services or nursing supervision and assistance with personal care on a daily basis. Long-term care facilities include:

(A) nursing facilities,

(B) chronic disease hospitals—inpatient, and

(C) intermediate care facilities for the mentally retarded (ICFs/MR).

(18) "Medical Appropriateness or Medically Appropriate" means health care that is provided in a timely manner and meets professionally recognized standards of acceptable medical care; is delivered in the appropriate medical setting; and is the least costly of multiple, equally-effective, alternative treatments or diagnostic modalities.

(19) "Medical Assistance Program" means the medical assistance provided pursuant to Chapter 319v of the Connecticut General Statutes (CGS) and authorized by Title XIX of the Social Security Act. The program is also referred to as Medicaid.

(20) "Medical Necessity or Medically Necessary" means health care provided to correct or diminish the adverse effects of a medical condition or mental illness; to assist an individual in attaining or maintaining an optimal level of health; to diagnose a condition;

or to prevent a medical condition from occurring.

(21) "Medical Record" means the definition contained in section 19a-14-40 of the Regulations of Connecticut State Agencies, which is part of the Public Health Code.

(22) "Prior Authorization" means approval for the provision of a service or the delivery of goods from the department before the provider actually provides the service or delivers the goods.

(23) "Provider" means a psychiatrist.

(24) "Provider Agreement" means the signed, written, contractual agreement between the department and the provider of services or goods.

(25) "Psychiatric Services" means services provided to individuals, groups, and families, by or under the supervision of a licensed psychiatrist in private or group practice. In such a setting the psychiatrist retains the primary medical and clinical responsibility for work up of the initial evaluation, diagnosis, and prescription of the treatment plan, rehabilitation, and discharge of the client. Such services include the diagnosis of specific mental and social problems which disrupt an individual's daily functioning and provide treatment to reduce the symptoms and signs associated with these disturbances.

(26) "Psychiatrist" means a physician licensed pursuant to section 20-10 of the Connecticut General Statutes who specializes in the study, diagnosis, treatment, and prevention of mental and social disorders.

(27) "State Plan" means the document which contains the services covered by the Connecticut Medical Assistance Program in compliance with Part 430, Subpart B, of Title 42 of the Code of Federal Regulations (CFR).

(Adopted effective May 11, 1998)

Sec. 17b-262-454. Provider participation

In order to enroll in the Medical Assistance Program and receive payment from the department, providers shall:

(a) meet and maintain all applicable licensing, accreditation, and certification requirements;

(b) meet and maintain all departmental enrollment requirements; and

(c) have a valid provider agreement on file which is signed by the provider and the department upon application for enrollment into the Medical Assistance Program. This agreement, which shall be periodically updated, shall continue to be in effect for the duration of the agreement or for the stated period in the agreement. The provider agreement specifies conditions and terms which govern the program and to which the provider is mandated to adhere in order to participate in the program.

(Adopted effective May 11, 1998)

Sec. 17b-262-455. Eligibility

Payment for psychiatrists' services shall be available on behalf of all persons eligible for the Medical Assistance Program subject to the conditions and limitations which apply to

these services.

(Adopted effective May 11, 1998)

Sec. 17b-262-456. Services covered and limitations

Except for the limitations and exclusions listed below, the department shall pay for the professional services of a licensed psychiatrist which conform to accepted methods of diagnosis and treatment, but shall not pay for anything of an unproven, educational, social, research, experimental, or cosmetic nature; for services in excess of those deemed medically necessary and medically appropriate by the department to treat the client's condition; or for services not directly related to the client's diagnosis, symptoms, or medical history.

(a) The department shall pay for:

(1) psychiatric evaluation;

(2) psychotherapy, including: individual, group, family, hypnosis, and electroshock;

(3) psychiatric consultation;

(4) drugs, as limited in subsection (b) of section 17b-262-456;

(5) all admitting and inpatient services performed by the admitting psychiatrist in an acute care hospital after the psychiatrist has received prior authorization for the admission pursuant to the department's utilization review program as delineated in section 17-134d-80 of the Regulations of Connecticut State Agencies; and

(6) HealthTrack Services and HealthTrack Special Services.

(b) Limitations on covered services shall be as follows:

(1) a psychiatric evaluation shall be limited to one evaluation in any twelve month period per client per provider;

(2) only one unit of therapy of the same type shall be paid for on the same day:

(3) group psychiatric sessions shall be limited in size to a maximum of eight persons per group session regardless of the payment source of each participant;

(4) services covered shall be limited to those listed in the department's applicable fee schedule; and

(5) hypnosis and electroshock therapy shall be personally provided by a psychiatrist.

(c) **Services Not Covered**

The department shall not pay for the following psychiatric services:

(1) information or services furnished by the provider to the client over the telephone;

(2) concurrent services for the same client involving the same services or procedure;

(3) office visits to obtain a prescription, the need for which has already been ascertained;

(4) procedures performed in the process of preparing an individual for transsexual surgery; and

(5) cancelled office visits or appointments not kept.

(Adopted effective May 11, 1998)

Sec. 17b-262-457. Need for service

The department shall pay for medically necessary and medically appropriate psychiatric

services for Medical Assistance Program eligible clients which are provided by a licensed physician who specializes in the study, diagnosis, treatment, and prevention of mental and social diseases.

(Adopted effective May 11, 1998)

Sec. 17b-262-458. Prior authorization

(a) Prior authorization, on forms and in a manner as specified by the department, is required for all clients, including clients originally referred by another state agency for:

(1) treatment services in excess of thirteen visits in a calendar quarter;

(2) treatment services to hospitalized clients from the date of admission; and

(3) HealthTrack Special Services. HealthTrack Special Services are determined medically necessary and medically appropriate on a case-by-case basis. The request for HealthTrack Special Services shall include:

(i) a written statement from the prescribing physician, or other licensed practitioner of the healing arts, performing such services within his or her respective scope of practice as defined under state law, justifying the need for the item or service requested;

(ii) a description of the outcomes of any alternative measures tried; and

(iii) if applicable and requested by the department, any other documentation required in order to render a decision.

(b) The procedure or course of treatment authorized shall be initiated within six months of the date of authorization. The form shall include the progress made to date and the future gains expected through additional treatment.

(c) Initial authorization for outpatient services shall be up to six months.

(d) Initial authorization for hospital inpatient services shall be authorized for up to forty-two days from the date of initial admission for a specific episode of illness.

(e) Requests for continued treatment beyond the initial authorized period shall be submitted prior to the onset of services for which authorization is requested. The form shall include the progress made to date and the future gains expected through additional treatment.

(f) Outpatient services beyond the initial authorized period shall be extended up to six months.

(g) One extension of hospital inpatient services for the same episode of illness shall be allowed up to an additional twenty one days unless the client requires hospitalization for a concurrent medical problem.

(h) Clients who require hospitalization for a concurrent medical problem shall receive hospital inpatient psychiatric services until hospital inpatient treatment for the concurrent medical problem is no longer necessary.

(i) The authorization request form shall include the name of the physician, person, or agency making the referral.

(j) In emergency or urgent situations involving services which require prior authorization, the provider of the service may request verbal approval by the department during normal working hours, or no later than the next business day if the emergency or urgent situation

occurs outside of the department's normal working hours, when such authorization may be given. However, approval in such a manner shall be limited to psychiatric services that are immediately necessary and vital to the health and safety of the client.

(k) In order to receive payment from the department a provider shall comply with all prior authorization requirements. The department in its sole discretion determines what information is necessary in order to approve a prior authorization request. Prior authorization does not, however, guarantee payment unless all other requirements for payment are met.

(Adopted effective May 11, 1998)

Sec. 17b-262-459. Billing procedures

(a) Claims from psychiatrists shall be submitted on the department's designated form or electronically transmitted to the department's fiscal agent and shall include all information required by the department to process the claim for payment.

(b) The amount billed to the department shall represent the psychiatrist's usual and customary charge for the services delivered.

(c) When a Medical Assistance Program client is referred to a psychiatrist for consultation, the consultant psychiatrist shall include the referring practitioner's provider number and name. If no provider number has been assigned, the consultant psychiatrist shall enter the entire name as well as the state license number of the referring physician on the billing form.

(d) Psychiatric consultations in the hospital, home, or long-term care facility shall be billed as a comprehensive consultation.

(e) All charges billed for supplies and materials provided by a psychiatrist, except glasses, shall be reviewed by the department.

(Adopted effective May 11, 1998)

Sec. 17b-262-460. Payment

(a) Payment shall be made at the lowest of:

(1) the provider's usual and customary charge to the general public;

(2) the lowest Medicare rate;

(3) the amount in the applicable fee schedule as published by the department;

(4) the amount billed by the provider; or

(5) the lowest price charged or accepted for the same of substantially similar goods or services by the provider from any person or entity.

(b) A psychiatrist who is fully or partially salaried by a general hospital, public or private institution, physicians' group, or clinic shall not receive payment from the department unless the psychiatrist maintains an office for private practice at a location separate from the hospital, institution, physicians' group, or clinic in which the psychiatrist is employed. Psychiatrists who are solely hospital, institution, physicians' group, or clinic-based, either on a full- or part-time salary are not entitled to payment from the department for services rendered to Medical Assistance Program clients.

(c) A psychiatrist who maintains an office for private practice separate from the hospital, institution, physicians' group, or clinic shall be able to bill for services provided at the private practice location or for services provided to the psychiatrist's private practice clients in the hospital, institution, physicians' group, or clinic only if the client is not a patient of the hospital, institution, physicians' group, or clinic.

(Adopted effective May 11, 1998)

Sec. 17b-262-461. Payment rate

The commissioner establishes the fees contained in the psychiatrists' and allied health professionals' fee schedules pursuant to section 4-67c of the Connecticut General Statutes.

(Adopted effective May 11, 1998)

Sec. 17b-262-462. Payment limitations

(a) Psychiatrists' services shall be performed at the psychiatrist's private or group practice location, hospital, long-term care facility, clinic, or the client's home.

(b) The psychiatrist who employs allied health professionals shall personally conduct the evaluation and, accordingly, develop the treatment plan in all cases.

(c) In situations where the psychiatrist employs allied health professionals on a salary or fee-for-service basis, the psychiatrist shall be paid at the psychiatrists' rate only under the following conditions:

(1) for clients personally being treated by the psychiatrist; and

(2) when the psychiatrist personally interviews the client as part of the psychiatrist's supervisory responsibilities, but only at that rate which corresponds to the time or service he or she actually provides to the client.

(d) Services provided by allied health professionals shall be billed at the rate for allied health professionals established by the department and not at the scheduled rate for psychiatrists.

(e) Fees for psychiatric evaluations include an allowance for the preparation of a full written report.

(f) When a psychiatrist renders consultation services and thereafter assumes the continuing care of the client, any subsequent services rendered by the psychiatrist or the psychiatrist's staff shall no longer be considered as a consultation and shall be billed at the rate applicable for the ongoing service.

(g) The fee for any procedure, as stipulated in the fee schedule for psychiatric services published by the department, represents the maximum amount payable per day regardless of the time it takes to complete the procedure.

(h) Payment for hospital inpatient services shall be limited to admissions to acute care hospitals.

(i) Payment for services provided by the admitting psychiatrist in an acute care hospital shall not be made, or shall be recouped, if it is determined by the department's utilization review program, either prospectively or retrospectively, that the admission did not fulfill

the accepted professional criteria for medical necessity, medical appropriateness, appropriateness of setting, or quality of care.

(j) The department shall pay psychiatrists for drugs which are administered or dispensed directly to a client under the following conditions:

(1) excluding oral medications, payment shall be made to a psychiatrist for the estimated acquisition cost as determined by the department for drugs which are administered directly to the client; and

(2) for legend drugs which must be administered by a psychiatrist, the department shall reimburse the psychiatrist for the estimated acquisition cost as determined by the department for the amount of the drug which is administered.

(Adopted effective May 11, 1998)

Sec. 17b-262-463. Documentation

(a) Psychiatrists shall maintain a specific record for all services received for each client eligible for Medical Assistance Program payment including, but not limited to: name, address, birth date, Medical Assistance Program identification number, pertinent diagnostic information, a current treatment plan signed by the psychiatrist, documentation of services provided, and the dates the services were provided.

(b) All required documentation shall be maintained for at least five years in the psychiatrist's file subject to review by authorized department personnel. In the event of a dispute concerning a service provided, documentation shall be maintained until the end of the dispute or five years, whichever is greater.

(c) Failure to maintain all required documentation shall result in the disallowance and recovery by the department of any amounts paid to the psychiatrist for which the required documentation is not maintained or provided to the department upon request.

(Adopted effective May 11, 1998)

Sec. 17b-262-464—17b-262-466. Reserved

Requirements for Payment of Psychologists' Services

Sec. 17b-262-467. Scope

Psychologists' services provide professional therapeutic intervention relating to mental, emotional, and social problems involving individuals or groups, taking into consideration the sum of actions, traits, attitudes, thoughts, and mental state of an individual. Sections 17b-262-467 through 17b-262-478 inclusive set forth the Department of Social Services requirements for payment of accepted methods of treatment by licensed psychologists for clients who are determined eligible to receive services under Connecticut's Medical Assistance Program pursuant to section 17b-262 of the Connecticut General Statutes (CGS).

(Effective June 8, 1998)

Sec. 17b-262-468. Definitions

For the purposes of sections 17b-262-467 through 17b-262-478 the following definitions shall apply:

(1) **"Client"** means a person eligible for goods or services under the department's Medical Assistance Program.

(2) **"Commissioner"** means the Commissioner of Social Services appointed pursuant to subsection (a) of section 17b-1 of the Connecticut General Statutes.

(3) **"Department"** means the Department of Social Services or its agent.

(4) **"HealthTrack Services"** means the services described in subsection (r) of section 1905 of the Social Security Act.

(5) **"HealthTrack Special Services"** means medically necessary and medically appropriate health care, diagnostic services, treatment, or other measures necessary to correct or ameliorate disabilities and physical and mental illnesses and conditions discovered as a result of a periodic comprehensive health screening or interperiodic encounter. Such services are provided in accordance with subdivision (5) of subsection (r) of section 1905 of the Social Security Act, and are:

(A) services not covered under the State Plan or contained in a fee schedule published by the department; or

(B) services covered under the State Plan and contained in a fee schedule published by the department which exceed the limit on the amount of services established by the department that are contained in regulation.

(6) **"Interperiodic Encounter"** means any medically necessary visit to a Connecticut Medical Assistance provider, other than for the purpose of performing a periodic comprehensive health screening. Such encounters include, but are not limited to, physician's office visits, clinic visits, and other primary care visits.

(7) **"Licensed Practitioner of the Healing Arts"** means a professional person providing health care pursuant to a license issued by the Department of Public Health (DPH).

(8) **"Medical Appropriateness or Medically Appropriate"** means health care that is provided in a timely manner and meets professionally recognized standards of acceptable medical care; is delivered in the appropriate medical setting; and is the least costly of multiple, equally-effective, alternative treatments or diagnostic modalities.

(9) **"Medical Assistance Program"** means the medical assistance provided pursuant to Chapter 319v of the Connecticut General Statutes (CGS) and authorized by Title XIX of the Social Security Act. The program is also referred to as Medicaid.

(10) **"Medical Necessity or Medically Necessary"** means health care provided to correct or diminish the adverse effects of a medical condition or mental illness; to assist an individual in attaining or maintaining an optimal level of health; to diagnose a condition; or to prevent a medical condition from occurring.

(11) **"Prior Authorization"** means approval for the provision of a service or the delivery of goods from the department before the provider actually provides the service or delivers the goods.

(12) **“Provider”** means a psychologist.

(13) **“Provider Agreement”** means the signed, written, contractual agreement between the department and the provider of services or goods.

(14) **“Psychologist”** means a health professional, licensed by the Board of Examiners of Psychologists of Connecticut pursuant to section 20-186 and under Chapter 383 of the Connecticut General Statutes, who is engaged in private practice and has clinical training and experience approved by the department to provide psychological services to clients eligible under Connecticut’s Medical Assistance Program.

(15) **“Psychologists’ Services”** that are permitted means clinical, diagnostic, and remedial services personally performed by a psychologist. Services include:

(A) counseling and psychotherapy to individuals who are experiencing problems of a mental or behavioral nature; and

(B) measuring and testing of personality, aptitudes, emotions, and attitudes.

(16) **“Qualified Neuropsychologist”** means a psychologist who:

(A) documents completion of a Ph.D. or Psy.D. degree in clinical psychology from a program approved by the American Psychological Association with extensive pre- or post-doctoral coursework in basic neurosciences, neuroanatomy, neuropathol-ogy, clinical neurology, psychological assessment, clinical neuropsychological assessment, psychopathology and psychological intervention; and either

(B) has completed one year of full-time supervised clinical neuropsychological experience at the post-doctoral level and at least one year of independent professional experience as a clinical neuropsychologist, or, in lieu of (B), has

(C) the equivalent of three years of unsupervised post-doctoral experience as a clinical neuropsychologist within the past ten years.

(17) **“Neuropsychological Evaluation”** means a full battery of tests used to develop a diagnosis. The evaluation is the sum of all the testing and diagnostic interview sessions. The components of the neuropsychological evaluation are: patient history; assessment of perceptual motor functions; language functions; attention; memory, learning, intellectual processes and level; and emotional, behavioral, and personality functioning. The evaluation must be accomplished by means of appropriate psychological procedures administered by a qualified neuropsychologist.

(18) **“State Plan”** means the document which contains the services covered by the Connecticut Medical Assistance Program in compliance with Part 430, Subpart B, of Title 42 of the Code of Federal Regulations (CFR).

(Effective June 8, 1998)

Sec. 17b-262-469. Provider participation

In order to enroll in the Medical Assistance Program and receive payment from the department, providers shall:

(a) meet and maintain all applicable licensing, accreditation, and certification requirements;

(b) meet and maintain all departmental enrollment requirements; and

(c) have a valid provider agreement on file which is signed by the provider and the department upon application for enrollment into the Medical Assistance Program. This agreement, which shall be periodically updated, shall continue to be in effect for the duration of the agreement or for the stated period in the agreement. The provider agreement specifies conditions and terms which govern the program and to which the provider is mandated to adhere in order to participate in the program.

(Effective June 8, 1998)

Sec. 17b-262-470. Eligibility

Payment for psychologists' services shall be available on behalf of all persons eligible for the Medical Assistance Program subject to the conditions and limitations which apply to these services.

(Effective June 8, 1998)

Sec. 17b-262-471. Services covered and limitations

Except for the limitations and exclusions listed below, the department shall pay for the professional services of a licensed psychologist which conform to accepted methods of diagnosis and treatment, but shall not pay for anything of an unproven, educational, social, research, experimental, or cosmetic nature; for services in excess of those deemed medically necessary and medically appropriate by the department to treat the client's condition; or for services not directly related to the client's diagnosis, symptoms, or medical history.

(a) The department shall pay for the following psychological services:

(1) Psychodiagnostic Evaluations

(A) Intellectual Evaluation - Individual

Evaluation of intellectual functioning by means of appropriate psychological procedures, such as the Wechsler Adult Intelligence Scale, Wechsler Intelligence Scale for Children, and Stanford-Binet Intelligence Scale;

(B) Scholastic Achievement or Group Intelligence

(i) Scholastic Achievement: Determination of acquired abilities in areas of educational achievement through the administration and evaluation of tests, California Reading Test, and Wide Range Achievement Test; and

(ii) Group Intellectual Evaluation: Determination of intellectual functioning by means of group intelligence tests such as the Lorge-Thorndike Intelligence Test, Otis Quick-Scoring Mental Ability Test, and California Short-Form Test of Mental Maturity;

(C) Personality Diagnosis and Evaluation

Study of personality dynamics, interpersonal relations, emotional adjustment, and stability, through the utilization of psychological procedures such as Rorschach, MMPI, Thematic Apperception Test, Children's Apperception Test, and Figure-Drawing;

(D) Evaluation of Organic Brain Involvement: Organicity

Assessment of functions requiring memory, concept formation, visual motor skills, by

means of psychological procedures such as the Wechsler Memory Scale, Goldstein-Scheerer Battery Graham-Kendall Memory for Designs, and Bender Visual Motor Gestalt Test;

(E) Evaluation of Aptitudes, Interests, and Educational Adjustment

Assessment of vocational aptitudes and interests and educational achievement by means of such procedures as manipulation tests of dexterity and coordination, vocational aptitude tests, interest tests, and achievement tests; and

(F) Neuropsychological Evaluation

Assessment of perceptual or motor functions; attention; memory; and learning; intellectual processes; and emotion, behavior, and personality by means of appropriate psychological procedures administered by a qualified neuropsychologist, such as the Wechsler Adult Intelligence Scale, the Wide Range Achievement Test, the Wechsler Memory Scale, the Luria Nebraska Neuropsychological Battery, and the Halstead-Reitan Neuropsychological Battery.

(2) Counseling and Psychotherapy

(A) Diagnostic Interview

Initial contact, review of available records, and personal interview with subject. Applicable only when formal testing is not possible;

(B) Individual Counseling or Psychotherapy; and

(C) Group Counseling or Psychotherapy.

(3) Staff Consultation

Attendance at staff conferences to present and to discuss psychological findings in planning for the individual; and

(4) HealthTrack Services and HealthTrack Special Services.

(b) Limitations on covered services shall be as follows:

(1) a diagnostic interview or psychodiagnostic evaluation procedure is limited to one of each in any twelve month period per psychologist for the same client;

(2) only one unit of individual counseling or psychotherapy and one unit of group counseling or psychotherapy shall be paid for on the same day;

(3) the department shall not pay for more than one psychodiagnostic evaluation in any twelve month period when performed by the same psychologist for the same client;

(4) group psychotherapy sessions shall be limited in size to a maximum of eight persons per group session regardless of the payment source of each participant;

(5) only two staff consultations, as described in subdivision (3) of subsection (a) of section 17b-262-471, shall be allowed per year per client per psychologist; and

(6) services covered are limited to those listed in the department's published fee schedule.

(Effective June 8, 1998)

Sec. 17b-262-472. Services not covered

The department shall not pay for the following psychological services:

(a) information or services furnished by the psychologist to the client over the telephone;

(b) all evaluations, diagnostic interviews, and therapy services performed in hospital

inpatient or outpatient settings;

(c) concurrent services involving similar treatment modalities for the same client by different health professionals;

(d) cancelled office visits or for appointments not kept; and

(e) psychological services which are primarily for vocational or educational guidance.

(Effective June 8, 1998)

Sec. 17b-262-473. Need for service and authorization process

(a) **Need for Service**

The department shall pay for psychological services which are provided by a licensed psychologist and are medically necessary and medically appropriate for the prevention, diagnosis, and treatment of intellectual functioning and mental illness.

(b) **Prior Authorization**

(1) Prior authorization, on forms and in a manner as specified by the department, is required for:

(A) all clients for all counseling and psychotherapy interviews in excess of thirteen visits in a calendar quarter, per type of treatment for the same provider and client; and

(B) HealthTrack Special Services. HealthTrack Special Services are determined medically necessary and medically appropriate on a case-by-case basis. The request for HealthTrack Special Services shall include:

(i) a written statement from the prescribing physician, or other licensed practitioner of the healing arts, performing such services within his or her respective scope of practice as defined under state law, justifying the need for the item or service requested;

(ii) a description of the outcomes of any alternative measures tried; and

(iii) if applicable and requested by the department, any other documentation required in order to render a decision.

(2) For services requiring prior authorization, the procedure or course of treatment shall be initiated within six months of the date of authorization.

(3) The initial authorization period shall be up to three months.

(4) All authorization request forms shall include an explanation of the need for additional treatment for services in excess of the limitations described in subparagraph (A) of subdivision (1) of subsection (b) of section 17b-262-473, and the future gains expected.

(5) If prior authorization is needed beyond the initial authorization period, requests for continued treatment beyond the initial authorized period shall be considered for up to six months per request.

(6) The provider shall determine as soon as possible whether the number of service visits necessary shall exceed thirteen visits in a calendar quarter. If the number of visits shall exceed the limit, authorization shall be obtained from the department prior to the onset of the service visits for which authorization is needed.

(7) The authorization request form shall include the name of the physician, person, or agency making the referral.

(8) In urgent situations involving services which require prior authorization, the provider of service may request verbal approval by the department during normal working hours, or no later than the next business day if the urgent situation occurs outside of the department's normal working hours, when such authorization may be given. However, approval in such a manner shall be limited to psychological services that are immediately necessary and vital to the health and safety of the client.

(9) In order to receive payment from the department a provider shall comply with all prior authorization requirements. The department in its sole discretion determines what information is necessary in order to approve a prior authorization request. Prior authorization does not, however, guarantee payment unless all other requirements for payment are met.

(Effective June 8, 1998)

Sec. 17b-262-474. Billing procedures

(a) Claims from psychologists shall be submitted on the department's designated form or electronically transmitted to the department's fiscal agent and shall include all information required by the department to process the claim for payment.

(b) The amount billed to the department shall represent the psychologist's usual and customary charge for the services delivered.

(c) Claims submitted for services not requiring prior authorization shall include the name of the physician, person, or agency making the referral—if there was a referral.

(d) When a psychologist is requested to attend a staff conference for a Medical Assistance Program client, the name of the referring practitioner, clinic, or agency shall be entered in the appropriate section of the claim form.

(e) Neuropsychological evaluations shall be billed as one unit regardless of the number of sessions.

(Effective June 8, 1998)

Sec. 17b-262-475. Payment

(a) Psychologists who are fully or partially salaried by a general hospital, public or private institution, group practice, or clinic shall not receive payment from the department unless the psychologist maintains an office for private practice at a separate location from the hospital, institution, or clinic in which the psychologist is employed and bills for a service provided to the psychologist's private practice client at the psychologist's private practice location only.

(b) Payment for services directly performed by a psychologist in private practice shall be made at the lowest of:

(1) the provider's usual and customary charge to the general public;

(2) the lowest Medicare rate;

(3) the amount in the applicable fee schedule as published by the department;

(4) the amount billed by the provider; or

(5) the lowest price charged or accepted for the same or substantially similar goods or

services by the provider from any person or entity.

(Effective June 8, 1998)

Sec. 17b-262-476. Payment rate

The commissioner establishes the fees contained in the department's fee schedule pursuant to section 4-67c of the Connecticut General Statutes.

(Effective June 8, 1998)

Sec. 17b-262-477. Payment limitations

(a) The psychologist's interview of the client's family during the course of treatment in the psychologist's office shall be paid at the rate for individual therapy regardless of the number of persons in attendance.

(b) The fees for evaluative and treatment services, as stipulated in the psychologist's fee schedule, represent one unit of service, and only one unit shall be billed per day per service regardless of the number of days to complete the unit billed.

(c) The department shall not reimburse the psychologist for services performed by allied health professionals or paraprofessionals who are in the employ of the psychologist. The psychologist shall be paid for services only to the clients personally being treated by the psychologist.

(Effective June 8, 1998)

Sec. 17b-262-478. Documentation

(a) Psychologists shall maintain a specific record for all services received for each client eligible for Medical Assistance Program payment including, but not limited to: name, address, birth date, Medical Assistance Program identification number, pertinent diagnostic information, a current treatment plan signed by the psychologist, documentation of services provided, and the dates the services were provided.

(b) The evaluation report for psychodiagnostic tests, including the Aptitudes, Interests, and Education Adjustment Evaluation, shall be on file with the psychologist to justify medical necessity and medical appropriateness of treatment.

(c) All required documentation shall be maintained for at least five years in the psychologist's file subject to review by authorized department personnel. In the event of a dispute concerning a service provided, documentation shall be maintained until the end of the dispute or five years, whichever is greater.

(d) Failure to maintain all required documentation shall result in the disallowance and recovery by the department of any amounts paid to the psychologist for which the required documentation is not maintained and provided to the department upon request.

(Effective June 8, 1998)

Sec. 17b-262-479—17b-262-492. Reserved

Requirements for Client Copayment on Prescription Drugs, Over-The-Counter Drugs, and Refills Under the Medical Assistance Program

Sec. 17b-262-493. Scope

Sections 17b-262-493 to 17b-262-498 inclusive, set forth the copayment requirements for clients who are eligible to receive prescription drugs, over-the-counter drugs, or refills covered under the Medicaid, General Assistance and State Administered General Assistance Programs and furnished by a pharmacy provider enrolled in the Connecticut Medical Assistance Program pursuant to section 17b-259a and section 17b-262 of the Connecticut General Statutes and subject to the exclusions as set forth in section 17b-262-496.

(Adopted effective November 13, 1997)

Sec. 17b-262-494. Definitions

For the purposes of sections 17b-262-493 to 17b-262-498 inclusive, the following definitions shall apply:

(1) "Client" means a person eligible for services under the department's Medical Assistance Program.

(2) "Compounded Prescriptions" means two or more drugs mixed together in which at least one ingredient is a legend drug. A compounded prescription shall include the name, strength, and amount of each prescribed ingredient.

(3) "Copayment" means the set portion of the department's fee for prescription drugs, over-the-counter drugs, or refills which shall be the responsibility of the client to pay to the pharmacy provider for such services furnished to the client.

(4) "Department" means the department of social services.

(5) "Medical Assistance Program" means the medical assistance provided pursuant to Chapter 319V of the Connecticut General Statutes and authorized by Title XIX of the Social Security Act. The program is also referred to as Medicaid.

(6) "Pharmacy" means a facility licensed by the Commission of Pharmacy in the Department of Consumer Protection under Section 20-594 of the Connecticut General Statutes or by the appropriate regulatory body of the state in which it is located.

(7) "Provider" means any individual or entity enrolled in the department's Medical Assistance Program and performing within the scope of his or her practice under state law and capable of furnishing services or goods to Medical Assistance clients under the terms of a provider agreement with the department.

(8) "Provider Agreement" means the signed, written, contractual agreement between the department and the provider of services or goods.

(Adopted effective November 13, 1997)

Sec. 17b-262-495. Services requiring a copayment

Except for the exclusions specified in section 17b-262-496 below, a copayment shall be

imposed on each prescription, over-the-counter drug, or refill which is furnished to a client and covered in the department's fee schedule for pharmacy providers.

(Adopted effective November 13, 1997)

Sec. 17b-262-496. Copayment exclusions

The following list contains those clients and services not subject to a copayment:

(a) The categories of clients and services described in subsection (b) of section 1916 of the Social Security Act and Part 447, section 447.53, of Title 42 of the Code of Federal Regulations (CFR), are specifically excluded from the copayment requirement;

(b) Children who are at least 18 years of age but under 21 years of age; and

(c) Compounded prescriptions.

(Adopted effective November 13, 1997)

Sec. 17b-262-497. Copayment responsibilities

(a) Each pharmacy provider shall collect the copayment amount from the client at the time of the service unless the pharmacy provider, in dispensing a prescription, over-the-counter drug, or refill, does not have face-to-face contact with the client, in which case, the pharmacy shall bill the client for the amount of the copayment;

(b) The copayment shall be automatically deducted from the maximum allowable amount paid by the department to the pharmacy provider for each prescription drug, over-the-counter drug, or refill;

(c) A pharmacy provider participating in the Connecticut Medical Assistance Program may not deny prescription drugs, over-the-counter drugs, or refills to any client because of the client's inability to pay the copayment amount. The client's inability to pay does not eliminate the client's liability for the copayment charge or prevent the provider from attempting to collect the copayment amount from the client at a later time;

(d) The client's own declaration that he or she is unable to pay the copayment amount at the time of the service is the basis for determining when a client is unable to pay; and

(e) No pharmacy provider may waive the copayment requirement or in any way compensate the client for the copayment amount.

(Adopted effective November 13, 1997)

Sec. 17b-262-498. Copayment rate

The copayment amount shall be $1.00 for each prescription drug, over-the-counter drug or refill.

(Adopted effective November 13, 1997)

Requirements for Payment of Inpatient Psychiatric Hospital Services

Sec. 17b-262-499. Scope

Sections 17b-262-499 through 17b-262-510 inclusive set forth the Department of Social

Services requirements for payment for Connecticut's Medical Assistance Program, when clients under age twenty-one and age sixty-five or over receive inpatient psychiatric hospital services in accordance with section 17b-262-499 through section 17b-262-510.

(Adopted effective March 6, 1998)

Sec. 17b-262-500. Definitions

For the purposes of sections 17b-262-499 through 17b-262-510 the following definitions shall apply:

(1) "Active Treatment" means the definition contained in 42 Code of Federal Regulations (CFR), Part 441, section 441.154.

(2) "Acute" means having rapid onset, severe symptoms, and a short course.

(3) "Acute Care" means medical care needed for an illness, episode, or injury which requires short-term, intense care, and hospitalization for a short period of time.

(4) "Allied Health Professional (AHP)" means a professional or paraprofessional individual who is qualified by special training, education, skills, and experience in mental health care and treatment and shall include, but shall not be limited to: psychologists, social workers, psychiatric nurses, and other qualified therapists.

(5) "Certification of Need Review" means an evaluation process for clients under the age of twenty-one who are requesting inpatient admission to a psychiatric hospital. This evaluation is conducted by the department acting as the independent team.

(6) "Client" means a person eligible for goods or services under the department's Medical Assistance Program.

(7) "Client Age Sixty-Five or Over" means the definition contained in 42 CFR, Part 441, section 441.100.

(8) "Client Under Age Twenty-One" means the definition contained in 42 CFR, Part 441, section 441.151.

(9) "Department" means the Department of Social Services or its agent.

(10) "Elective Admission" means any psychiatric admission to a psychiatric hospital or psychiatric facility that is nonemergency, including urgent admissions and transfers from one facility to another.

(11) "HealthTrack Services" means the services described in subsection (r) of section 1905 of the Social Security Act.

(12) "HealthTrack Special Services" means medically necessary and medically appropriate health care, diagnostic services, treatment, or other measures necessary to correct or ameliorate disabilities and physical and mental illnesses and conditions discovered as a result of a periodic comprehensive health screening or interperiodic encounter. Such services are provided in accordance with subdivision (5) of subsection (r) of section 1905 of the Social Security Act, and are:

(A) services not covered under the State Plan or contained in a fee schedule published by the department; or

(B) services covered under the State Plan and contained in a fee schedule published by

the department which exceed the limit on the amount of services established by the department that are contained in regulation.

(13) “Independent Team” means the definition contained in 42 CFR, Part 441, section 441.153. In addition, the independent team may not include anyone who is related, in any way, to the admitting facility, or who is directly responsible for the care of patients whose care is being reviewed, or has a financial interest in the admitting facility. The department performs the functions of the independent team.

(14) “Inpatient” means the definition contained in 42 CFR, Part 440, section 440.2. The client must also be present in the hospital at midnight for the census count.

(15) “Interdisciplinary Team” for review of clients under the age of twenty-one, means the definition contained in 42 CFR, Part 441, section 441.156.

(16) “Interperiodic Encounter” means any medically necessary visit to a Connecticut Medical Assistance provider, other than for the purpose of performing a periodic comprehensive health screening. Such encounters include, but are not limited to, physician’s office visits, clinic visits, and other primary care visits.

(17) “Joint Commission on Accreditation of Healthcare Organizations (JCAHO)” means a national, private, not-for-profit organization founded in 1951, which offers accreditation to health care organizations throughout the United States.

(18) “Leave of Absence” means a conditional release which is a period of time after admission and prior to the day of discharge, in which the client has been permitted by the attending physician to be absent from the facility premises.

(19) “Medical Appropriateness or Medically Appropriate” means health care that is provided in a timely manner and meets professionally recognized standards of acceptable medical care; is delivered in the appropriate medical setting; and is the least costly of multiple, equally-effective, alternative treatments or diagnostic modalities.

(20) “Medical Assistance Program” means the medical assistance provided pursuant to Chapter 319v of the Connecticut General Statutes (CGS) and authorized by Title XIX of the Social Security Act. The program is also referred to as Medicaid.

(21) “Medical Necessity or Medically Necessary” means health care provided to correct or diminish the adverse effects of a medical condition or mental illness; to assist an individual in attaining or maintaining an optimal level of health; to diagnose a condition; or to prevent a medical condition from occurring.

(22) “Medical Record” means the definitions contained in 42 CFR, Part 482, section 482.6l, and subsection (d) of section 19-13-D3 of the Regulations of Connecticut State Agencies, which is part of the Public Health Code.

(23) “Plan of Care” means the definitions contained in 42 CFR, Part 441, Subpart D, and Part 456, sections 456.180 through 456.181.

(24) “Preadmission Review” means a review prior to, or, in the case of an emergency admission, within fourteen days after a client’s admission to an inpatient psychiatric facility with the purpose of determining the medical necessity, appropriateness, and quality of the health care services to be delivered, or in the case of an emergency, delivered in the hospital.

(25) "Prior Authorization" means approval for the provision of a service or delivery of goods from the department before the provider actually provides the service or delivers the goods.

(26) "Provider" means a psychiatric hospital or psychiatric facility.

(27) "Provider Agreement" means the signed, written, contractual agreement between the department and the provider of services or goods.

(28) "Psychiatric Emergency" means a sudden onset of a psychiatric condition, as determined by a physician, that manifests itself by acute symptoms of such severity that the absence of immediate medical care and treatment in an inpatient psychiatric facility could reasonably be expected to result in serious dysfunction, disability, or death of the client or harm to self or another person by the client. Court commitments and clients admitted on a Physician Emergency Certificate are not automatically deemed to qualify as a psychiatric emergency.

(29) "Psychiatric Facility" means an institution which is not a hospital and is accredited by the Joint Commission on Accreditation of Hospitals and Healthcare Organizations (JCAHO), to provide inpatient psychiatric services under the direction of a physician to clients who are under the age of twenty-one or age sixty-five or over, and meets specific conditions contained at 42 CFR, Part 435, section 435.1009.

(30) "Psychiatric Hospital" means an accredited or state licensed institution which is engaged in providing hospital level psychiatric services, under the supervision of a physician, for the diagnosis and treatment of mentally ill persons. Specific conditions for psychiatric hospital contained at 42 CFR, Part 482, sections 482.60 through 482.62, and at 42 CFR, Part 435, section 435.1009, shall be implemented. Psychiatric units or beds in a general, acute care hospital are not included in this definition.

(31) "Quality of Care" means the evaluation of medical care to determine if it meets the professionally recognized standard of acceptable medical care for the condition and the client under treatment.

(32) "Retrospective Review" means the review conducted after services are provided to a client, to determine the medical necessity, appropriateness, and quality of the services provided.

(33) "State Plan" means the document which contains the services covered by the Connecticut Medical Assistance Program in compliance with Part 430, Subpart B, of Title 42 of the Code of Federal Regulations.

(34) "Transfer" means that an individual is discharged from the hospital or facility and directly admitted to another.

(35) "Under the Direction of a Physician" means that health services may be provided by allied health professionals whether or not the physician is physically present at the time that the services are provided. The physician shall:

(A) assume professional responsibility for the services provided;

(B) assure that the services are medically appropriate; and

(C) be readily available within five minutes but not necessarily on the premises.

(36) "Urgent Admission" means an elective, nonemergency admission.

(37) "Utilization Review" means the evaluation of the necessity, appropriateness, and quality of the use of medical services, procedures, and facilities. Utilization Review evaluates the medical necessity and medical appropriateness of admissions, the services performed or to be performed, the length of stay, and the discharge practices. It is conducted on a concurrent, prospective, or retrospective basis.

(Adopted effective March 6, 1998)

Sec. 17b-262-501. Provider participation

In order to enroll in the Medical Assistance Program and receive payment from the department, providers shall meet the following requirements:

(a) **General:**

(1) meet and maintain all applicable licensing, accreditation, and certification requirements;

(2) meet and maintain all departmental enrollment requirements; and

(3) have a valid provider agreement on file which is signed by the provider and the department upon application for enrollment into the Medical Assistance Program. This agreement, which shall be periodically updated, shall continue to be in effect for the duration of the agreement or for the stated period in the agreement. The provider agreement specifies conditions and terms which govern the program and to which the provider is mandated to adhere in order to participate in the program.

(b) **Specific:**

(1) providers of inpatient psychiatric services shall be licensed, when appropriate, by the state and accredited as a psychiatric hospital by the Joint Commission on Accreditation of Healthcare Organizations, and

(2) psychiatric hospitals outside of Connecticut shall meet all of the above provider requirements. They shall also be an enrolled Medical Assistance Program provider in their state of residence, when that state participates in the optional program of Medical Assistance Program psychiatric inpatient services provided to clients age twenty-one and under and age sixty-five and over.

(Adopted effective March 6, 1998)

Sec. 17b-262-502. Eligibility

Payment for inpatient psychiatric hospital services shall be available on behalf of Medical Assistance Program clients under age twenty-one and age sixty-five or over under the conditions and limitations which apply to these services.

(Adopted effective March 6, 1998)

Sec. 17b-262-503. Services covered

The department shall pay for the following:

(a) medically necessary and medically appropriate inpatient psychiatric services for

clients under age twenty-one or age sixty-five or over when the need for services as stated in section 17b-262-499 through section 17b-262-511 are met and provided by an enrolled Medical Assistance Program provider;

(b) inpatient hospital tests when the tests are specifically ordered by the attending physician or other licensed practitioner who is responsible for the diagnosis and treatment of the client, and who is acting within the scope of practice as defined under state law;

(c) HealthTrack Services; and

(d) HealthTrack Special Services. HealthTrack Special Services require prior authorization on a case-by-case basis to determine that the services are medically necessary and medically appropriate.

(Adopted effective March 6, 1998)

Sec. 17b-262-504. Services not covered

The department shall not pay for the following inpatient psychiatric hospital services which are not covered under the Medical Assistance Program:

(a) procedures or services of an unproven, educational, social, research, experimental, or cosmetic nature or for any diagnostic, therapeutic, or treatment procedures in excess of those deemed medically necessary and appropriate by the department to treat the client's condition;

(b) services that do not directly relate to the client's diagnosis, symptoms, or medical history;

(c) services or items furnished for which the provider does not usually charge;

(d) the day of discharge or transfer;

(e) an inpatient psychiatric hospital admission or a day of care that does not meet all the department's requirements for inpatient services;

(f) an inpatient psychiatric hospital admission or a day of care that is denied by the hospital's Utilization Review Committee;

(g) a day when the client, who is age sixty-five or over, is absent from the psychiatric hospital at the midnight census, even though the leave or transfer is medically authorized and part of the treatment plan;

(h) a day when the client, who is under age twenty-one, is absent from the psychiatric hospital at the midnight census, even though the leave or transfer is medically authorized and part of the treatment plan; or

(i) costs associated with the education or vocational training of the client which shall be excluded from Medical Assistance Program payments.

(Adopted effective March 6, 1998)

Sec. 17b-262-505. Certification of need review requirements for inpatient psychiatric services for a client under age twenty-one in a psychiatric hospital

(a) In order to receive payment for inpatient psychiatric hospital services for individuals under age twenty-one, each individual admission, including elective and emergency

admissions, shall have a certification of need review.

(b) The certification of need review shall be a part of the client's medical record, with written documentation certifying that:

(1) ambulatory care resources available in the community do not meet the treatment needs of the client;

(2) proper treatment of the client's psychiatric condition requires inpatient care under the direction of a physician; and

(3) the services shall reasonably be expected to improve the client's condition or prevent further regression so that inpatient services shall no longer be needed.

(c) When the admission of a Medical Assistance Program client is elective, an independent team is responsible to perform the certification of need review. The department shall act as the independent team.

(d) When the admission is an individual who is not Medical Assistance Program eligible and who applies for the Medical Assistance Program while in the hospital, the certification of need review shall be conducted at the time of application for Medical Assistance Program coverage or by the first day of Medical Assistance Program coverage. An interdisciplinary team conducts the certification of need review which shall cover any period prior to application for which Medical Assistance Program claims are made. In addition, this certification of need review shall be validated by the independent team.

(e) For emergency admissions, the certification of need review shall be completed by an interdisciplinary team within fourteen days after the emergency admission and validated by the independent team.

(f) When the client is transferred from a psychiatric hospital to an acute care hospital and upon discharge readmitted to the psychiatric hospital, a new certification of need review by the independent team is required.

(Adopted effective March 6, 1998)

Sec. 17b-262-506. Individual plan of care requirements for inpatient psychiatric services for a client under age twenty-one in a psychiatric hospital

(a) Inpatient psychiatric services for clients under age twenty-one shall constitute active treatment, as documented in the professionally developed and supervised individual plan of care.

(b) Before admission or before authorization for payment, the interdisciplinary team shall establish a written plan of care for each applicant or client, designed to achieve the client's discharge from inpatient status at the earliest possible time. This plan shall:

(1) be based on a diagnostic evaluation that includes examinations of the medical, psychological, social, behavioral, and developmental aspects of the client's situation and thereby reflect the need for inpatient psychiatric care;

(2) be developed by the interdisciplinary team of professionals in consultation with the client, and his or her parents, legal guardian, or others into whose care he or she will be released after discharge;

(3) state the treatment objective;

(4) prescribe an integrated program of therapies, activities, and experiences designed to meet the treatment objectives;

(5) include, at an appropriate time, post-discharge plans and coordination of inpatient services with partial discharge plans and related community services to ensure continuity of care with the client's family, school, and community upon discharge; and

(6) be a recorded document which is maintained in the client's medical record.

(c) In addition, the individual plan of care shall be reviewed every thirty days by the interdisciplinary team, starting at the date of admission. The purpose of the review is to determine that services being provided are currently required or were required on an inpatient basis, and to recommend any changes to the plan that are indicated by the client's overall progress towards the treatment goals.

(d) The development and review of the plan of care shall satisfy the utilization control requirements for recertification and the establishment and periodic review of the plan of care.

(Adopted effective March 6, 1998)

Sec. 17b-262-507. Individual plan of care for a client age sixty-five or over in a psychiatric hospital

(a) A written, individual plan of care shall be developed to ensure that institutional care maintains the client at, or restores them to, the greatest possible degree of health and independent functioning. The plan of care for an elective admission shall be completed by the attending or staff physician prior to admission. The plan of care for clients age sixty-five or over, in addition to the requirements specified in the definitions, shall also include:

(1) an initial review of the client's medical, psychiatric, and social needs;

(2) periodic review of the client's medical, psychiatric, and social needs;

(3) a determination, at least every ninety days, of the client's need for continuing institutional care and for alternative care arrangements;

(4) appropriate medical treatment in the institution; and

(5) appropriate social services.

(b) In the situation where an individual applies for Medical Assistance Program eligibility after an elective or emergency admission to the psychiatric hospital, the plan of care shall be completed at the same time that the Medical Assistance Program application is submitted to the department or by the first day of Medical Assistance Program coverage. It shall cover both the period prior to and after application for which Medical Assistance Program claims are made.

(Adopted effective March 6, 1998)

Sec. 17b-262-508. Utilization review program for inpatient psychiatric services for clients under age twenty-one or age sixty-five or over

(a) The department's Utilization Review Program conducts utilization review activities

for services delivered by the inpatient psychiatric hospital to clients where the Medical Assistance Program has been determined to be the appropriate payer.

(b) To determine that inpatient psychiatric services or admissions are medically necessary and medically appropriate, the department may:

(1) require preadmission review or prior authorization of each inpatient psychiatric hospital admission, including a certificate of need review, for clients under age twenty-one, unless the department notifies the providers that a specific admission, diagnosis, or procedure does not require such authorization; and

(2) perform retrospective reviews at the department's discretion which may be a random or targeted sample of the admissions and services delivered. The review may be focused on the appropriateness, necessity, or quality of the health care services provided.

(c) If the department decides to impose prior authorization or preadmission review requirements, all effected providers shall be notified at least thirty days in advance of date of implementation.

(d) All claims for payment for admission and all days of stay and services that are provided shall be documented. Lack of said documentation itself may be adequate ground for the department, in its discretion, to deny or recoup payment for the admission for some or all of the days of stay or services provided.

(e) The department shall conduct medical review and inspections of care in psychiatric hospitals.

(Adopted effective March 6, 1998)

Sec. 17b-262-509. Billing procedures

Claims from inpatient psychiatric providers shall be submitted on the department's uniform billing form or electronically transmitted to the department's fiscal agent and shall include all information required by the department to process the claim for payment.

(Adopted effective March 6, 1998)

Sec. 17b-262-510. Documentation and record retention

(a) A provider shall meet the special medical record requirements for a psychiatric hospital and shall maintain records to support claims made for payment. All documentation shall be made available upon request by and to authorized department, state, or federal personnel in accordance with state and federal laws. Documentation shall be retained by the provider for a period of five years, or if any dispute arises concerning a service, until such dispute has been finally resolved.

(b) Failure to maintain all required documentation or to provide it to the department upon request, may result in the disallowance and recovery by the department of any amounts paid out for which the required documentation is not maintained or provided.

(Adopted effective March 6, 1998)

Sec. 17b-262-511. Reserved

Requirements for Payment to Independent Radiology and Ultrasound Centers

Sec. 17b-262-512. Scope

Sections 17b-262-512 through 17b-262-520 inclusive set forth the Department of Social Services requirements for the payment of radiology services performed by an independent radiology or ultrasound center provided in a freestanding center, which is not part of a physician's office nor a hospital outpatient department or clinic, for clients who are determined eligible to receive services under Connecticut's Medical Assistance Program pursuant to section 17b-262 of the Connecticut General Statutes (CGS).

(Adopted effective March 6, 1998)

Sec. 17b-262-513. Definitions

For the purposes of sections 17b-262-512 through 17b-262-520 the following definitions shall apply:

(1) "Acute" means having rapid onset, severe symptoms, and a short course.

(2) "Client" means a person eligible for goods or services under the department's Medical Assistance Program.

(3) "Commissioner" means the Commissioner of Social Services appointed pursuant to subsection (a) of section 17b-1 of the Connecticut General Statutes.

(4) "Department" means the Department of Social Services or its agent.

(5) "Electrocardiogram (EKG) Services" means diagnostic services derived from an electrocardiogram device which measures the electrical variations in heart muscles.

(6) "Electroencephalogram (EEG) Services" means diagnostic services derived from an electroencephalogram instrument which records the electrical activity of the brain.

(7) "Emergency" means a medical condition, including labor and delivery, manifesting itself by acute symptoms of sufficient severity, including severe pain, such that the absence of immediate medical attention could reasonably be expected to result in placing the client's health in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part.

(8) "Freestanding Radiology or Ultrasound Center" means those centers which offer radiology or ultrasound services but which are not part of a physician's office nor an inpatient or outpatient hospital service.

(9) "HealthTrack Services" means the services described in subsection (r) of section 1905 of the Social Security Act.

(10) "HealthTrack Special Services" means medically necessary and medically appropriate health care, diagnostic services, treatment, or other measures necessary to correct or ameliorate disabilities and physical and mental illnesses and conditions discovered as a result of a periodic comprehensive health screening or interperiodic encounter. Such services are provided in accordance with subdivision (5) of subsection (r) of section 1905 of the Social Security Act, and are:

(A) services not covered under the State Plan or contained in a fee schedule published by the department; or

(B) services covered under the State Plan and contained in a fee schedule published by the department which exceed the limit on the amount of services established by the department that are contained in regulation.

(11) "Interperiodic Encounter" means any medically necessary visit to a Connect-icut Medical Assistance provider, other than for the purpose of performing a periodic comprehensive health screening. Such encounters include, but are not limited to, physician's office visits, clinic visits, and other primary care visits.

(12) "Licensed Practitioner of the Healing Arts" means a professional person providing health care pursuant to a license issued by the Department of Public Health (DPH).

(13) "Medical Appropriateness or Medically Appropriate" means health care that is provided in a timely manner and meets professionally recognized standards of acceptable medical care; is delivered in the appropriate medical setting; and is the least costly of multiple, equally-effective alternative treatments or diagnostic modalities.

(14) "Medical Assistance Program" means the medical assistance provided pursuant to Chapter 319v of the Connecticut General Statutes and authorized by Title XIX of the Social Security Act. The program is also referred to as Medicaid.

(15) "Medical Necessity or Medically Necessary" means health care provided to correct or diminish the adverse effects of a medical condition or mental illness; to assist an individual in attaining or maintaining an optimal level of health; to diagnose a condition; or to prevent a medical condition from occurring.

(16) "Prior Authorization" means approval for the provision of a service or the delivery of goods from the department before the provider actually provides the service or delivers the goods.

(17) "Provider" means a radiology or ultrasound center which provides professional and technical services and which is independent of a physician's office or an inpatient or outpatient hospital department or clinic.

(18) "Provider Agreement" means the signed, written, contractual, agreement between the department and the provider of services or goods.

(19) "Radiology" means any diagnostic and treatment service administered through the use of radiant energy.

(20) "State Plan" means the document which contains the services covered by the Connecticut Medical Assistance Program in compliance with Part 430, Subpart B, of Title 42 of the Code of Federal Regulations (CFR).

(21) "Ultrasound Services" means diagnostic and therapeutic services administered by ultrasound equipment—equipment emitting inaudible sound frequencies in the approximately 20,000 to 10,000,000,000 cycles per second range.

(Adopted effective March 6, 1998)

Sec. 17b-262-514. Provider participation

In order to enroll in the Medical Assistance Program and receive payment from the department, providers shall:

(a) meet and maintain all applicable licensing, accreditation, and certification requirements;

(b) meet and maintain all departmental enrollment requirements; and

(c) have a valid provider agreement on file which is signed by the provider and the department upon application for enrollment into the Medical Assistance Program. This agreement, which shall be periodically updated, shall continue to be in effect for the duration of the agreement or for the stated period in the agreement. The provider agreement specifies conditions and terms which govern the program and to which the provider is mandated to adhere in order to participate in the program.

(Adopted effective March 6, 1998)

Sec. 17b-262-515. Eligibility

Payment for radiology or ultrasound center services shall be available on behalf of all persons eligible for the Medical Assistance Program subject to the conditions and limitations which apply to these services.

(Adopted effective March 6, 1998)

Sec. 17b-262-516. Services covered

The department shall pay for:

(a) medically appropriate and medically necessary radiology or ultrasound center services as published in the department's fee schedule when ordered by a licensed physician or other licensed practitioner of the healing arts; and

(b) HealthTrack Services and HealthTrack Special Services.

(Adopted effective March 6, 1998)

Sec. 17b-262-517. Need for service and authorization process

(a) **Need for Service**

The department shall pay for independent radiology and ultrasound center services which are ordered by a duly licensed physician or other licensed practitioner of the healing arts and which the department deems to be medically necessary and medically appropriate.

(b) **Prior Authorization**

Prior authorization, on forms and in a manner as specified by the department, shall be required for HealthTrack Special Services:

(1) HealthTrack Special Services are determined medically necessary and medically appropriate on a case-by-case basis; and

(2) the request for HealthTrack Special Services shall include:

(A) a written statement from the prescribing physician, or other licensed practitioner of the healing arts, performing such services within his or her respective scope of practice as

defined under state law, justifying the need for the item or service requested;

(B) a description of the outcomes of any alternative measures tried; and

(C) if applicable and requested by the department, any other documentation required in order to render a decision.

(c) In order to receive payment from the department a provider shall comply with all prior authorization requirements. The department in its sole discretion determines what information is necessary in order to approve a prior authorization request. Prior authorization does not, however, guarantee payment unless all other requirements for payment are met.

(Adopted effective March 6, 1998)

Sec. 17b-262-518. Billing procedures

(a) Claims from independent radiology or ultrasound center providers shall be submitted on the department's designated form or electronically transmitted to the department's fiscal agent and shall include all information required by the department to process the claim for payment.

(b) The payment for radiology or ultrasound center services includes all consultation services as well as the written report to the referring physician.

(Adopted effective March 6, 1998)

Sec. 17b-262-519. Payment rate and limitations

(a) The commissioner shall establish the fees contained in the department's published fee schedule for independent radiology and ultrasound centers pursuant to section 4-67c of the Connecticut General Statutes.

(b) The payment rate shall be made at the lowest of:

(1) the provider's usual and customary charge to the general public;

(2) the lowest Medicare rate;

(3) the amount in the applicable fee schedule as published by the department;

(4) the amount billed by the provider; or

(5) the lowest price charged or accepted for the same or substantially similar goods or services by the provider from any person or entity.

(c) When emergency services are rendered after normal posted business hours, a fee as indicated on the provider's fee schedule shall be reimbursed to the provider per patient.

(d) Actual allowable procedures billable to the Medical Assistance Program are negotiated individually by provider.

(Adopted effective March 6, 1998)

Sec. 17b-262-520. Documentation

(a) Independent radiology or ultrasound center providers shall maintain a specific record for each client eligible for Medical Assistance Program payment including, but not limited to: name, address, birth date, Medical Assistance Program identification number, pertinent diagnostic information, documentation of the services provided, and the dates the services

were provided.

(b) All required documentation shall be maintained for at least five years in the provider's file subject to review by authorized department personnel. In the event of a dispute concerning a service provided, documentation shall be maintained until the end of the dispute or five years, whichever is greater.

(c) Failure to maintain all required documentation shall result in the disallowance and recovery by the department of any amounts paid to the provider for which the required documentation is not maintained and provided to the department by request.

(Adopted effective March 6, 1998)

Sec. 17b-262-521. Reserved

Requirements for Provider Participation in the Connecticut Medical Assistance Program

Sec. 17b-262-522. Scope

Sections 17b-262-522 through 17b-262-532, inclusive, of the Regulations of Connecticut State Agencies set forth the Department of Social Services general requirements to which providers of Medical Assistance Program goods and services shall adhere in order to participate in, and receive payment from, the Connecticut Medical Assistance Program pursuant to section 17b-262 of the Connecticut General Statutes.

(Adopted effective February 8, 1999; Amended April 1, 2003)

Sec. 17b-262-523. Definitions

For the purposes of sections 17b-262-522 through 17b-262-532, inclusive, of the Regulations of Connecticut State Agencies the following definitions apply:

(1) **"Acute"** means symptoms that are severe and have a rapid onset and a short course;

(2) **"Border provider"** means a provider located in a state bordering Connecticut, in an area that allows it to generally serve Connecticut residents, and that is enrolled as and treated as a Connecticut Medical Assistance Program provider. Such providers are certified, accredited, or licensed by the applicable agency in their state and are deemed border providers by the department on a case by case basis;

(3) **"Claim"** means a request for payment submitted by a provider to the department, or its fiscal agent, in accordance with the billing requirements set forth by the department;

(4) **"Client"** means a person eligible for goods or services under the department's Medical Assistance Program;

(5) **"Commissioner"** means the commissioner of the Connecticut Department of Social Services appointed pursuant to subsection (a) of section 17b-1 of the Connecticut General Statutes;

(6) **"Copayment"** means a nominal fee, chargeable to the client and not payable from the department, for specified goods or services and which meets the requirements of section 1916 of the Social Security Act and 42 CFR 447.15 and 42 CFR 447.50 to 42 CFR 447.58,

inclusive;

(7) **"Coverable Medical Assistance Program good or service"** means any good or service which is payable by the Medical Assistance Program under its regulations;

(8) **"Department"** means the Connecticut Department of Social Services or its agent;

(9) **"Emergency"** means a medical condition, including labor and delivery, manifesting itself by acute symptoms of sufficient severity, including severe pain, such that the absence of immediate medical attention could reasonably be expected to result in placing the client's health in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part;

(10) **"Free of charge"** means a good or service for which no individual client has an obligation to pay and for which no third party payment is ever sought;

(11) **"Lock-in"** means the department's restriction of a client to a specific provider for certain Medical Assistance Program goods or services under the authority of section 17-134d-11 of the Regulations of Connecticut State Agencies;

(12) **"Medical appropriateness or medically appropriate"** means health care that is provided in a timely manner and meets professionally recognized standards of acceptable medical care; is delivered in the appropriate [medical]setting; and is the least costly of multiple, equally-effective alternative treatments or diagnostic modalities;

(13) **"Medical Assistance Program"** means the medical assistance provided pursuant to Chapter 319v of the Connecticut General Statutes and authorized by Title XIX of the Social Security Act. The program is also referred to as Medicaid;

(14) **"Medical Assistance Program goods or services"** means medical care or items that are furnished to a client to meet a medical necessity in accordance with applicable statutes or regulations that govern the Medical Assistance Program;

(15) **"Medical necessity or medically necessary"** means health care provided to correct or diminish the adverse effects of a medical condition or mental illness; assist an individual in attaining or maintaining an optimal level of health; diagnose a condition; or prevent a medical condition from occurring;

(16) **"Medicare"** means the federal health care program authorized by Title XVIII of the Social Security Act;

(17) **"Out-of-state provider"** means a provider who is licensed, certified, or accredited in a state other than Connecticut; has a business address outside of Connecticut; and does not meet the definition of "border provider";

(18) **"Overpayment"** means any payment that represents an excess over the allowable payment under state law including, but not limited to, amounts obtained through fraud and abuse;

(19) **"Point of sale or POS"** means the department's on-line, real time pharmacy electronic claims transmission. This process also includes prospective drug utilization review;

(20) **"Prior authorization"** means approval for the provision of a service or delivery of goods from the department before the provider actually provides the service or delivers

the goods;

(21) **"Prospective drug utilization review or pro-DUR"** means a client-specific drug utilization review prior to dispensing;

(22) **"Provider"** means any individual or entity that furnishes Medical Assistance Program goods or services pursuant to a provider agreement with the department and is duly enrolled and in good standing or, as the context may require, an individual or entity applying for enrollment in the Medical Assistance Program;

(23) **"Provider agreement"** means the signed, written, contractual agreement between the department and the provider of services or goods;

(24) **"Provider enrollment or reenrollment form"** means the department's form which requests the provider's data such as, but not limited to: name, address, licensure or certification information, service protocols, and any other information required by the department to assess provider eligibility for participation in the Medical Assistance Program;

(25) **"Suspension"** means limiting program participation of providers who, although not convicted of program-related crimes, are found by the department to have violated rules, regulations, standards or laws governing any such program;

(26) **"Termination"** means precluding medical assistance program participation by providers that have been convicted of a crime involving medicaid or medicare;

(27) **"Third party"** means any individual, private or public organization, or entity that is or may be liable to pay all or part of the medical costs of injury, disease, or disability for a client pursuant to 42 CFR 433.136;

(28) **"Third party liability"** as it applies to Medical Assistance Program claims processing, means payment resources available from both private and public health insurance that can be applied toward Medical Assistance Program clients' medical and health benefit expenses. A pending tort recovery or cause of action, worker's compensation or accident insurance settlement is not a third party liability; and

(29) **"Type and specialty"** means the department's categorization of Medical Assistance Program providers according to the type and specialty of the goods or services furnished by the provider.

(Adopted effective February 8, 1999; Amended April 1, 2003)

Sec. 17b-262-524. Provider participation

(a) To enroll in the Medical Assistance Program and receive payment from the department for the provision of goods or services to Medical Assistance Program clients, providers shall:

(1) Meet and maintain all applicable licensing, accreditation and certification requirements;

(2) meet and maintain all departmental enrollment requirements including the timely submission of a completed provider enrollment or reenrollment form and submission of all enrollment information and such affidavits as the department may require; and

(3) have a valid provider agreement on file which is signed by the provider and the

department. This agreement, which shall be periodically updated, shall continue to be in effect for the duration specified in the agreement. The provider agreement specifies conditions and terms that govern the program and to which the provider is mandated to adhere in order to participate in the program.

(b) Additionally, the department shall at its discretion:

(1) Require documentation or other information necessary to ensure that requirements for enrollment in a type of service and specialty have been met pursuant to all applicable statutes and regulations;

(2) require that an out-of-state or border provider submit such supplemental documentation as it requires in the event their licenses, certificates, permits or other credentials do not disclose the required information, or if the criteria for attainment of such credentials is different from similarly situated in-state providers;

(3) require submission of a schedule of charges to the general public or any other pertinent data or information necessary to facilitate review of new or existing services;

(4) approve or disapprove enrollment or reenrollment of any provider based upon the department's requirements. The department in its sole discretion shall determine whether the provider meets the requirements for enrollment;

(5) deny initial enrollment or reenrollment of any provider when such enrollment or reenrollment is determined not to be in the best interests of the Medical Assistance Program;

(6) deny enrollment or reenrollment of any provider who does not offer coverable Medical Assistance Program goods or services regardless of whether the provider meets all other enrollment requirements; and

(7) enroll out-of-state providers if they provide services to clients who are out-of-state in accordance with section 17b-262-532 of the Regulations of Connecticut State Agencies.

(c) At the discretion of the department, out-of-state providers shall be eligible for enrollment or reenrollment into the Medical Assistance Program based on documentation of current enrollment in the Medical Assistance Program in another state.

(d) Failure by the provider to submit any required documents or information for reenrollment, at such times and in such a manner as the department shall require, may result in the loss of the provider's eligibility to participate in the Medical Assistance Program.

(e) Specific enrollment requirements for provider types and specialties are set forth in the Regulations of Connecticut State Agencies dealing with the specific provider type and specialty. The department in accordance with the governing Regulations of Connecticut State Agencies shall, in its sole discretion, determine the category of provider type and specialty into which a provider falls.

(f) For purposes of this section, the terms "institution" or "general hospital" include (1) any wholly or partially owned subsidiary of the institution or general hospital; (2) any entity that is related to the institution or general hospital, including, but not limited to, a parent company, or wholly or partially owned subsidiary of the institution or general hospital; and (3) any other entity, such as a partnership, that is established by (A) the institution or general hospital or (B) any entity related to the institution or general hospital, including a parent

company and its wholly or partially owned subsidiaries.

(g) Notwithstanding any provisions of the Regulations of Connecticut State Agencies or any medical services policy, any provider who is (1) compensated directly or indirectly by an institution or general hospital or (2) located within an institution or general hospital, which includes being located in an institution or general hospital complex, campus or auxiliary or satellite location, may bill the department for services rendered to the provider's medical assistance program private practice clients who receive services at the institution or general hospital location if all of the following criteria are met:

(1) The provider maintains a practice at a location other than the location which is within the institution or general hospital complex, campus or auxiliary or satellite location;

(2) the provider is enrolled as a medical assistance program provider at the location that is separate from the institution or general hospital location and actively bills, as determined by the department, the Medical Assistance Program for services rendered at that separate location;

(3) the operations of the provider are entirely separate and independent from the institution or general hospital. The department considers the operations of a provider as entirely separate and independent if the following criteria are met:

(A) the provider does not utilize space that is directly or indirectly owned by the institution or general hospital unless the space is rented at fair market value;

(B) the provider and provider staff do not receive compensation in any form from the institution or general hospital for any reason for clinical services at the institution or general hospital;

(C) the provider and the institution or general hospital do not share administrative and support staff; and

(D) the provider and the institution or general hospital have no direct or indirect relationship relative to ownership or control;

(4) any direct and indirect costs associated with the services performed by the provider or provider staff are not included in the annual cost report of the institution or general hospital; and

(5) the provider has performed an evaluation and management service for the client at its separate location within the previous year.

(h) Notwithstanding the criteria identified in subdivision (3) of subsection (g) of this section, the provider may bill if the provider can demonstrate to the satisfaction of the department that the arrangements between the provider and the institution or general hospital do not result in duplication of payments. Evidence of lack of duplication of payments may include, but is not limited to, a copy of the provider-facility contract.

(i) Notwithstanding the requirements of subsections (g) and (h) of this section, a medical foundation established pursuant to sections 33-182aa to 33-182ff, inclusive, of the Connecticut General Statutes may bill the department for goods or services provided to Medical Assistance Program clients only after obtaining the department's approval. In order to obtain such approval, and as requested by the department from time to time, the medical

foundation shall demonstrate, to the department's satisfaction, that mechanisms are in place to ensure that there will be no duplicate billing to or payment by the department relating to the provision of such goods or services. Not later than three months after the medical foundation begins billing the department, and as requested by the department from time to time, the medical foundation shall demonstrate to the department that no such duplicate billing in fact occurs. Duplicate billing includes, but is not limited to, claims for costs associated with related party transactions among the medical foundation, the hospital and any other related party, as defined in subsection (o) of section 17b-262-531 of the Regulations of Connecticut State Agencies.

(Adopted effective February 8, 1999; Amended April 1, 2003; Amended June 5, 2012)

Sec. 17b-262-525. Termination or suspension of provider agreement

(a) Providers shall be subject to all of the conditions contained in section 17b-99 of the Connecticut General Statutes and sections 17-83k-1 through 17-83k-7 of the Regulations of Connecticut State Agencies.

(b) A provider agreement may be terminated by mutual consent or without cause by either the department or the provider by giving a thirty day written notification to the affected party, or as otherwise provided by federal or state law.

(Adopted effective February 8, 1999; Amended April 1, 2003)

Sec. 17b-262-526. General provider requirements

To maintain enrollment in the Connecticut Medical Assistance Program, a provider shall abide by all federal and state statutes regulations and operational procedures promulgated by the department which govern the Medical Assistance Program and shall:

(1) abstain from discriminating or permitting discrimination against any person or group of persons on the basis of race, color, religious creed, age, marital status, national origin, sex, mental or physical disability, or sexual orientation pursuant to 45 CFR 80.3 and 45 CFR 80.4;

(2) accept as payment in full either the department's payment or a combination of department, third party payment, and any authorized client copayment which is no more than the department's schedule of payment, except with regard to the department's obligations for payment of Medicare coinsurance and deductibles;

(3) agree to pursue and exhaust all of a client's third party resources prior to submitting claims to the department for payment; to report any and all third party payments; to acknowledge the department as the [payor] payer of last resort; and to assist in identifying other possible sources of third party liability for which a legal obligation for payment of all or part of the Medical Assistance Program goods or services furnished exists;

(4) be qualified to furnish Medical Assistance Program goods or services; be currently certified and enrolled in the Medicare program if required by any federal or state statutes or regulations which govern the Medical Assistance Program goods or services furnished by a provider under the provider's assigned type and specialty;

(5) meet and adhere to all applicable licensing, accreditation, and certification requirements and all applicable state and local zoning and safety requirements pertaining to the provider's assigned type and specialty in the jurisdiction where the Medical Assistance Program goods or services are furnished;

(6) meet and adhere to any additional department requirements, after enrollment, promulgated in conformance with federal and state statutes, regulations and operational procedures which govern the provider's assigned provider type and specialty;

(7) maintain a specific record for each client eligible for Medical Assistance Program payment including, but not limited to: name; address; birth date; Medical Assistance Program identification number; pertinent diagnostic information and x-rays; current and all prior treatment plans prepared by the provider; pertinent treatment notes signed by the provider; documentation of the dates of service; and other requirements as provided by federal and state statutes and regulations pursuant to 42 CFR 482.61, and, to the extent such requirements apply to a provider's licensure category, record requirements set forth in chapter iv of the Connecticut Public Health Code (sections 19-13-D1 to 19-13-D105 of the Regulations of Connecticut State Agencies). Such records and information shall be made available to the department upon request;

(8) maintain all required documentation for at least five years or longer as required by state or federal law or regulation in the provider's file subject to review by authorized department personnel. In the event of a dispute concerning goods or services provided, documentation shall be maintained until the end of the dispute,for five years, or the length of time required by state or federal law or regulation, whichever is greatest. Failure to maintain and provide all required documentation to the department upon request shall result in the disallowance and recovery by the department of any future or past payments made to the provider for which the required documentation is not maintained and not provided to the department upon request, as permitted by state and federal law;

(9) notify the department in writing of all substantial changes in information which were provided on the application submitted to the department for provider enrollment or reenrollment in the Medical Assistance Program;

(10) disclose, in accordance with 42 CFR 455.106, any information requested by the department regarding the identity of any person who has ownership or a controlling interest in the provider's business who has been convicted of a criminal offense related to that person's involvement in Medicare or the Medical Assistance Program;

(11) furnish all information relating to the provider's business ownership, as well as transactions with subcontractors, in accordance with federal and state statutes and regulations;

(12) not deny goods or services to a client solely on the basis of the client's inability to meet a copayment; and

(13) agree to participate in studies of access, quality and outcome conducted by the department or its agents. The department shall reimburse providers for costs above and

beyond nominal costs incurred by such participation.

(Adopted effective February 8, 1999; Amended April 1, 2003)

Sec. 17b-262-527. Need for goods or services

The department shall review the medical appropriateness and medical necessity of medical goods and services provided to Medical Assistance Program clients both before and after making payment for such goods and services.

(Adopted effective February 8, 1999; Amended April 1, 2003)

Sec. 17b-262-528. Prior authorization

(a) Prior authorization, to determine medical appropriateness and medical necessity, shall be required as a condition of payment for certain Medical Assistance Program goods or services as set forth in the regulations of the department governing specific provider types and specialties. The department shall not make payment for such goods and services when such authorization is not obtained by the provider of the goods or services.

(b) Prior authorization shall be granted by the department to a provider to furnish specified goods or services within a defined time period as set forth in the regulations of the department governing specific provider types and specialties.

(c) Payment for medical goods or services provided to a client, for which prior authorization is given, is contingent upon the client's eligibility at all times such goods and services are furnished.

(d) In order to receive payment from the department a provider shall comply with all prior authorization requirements. The department in its sole discretion determines what information is necessary in order to approve a prior authorization request. Prior authorization does not, however, guarantee payment unless all other requirements for payment are met.

(e) Coverable Medical Assistance Program goods or services requiring prior authorization may be so identified on the department's applicable fee schedule or identified in regulation.

(Adopted effective February 8, 1999; Amended April 1, 2003)

Sec. 17b-262-529. Billing procedures

(a) Claims from providers shall be submitted on the department's designated form or electronically transmitted to the department's fiscal agent within twelve months of the date the service was provided or the good was delivered and shall include all information required by the department to process the claim for payment, as set forth in the Regulations of Connecticut State Agencies and specified in the department's provider billing manuals. The date of service is the actual date on which the service was provided.

(b) Exceptions to the procedures set forth in subsection (a) of section 17b-262-529 of the Regulations of Connecticut State Agencies shall be as follows:

(1) when an individual is an applicant of the Medical Assistance Program or an applicant for a categorically related program which qualifies the individual for the Medical Assistance

Program, and the determination of eligibility comes after the last date of service and eligibility is retroactive, the provider shall submit claims for goods or services received within one year of the effective date of the determination of eligibility or effective date of award, whichever comes later;

(2) when there is an issue related to Medical Assistance Program eligibility or to payment for goods or services which is subject to the grievance process, the provider shall submit claims within the guidelines in subsection (a) of section 17b-262-529 of the Regulations of Connecticut State Agencies or within twelve months of the effective date of the resolution in favor of Medical Assistance Program payments for goods or services, whichever is later; and

(3) when a provider has submitted a claim to a third party insurer and has not received a response within a reasonable time, the one year shall begin twelve months from the date of receipt of the explanation of benefits form. The provider shall be responsible for any followup to the third party insurers.

(Adopted effective February 8, 1999; Amended April 1, 2003)

Sec. 17b-262-530. Payment rates

(a) All schedules of payment for coverable Medical Assistance Program goods and services shall be established by the commissioner and paid by the department in accordance with all applicable federal and state statutes and regulations.

(b) A provider whose rates are established by the department based on the provider's cost may be required to submit data in a format prescribed by the department which may include but not be limited to, the following:

(1) a copy of the provider's financial statement and an independent auditor's report for the most recently completed fiscal year, or anticipated costs if the program or service is new;

(2) a copy of the provider's financial statement for the current year to date;

(3) a current copy of the provider's usual and customary charges to the general public; and

(4) the provider's most recent Medicare cost report, if one is required to be filed by the provider.

(Adopted effective February 8, 1999; Amended April 1, 2003)

Sec. 17b-262-531. Payment limitations

Payment, by the department, to all providers shall be limited to medically appropriate and medically necessary goods or services furnished to Medical Assistance Program clients. The following payment limitations shall also apply:

(a) the department shall not make payment for any claim for Medical Assistance Program goods or services for persons not eligible for the Medical Assistance Program on the date the good or service is provided, except for those medical services required and requested by the department to determine a person's eligibility for the program;

(b) the department shall not make payment for any Medical Assistance Program goods or services which are not covered under, and furnished in accordance with federal and state statutes and regulations including 42 USC 1396b(f);

(c) the department shall not make an additional payment when a third party payment is equal to or greater than the department's schedule of payment for the same Medical Assistance Program good or service, except to meet the department's obligations as defined by federal and state laws and regulations;

(d) the department shall not make payment for Medical Assistance Program goods or services furnished by a provider after the date of termination of the provider, or during a period of suspension, from the Medical Assistance Program, except as may be determined by the commissioner;

(e) the department shall make payment only to a duly enrolled provider;

(f) the department shall not pay for goods or services that are furnished to providers or clients free of charge;

(g) the department shall not pay for any procedures, goods, or services of an unproven, educational, social, research, experimental, or cosmetic nature; for any diagnostic, therapeutic, or treatment goods or services in excess of those deemed medically necessary and medically appropriate by the department to treat the client's condition; or for services not directly related to the client's diagnosis, symptoms, or medical history;

(h) the department shall not pay for cancelled office visits and appointments not kept;

(i) the department shall make payment only to the provider to whom a client is locked-in, pursuant to section 17-134d-11 of the Regulations of Connecticut State Agencies, except in an emergency;

(j) a provider shall not charge an eligible Medical Assistance Program client, or any financially responsible relative or representative of that individual, for any portion of the cost of goods or services which are covered and payable under the Connecticut Medical Assistance Program. If a client or representative has paid for the goods or services and the client subsequently becomes eligible for the medical assistance program, payment made by or on behalf of the client shall be refunded by the provider to the payer. The provider then may bill the Medical Assistance Program for the goods or services provided. The provider shall obtain appropriate documentation that the payment was refunded prior to the submission of the claim and shall maintain said documentation;

(k) a provider shall not charge for medical goods or services for which a client would be entitled to have payment made, but for the provider's failure to comply with the requirements for payment established by these regulations;

(*l*) a provider shall only charge an eligible Medical Assistance Program client, or any financially responsible relative or representative of that individual, for goods or services which are not coverable under the Medical Assistance Program, when the client knowingly elects to receive the goods or services and enters into an agreement in writing for such goods or services prior to receiving them;

(m) Refunds by vendors to persons eligible for the medical assistance program shall be

in acordance with section 17b-103 of the Connecticut General Statutes. The provider shall obtain and maintain appropriate documentation that the payment was refunded prior to submission of the claim;

(n) a provider shall charge a client a copayment for Medical Assistance Program goods or services only when the department specifically authorizes the provider to collect such copayment from the client;

(o) Any cost used to establish the amount to be reimbursed by the medical assistance program which was incurred by a provider through a related party transaction shall not include any amount in excess of the cost to the related party. Only the actual cost of the product or service to the related party may be used to establish reimbursement by the Medical Assistance Program. Such related party cost shall also meet all other requirements for reimbursement, including, but not limited to, being reasonable and directly related to patient care. For purposes of this section, "related party" is defined as persons or organizations related through an ability to control, ownership, family relationship or business association, and includes persons related through marriage; and

(p) The provider shall be prohibited from reassigning claims in accordance with 42 CFR 447.10.

(Adopted effective February 8, 1999; Amended April 1, 2003)

Sec. 17b-262-532. Payment for out-of-state goods or services

(a) Pursuant to 42 CFR 431.52, payment for Medical Assistance Program goods or services furnished to clients while they are out-of-state shall be made by the department to the same extent as payment is made to in-state providers, unless otherwise specified in state statutes or regulations which govern the provider's assigned type and specialty, only when any of the following conditions is met:

(1) Medical Assistance Program goods or services are needed by a client because a medical emergency occurred while the client was outside of the state;

(2) Medical Assistance Program goods or services are needed because a client's health would be endangered if required to travel to Connecticut;

(3) the department determines that the Medical Assistance Program goods or services are[more readily] available only in another state and prior authorization was granted to the provider; or

(4) it is general practice for clients in a particular locality of Connecticut to use the medical resources in a bordering state. The department shall allow providers, who are designated by the department to be border providers, to be treated in the same manner as in-state providers.

(b) In addition, payment for Medical Assistance Program goods or services furnished to clients while they are out-of-state shall be made to the same extent as payment is made to in-state providers when:

(1) enrollment is for copayment or deductible of a Medicare claim; and

(2) a child for whom the department makes adoption assistance or foster care

maintenance payment resides outside of Connecticut, or an individual approved to attend school out-of-state resides in Connecticut.

(c) In order to be paid for goods or services, out-of-state providers shall enroll in the Connecticut Medical Assistance Program.

(d) Out-of-state pharmacies rendering services in-state to clients shall:

(1) participate in on-line point of sale and prospective drug use review claims processing; and

(2) pursuant to section 20-627 of the Connecticut General Statutes, out-of-state pharmacy providers shall, when doing business in Connecticut, receive a certificate of registration from the Department of Consumer Protection, upon approval of the Commission of Pharmacy, and provide a toll-free telephone number disclosed on labels for drugs dispensed in Connecticut.

(e) For payment for emergency services, providers shall be required to submit a claim and applicable medical emergency room reports, discharge summaries, or other documentation as determined by the department which confirms the emergency.

(f) In most cases, enrollment shall be for dates of service or provision of goods only. An exception to this rule may apply to providers of goods or services to children for whom the department makes adoption assistance or foster care maintenance payments who reside outside of Connecticut, or individuals approved to attend school out-of-state who reside in Connecticut. In these situations, a provider shall not be required to submit a claim to initiate the enrollment process. The provider shall indicate the name of the child or individual for whom it shall be providing services at the time of enrollment.

(g) Timely filing requirement shall be the same for out-of-state providers as for in-state providers except that the date of first contact with the department's fiscal agent to become enrolled in the Medical Assistance Program or to submit a claim shall be within twelve months of the date of provision of the service or delivery of the good.

(h) Pursuing other third party liabilities shall be the same for out-of-state providers as for in-state providers.

(i) Out-of-state independent laboratories, border hospitals, and physician groups having admitting privileges in a border hospital shall be exempt from the out-of-state criteria delineated in subsection (a) of section 17b-262-532 of the Regulations of Connecticut State Agencies. All other border providers shall be considered for enrollment in the Medical Assistance Program on a case-by-case basis.

(j) The Medical Assistance Program shall not cover out-of-state long-term care services unless such services are not available in the state of Connecticut and receive prior authorization from the department.

(k) Out-of-state providers shall, upon request of authorized department representatives, make available fiscal and medical records as required by applicable Medical Assistance Program regulations and the provider agreement. Such records shall be made available for review by authorized department representatives at a location within the State of

Connecticut.

(Adopted effective February 8, 1999; Amended April 1, 2003)

Sec. 17b-262-533. Sums paid in excess of the authorized schedules of payment or for other reasons of ineligibility for payment

Any payment, or part thereof, for Medical Assistance Program goods or services which represents an excess over the payment authorized, or a violation due to abuse or fraud, shall be payable to the department. Any such sum not returned to the department by a provider may be recovered in an action brought by the department against the provider. Such sums may also be recouped from current payment due the provider in accordance with law.

(Adopted effective February 8, 1999)

Sec. 17b-262-534. Reserved

Requirements for Payment of Chiropractic Services

Sec. 17b-262-535. Scope

Sections 17b-262-535 through 17b-262-545 inclusive set forth the Department of Social Services requirements for payment of chiropractic services, performed by licensed practitioners of chiropractic in private or group practices, for clients who are determined eligible to receive services under Connecticut's Medical Assistance Program pursuant to section 17b-262 of the Connecticut General Statutes (CGS).

(Adopted effective March 6, 1998)

Sec. 17b-262-536. Definitions

For the purposes of sections 17b-262-535 through 17b-262-545 the following definitions shall apply:

(1) "Acute" means having rapid onset, severe symptoms, and a short course.

(2) "Chiropractic" means the services described in Title 42 of the Code of Federal Regulations (CFR), Part 440, section 440.60, and subsection (1) of section 20-24 of the Connecticut General Statutes.

(3) "Client" means a person eligible for goods or services under the department's Medical Assistance Program.

(4) "Commissioner" means the Commissioner of Social Services appointed pursuant to subsection (a) of section 17b-1 of the Connecticut General Statutes.

(5) "Department" means the Department of Social Services or its agent.

(6) "Emergency" means a medical condition, including labor and delivery, manifesting itself by acute symptoms of sufficient severity, including severe pain, such that the absence of immediate medical attention could reasonably be expected to result in placing the client's health in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part.

(7) "HealthTrack Services" means the services described in subsection (r) of section

1905 of the Social Security Act.

(8) “HealthTrack Special Services” means medically necessary and medically appropriate health care, diagnostic services, treatment, or other measures necessary to correct or ameliorate disabilities and physical and mental illnesses and conditions discovered as a result of a periodic comprehensive health screening or interperiodic encounter. Such services are provided in accordance with subdivision (5) of subsection (r) of section 1905 of the Social Security Act, and are:

(A) services not covered under the State Plan or contained in a fee schedule published by the department; or

(B) services covered under the State Plan and contained in a fee schedule published by the department which exceed the limit on the amount of services established by the department that are contained in regulation.

(9) “Interperiodic Encounter” means any medically necessary visit to a Connecticut Medical Assistance provider, other than for the purpose of performing a periodic comprehensive health screening. Such encounters include, but are not limited to, physician’s office visits, clinic visits, and other primary care visits.

(10) “Licensed Practitioner of the Healing Arts” means a professional person providing health care pursuant to a license issued by the Department of Public Health (DPH).

(11) “Medical Appropriateness or Medically Appropriate” means health care that is provided in a timely manner and meets professionally recognized standards of acceptable medical care; is delivered in the appropriate medical setting; and is the least costly of multiple, equally-effective, alternative treatments or diagnostic modalities.

(12) “Medical Assistance Program” means the medical assistance provided pursuant to Chapter 319v of the Connecticut General Statutes (CGS) and authorized by Title XIX of the Social Security Act. The program is also referred to as Medicaid.

(13) “Medical Necessity or Medically Necessary” means health care provided to correct or diminish the adverse effects of a medical condition or mental illness; to assist an individual in attaining or maintaining an optimal level of health; to diagnose a condition; or prevent a medical condition from occurring.

(14) “Medical Record” means the definition contained in section 19a-14-40 of the Regulations of Connecticut State Agencies, which is also the Public Health Code.

(15) “Prior Authorization” means approval for the provision of a service or the delivery of goods from the department before the provider actually provides the service or delivers the goods.

(16) “Provider” means one who is licensed to practice chiropractic.

(17) “Provider Agreement” means the signed, written, contractual agreement between the department and the provider of services or goods.

(18) “State Plan” means the document which contains the services covered by the Connecticut Medical Assistance Program in compliance with Part 430, Subpart B, of Title 42 of the Code of Federal Regulations (CFR).

(19) “Subluxation” means an incomplete dislocation, off centering, misalignment

fixation of a joint or abnormal spacing of a vertebra as used by the practitioner of chiropractic.

(Adopted effective March 6, 1998)

Sec. 17b-262-537. Provider participation

In order to enroll in the Medical Assistance Program and receive payment from the department, providers shall:

(a) meet and maintain all applicable licensing, accreditation, and certification requirements;

(b) meet and maintain all departmental enrollment requirements; and

(c) have a valid provider agreement on file which is signed by the provider and the department upon application for enrollment into the Medical Assistance Program. This agreement, which shall be periodically updated, shall continue to be in effect for the duration of the agreement or for the stated period in the agreement. The provider agreement specifies conditions and terms which govern the program and to which the provider is mandated to adhere in order to participate in the program.

(Adopted effective March 6, 1998)

Sec. 17b-262-538. Eligibility

Payment for chiropractic services shall be available on behalf of all persons eligible for the Medical Assistance Program subject to the conditions and limitations which apply to these services.

(Adopted effective March 6, 1998)

Sec. 17b-262-539. Services covered and limitations

(a) Except for the limitations and exclusions listed below, the department shall pay for the following:

(1) the manual manipulation of the spine, but not for any procedures or services of an unproven, educational, social, research, experimental, or cosmetic nature; for services in excess of those deemed medically necessary and medically appropriate by the department to treat the client's condition; or for services not directly related to the client's diagnosis, symptoms, or medical history;

(2) services provided in the provider's office, client's home, hospital, nursing facility, rest home, home for the aged, boarding home, or intermediate care facility for the mentally retarded (ICF/MR); and

(3) HealthTrack Services and HealthTrack Special Services.

(b) Limitations on covered services shall be as follows:

(1) those services listed in the department's fee schedule and within the scope of the provider's practice;

(2) the department shall pay for no more than one visit per day per client per provider; and

(3) the department shall pay for a maximum of four exams or treatments in a single visit to a home, hospital, nursing facility, rest home, home for the aged, boarding home, or intermediate care facility for the mentally retarded (ICF/MR).

(Adopted effective March 6, 1998)

Sec. 17b-262-540. Services not covered

The department shall not pay for the following chiropractic services which are not covered under the Medical Assistance Program:

(a) chiropractic practice does not include the prescription or administration of any medicine or drug or the performance of any surgery;

(b) x-rays furnished by a practitioner of chiropractic;

(c) an initial visit for exam and diagnosis;

(d) manipulation of other parts of the body such as: the shoulder, arm, knee—even when for subluxation of the spine;

(e) lab work ordered by a practitioner of chiropractic;

(f) for information or services provided to a client over the telephone; and

(g) for cancelled office visits or appointments not kept.

(Adopted effective March 6, 1998)

Sec. 17b-262-541. Need for service

The department shall pay for medically necessary and medically appropriate treatment only when:

(a) provided by a licensed practitioner of chiropractic and the services are within the scope of practice of the practitioner, and

(b) the services are made part of the client's medical record.

(Adopted effective March 6, 1998)

Sec. 17b-262-542. Prior authorization

(a) Prior authorization, on forms and in a manner as specified by the department, is required for:

(1) manipulation of the spine in excess of five per client per provider per month; and

(2) HealthTrack Special Services. HealthTrack Special Services are determined medically necessary and medically appropriate on a case-by-case basis. The request for HealthTrack Special Services shall include:

(A) a written statement from the prescribing physician, or other licensed practitioner of the healing arts, performing such services within his or her respective scope of practice as defined under state law, justifying the need for the item or service required;

(B) a description of the outcomes of any alternative measures tried; and

(C) if applicable and requested by the department, any other documentation required in order to render a decision.

(b) The procedure or course of treatment authorized shall be initiated within six months

of the date of authorization.

(c) The initial authorization period shall be up to three months.

(d) If prior authorization is needed beyond the initial authorization period, requests for continued treatment beyond the initial authorization period shall be considered up to six months per request.

(e) For services requiring prior authorization, a provider shall be required to provide pertinent medical or social information adequate for evaluating the client's medical need for services. Except in emergency situations, or when authorization is being requested for more than one visit in the same day, approval shall be received before services are rendered.

(f) In an emergency situation which occurs after working hours or on a weekend or holiday, the provider shall secure verbal approval on the next working day for the services provided. This applies only to those services which normally require prior authorization.

(g) In order to receive payment from the department a provider shall comply with all prior authorization requirements. The department in its sole discretion determines what information is necessary in order to approve a prior authorization request. Prior authorization does not, however, guarantee payment unless all other requirements for payment are met.

(Adopted effective March 6, 1998)

Sec. 17b-262-543. Billing procedures

(a) The amount billed to the department shall represent the practitioner of chiropractic's usual and customary charge for the services delivered.

(b) Claims from practitioners of chiropractic shall be submitted on a hard copy invoice or electronically transmitted to the department's fiscal agent, in a form and manner as specified by the department, and shall include all information required by the department to process the claim.

(Adopted effective March 6, 1998)

Sec. 17b-262-544. Payment

(a) Payment shall be made at the lowest of:

(1) the provider's usual and customary charge to the general public;

(2) the lowest Medicare rate;

(3) the amount in the applicable fee schedule as published by the department;

(4) the amount billed by the provider; or

(5) the lowest price charged or accepted for the same or substantially similar goods or services by the provider from any person or entity.

(b) **Payment Rate**

(1) The commissioner establishes the fees contained in the practitioner of chiropractic's fee schedule pursuant to section 4-67c of the Connecticut General Statutes.

(2) Payment rates, as established by the commissioner, are the same for in- and out-of-state providers.

(c) **Payment Limitations**

The fee paid by the department for visits to a home, hospital, nursing facility, rest home, home for the aged, boarding home, or intermediate care facility for the mentally retarded (ICF/MR) shall include payment for travel and all such incidental expenses.

(Adopted effective March 6, 1998)

Sec. 17b-262-545. Documentation

(a) Practitioners of chiropractic shall maintain a specific record for all services received for each client eligible for Medical Assistance Program payment including, but not limited to: name, address, birth date, Medical Assistance Program identification number, pertinent diagnostic information, a current treatment plan signed by the provider, documentation of services provided, and the dates the services were provided.

(b) All required documentation shall be maintained for at least five years in the practitioner of chiropractic's file subject to review by authorized department personnel. In the event of a dispute concerning a service provided, documentation shall be maintained until the end of the dispute or five years, whichever is greater.

(c) Failure to maintain all required documentation shall result in the disallowance and recovery by the department of any amounts paid to the provider for which the required documentation is not maintained or provided to the department upon request.

(Adopted effective March 6, 1998)

Sec. 17b-262-546. Reserved

Requirements for Payment of Natureopathic Services

Sec. 17b-262-547. Scope

Sections 17b-262-547 through 17b-262-557 inclusive set forth the Department of Social Services requirements for payment of natureopathic services provided by licensed natureopaths for clients who are determined eligible to receive services under Connecticut's Medical Assistance Program pursuant to section 17b-262 of the Connecticut General Statutes (CGS).

(Adopted effective March 6, 1998)

Sec. 17b-262-548. Definitions

For the purposes of sections 17b-262-547 through 17b-262-557 the following definitions shall apply:

(1) "Acute" means having rapid onset, severe symptoms, and a short course.

(2) "Client" means a person eligible for goods or services under the department's Medical Assistance Program.

(3) "Commissioner" means the Commissioner of Social Services appointed pursuant to subsection (a) of section 17b-1 of the Connecticut General Statutes.

(4) "Department" means the Department of Social Services or its agent.

(5) "Emergency" means a medical condition, including labor and delivery, manifesting

itself by acute symptoms of sufficient severity, including severe pain, such that the absence of immediate medical attention could reasonably be expected to result in placing the client's health in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily part or organ.

(6) "HealthTrack Services" means the services described in subsection (r) of section 1905 of the Social Security Act.

(7) "HealthTrack Special Services" means medically necessary and medically appropriate health care, diagnostic services, treatment, or other measures necessary to correct or ameliorate disabilities and physical and mental illnesses and conditions discovered as a result of a periodic comprehensive health screening or interperiodic encounter. Such services are provided in accordance with subdivision (5) of subsection (r) of section 1905 of the Social Security Act, and are:

(A) services not covered under the State Plan or contained in a fee schedule published by the department; or

(B) services covered under the State Plan and contained in a fee schedule published by the department which exceed the limit on the amount of services established by the department that are contained in regulation.

(8) "Interperiodic Encounter" means any medically necessary visit to a Connecticut Medical Assistance provider, other than for the purpose of performing a periodic comprehensive health screening. Such encounters include, but are not limited to, physician's office visits, clinic visits, and other primary care visits.

(9) "Licensed Practitioner of the Healing Arts" means a professional person providing health care pursuant to a license issued by the Department of Public Health (DPH).

(10) "Medical Appropriateness or Medically Appropriate" means health care that is provided in a timely manner and meets professionally recognized standards of acceptable medical care; is delivered in the appropriate medical setting; and is the least costly of multiple, equally-effective, alternative treatments or diagnostic modalities.

(11) "Medical Assistance Program" means the medical assistance provided pursuant to Chapter 319v of the Connecticut General Statutes (CGS) and authorized by Title XIX of the Social Security Act. The program is also referred to as Medicaid.

(12) "Medical Necessity or Medically Necessary" means health care provided to correct or diminish the adverse effects of a medical condition or mental illness; to assist an individual in attaining or maintaining an optimal level of health; to diagnose a condition; or prevent a medical condition from occurring.

(13) "Medical Record" means the definition contained in section 19a-14-40 of the Regulations of Connecticut State Agencies, which is also the Public Health Code.

(14) "Natureopathy" means the practice of natureopathy as defined in subsections (a) and (b) of section 20-34 of the Connecticut General Statutes.

(15) "Prior Authorization" means approval for the provision of a service or the delivery of goods from the department before the provider actually provides the service or delivers the goods.

(16) "Provider" means one who is licensed to practice natureopathy.

(17) "Provider Agreement" means the signed, written, contractual agreement between the department and the provider of services or goods.

(18) "State Plan" means the document which contains the services covered by the Connecticut Medical Assistance Program in compliance with Part 430, Subpart B, of Title 42 of the Code of Federal Regulations (CFR).

(Adopted effective March 6, 1998)

Sec. 17b-262-549. Provider participation

In order to participate in the Medical Assistance Program and receive payment from the department, providers shall:

(a) meet and maintain all applicable licensing, accreditation, and certification requirements,

(b) meet and maintain all departmental enrollment requirements, and

(c) have a valid provider agreement on file which is signed by the provider and the department upon application for enrollment into the Medical Assistance Program. This agreement, which shall be periodically updated, shall continue to be in effect for the duration of the agreement or for the stated period in the agreement. The provider agreement specifies conditions and terms which govern the program and to which the provider is mandated to adhere in order to participate in the program.

(Adopted effective March 6, 1998)

Sec. 17b-262-550. Eligibility

Payment for natureopathic services shall be available on behalf of all persons eligible for the Medical Assistance Program subject to the conditions and limitations which apply to these services.

(Adopted effective March 6, 1998)

Sec. 17b-262-551. Services covered and limitations

Except for the limitations and exclusions listed below, the department shall pay for the professional services of a licensed natureopath which conform to accepted methods of diagnosis and treatment, but shall not pay for any procedures or services of an unproven, educational, social, research, experimental, or cosmetic nature; for services in excess of those deemed medically necessary and medically appropriate by the department to treat the client's condition; or for services not directly related to the client's diagnosis, symptoms, or medical history.

(a) The department shall pay for the following:

(1) services provided in the provider's office or client's home, hospital, nursing facility, rest home, home for the aged, boarding home, or intermediate care facility for the mentally retarded (ICF/MR), and

(2) HealthTrack Services and HealthTrack Special Services.

(b) Limitations on covered services shall be as follows:

(1) services covered shall be limited to those listed in the department's fee schedule and within the scope of the provider's practice;

(2) only one visit per day per client per provider shall be paid for; and

(3) the department shall pay for a maximum of four exams or treatments in a single visit to a home, hospital, nursing facility, rest home, home for the aged, boarding home, or intermediate care facility for the mentally retarded (ICF/MR).

(Adopted effective March 6, 1998)

Sec. 17b-262-552. Services not covered

The department shall not pay for the following natureopathic services:

(a) the administration of internal medication or substances simulating medicine, or the form of medicine;

(b) the administration of dehydrated foods;

(c) for information or services provided to a client over the telephone; and

(d) for cancelled office visits or appointments not kept.

(Adopted effective March 6, 1998)

Sec. 17b-262-553. Need for service

The department shall pay for medically necessary and medically appropriate treatment only when:

(a) provided by a licensed natureopath and the services are within the scope of the natureopath's scope of practice, and

(b) the services are made part of the client's medical record.

(Adopted effective March 6, 1998)

Sec. 17b-262-554. Prior authorization

(a) Prior authorization, on forms and in a manner as specified by the department, shall be required for:

(1) professional office or home visits in excess of five per client per provider per month, and

(2) HealthTrack Special Services. HealthTrack Special Services are determined medically necessary and medically appropriate on a case-by-case basis. The request for HealthTrack Special Services shall include:

(i) a written statement from the prescribing physician, or other licensed practitioner of the healing arts, performing such services within his or her respective scope of practice as defined under state law, justifying the need for the item or service requested;

(ii) a description of the outcomes of any alternative measures tried; and

(iii) if applicable and requested by the department, any other documentation required in order to render a decision.

(b) The procedure or course of treatment authorized shall be initiated within six months

of the date of authorization.

(c) The initial authorization period shall be up to three months.

(d) If prior authorization is needed beyond the initial authorization period, requests for continued treatment beyond the initial authorization period shall be considered up to six months per request.

(e) For services requiring prior authorization, a provider shall be required to provide pertinent medical or social information adequate for evaluating the client's medical need for services. Except in emergency situations, or when authorization is being requested for more than one visit in the same day, approval shall be received before services are rendered.

(f) In an emergency situation which occurs after working hours or on a weekend or holiday, the provider shall secure verbal approval on the next working day for the services provided. This applies only to those services which normally require prior authorization.

(g) Eligibility for Medical Assistance Program coverage must be verified at every visit even though prior authorization has been received for the entire number of visits.

(h) In order to receive payment from the department a provider shall comply with all prior authorization requirements. The department in its sole discretion determines what information is necessary in order to approve a prior authorization request. Prior authorization does not, however, guarantee payment unless all other requirements for payment are met.

(Adopted effective March 6, 1998)

Sec. 17b-262-555. Billing procedures

(a) Claims for natureopathic services shall be submitted on hard copy invoice or electronically transmitted to the department's fiscal agent, in a form and manner as specified by the department, and shall include all information required by the department to process the claim.

(b) The amount billed to the department shall represent the provider's usual and customary charge for the services delivered.

(Adopted effective March 6, 1998)

Sec. 17b-262-556. Payment

(a) Payment shall be made at the lowest of:

(1) the provider's usual and customary charge to the general public;

(2) the lowest Medicare rate;

(3) the amount in the applicable fee schedule as published by the department;

(4) the amount billed by the provider; or

(5) the lowest price charged or accepted for the same or substantially similar goods or services by the provider from any person or entity.

(b) **Payment Rate**

(1) The commissioner establishes the fees contained in the natureopath's fee schedule pursuant to section 4-67c of the Connecticut General Statutes.

(2) Payment rates, as established by the commissioner, are the same for in- and out-of-

state providers.

(c) **Payment Limitations**

The fee issued by the department for visits to a home, hospital, nursing facility, rest home, home for the aged, boarding home, or intermediate care facility for the mentally retarded (ICF/MR) shall include payment for travel and all such incidental expenses.

(Adopted effective March 6, 1998)

Sec. 17b-262-557. Documentation

(a) Natureopathic care providers shall maintain a specific record for all services received for each client eligible for Medical Assistance Program payment including, but not limited to: name, address, birth date, Medical Assistance Program identification number, pertinent diagnostic information, a current treatment plan signed by the provider, documentation of services provided, and the dates the services were provided.

(b) All required documentation shall be maintained for at least five years in the natureopathic care provider's file subject to review by authorized department personnel. In the event of a dispute concerning a service provided, documentation shall be maintained until the end of the dispute or five years, whichever is greater.

(c) Failure to maintain all required documentation shall result in the disallowance and recovery by the department of any amounts paid to the provider for which the required documentation is not maintained or provided to the department upon request.

(Adopted effective March 6, 1998)

Sec. 17b-262-558. Reserved

Requirements for Payment of Vision Care Services

Sec. 17b-262-559. Scope

Sections 17b-262-559 through 17b-262-571, inclusive, set forth the Department of Social Services requirements for payment of accepted methods of treatment provided by an ophthalmologist, optometrist, or optician for clients who are determined eligible to receive services under Connecticut's Medical Assistance Program pursuant to section 17b-262 of the Connecticut General Statutes (CGS).

(Adopted effective March 6, 1998; Amended June 11, 2003)

Sec. 17b-262-560. Definitions

For the purposes of sections 17b-262-559 through 17b-262-571 the following definitions shall apply:

(1) "Acute" means having rapid onset, severe symptoms, and a short course.

(2) "Client" means a person eligible for goods or services under the department's Medical Assistance Program.

(3) "Commissioner" means the Commissioner of Social Services appointed pursuant to subsection (a) of section 17b-1 of the Connecticut General Statutes.

(4) "Department" means the Department of Social Services or its agent.

(5) "Doctor of Osteopathy" means a doctor of osteopathy licensed pursuant to section 20-17 of the Connecticut General Statutes.

(6) "Early and Periodic Screening, Diagnostic and Treatment Services (EPSDT)" means the services described in subsection (r) of section 1905 of the Social Security Act.

(7) "Emergency" means a medical condition, including labor and delivery, manifesting itself by acute symptoms of sufficient severity, including severe pain, such that the absence of immediate medical attention could reasonably be expected to result in placing the client's health in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part.

(8) "Fees" means the rates for services, treatments, and drugs administered by ophthalmologists, optometrists, and opticians which shall be established by the commissioner of the department and contained in the department's fee schedules.

(9) "Incomplete Eye Exam" means an annual eye exam which is not completed since the preliminary findings reveal that visual analysis is not indicated.

(10) "Interperiodic Encounter" means any medically necessary visit to a Connect-icut Medical Assistance provider, other than for the purpose of performing a periodic comprehensive health screening. Such encounters include, but are not limited to, physician's office visits, clinic visits, and other primary care visits.

(11) "Licensed Practitioner of the Healing Arts" means a professional person providing health care pursuant to a license issued by the Department of Public Health (DPH).

(12) "Medical Appropriateness or Medically Appropriate" means health care that is provided in a timely manner and meets professionally recognized standards of acceptable medical care; is delivered in the appropriate medical setting; and is the least costly of multiple, equally-effective, alternative treatments or diagnostic modalities.

(13) "Medical Assistance Program" means the medical assistance provided pursuant to Chapter 319v of the Connecticut General Statutes (CGS) and authorized by Title XIX of the Social Security Act. The program is also referred to as Medicaid.

(14) "Medical Necessity or Medically Necessary" means health care provided to correct or diminish the adverse effects of a medical condition or mental illness; to assist an individual in attaining or maintaining an optimal level of health; to diagnose a condition; or prevent a medical condition from occurring.

(15) "Medical Record" means the definition contained in section 19a-14-40 of the Regulations of Connecticut State Agencies, which is also the Public Health Code.

(16) "Modified Lens Prescription" means a prescription given to a client because of:

(A) a radical change in the prescription;

(B) a large initial prescription; or

(C) amblyopia, latent hyperopia, or inadequate care previously received.

(17) "Ophthalmologist" means a physician licensed pursuant to Chapter 370 of the Connecticut General Statutes, who within his or her scope of practice as defined by state law, specializes in the branch of medicine dealing with the structure, functions, pathology,

and treatment of the eyes. The practice includes the use of surgery, x-ray, photocoagulation, ionizing radiation, and drugs for examination of the eyes.

(18) "Optician" means an individual licensed pursuant to section 20-145 of the Connecticut General Statutes having a knowledge of optics and is skilled in the technique of producing and reproducing ophthalmic lenses and kindred products and who, within his or her scope of practice as defined by state law, prepares and dispenses ophthalmic lenses and products to correct visual defects.

(19) "Optometrist" means an individual licensed pursuant to Chapter 380 of the Connecticut General Statutes to practice optometry as delineated in subsections (a) (1) and (2) of section 20-127 of the Connecticut General Statutes.

(20) "Physician" means a physician licensed pursuant to section 20-10 of the Connecticut General Statutes.

(21) "Prior Authorization" means approval for the provision of a service or delivery of goods from the department before the provider actually provides the service or delivers the goods.

(22) "Progressive Myopia" means a known progressive myopia, changing .75 diopters in the past six months.

(23) "Provider" means a licensed ophthalmologist, optometrist, or optician.

(24) "Provider Agreement" means the signed, written, contractual agreement between the department and the provider of services or goods.

(25) "State Plan" means the document which contains the services covered by the Connecticut Medical Assistance Program in compliance with Part 430, Subpart B, of Title 42 of the Code of Federal Regulations (CFR).

(26) "Usable Lens" means a lens which is not scratched or otherwise defective so as to impair use or endanger the wearer.

(27) "Usual and Customary Charge" means the amount that the provider charges for the service or procedure in the majority of non-Medicaid cases. If the provider varies the charges so that no one amount is charged in the majority of cases, usual and customary shall be defined as the median charge. When calculating the median charge, token charges for charity patients and other exceptional charges are to be excluded.

(Adopted effective March 6, 1998; Amended June 11, 2003)

Sec. 17b-262-561. Provider participation

In order to enroll in the Medical Assistance Program and receive payment from the department, providers shall:

(a) meet and maintain all applicable licensing, accreditation, and certification requirements;

(b) meet and maintain all departmental enrollment requirements; and

(c) have a valid provider agreement on file which is signed by the provider and the department upon application for enrollment into the Medical Assistance Program. This agreement, which shall be periodically updated, shall continue to be in effect for the duration

of the agreement or for the stated period in the agreement. The provider agreement specifies the conditions and terms which govern the program and to which the provider is mandated to adhere in order to participate in the program.

(Adopted effective March 6, 1998; Amended June 11, 2003)

Sec. 17b-262-562. Eligibility

Payment for vision care services shall be available on behalf of all persons eligible for the Medical Assistance Program subject to the conditions and limitations which apply to these services.

(Adopted effective March 6, 1998; Amended June 11, 2003)

Sec. 17b-262-563. Services covered and limitations

(a) Except for the limitations and exclusions listed below, the department shall pay for the professional services of a licensed ophthalmologist, optometrist, or optician which conform to accepted methods of diagnosis and treatment, but shall not pay for anything of an unproven, educational, social, research, experimental, or cosmetic nature; for services in excess of those deemed medically necessary and medically appropriate by the department to treat the client's condition; or for services not directly related to the client's diagnosis, symptoms, or medical history.

(b) The department shall pay providers for:

(1) only those procedures listed in the provider's fee schedule and within the scope of the provider's practice;

(2) services provided in the provider's office, client's home, hospital, nursing facility, rest home, intermediate care facility for the mentally retarded (ICF/MR), chronic disease hospital, boarding home, state-owned or state-operated institution, or home for the aged;

(3) two pairs of eyeglasses, distance and near, permitted in lieu of bifocals, when need for same is substantiated in the client's medical record by clinical data from the provider; and

(4) Early periodic screening, diagnostic and treatment services.

(Adopted effective March 6, 1998; Amended June 11, 2003)

Sec. 17b-262-564. Services not covered

The department shall not pay for the following:

(a) information or services provided to a client by a provider over the telephone;

(b) cancelled office visits and appointments not kept;

(c) a spare pair of eyeglasses; and

(d) visual analysis within forty-two consecutive days from the date of an eye examination.

(Adopted effective March 6, 1998; Amended June 11, 2003)

Sec. 17b-262-565. Need for service

The department shall pay for medically necessary and medically appropriate vision care services for Medical Assistance Program eligible clients, in relation to the diagnosis for which care is required, provided that:

(a) the services are within the scope of the provider's practice;

(b) the services are made part of the client's medical record; and

(c) for contact lenses, glasses, or vision training, only when prescribed by a physician, doctor of osteopathy, or optometrist.

(Adopted effective March 6, 1998; Amended June 11, 2003)

Sec. 17b-262-566. Early periodic screening, diagnostic and treatment services

(a) Prior authorization for EPSDT services not on the Vision Care fee schedule or which are on such fee schedule but for which there are limitations in the amount, frequency or circumstances under which such services can be used, either in the fee schedule or in the Regulations of Connecticut State Agencies published by the department, may be obtained using the following procedures:

(1) Services not on the fee schedule, or for which there are limitations on their use, may be authorized on a case-by-case basis. Requests for prior authorization to provide services shall be made on forms and in a manner as specified by the department.

(2) Providers requesting prior authorization to provide services shall be required to provide pertinent medical or social information adequate for evaluating the client's medical need for services. This information shall include: (A) a written statement from the prescribing physician, or other practitioner of the healing arts, performing such services within such practitioner's respective scope of practice as defined under state law, justifying the need for the item or service requested; (B) a description of the outcomes of any alternative measures tried; and (C) if applicable and requested by the department, any other documentation required in order to render a decision.

(3) Except in emergency situations, or when authorization is being requested for more than one visit in the same day, approval shall be received before services are rendered. In an emergency situation which occurs after working hours or on a weekend or holiday, the provider shall secure verbal approval on the next working day for the services provided.

(b) In order to receive payment from the department a provider shall comply with all prior authorization requirements. The department, in its sole discretion determines what information is necessary in order to approve an authorization request. Prior authorization does not, however, guarantee payment unless all other requirements for payment are met.

(Adopted effective March 6, 1998; Amended June 11, 2003)

Sec. 17b-262-567. Billing procedures

(a) Claims from providers shall be submitted on the department's designated form or electronically submitted to the department's fiscal agent and shall include all information required by the department to process the claim for payment.

(b) Claims for a full or partial eye examination in a nursing facility or a state-owned or state-operated institution shall contain the name of the prescribing practitioner.

(c) The amount billed to the department shall represent the provider's usual and customary charge for the services delivered.

(Adopted effective March 6, 1998; Amended June 11, 2003)

Sec. 17b-262-568. Payment

(a) Payment rates shall be the same for in-state and out-of-state providers.

(b) Payment for professional services shall be made at the lowest of:

(1) the provider's usual and customary charge;

(2) the lowest Medicare rate;

(3) the amount in the applicable fee schedule as published by the department; or

(4) the amount billed by the provider.

(c) Payment for supplies and equipment shall be made at the lowest of:

(1) the provider's usual and customary charge;

(2) the lowest Medicare rate;

(3) the amount in the applicable fee schedule as published by the department; or

(4) the amount billed by the provider.

(d) The department shall pay for lenses for clients who own their own frames and are eligible for lenses.

(Adopted effective March 6, 1998; Amended June 11, 2003)

Sec. 17b-262-569. Payment rate

The commissioner establishes the fees contained in the department's fee schedule pursuant to section 4-67c of the Connecticut General Statutes.

(Adopted effective March 6, 1998; Amended June 11, 2003)

Sec. 17b-262-570. Payment limitations

(a) Contact lenses shall be covered, when such lenses provide better management of a visual or ocular condition than can be achieved with spectacle lenses, including, but not limited to the diagnosis of: Unilateral Aphakia, Keratoconus, Corneal Transplant, and High Anisometropia.

(b) Prescription sunglasses shall be covered when light sensitivity which will hinder driving or seriously handicap the outdoor activity of a client is evident.

(c) Trifocals shall be covered only when the client has a special need due to a job training program or extenuating circumstances.

(d) Oversize lens shall be covered only when needed for physiological reasons, and not for cosmetic reasons.

(e) Services and materials covered shall be limited to those listed in the department's fee schedule.

(f) Extended wear contact lenses shall be covered for aphakia and for clients whose

coordination or physical condition makes daily usage of contact lenses impossible.

(g) When the preliminary findings of an eye examination reveal that a visual analysis cannot or should not be completed, payment shall be made only for an incomplete eye exam.

(h) Providers shall be limited to a maximum of six full or partial eye examinations in a chronic disease hospital, boarding home, home for the aged, nursing facility, ICF/MR, or state-owned or state-operated institution in any one day, in any one home or institution.

(i) A written request shall be provided by the provider from the prescribing practitioner of a nursing facility and state-owned or state-operated institution, for a full or partial eye examination, to be performed on a client in the facility or institution.

(j) Payment for ocular prosthesis shall be made only to the provider performing the actual fitting.

(k) The payment limitations set forth in section 17b-262-448 of the department's regulations governing physicians' services are hereby incorporated by reference and made applicable to services provided by ophthalmologists.

(*l*) The department shall pay for eyeglasses for a client, as long as the client was eligible on the date the eyeglasses were ordered or requested by the client.

(m) The department shall pay for eyeglass frames when the client meets all eligibility requirements. The Medical Assistance Program published fee shall be considered maximum payment in full. A provider shall not bill the Medical Assistance Program for eyeglass frames and receive payment from the client for the difference in cost.

(Adopted effective March 6, 1998; Amended June 11, 2003)

Sec. 17b-262-571. Documentation

(a) Vision care providers shall maintain a specific record for all services and supplies received for each client eligible for Medical Assistance Program payment including, but not limited to: name, address, birth date, Medical Assistance Program identification number, pertinent diagnostic information, a current treatment plan signed by the provider, documentation of services and supplies provided, and the dates the services or supplies were provided.

(b) All required documentation in its original form shall be maintained for at least five years in the vision care provider's file subject to review by authorized department personnel. In the event of a dispute concerning a service or supply provided, documentation shall be maintained until the end of the dispute or five years, whichever is greater.

(c) Failure to maintain all required documentation shall result in the disallowance and recovery by the department of any amounts paid to the vision care provider for which the required documentation is not maintained and not provided to the department upon request.

(Adopted effective March 6, 1998; Amended June 11, 2003)

Sec. 17b-262-572. Reserved

Requirements for Payment of Nurse-Midwifery Services

Sec. 17b-262-573. Scope

Sections 17b-262-573 through 17b-262-585 inclusive set forth the Department of Social Services requirements for payment of nurse-midwifery services performed by licensed nurse-midwifes for clients who are determined eligible to receive such services under Connecticut's Medical Assistance Program pursuant to section 17b-262 of the Connecticut General Statutes (CGS).

(Adopted effective March 6, 1998)

Sec. 17b-262-574. Definitions

For the purposes of sections 17b-262-573 through 17b-262-585 the following definitions shall apply:

(1) "Acute" means having rapid onset, severe symptoms, and a short course.

(2) "Client" means a person eligible for goods or services under the department's Medical Assistance Program.

(3) "Commissioner" means the Commissioner of Social Services appointed pursuant to subsection (a) of section 17b-1 of the Connecticut General Statutes.

(4) "Consultation and Collaborative Management" means those services rendered by the obstetrician-gynecologist who is part of the health care team whose opinion or advice is requested by the client's nurse-midwife in the evaluation or treatment of the client. The consultant obstetrician-gynecologist may prescribe a course of treatment provided by the nurse-midwife. It does not necessarily mean the client shall be seen by the obstetrician-gynecologist.

(5) "Department" means the Department of Social Services or its agent.

(6) "Directed" means a nurse-midwife shall always function within a health care system in a team relationship with a physician and shall never be independent of physician back-up for consultation and collaborative management, or referral.

(7) "Emergency" means a medical condition, including labor and delivery, manifesting itself by acute symptoms of sufficient severity, including severe pain, such that the absence of immediate medical attention could reasonably be expected to result in placing the client's health in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part.

(8) "Essentially Normal" means a philosophic view of childbirth as a natural, normal process. Essentially normal means that if a client develops complications, the nurse-midwife either consults or collaborates with the physician in the management of care of the client or, depending on the severity of the complication, refers the client to the physician. This reflects again the team relationship with the physician, because normal is defined by the nurse-midwifes and physicians in a particular practice setting.

(9) "Family Planning Services" means any medically approved diagnostic procedure,

treatment, counseling, drug, supply, or device which is prescribed or furnished by a provider to individuals of child-bearing age for the purpose of enabling such individuals to freely determine the number and spacing of their children.

(10) "Health Care Team" means the nurse-midwife shall function in a team relationship with a physician and shall never be independent of physician back-up for consultation and collaborative management, or referral.

(11) "HealthTrack Services" means the services described in subsection (r) of section 1905 of the Social Security Act.

(12) "HealthTrack Special Services" means medically necessary and medically appropriate health care, diagnostic services, treatment, or other measures necessary to correct or ameliorate disabilities and physical and mental illnesses and conditions discovered as a result of a periodic comprehensive health screening or interperiodic encounter. Such services are provided in accordance with subdivision (5) of subsection (r) of section 1905 of the Social Security Act, and are:

(A) services not covered under the State Plan or contained in a fee schedule published by the department; or

(B) services covered under the State Plan and contained in a fee schedule published by the department which exceed the limit on the amount of services established by the department that are contained in regulation.

(13) "Interperiodic Encounter" means any medically necessary visit to a Connecticut Medical Assistance provider, other than for the purpose of performing a periodic comprehensive health screening. Such encounters include, but are not limited to, physician's office visits, clinic visits, and other primary care visits.

(14) "Licensed Practitioner of the Healing Arts" means a professional person providing health care pursuant to a license issued by the Department of Public Health (DPH).

(15) "Long-Term Care Facility" means a medical institution which provides, at a minimum, skilled nursing services or nursing supervision and assistance with personal care on a daily basis. Long-term care facilities include:

(A) nursing facilities,

(B) chronic disease hospitals—inpatient, and

(C) intermediate care facilities for the mentally retarded (ICFs/MR).

(16) "Management of Care" means the responsibilities and accountability the nurse-midwife shall assume and the mandatory relationship this shall require with a physician. This management is independent in the fact that a client who experiences an essentially normal maternity cycle or requires well-woman gynecological care may have her care provided entirely by the nurse-midwife.

(17) "Maternity Cycle" means a period limited to:

(A) pregnancy,

(B) labor,

(C) birth, and

(D) the immediate postpartum period, not to exceed six weeks from the child's date of

birth.

(18) "Medical Appropriateness or Medically Appropriate" means health care that is provided in a timely manner and meets professionally recognized standards of acceptable medical care; is delivered in the appropriate medical setting; and is the least costly of multiple, equally-effective, alternative treatments or diagnostic modalities.

(19) "Medical Assistance Program" means the medical assistance provided pursuant to Chapter 319v of the Connecticut General Statutes (CGS) and authorized by Title XIX of the Social Security Act. The program is also referred to as Medicaid.

(20) "Medical Necessity or Medically Necessary" means health care provided to correct or diminish the adverse effects of a medical condition or mental illness; to assist an individual in attaining or maintaining an optimal level of health; to diagnose a condition; or prevent a medical condition from occurring.

(21) "Medical Record" means the definition contained in section 19a-14-40 of the Regulations of Connecticut State Agencies, which is also the Public Health Code.

(22) "Nurse-midwife" means a person who meets all of the conditions established in subsection (2) of section 20-86a of the Connecticut General Statutes.

(23) "Nurse-midwifery Services" are the services established in subsection (1) of section 20-86a and section 20-86b of the Connecticut General Statutes.

(24) "Physician" means a physician licensed pursuant to section 20-10 of the Connecticut General Statutes who practices as an obstetrician-gynecologist.

(25) "Prior Authorization" means approval for the provision of a service or the delivery of goods from the department before the provider actually provides the service or delivers the goods.

(26) "Provider" means a licensed nurse-midwife.

(27) "Provider Agreement" means the signed, written, contractual agreement between the department and the provider of services or goods.

(28) "Referral" means the nurse-midwife requests a consultation and collaboration with the physician on a client which results in the physician providing the care for the client.

(29) "State Plan" means the document which contains the services covered by the Connecticut Medical Assistance Program in compliance with Part 430, Subpart B, of Title 42 of the Code of Federal Regulations (CFR).

(Adopted effective March 6, 1998)

Sec. 17b-262-575. Provider participation

In order to enroll in the Medical Assistance Program and receive payment from the department, a nurse-midwife shall:

(a) meet all applicable licensing, accreditation, and certification requirements;

(b) meet and maintain all departmental enrollment requirements; and

(c) have a valid provider agreement on file which is signed by the provider and the department upon application for enrollment into the Medical Assistance Program. This agreement, which shall be periodically updated, shall continue to be in effect for the duration

of the agreement or for the stated period in the agreement. The provider agreement specifies the conditions and terms which govern the program and to which the provider is mandated to adhere in order to participate in the program.

(Adopted effective March 6, 1998)

Sec. 17b-262-576. Eligibility

Payment for nurse-midwifery services shall be available on behalf of all women and newborns, only throughout the maternity cycle, eligible for the Medical Assistance program subject to the conditions and limitations which apply to these services.

(Adopted effective March 6, 1998)

Sec. 17b-262-577. Services covered and limitations

Except for the limitations and exclusions listed below, the department shall pay for the professional services of a licensed and certified nurse-midwife which conform to accepted methods of diagnosis and treatment, but shall not pay for any procedures or services of an unproven, educational, social, research, experimental, or cosmetic nature; for services in excess of those deemed medically necessary and medically appropriate by the department to treat the client's condition; or for services not directly related to the client's diagnosis, symptoms, or medical history.

(a) The department shall pay for the following:

(1) services provided in the provider's office, client's home, hospital, nursing facility, intermediate care facility for the mentally retarded (ICF/MR), chronic disease hospital, boarding home, state-owned or -operated institution, or home for the aged;

(2) family planning services as described in the Regulations of Connecticut State Agencies; and

(3) HealthTrack Services and HealthTrack Special Services.

(b) Limitations on covered services shall be as follows:

(1) services concerned with the care and management of the care of essentially normal mothers and newborns, only throughout the maternity cycle, and well-woman gynecological care, including family planning services; and

(2) services covered shall be limited to these listed in the department's applicable fee schedule.

(Adopted effective March 6, 1998)

Sec. 17b-262-578. Services not covered

The department shall not pay for the following:

(a) nurse-midwifery services to newborns occurring beyond the maternity cycle;

(b) any examinations, laboratory tests, biological products, immunizations, or other products which are furnished free of charge;

(c) information or services provided to a client by a provider over the telephone;

(d) an office visit for the sole purpose of the client obtaining a prescription where the

need for the prescription has already been determined; and
(e) cancelled office visits and appointments not kept.

(Adopted effective March 6, 1998)

Sec. 17b-262-579. Need for service

The department shall pay for medically necessary and appropriate nurse-midwifery services for Medical Assistance Program eligible clients:

(a) requiring care during an essentially normal maternity cycle or requiring well-woman gynecological care;

(b) of child-bearing age who indicate a need for family planning services and are free from coercion or mental pressure and are free to choose the method of family planning to be used;

(c) provided by a licensed and certified nurse-midwife within the scope of the nurse-midwife's practice; and

(d) if the services are made part of the client's medical record.

(Adopted effective March 6, 1998)

Sec. 17b-262-580. Prior authorization

(a) Prior authorization, on forms and in a manner as specified by the department, is required for:

(1) more than one visit per day per client; and

(2) HealthTrack Special Services.

(A) HealthTrack Special Services are determined medically necessary and medically appropriate on a case-by-case basis; and

(B) the request for HealthTrack Special Services shall include:

(i) a written statement from the prescribing physician, or other licensed practitioner of the healing arts, performing such services within his or her respective scope of practice as defined under state law, justifying the need for the item or services required;

(ii) a description of the outcomes of any alternative measures tried; and

(iii) if applicable and requested by the department, any other documentation required in order to render a decision.

(b) The procedure or course of treatment authorized shall be initiated within six months of the date of authorization.

(c) The initial authorization period shall be up to three months.

(d) If prior authorization is needed beyond the initial authorization period, request for continued treatment beyond the initial authorization period shall be considered up to six months per request.

(e) For services requiring prior authorization, a nurse-midwife shall be required to provide pertinent medical or social information adequate for evaluating the client's medical need for services. Except in emergency situations, or when authorization is being requested for more than one visit in the same day, approval shall be received before services are

rendered.

(f) In an emergency situation which occurs after working hours or on a weekend or holiday, the provider shall secure verbal approval on the next working day for the services provided. This applies only to those services which normally require prior authorization.

(g) In order to receive payment from the department a provider shall comply with all prior authorization requirements. The department in its sole discretion determines what information is necessary in order to approve a prior authorization request. Prior authorization does not, however, guarantee payment unless all other requirements for payment are met.

(Adopted effective March 6, 1998)

Sec. 17b-262-581. Billing procedures

(a) Claims from nurse-midwifes shall be submitted on the department's designated form or electronically transmitted to the department's fiscal agent and shall include all information required by the department to process the claim for payment.

(b) If a provider assumes the continuing care of a client or provides services to a client as a result of a referral by a nurse-midwife because the services cannot be provided by the nurse-midwife, an obstetrical-gynecological surgical procedure as an example, this procedure would be billed as a separate procedure, by any provider giving this service.

(c) When a Medical Assistance Program client is referred to a provider for consultation, the consultant provider shall include the referring practitioner's provider number and name. If no provider number has been assigned, the consultant provider shall enter the entire name as well as the state license number of the referring provider on the billing form.

(d) The fee for routine care of a newborn in the hospital shall be all inclusive and shall be billed only once per child. The fee includes initiation of diagnostic and treatment programs, preparation of hospital records, history and physical examination of the baby, and conferences with the parents. Subsequent hospital care for evaluation and management of a normal newborn is paid per day.

(e) The following routine laboratory tests shall be included in the fee for an office visit and shall not be billed on the same date of service: urinalysis without microscopy, hemoglobin determination, and urine glucose. Payment for these tests is included in the fee for a routine workup.

(f) Laboratory services performed in the nurse-midwife's office are payable to the nurse-midwife. Nurse-midwife's shall bill for these services as separate line items. When a nurse-midwife refers a client to a private laboratory for services, the laboratory shall bill directly. No laboratory charge shall then be paid to the nurse-midwife.

(g) Payment for laboratory services shall be limited to services provided by Medical Assistance providers who are in compliance with the provisions of the Clinical Laboratory Improvement Amendments of 1988 (CLIA).

(h) When a newborn requires other than routine care following delivery, the provider shall bill for the appropriate critical care. The department shall not pay both the critical care

and routine care for the same child.

(Adopted effective March 6, 1998)

Sec. 17b-262-582. Payment

Payment shall be made at the lowest of:

(a) the provider's usual and customary charge to the general public;

(b) the lowest Medicare rate;

(c) the amount in the applicable fee schedule as published by the department;

(d) the amount billed by the provider; or

(e) the lowest price charged or accepted for the same or substantially similar goods or services by the provider from any person or entity.

(Adopted effective March 6, 1998)

Sec. 17b-262-583. Payment rate

(a) The commissioner establishes the fees contained in the department's fee schedule pursuant to section 4-67c of the Connecticut General Statutes.

(b) Payment rates shall be the same for in-state and out-of-state providers.

(c) Nurse-midwifery rates for each procedure shall be set at 90% of the department's fee for physician procedure codes.

(Adopted effective March 6, 1998)

Sec. 17b-262-584. Payment limitations

(a) The department shall pay for an initial visit by a nurse-midwife only once per client. Initial visits refer to the nurse-midwife's first contact with the client and reflect higher fees for the additional time required for setting up records and developing past history. The only exception to this is when the nurse-midwife-client relationship has been discontinued for three or more years and is then reinstated.

(b) The department shall pay for an initial visit once per inpatient hospitalization.

(c) Nurse-midwifes who are fully or partially salaried by a general hospital, public or private institution, group practice, or clinic shall not receive payment from the department unless the nurse-midwife maintains an office for private practice at a separate location from the hospital, institution, group, or clinic in which the nurse-midwife is employed. Nurse-midwifes who are solely hospital, institution, group, or clinic based, either on a full- or part-time salary are not entitled to payment from the department for services rendered to Medical Assistance Program clients.

(d) A nurse-midwife who maintains an office for private practice separate from the hospital, institution, group, or clinic, shall be able to bill for services provided at the private practice location or for services provided to the nurse-midwife's private clients in the hospital, institution, group, or clinic only if the client is not a client of the hospital, institution, group, or clinic.

(e) Fees for medical procedures shall include the fee for an emergency room visit. The

department shall not pay a provider at a higher rate for any medical procedure which is performed in an emergency room.

(f) Payment for the total obstetric care procedure, shall include office visits for maternity care six months prior to delivery and six weeks after delivery.

(g) If antepartum care, vaginal delivery, or postpartum care are billed as separate procedures, total payment shall not exceed the fee for the total obstetric care procedure.

(h) If a client's medical problem necessitates the concurrent services and skills of two or more providers, each provider shall be entitled to the listed fee for the service.

(i) There shall be no payment for consultation and collaborative management services with an obstetrician-gynecologist when functioning as part of the health care team in the evaluation and treatment of a client.

(j) Although a nurse-midwife shall always function within a health care system in a team relationship with a physician which is directed and shall never be independent of physician back-up for consultation and collaborative management, or referral, directed does not necessarily imply the physical presence of the physician when care is being given by a certified and licensed nurse-midwife.

(Adopted effective March 6, 1998)

Sec. 17b-262-585. Documentation

(a) Nurse-midwifes shall maintain a specific medical record for all services rendered to each client eligible for Medical Assistance Program payment including, but not limited to: name, address, birth date, Medical Assistance Program identification number, pertinent diagnostic information, a current treatment plan signed by the nurse-midwife, documentation of services provided, and the dates the services were provided.

(b) All required documentation shall be maintained for at least five years in the nurse-midwife's file subject to review by the authorized department personnel. In the event of a dispute concerning a service provided, documentation shall be maintained until the end of the dispute or five years, whichever is greater.

(c) Failure to maintain all required documentation shall result in the disallowance and recovery by the department of any amounts paid to the nurse-midwife for which the required documentation is not maintained or provided to the department upon request.

(Adopted effective March 6, 1998)

Sec. 17b-262-586. Reserved

Requirements for Payment of Personal Care Assistance Services for Adults

Sec. 17b-262-587. Purpose and scope

Sections 17b-262-587 through 17b-262-596b, inclusive, of the Regulations of Connecticut State Agencies set forth the Department of Social Services' requirements for payment of personal care assistance services for adults. The Department operates the Personal Care Assistance Waiver Program that assists eligible disabled adults by paying for

personal care assistance services. The purpose of sections 17b-262-587 through 17b-262-596b, inclusive, of the Regulations of Connecticut State Agencies is to describe the program requirements, services available and limitations under (1) the Personal Care Assistance Waiver Program, which is conducted under a federal waiver under section 1915(c) of the Social Security Act to the Medical Assistance Program pursuant to section 17b-262 of the Connecticut General Statutes (CGS).

(Adopted effective February 8, 1999; Amended March 9, 2006)

Sec. 17b-262-588. Definitions

For the purposes of sections 17b-262-587 through 17b-262-596b, inclusive, of the Regulations of Connecticut State Agencies, the following definitions shall apply:

(1) **"Activities of Daily Living"** means hands-on activities or tasks, which are essential for a consumer's healthful and safe existence and include, but are not limited to: bathing, dressing, eating, transfers, and bowel and bladder care.

(2) **"Adult"** means a person 18 through 64 years of age inclusive.

(3) **"Applicant"** means a person who directly or through a representative completes a Personal Care Assistance Request Form and submits it to the department.

(4) **"Assessment"** means a comprehensive written evaluation conducted by non-medical department personnel which uses a standard assessment form and which consists of:

(A) an identification of the consumer's limitations in activities of daily living;

(B) the identification of the personal care assistance services required by the consumer and a determination that such services are appropriate for the consumer and, in the non-medical opinion of the department can reasonably be expected to meet the health and safety needs of the consumer;

(C) identification of the training and support needs of the consumer for personal care assistance services;

(D) a face-to-face interview with the consumer;

(E) documentation of the number of hours needed by the consumer to complete the activities of daily living and instrumental activities of daily living with the help of a personal care assistant;

(F) a determination confirming that the consumer would otherwise require institutional care in a nursing facility;

(G) development of a total cost of care plan for the consumer; and

(H) development of a consumer personal care services plan.

(5) **"Average nursing facility cost"** means a weighted average calculated by multiplying the nursing facility Medical Assistance Program rates in effect on July 1 of each calendar year for each facility by their respective number of days, adding the products and then dividing that total by the total patient days, and reducing the result by the average applied income for nursing facility patients.

(6) **"Consumer"** means an applicant or eligible person.

(7) **"Commissioner"** means the chief executive officer of the department appointed

pursuant to subsection (a) of section 17b-1 of the Connecticut General Statutes.

(8) **"Cost Effective"** means the Department's payments for the consumer's total costs of care do not exceed the average nursing facility cost.

(9) **"Cost-of-Care Plan"** means a plan, which specifies all costs to the State of Connecticut that are associated with the care of the consumer.

(10) **"Department"** means the Department of Social Services or its agent.

(11) **"Eligible Person"** means an applicant who meets the criteria to receive personal care assistance services in accordance with section 17b-262-589 of the Regulations of Connecticut State Agencies and who meets all the eligibility requirements for participation in the Medicaid program as set forth in the Department's regulations that are contained in its Uniform Policy Manual.

(12) **"Fiscal Intermediary"** means an organization selected by the department to perform the payroll function for the administration of this program including but not limited to the fulfillment of all household employer tax obligations.

(13) **"Instrumental Activities of Daily Living"** means household maintenance activities and tasks, which are essential for a consumer's healthful and safe existence and include, but are not limited to: cooking, cleaning, and shopping.

(14) **"Medical Assistance Program"** means the medical assistance provided pursuant to Chapter 319v of the Connecticut General Statutes and authorized by Title XIX of the Social Security Act, as amended from time to time.

(15) **"Nursing Facility"** means an institution as defined in section 1919 of the Social Security Act, as amended from time to time, that participates in Connecticut's Title XIX medical assistance program pursuant to the terms of a provider agreement with the Department.

(16) **"Personal Care Assistance Request Form"** means a department form used to screen a consumer for financial and functional eligibility for personal care assistance services.

(17) **"Personal Care Assistant"** means any person, excluding the consumer's spouse, and excluding the consumer's conservator and any person related to the consumer's conservator who is employed by the consumer or the consumer's conservator and is qualified to assist the consumer in carrying out the tasks required in the personal care services plan.

(18) **"Personal Care Assistance Services" or "Services"** means physical assistance to enable the consumer to carry out activities of daily living and instrumental activities of daily living.

(19) **"Personal Care Services Plan" or "Service Plan"** means an individualized written plan documenting all necessary personal care assistance services, hours, costs, and training requirements for the consumer as determined by an assessment.

(20) "**Personal Emergency Response System" (PERS)-** means an electronic device that enables consumers to secure help in an emergency. The system is connected to the person's phone and programmed to signal a response center once the help button is activated.

PERS service providers shall be enrolled as performing providers under Medicaid.

(21) **"Representative"** means a person designated by the consumer to act for the consumer and under the consumer's direction for purposes such as completing paperwork, making phone calls, advertising for personal care assistants, assisting with interviewing or scheduling, and sending paperwork to the fiscal intermediary. When the consumer has a court appointed conservator that person shall act as the consumer's representative in all matters. The conservator cannot also be employed as the consumer's personal care assistant or be related to any person employed as the consumer's personal care assistant.

(22) **"Uniform Policy Manual"** means department regulations promulgated pursuant to section 17b-10 of the Connecticut General Statutes governing eligibility for public assistance and special programs, and maintained in policy manual form including the Department's Title XIX medical assistance program.

(23) **"Waiting List"** means a record maintained by the department, which includes the names of the consumers seeking personal care assistance services, and specifies the date the Personal Care Assistance Request Form was received.

(24) **"Waiver Program"** means the program described in the federal waiver approved pursuant to section 1915(c) of the Social Security Act, as amended from time to time, by the Secretary of the United States Department of Health and Human Services for the provision of personal care assistance services to adults, as a partially federally reimbursed service that may be provided under Connecticut's Medicaid program.

(Adopted effective February 8, 1999; Amended March 9, 2006)

Sec. 17b-262-589. Eligibility and determination of need

(a) In order to be eligible to receive coverage for the cost of personal care assistance services under the Department's Personal Care Assistance Waiver Program, an individual shall either have already been determined eligible to participate in the Department's Title XIX medical assistance program and also be determined to meet the additional programmatic requirements for coverage of personal care assistance services that are specified in this section or qualify for personal care assistance services by meeting all of the technical, special financial, and programmatic requirements stated in this section.

(b) An individual who has not previously been determined eligible for medical assistance and who receives personal care assistance services after meeting the requirements of this section is thereby automatically determined eligible for the medical assistance program and for all other medically necessary services that are covered by the program.

(c) The technical requirements for eligibility are:

(1) A recipient of medical assistance benefits who applies for coverage of personal care assistance services and applicants for personal care assistance services shall meet all requirements for eligibility in the Department's medical assistance program that are applicable to disabled adults as stated in the regulations promulgated by the Department and contained in its Uniform Policy Manual pursuant to Section 17b-10 of the Connecticut General Statutes, including, without limitation, 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 personal care assistance services are treated as if they were institutionalized and all medical assistance eligibility rules that apply to institutionalized applicants or recipients of medical assistance benefits are also applied in the same way to applicants or recipients of personal care assistance services. Specifically, without limiting the scope of this subsection, applicants and recipients for personal care assistance services are subject to the same rules that govern eligibility related to the transfer of assets and to the treatment of the resources and income of spouses of institutionalized applicants for assistance.

(d) The special financial eligibility rules are:

(1) A recipient of medical assistance benefits who applies for personal care assistance services or an applicant for personal care assistance services who meets all other technical requirements for eligibility may only be found eligible for personal care assistance services if his or her countable income is less than the special institutional income limit of 300 percent of the benefit amount that would be payable under the federal Supplemental Security Income ("SSI") program to an individual in his or her own home who has no income or resources. Income eligibility for personal care assistance services under this section is determined solely by reference to the individual'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 for assistance. Except as noted below, the applicant's countable income for purposes of this subsection is determined by reference to the same methodologies that are employed by the Department in determining the countable income of an institutionalized applicant for assistance. Individuals who qualify for medical assistance related to the treatment of income under other optional coverage groups, including the medically needy, but who do not qualify for personal care assistance services under the 300 percent of the SSI income limit, may receive coverage of medically necessary services to the extent such services are available generally to recipients of medical assistance, but may not receive coverage for those services that are only provided to individuals who are covered under this or any other waiver of federal Medicaid requirements.

(2) An applicant or recipient of assistance may not reduce his or her income, or fail to pursue potential sources of income in order to obtain or retain eligibility for assistance under the special institutional income limit of 300 percent of the SSI benefit amount.

(e) The programmatic requirements for eligibility are:

In addition to meeting all technical and special financial eligibility requirements stated above in subsections (c) and (d) of this section, an applicant for coverage of personal care assistance services shall meet all of the following programmatic requirements for eligibility:

(1) the consumer shall be 18 through 64 years of age inclusive;

(2) the consumer shall have a primary medical diagnosis that is a chronic, severe, and permanent physical disability which results in a significant need for physical assistance

with two or more of the following activities of daily living: bathing, dressing, eating, transfers, bowel and bladder care; and the consumer shall be in a condition that would otherwise require institutionalization in a nursing facility without such services. An individual whose primary disability is mental retardation, mental illness or whose need for personal care assistance is the result of a degenerative neurologically based dementia, including but not limited to Alzheimer's disease, is not eligible for personal care assistance services. In the case of dual diagnosis, the Department may request an assessment, made by a qualified medical provider, to determine which disabling condition is primary;

(3) the consumer shall have the cognitive ability to be the essential participant in the development of his or her personal care services plan and to hire, direct, and fire his or her personal care assistants unless the consumer has a conservator who acts on his or her behalf and fulfills the foregoing requirements;

(4) the consumer shall lack family and community supports to meet his or her needs for personal care assistance services;

(5) the consumer shall wish to live in the community by utilizing personal care assistance services;

(6) the consumer shall be capable of understanding and shall acknowledge that there is risk inherent in his or her living in the community, that his or her safety cannot be guaranteed, and shall accept full liability if he or she chooses to live in the community and absolve the Department of responsibility for anything that might result from this choice;

(7) the consumer shall acknowledge that he or she is the employer of his or her personal care assistants and shall sign a written document accepting full responsibility as the employer of his or her personal care assistants;

(8) the consumer, in order to insure his or her health and safety, shall have a back-up plan which shall be documented in the department's record identifying how he or she will provide for personal care assistance service needs in the event that a personal care assistant is not available to provide the services as scheduled;

(9) the consumer shall file such forms as may be necessary with the Internal Revenue Service and the State Department of Labor designating the fiscal intermediary as the consumer's agent for the purpose of managing employment benefit accounts for the personal care assistants and shall provide all other documentation needed by the fiscal intermediary in order to process payroll;

(10) the consumer shall have a personal care assistance plan that is cost effective; (refer to section 17b-262-594)

(11) the consumer shall replace state funded homemaker, companion, and personal care assistance services provided by the Department under the Community Based Services Program or Personal Care Assistance Working Person's Program with personal care assistance services under this waiver program;

(12) the consumer shall replace home health aide services provided under the Medicaid program with personal care services funded under the waiver program unless the provision of both services is otherwise determined necessary by the Department. If any home health

aide services are approved, there shall be no duplication of services provided by the personal care assistance plan;

(13) if an applicant is eligible for, or receiving, comparable services under Section 101 (a)(8) of the Rehabilitation Act as amended in 1992, such applicant is ineligible for personal care assistance services under this Personal Care Assistance Waiver program. The applicant may be eligible for additional services through the waiver as long as those services are not related to attendance at school or employment. A plan, which is developed for a consumer in these circumstances, shall be developed jointly by appropriate staff from the Department's Social Work Services Division and the consumer;

(14) the consumer shall hire qualified personal care assistants within three months of approval of the service plan and a determination of Medicaid eligibility or the application shall be denied and the consumer will not maintain his or her slot on the waiting list. The application and eligibility determination process can be resumed at any time in the future;

(15) the consumer shall pursue and accept comparable services from other resources when requested by the Department.

(f) If a cost of care plan that is both cost effective and reasonably ensures the health and safety of the consumer in the non-medical opinion of the Department cannot be developed, the consumer is not eligible for personal care assistance waiver services. If the consumer requires full time acute care hospitalization he or she is not eligible for waiver services if unable to receive them for a period of thirty days or more due to such hospitalization. A new application and assessment shall be completed for such consumer.

(g) A disabled individual who is determined eligible for and who receives personal care assistance services under this Title XIX Medical Assistance Personal Care Assistance Waiver program as an alternative to institutionalization is subject to the same rights and responsibilities as an institutionalized recipient of medical assistance, including, without limitation, those requirements relating to third party liability, securing support, recovery, and liens that are applicable to institutionalized recipients of public assistance.

(h) Any consumer who is found by the Department to have knowingly signed a time sheet authorizing payment for services that were not provided may be discharged from the Personal Care Assistance Waiver program. Any consumer discharged under this subsection shall be ineligible for personal care assistance services under the Personal Care Assistance Waiver program for a period of not more than two years.

(Adopted effective February 8, 1999; Amended March 9, 2006)

Sec. 17b-262-590. Application process

(a) The application process consists of:

(1) a financial eligibility determination by the Department in accordance with the eligibility standards for participation in the Department's Title XIX medical assistance program that are contained in the Uniform Policy Manual;

(2) a preliminary determination by central office administrative staff as to the consumer's needs and financial eligibility based on a review of the information provided on the

"Personal Care Assistance Request" form; and

(3) a referral to the appropriate regional office when an assessment for services is indicated to determine if a cost effective plan of services can be developed to provide services to the person in the community.

(b) A determination as to whether the consumer needs services without which the consumer would otherwise require institutionalization shall be made by non-medical Department staff based upon an assessment conducted in collaboration with the consumer.

(c) A determination of the personal care assistance services required by the consumer shall consist of:

(1) completion of an assessment by the department; and

(2) development of a personal care services plan by the department in consultation with the consumer. The plan shall be reviewed annually or more often when a change in the consumer's condition has occurred or when other circumstances may warrant; and

(3) a determination documented on a cost of care plan of whether the personal care assistance services combined with all other state administered services are cost effective; and

(4) authorization for personal care assistance services in the community if appropriate and cost effective.

(d) Eligibility shall be redetermined annually for each recipient.

(Adopted effective February 8, 1999; Amended March 9, 2006)

Sec. 17b-262-591. Waiting list

(a) As a result of the limitation of the number of slots and/or funding, the Department shall establish and maintain a statewide waiting list for the Personal Care Assistance Waiver program when the Department has filled its maximum allocation of slots or reached the funding level in the approved waiver. Names shall be placed on the waiting list in the same order as the "Personal Care Assistance Request" form is received in Central Office.

(b) When an opening occurs, applications shall be solicited by contacting consumers in the order their names appear on the waiting list.

(c) A consumer is removed from the waiting list if he or she:

(1) asks to be removed;

(2) moves out of state;

(3) reaches age 65; or

(4) is deceased.

(Adopted effective February 8, 1999; Amended March 9, 2006)

Sec. 17b-262-592. Limitations

(a) The Department does not offer Personal Care Assistance Waiver services to more than the number of consumers specified in the federally approved Personal Care Assistance Waiver or to more than the number of consumers who can be served within the funding limitations established in the approved waiver.

(b) In order to be eligible for a personal care services plan that, combined with all other state administered home care and community based services, exceeds 60% of the average nursing facility cost, the consumer shall require physical assistance with three or more of the following activities of daily living: bathing, dressing, eating, transferring and bowel and bladder care.

(c) In order to be eligible for a personal care services plan that, combined with all other state administered home care and community based services, exceeds 80% of the average nursing facility cost, the consumer shall require assistance with all of the following activities of daily living: bathing, dressing, eating, transferring and bowel and bladder care.

(d) In addition, any plan exceeding 60% of the average nursing facility cost shall meet the following requirements:

(1) there shall be documentation of any changes in the consumer's needs or other circumstances which affect the plan if the cost of care plan exceeds the costs of services provided prior to application to this program; and

(2) the projected overall program costs for the total personal care assistance services population shall not be exceeded as a result of the approval of this consumer's personal care services plan; and

(3) all informal and family supports shall have been explored and documented in the record. It is not the intent of the program to displace services that have been provided free of charge by family members and relatives, and may reasonably be expected to continue in the future, and a personal care services plan shall not be developed which substitutes the paid services of a personal care assistant for voluntary services provided by family members.

(Adopted effective February 8, 1999; Amended March 9, 2006)

Sec. 17b-262-593. Services covered

(a) Services covered are:

(1) personal care assistance services provided in accordance with a personal care services plan which enable the consumer to carry out activities of daily living and instrumental activities of daily living in a community living arrangement; and

(2) as a result of being determined eligible for Medicaid, any other covered service to the extent that it is necessary, in accordance with Title XIX contained in the Social Security Amendments of 1965 and state and federal regulations adopted pursuant thereto.

(3) personal care assistance services up to 25.75 hours per week provided by a single personal care assistant and up to 40 hours per week provided by a single personal care assistant if the consumer documents, to the department's satisfaction, that the consumer has obtained and maintained worker's compensation insurance for the single personal care assistant and that such insurance shall remain in full force and effect for at least one year from the date the personal care assistant begins providing personal care assistance services to the consumer. Personal care assistance services beyond 25.75 hours per week shall not be covered without the submission of such documentation. The social worker shall verify the continuation of the worker's compensation insurance coverage at the time of the annual

review.

(4) up to 10 additional hours of personal care assistance services beyond those already included in the approved service plan for the purpose of communicating with medical providers during a crisis or an emergency for those consumers who have difficulty communicating verbally their needs to medical providers, as determined by the social worker during the assessment process.

(5) for those consumers who either live alone or who remain at home alone with no available caregiver, a personal emergency response system (PERS) may be provided. The department social worker shall determine the need for the PERS as part of the assessment process.

(b) Services not covered are:

(1) services that are not in the consumer's approved cost of care plan;

(2) personal care assistance services provided either in a health care institution that is licensed by the Department of Public Health or in a living arrangement funded by the department which includes funding for the purpose of assisting clients to meet their daily needs as a component in the rate of reimbursement;

(3) personal care assistance services provided by the consumer's spouse, the consumer's conservator or any person related to the conservator;

(4) personal care assistance services which are duplicative of home health services which the consumer will receive concurrently while participating in the program;

(5) scheduled hours which a personal care assistant does not keep;

(6) transportation of the personal care assistant to and from the consumer's home;

(7) services in excess of those deemed necessary by the department to serve the consumer;

(8) services not related to the condition of the consumer or the consumer's physical limitations in performing activities of daily living and instrumental activities of daily living;

(9) any service that is required by state law to be provided by licensed staff;

(10) services in excess of 25.75 hours per week provided by a single personal care assistant, except as otherwise provided in subdivision (3) of subsection (a) of this section;

(11) services provided by an individual who formerly performed such services at no cost;

(12) personal care services provided at school or in the workplace;

(13) personal care services when the consumer is eligible to receive comparable services that are available from another resource;

(14) services performed by someone other than the provider designated in the service plan; and

(15) services performed by a provider who does not meet the qualifications outlined in the federally approved waiver.

(Adopted effective February 8, 1999; Amended March 9, 2006)

Sec. 17b-262-594. Determining the cost effectiveness of the service plan

In order to determine the cost effectiveness of the consumer's service plan, the

Department shall do all of the following:

(1) Obtain the monthly average nursing facility cost; and

(2) Determine the monthly cost of the service plan; and

(3) Determine the monthly cost of other medical services that the consumer will require in order to live in the community. These other medical services include: home health care, nursing services, physical therapy, occupational therapy and/or speech therapy. These costs are based on the consumer's expected utilization of these services, multiplied by the Medicaid rates established by the Department for such services; and

(4) Determine the monthly cost of other state administered home and community based services. These other home and community based services costs include but are not limited to those services provided by the department's Community Based Services Program and all funds provided by programs administered by any other state agency which help to maintain the consumer in the community; and

(5) Add the cost of other medical services and other state administered home and community based services to the costs of the service plan to obtain the consumer's total cost of care; and

(6) Compare the consumer's total cost of care to the average nursing facility cost.

The Department may not approve a personal care assistance plan when the cost of all of the foregoing services exceeds the cost of care in a nursing facility.

If due to a temporary acute condition the consumer requires personal care assistance services that exceed the monthly average nursing facility cost for a period that is not expected to exceed four months, the Department, at its discretion, may approve a plan that provides such additional personal care assistance services provided that the annualized cost of personal care assistance services and other services does not exceed the annualized cost of nursing facility services.

(Adopted effective February 8, 1999; Amended March 9, 2006)

Sec. 17b-262-595. Payment

(a) Payment for personal care assistance services for adults is made at the lowest of:

(1) the maximum rate determined by the department for personal care assistance services;

(2) a rate below the maximum based on an amount the consumer has negotiated with the personal care assistant; or

(3) the amount billed.

(b) Payment is made directly to the fiscal intermediary who, on behalf of the consumer, shall pay all required employment taxes and issue paychecks to the consumer made out in the names of the personal care assistants or directly to the personal care assistants.

(c) The fiscal intermediary shall inform consumers about the requirement that they obtain worker's compensation insurance for those single personal care assistants who provide the consumer with more than 25.75 hours per week of personal care assistance services, as set forth in subdivision (3) of subsection (a) of section 17b-262-593 of the Regulations of Connecticut State Agencies, and shall not issue payment for personal care assistance services

in excess of 25.75 hours per week by a single personal care assistant unless the consumer has complied with this requirement.

(Adopted effective February 8, 1999; Amended March 9, 2006)

Sec. 17b-262-596. Personal care assistant qualifications

(a) The consumer is responsible for ensuring that his or her personal care assistants meet all of the following qualifications:

(1) be at least 16 years of age except that, if the consumer chooses to hire an individual who is 16 or 17 years old, the consumer shall comply with specific standards and restrictions imposed by state and federal law;

(2) be able to understand and carry out directions given by the consumer or conservator;

(3) be physically able to perform all duties delineated in the service plan;

(4) be willing to receive training from the consumer or conservator in performance of all personal care assistance services delineated in the service plan;

(5) be able to handle emergencies; and

(6) demonstrate competencies in effective employer/employee relationships, disability awareness, use of equipment, and activities of daily living.

(b) The Commissioner shall require any person providing personal care assistance services to a consumer to submit to a criminal background check.

(c) The Commissioner shall have the discretion to refuse payments for personal care assistance services if the personal care assistant 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 section 53a-137 of the Connecticut General Statutes, robbery under section 53a-133 of the Connecticut General Statutes, larceny under sections 53a-119, 53a-122, 53a-123 and 53a-124 of the Connecticut General Statutes, or of a violation of section 53a-290 to 53a-296, inclusive involving vendor fraud, section 53-20 of the Connecticut General Statutes involving cruelty to persons, sections 53a-70, 53a-70a, 53a-70b, 53a-71, 53a-72a, 53a-72b, or 53a-73a of the Connecticut General Statutes involving sexual assault, section 53a-59 of the Connecticut General Statutes involving assault, section 53a-59a of the Connecticut General Statutes involving assault of an elderly, blind, disabled, pregnant or mentally retarded person, and sections 53a-320 to 53a-323, inclusive, of the Connecticut General Statutes involving abuse of elderly, blind, disabled or mentally retarded persons.

(d) A personal care assistant may be suspended from participation in the program if he or she has accepted payment for services that were never provided to the consumer or otherwise violates the rules, regulations, standards or laws governing the program, in accordance with sections 17-83k-1 to 17-83k-7, inclusive, of the Regulations of Connecticut State Agencies.

(e) The department may deny coverage of services performed by a personal care assistant who does not meet the department's qualifications as set forth in this section.

(Adopted effective February 8, 1999; Amended March 9, 2006)

Sec. 17b-262-596a. Fair hearings

Applicants for and recipients of services under the Personal Care Assistance program may request and receive a fair hearing, in accordance with the rules of the Department's Medicaid program when the Department:

(1) did not offer the choice of home and community-based services as an alternative to institutional care in a nursing facility; or

(2) does not reach a determination of financial eligibility within the Department's standard of promptness; or

(3) denies the application for any reason other than the limitations on the number of individuals who can be served and/or funding limitations as established in the approved waiver; or

(4) disapproves the consumer's service plan; or

(5) denies or terminates payment to a qualified personal care assistant of the consumer's choice; or

(6) discharges the consumer from the waiver program.

(Adopted effective February 8, 1999; Amended March 9, 2006)

Sec. 17b-262-596b. Repealed

Repealed March 9, 2006.

Requirements for Payment for Early Intervention Services to Children Age Birth to Three Years with Developmental Delays

Sec. 17b-262-597. Scope

Sections 17b-262-597 through 17b-262-605 inclusive set forth the Department of Social Services (DSS) requirements for payment of early intervention services provided by the Department of Mental Retardation (DMR), or another state agency, and their funded contractors, to children age Birth to Three years with developmental delays who are determined eligible for Connecticut's Medical Assistance Program pursuant to section 17b-262 of the Connecticut General Statutes.

(Effective August 28, 1998)

Sec. 17b-262-598. Definitions

For the purposes of section 17b-262-597 through 17b-262-605 the following definitions shall apply:

(1) "Allied Health Professional or AHP" means an individual who is licensed or certified or who is qualified by special training, education, skills, and experience to provide early intervention services. Such individuals include, but are not limited to: nurses, physician assistants, masters level social workers, special education teachers, speech therapy assistants, nutritionists, and family therapists.

(2) "Assessment" means the definition contained in Part H of the Individuals with

Disabilities Education Act (IDEA), Title 20 United States Code (USC), section 1477(a), and at Title 34 Code of Federal Regulations (CFR), Part 303, subdivisions (1) and (2) of subsection (a) of section 303.322, and at subdivision (2) of subsection (b) of section 303.322.

(3) "Assessment Team" means a multidisciplinary team of qualified, as defined in Title 34 CFR, Part 303, section 303.21, service providers selected by the performing provider, based on results of the child's evaluation, to perform an assessment to determine the service needs of the child based on the diagnosis of the evaluation team.

(4) "Assistive Technology Devices" means the assistive technology devices as defined in Part H of IDEA, Title 20 USC 1471 et seq., and at Title 34 CFR, Part 303, subdivision (1) of subsection (d) of section 303.12.

(5) "Assistive Technology Services" means the assistive technology services defined in Part H of IDEA, 20 USC et seq., and at Title 34 CFR, Part 303, subdivision (1) of subsection (d) of section 303.12.

(6) "Audiology" means the definition contained in Part H of IDEA, Title 20 USC et seq., and at Title 34 CFR, Part 303, subdivision (2) of subsection (d) of section 303.12.

(7) "Audiologist" means one who is licensed to practice audiology pursuant to Chapter 399 of the Connecticut General Statutes.

(8) "Billing Provider" means DMR or another state agency responsible for coordinating and delivering early intervention services to Birth to Three eligible children. Billing providers may also be responsible for service coordination and may be a performing provider.

(9) "Birth to Three Eligible Child" means a child from birth to age three who is:

(A) experiencing a significant developmental delay as measured by standardized diagnostic test or clinical opinion in one or more of the following areas:

(i) cognitive development;

(ii) physical development, including vision or hearing;

(iii) communication development; or

(iv) adaptive skills; or

(B) diagnosed as having a physical or mental condition that has a high probability of resulting in developmental delay; and

(C) qualified to receive services under the Medical Assistance Program pursuant to section 17b-262 of the Connecticut General Statutes.

(10) "Birth to Three System" means a statewide, comprehensive, coordinated, multidisciplinary, interagency program of early intervention services for infants and toddlers with disabilities.

(11) "Child" means a person who is under twenty-one years of age.

(12) "Commissioner" means the Commissioner of Social Services appointed pursuant to subsection (a) of section 17b-1 of the Connecticut General Statutes.

(13) "Department" means the Department of Social Services or its agent.

(14) "Developmental Delay" means a significant delay in one or more of the following areas: cognitive development; communication development; physical development,

including vision or hearing; social or emotional development; or adaptive skills or development.

(15) "Developmental Therapy" means special instruction.

(16) "DMR" means the Department of Mental Retardation.

(17) "Early Intervention Record" means the written record maintained for both the eligible child and the noneligible child for the Birth to Three System.

(18) "Early Intervention Services" means services which are defined in Part H of IDEA, Title 20 USC 1471 et seq., and those listed explicitly in Title 34 CFR, Part 303, subsection (d) of section 303.12.

(19) "Evaluation" means the definition contained in Part H of IDEA, Title 20 USC 1471 et seq., and at Title 34 CFR, Part 303, subdivisions (1) and (2) of subsection (a) of section 303.322, and subdivision (1) of subsection (b) of section 303.322, and as defined in section 17a-248 of the Connecticut General Statutes.

(20) "Evaluation Team" means two or more qualified allied health professionals, as defined in Title 34 CFR, Part 303, section 303.21, selected by the performing provider, from different disciplines matched to the needs of the child based on available information, to perform an evaluation.

(21) "Family Training, Counseling, and Home Visits" means the definition contained in Part H of IDEA, Title 20 USC 1471 et seq., and at Title 34 CFR, Part 303, subdivision (3) of subsection (d) of section 303.12.

(22) "Health Care Financing Administration or HCFA" means the federal agency within the Department of Health and Human Services which administers both the Medicaid and Medicare programs.

(23) "Health Services" means the definition contained in Part H of IDEA, Title 20 USC 1471 et seq., and at Title 34 CFR, Part 303, subdivision (4) of subsection (d) of section 303.13.

(24) "Individualized Family Service Plan (IFSP)" means the definition contained under Part H of IDEA, Title 20 USC 1471 et seq., and Title 20 USC, section 1477(d), and at Title 34 CFR, Part 303, subsection (b) of section 303.340.

(25) "Lead Agency" means the Department of Mental Retardation (DMR) pursuant to Title 34 of the CFR, Part 303, section 303.500.

(26) "Licensed Practitioner of the Healing Arts" means a professional person providing health care pursuant to a license issued by the Department of Public Health (DPH).

(27) "Medical Appropriateness or Medically Appropriate" means health care that is provided in a timely manner and meets professionally recognized standards of acceptable medical care; is delivered in the appropriate medical setting; and is the least costly of multiple, equally-effective, alternative treatments or diagnostic modalities.

(28) "Medical Assistance Program" means the medical assistance provided pursuant to Chapter 319V of the Connecticut General Statutes and authorized by Title XIX of the Social Security Act. The program is also referred to as Medicaid.

(29) "Medical Necessity or Medically Necessary" means health care provided to correct

or diminish the adverse effects of a medical condition or mental illness; to assist an individual in attaining or maintaining an optimal level of health; to diagnose a condition; or prevent a medical condition from occurring.

(30) "Medical Services" means the definition contained in Part H of IDEA and at Title 34 CFR, Part 303, subdivision (5) of subsection (d) of section 303.12.

(31) "Multidisciplinary Team" means the definition contained in Part H of IDEA, Title 20 USC, and at Title 34 CFR, Part 303, section 303.17, and a team of two or more persons from different disciplines, one of whom shall be an allied health professional.

(32) "Natural Environments" means the definition contained in Part H of IDEA, Title 20 USC 1471 et seq., and at Title 34 CFR, Part 303, subsection (b) of section 303.12.

(33) "Nursing Services" means the definition contained in Part H of IDEA, Title 20 USC 1471 et seq., and at Title 34 CFR, Part 303, subdivision (6) of subsection (d) of section 303.12.

(34) "Nutrition Services" means the definition contained in Part H of IDEA, Title 20 USC 1471 et seq., and at Title 34 CFR, Part 303, subdivision (7) of subsection (d) of section 303.12.

(35) "Occupational Therapy" means the definition contained in Part H of IDEA, Title 20 USC 1471 et seq., and at Title 34 CFR, Part 303, subdivision (8) of subsection (d) of section 303.12.

(36) "Part H of IDEA" means Part H of the Individuals with Disabilities Education Act (IDEA), Title 20 United States Code (USC), section 1471 et seq.

(37) "Performing Provider" means:

(A) any billing provider;

(B) any independent provider under contract with a billing provider; or

(C) any state agency under contract with a billing provider providing diagnostic services or treatment services recommended by a licensed practitioner of the healing arts and in accordance with the IFSP.

(38) "Physician" means an individual licensed under Chapter 370 or 371 of the Connecticut General Statutes as a doctor of medicine or osteopathy.

(39) "Physical Therapy" means the definition contained in Part H of IDEA, Title 20 USC 1471 et seq., and at Title 34 CFR, Part 303, subdivision (9) of subsection (d) of section 303.12, and section 20-74 of the Connecticut General Statutes.

(40) "Provider Agreement" means the signed, written, contractual agreement between the department and the provider of services or goods.

(41) "Psychological Services" means the definition contained in Part H of IDEA, Title 20 USC 1471 et seq., and at Title 34 CFR, Part 303, subdivision (10) of subsection (d) of section 303.12.

(42) "Service Coordination" means the definition contained in Part H of IDEA, Title 20 USC 1471 et seq., and at Title 34, CFR Part 303, subdivision (11) of subsection (d) of section 303.12.

(43) "Service Coordinator" means the person from the profession most immediately

relevant to the child's or family's needs who is employed or contracted by the performing provider to provide service coordination as defined in Title 34 CFR, Part 303, subsection (g) of section 303.344.

(44) "Service Page" means the section of the Individualized Family Service Plan (IFSP) which specifies service information as delineated in Part H of IDEA, Title 20 of the USC, section 1477 (d) (4), (5), and (6).

(45) "Social Work Services" means the definition contained in Part H of IDEA, Title 20 USC 1471 et seq., and at Title 34 CFR, Part 303, subdivision (d) of subsection (12) of section 303.12.

(46) "Special Instruction" means the services described in Part H of IDEA, Title 20 of the USC, and at Title 34 CFR, Part 303, subdivision (13) of subsection (d) of section 303.12, when delivered by a multidisciplinary team.

(47) "Speech-Language Pathology" means the definition contained in Part H of IDEA, Title 20 USC 1471 et seq., and at Title 34 CFR, Part 303, subdivision (14) of subsection (d) of section 303.12.

(48) "Transportation and Related Costs" means the definition contained in Part H of IDEA, Title 20 USC 1471 et seq., and at Title 34 CFR, Part 303, subdivision (15) of subsection (d) of section 303.12.

(49) "Vision Services" means the definition contained in Part H of IDEA, Title 20 USC 1471 et seq., and at Title 34 CFR, Part 303, subdivision (16) of subsection (d) of section 303.12.

(Effective August 28, 1998)

Sec. 17b-262-599. Provider participation

(a) **Billing Provider**

In order to enroll in the Medical Assistance Program and receive payment from the department for early intervention services rendered, the billing provider shall:

(1) meet and maintain all departmental enrollment requirements;

(2) have a valid billing provider agreement on file which is signed by the billing provider and the department upon application for enrollment into the Medical Assistance Program. This agreement, which shall be periodically updated, shall continue to be in effect for the duration of the agreement or for the stated period in the agreement. The provider agreement specifies conditions and terms which govern the program and to which the billing provider is mandated to adhere in order to participate in the program;

(3) ensure that an individual employed or contracted by the performing provider shall be selected as service coordinator for each child to serve as the person responsible for compliance with the duties as defined in Title 34 CFR, Part 303, section 303.22;

(4) provide early intervention services directly or by means of a contract with qualified allied health professionals pursuant to all applicable federal and state statutes and regulations and ensure that all performing providers are enrolled with the Medical Assistance Program prior to provision of service;

(5) select one or more performing providers through a competitive or non-competitive bidding process;

(6) process all claims submitted by all other performing providers under contract for provision of early intervention services in the Birth to Three System; and

(7) comply with all Medical Assistance Program documentation and other requirements.

(b) **Performing Provider**

In order to enroll in the Medical Assistance Program as a performing provider the provider shall:

(1) have a contract with the billing provider;

(2) meet and maintain all departmental enrollment requirements;

(3) have a valid performing provider agreement on file which is signed by the performing provider and the department;

(4) provide all early intervention services directly with allied health professionals pursuant to all applicable provisions of federal and state statutes and regulations; and

(5) comply with all Medical Assistance Program documentation and other requirements.

(Effective August 28, 1998)

Sec. 17b-262-600. Eligibility

(a) Payment for early intervention services shall be available for all children eligible for the Medical Assistance Program subject to the conditions and limitations which apply to early intervention services as provided by these regulations.

(b) Payment for early intervention services shall be available only for evaluations, assessments, and services that are contained in an IFSP and by consent of a parent or other person authorized to consent to such activities on behalf of an eligible child.

(c) Significant delay shall be demonstrated with scores on an appropriate norm-referenced standardized diagnostic instrument or other procedures, such as formal observations and informed clinical opinion, to substantiate:

(1) a score two standard deviations below the mean in one area of development; or

(2) scores one and one-half standard deviations below the mean in two areas of development.

(d) Other procedures shall be used to demonstrate significant delay when the use of the standardized diagnostic instrument is not appropriate due to a child's age or when a child requires significant adaptation to perform on a standardized instrument.

(Effective August 28, 1998)

Sec. 17b-262-601. Services covered and limitations

(a) The department shall pay for the following:

(1) evaluations and assessments;

(2) early intervention services, which are medically appropriate and medically necessary as follows:

(A) assistive technology devices and assistive technology services;

(B) audiology;
(C) family training, counseling, and home visits;
(D) health services;
(E) medical services;
(F) nursing services;
(G) nutrition services;
(H) occupational therapy;
(I) physical therapy;
(J) psychological services;
(H) service coordination;
(I) social work services;
(J) special instruction;
(K) speech-language pathology;
(L) transportation and related costs; and
(M) vision services; and

(3) services provided in the child's natural environment to the maximum extent appropriate to the needs of the child.

(b) Limitations on covered services shall be as follows:

(1) DMR, or another state agency, shall be the agencies eligible for enrollment with the department to bill for early intervention services to Birth to Three eligible children and their families and to enter into a billing provider agreement with the department for the provision of such services;

(2) services shall be limited to those early intervention services authorized, by a parent or other person empowered to consent on behalf of an eligible child, in the IFSP;

(3) effective July 1, 1996, service coordination shall become part of the early intervention services fee;

(4) special instruction, developmental therapy, requires a signature by a licensed practitioner of the healing arts documenting the existence of a multidisciplinary team, and stating that he or she has periodically reviewed the child's progress and has recommended appropriate techniques, activities, and strategies during discussions with the child's early intervention teacher. Documentation of this requirement in a format and manner to be described by the department shall be signed and dated quarterly;

(5) treatment services are limited to a maximum of one per day of the same type of treatment service per child;

(6) evaluation services are limited to a maximum of one per month, per child;

(7) services are limited to those listed in the department's fee schedule;

(8) services of an unproven, educational, social, experimental, research, or cosmetic nature are not covered;

(9) immunizations, biological products, and other products or examinations and laboratory tests for preventable diseases available free of charge are not covered;

(10) speech services involving nondiagnostic, nontherapeutic, routine, repetitive, and

reinforced procedures or services for the child's general welfare that are not planned and performed or supervised by a licensed speech pathologist are not covered;

(11) payment for services by an AHP whose scope of practice is defined under state law when the service that was provided is not within said scope of practice; and

(12) payment for services by an AHP whose scope of practice is not defined under state law when the service that was provided is not within the accepted standard in his or her respective profession or the AHP is otherwise prohibited under state law from providing said service.

(Effective August 28, 1998)

Sec. 17b-262-602. Billing procedures

All claims submitted to the department for payment of evaluation and early intervention services including assessments and assistive technology devices, shall be substantiated by documentation in the Birth to Three eligible child's early intervention record.

(Effective August 28, 1998)

Sec. 17b-262-603. Payment

(a) The department shall establish payment rates effective July 1, 1996.

(b) The rate period shall be the state fiscal year.

(c) Interim rates shall be issued for each rate period and such rates shall be replaced by rates computed on the basis of actual cost and service volume submitted to the department by the billing provider by December 31 each year for the immediately preceding state fiscal year.

(d) Payment shall not be made directly to AHPs or organizations under contract to a performing provider or a billing provider.

(e) Payment limitations shall be as follows:

(1) payment for evaluations; early intervention services, which includes assessments; and assistive technology devices shall not duplicate payments made under the Medical Assistance Program for other services which are covered under the Program;

(2) any Medical Assistance Program Birth to Three eligible child is qualified to be evaluated for eligibility for Part H of IDEA;

(3) payment shall be made for early intervention services only for the period covered by the written authorized IFSP;

(4) once a child is determined ineligible for Part H of IDEA, payment shall not be made for assessment and early intervention services;

(5) claims for payment shall be submitted to the department only by the billing provider or its designated agent;

(6) payment for early intervention services, excluding evaluations, shall not be made unless one or more of the individual services pursuant to section 17b-262-601 are rendered in a calendar month;

(7) payment shall be made for evaluations regardless of whether the child becomes

eligible for the Birth to Three System;
(8) evaluations shall be based on a cost per evaluation basis;
(9) other early intervention services, including assessments, shall be no more than two units per child per calendar month;
(10) rates for early intervention services shall include assistive technology devices having a cost equal to or less than two hundred and fifty dollars; and
(11) rates for assistive technology devices having a cost of more than two hundred and fifty dollars, shall be based on the applicable Medical Assistance Program durable medical equipment fee schedule.

(Effective August 28, 1998)

Sec. 17b-262-604. Documentation requirements

Early intervention services shall be paid by the department only when the lead agency ensures compliance of the following documentation requirements on file with the performing provider, as appropriate:
(a) **Evaluation**
(1) A copy of the evaluation report which shall meet the requirements of Part H of IDEA, Title 20 USC 1471 et seq., Title 20 USC section 1477(a), and at Title 34 CFR, Part 303, subdivision (1) of subsection (b) of section 303.322, shall be on file, recommending the specific medical diagnosis or diagnoses according to the International Classification of Diseases (ICD) in a form and manner specified by the department, and signed by all members of the evaluation team.
(2) The evaluation shall include:
(A) for eligible Birth to Three children, a signature on a form and manner to be specified by the department, by the physician who recommended the evaluation and stated diagnosis or diagnoses; which authorizes the development of the IFSP, and
(B) for ineligible children, a signature by a physician within forty-five days of the date the evaluation was completed and signed.
(b) **Assessment**
(1) A copy of the assessment which shall meet the requirements of Part H of IDEA, Title 20 USC 1471 et seq., Title 20 USC, section 1477(a), and at Title 34 CFR, Part 303, subdivisions (1) and (2) of subsection (a) of section 303.322 and subdivision (2) of subsection (b) of section 303.322, shall be on file.
(2) The assessment shall be a multidisciplinary team assessment of the child's and child's family's unique needs and the identification of services appropriate to meet such needs.
(3) The written assessment report shall be signed by all members of the multidisciplinary team recommending the type of services appropriate for the child as listed in the IFSP.
(4) If any member of the multidisciplinary team does not attend the IFSP meeting, that member shall provide a written report regarding recommended services appropriate to their scope of practice.
(c) **Individualized Family Service Plan (IFSP)**

(1) The IFSP shall meet the requirements of Part H of IDEA, Title 20 USC 1471 et seq., Title 20 USC, section 1477(b), (c), and (d), and at Title 34 CFR, Part 303, sections 303.340 through 303.346, and be provided in accordance with the Birth to Three eligible child's service page as delineated in the IFSP. The IFSP shall be evaluated not less than once a year and the family shall be provided a review of the plan at six month intervals, or more often where appropriate, based on infant and toddler and family needs.

(2) At a minimum, the IFSP shall:

(A) be developed by the multidisciplinary team, of which the service coordinator shall be a member, within forty-five days of referral for early intervention services and indicate that the Birth to Three eligible child, his or her family or their representative has participated in, or been given the opportunity to participate in, the development of the child's plan of services service page of the IFSP;

(B) include a signature by a physician functioning within his or her scope of practice as defined in state law recommending the diagnostic and treatment services contained in the IFSP and the ICD diagnosis code. The physician shall sign the document within forty-five days of the date the IFSP was completed and signed by the parent;

(C) be based on an assessment of a Birth to Three eligible child's and child's family's needs which include, but are not limited to, assessments of medical, clinical, social, educational, or other needs;

(D) include a statement of the major outcomes expected to be achieved for the Birth to Three eligible child and the family, and the criteria, procedures, and timelines used to determine the degree to which progress toward achieving the outcomes is being made and whether modifications or revisions of the outcomes or services are necessary;

(E) include a statement of specific early intervention services necessary to meet the unique needs of the Birth to Three eligible child and the family, including the frequency, intensity, and the method of delivering services;

(F) include the name of the service coordinator from the profession most immediately relevant to the Birth to Three eligible child's or family's needs who shall be responsible for the implementation of the plan and coordination with other agencies and persons;

(G) include the steps to be taken supporting the transition of the Birth to Three eligible child to other appropriate services; and

(H) develop and implement an interim IFSP for a Birth to Three eligible child whose developmental status requires early intervention services while the evaluation and assessment are being completed such as a Birth to Three eligible child discharged from a hospital and who needs immediate continuation of care. Interim IFSPs may be developed and implemented if written parental consent is obtained, the name of the service coordinator and the early intervention services that are needed immediately for the child and the child's family are included in the interim IFSP, and the initial evaluation is completed within forty-five days after the performing provider receives the referral.

(d) **Progress Notes**

(1) Progress notes shall be kept in a form and manner as specified by the department.

They shall provide a comprehensive treatment narrative of the contacts with the child and family throughout the month, highlighting activities, nature and extent of the contacts, and relationship of activities to the medical necessity and medical appropriateness of the early intervention services in relation to the outcomes specified in the evaluation, assessment reports, and the service page as delineated in the IFSP.

(2) Any changes or differences in treatment shall be noted and related to the dates of services. Any increases in services shall meet signature requirements contained in these regulations. If a child is seen more than once during the same week, a summary and progress note for the month is acceptable if any changes in progress or treatment are documented each time they occur with the specific date that they occurred. The progress notes at a minimum shall:

(A) include a summary of progress made according to the IFSP;

(B) include a summary statement of service delivered noting any significant changes in the child's condition;

(C) be kept by the performing provider or the state agency in a form and manner to be determined, as specified by the department; and

(D) include the signature of the AHP providing the service.

(e) **Medical Expertise**

(1) Records of services provided by individuals who are AHPs but do not have a scope of practice defined by state law, such as a special education teacher, shall include written documentation of the involvement of a licensed practitioner of the healing arts in the delivery of service.

(2) Except for service coordination, the documentation required by this subsection shall be updated and signed, and in the child's early intervention record at least quarterly. This documentation shall include:

(A) identifying information about the child;

(B) the name of the AHP; and

(C) a signed statement by a licensed practitioner of the healing arts who shall be a member of the multidisciplinary team.

(f) **Early Intervention Record**

(1) An early intervention record for a child eligible for the Birth to Three System shall be maintained as provided by these regulations. At a minimum, the record shall contain the following:

(A) the initial written referral, all evaluations, all assessments, and reassessments, as necessary, to determine needed services;

(B) the Birth to Three eligible child's name, date of birth, address, social security or medical assistance number, and other relevant historical and financial information;

(C) all IFSPs;

(D) a statement by a physician recommending diagnostic or treatment services;

(E) all records of actual service delivery indicating the dates of service, type of service, location of service, units of service, and dated signature of the individual AHP providing

the service;

(F) all records of service entries of service coordination indicating the date, place of service, the name of the service coordinator, and type of ongoing service coordination provided, and a signature, by an AHP, confirming monthly data; and

(G) a transition plan, as appropriate, and an exit form.

(2) For a child who is determined ineligible for the Birth to Three System, the early intervention record shall include at a minimum:

(A) a written review of the diagnostic services by a physician;

(B) the ineligible child's name, date of birth, address, social security or medical assistance number, and other relevant historical and financial information; and

(C) all evaluations and ICD code.

(g) **Other Documentation Requirements**

(1) A contract establishing the independent provider as a Birth to Three performing provider for a particular type of service at a particular rate shall be available and include the following:

(A) any relevant terms and conditions associated with being a Birth to Three performing provider including the agreement not to bill the Medical Assistance Program for these services provided to Birth to Three children; and

(B) the performing provider shall be responsible for the development, maintenance, and monitoring of current and updated lists of the names and credentials of all employed and contracted Birth to Three performing providers and their employees, and the effective dates they were eligible to provide Birth to Three services. The list shall:

(i) include the performing provider's certification number, license number, and the Medical Assistance Program number, if applicable; and

(ii) be kept by the performing providers, in a central location, and be available upon request to authorized persons such as the Health Care Financing Administration (HCFA) or the department.

(2) The billing provider may choose to require performing providers which employ more than twenty people qualified to provide services under the contract, when contracted for service provision, to maintain and update the necessary list of persons providing services, their credentials, and their Medical Assistance Program billing number if they are enrolled with the Medical Assistance Program as a billing provider. A statement to this effect shall be part of the contract between the billing provider and the performing provider and shall be signed and dated:

(A) the contract shall also provide for the transfer of employee lists, should the organization subsequently go out of business; and

(B) each state agency shall be responsible for maintaining the licensure and certification document on each state employee providing direct service in the Birth to Three System.

(3) The performing provider shall be responsible for maintaining fiscal and medical records which fully disclose services and goods rendered or delivered to all persons receiving services in the Birth to Three System:

(A) these records and information shall be made available to authorized representatives of the department and billing provider upon request;

(B) all documentation shall be entered in ink and incorporated into the early intervention record in a complete, prompt, and accurate manner; and

(C) all documentation shall be made available to authorized department personnel upon request in accordance with Title 42 CFR, Part 431, section 431.17.

(4) The procedural safeguards required by Part H of IDEA, Title 20, USC 1471 et seq., Title 20. USC, section 1480, and specifically Title 34 CFR, Part 303, section 303.400 et seq., shall be developed and implemented by the lead agency. In addition to these safeguards, any child who is a Birth to Three eligible child and is also a Medical Assistance Program client may avail themselves of the department's fair hearing process pursuant to section 17b-60 of the Connecticut General Statutes.

(Effective August 28, 1998)

Sec. 17b-262-605. Audit and record retention

(a) All supporting accounting and business records, statistical data, early intervention records, and other records relating to the provision of evaluation, assessment, service coordination, and early intervention services paid for by the department shall be subject to audit.

(b) Documentation as required for the Birth to Three System, including census and accounting records, shall be maintained for the longer of:

(1) six years from the end of the billing period; or

(2) six years from the date of services by the performing provider; or

(3) until such time as the department audit of documented services is completed and said audit is approved or disallowed as the case may be by the commissioner.

(Effective August 28, 1998)

Sec. 17b-262-606. Reserved

Requirements for Payment of Nurse Practitioner Services

Sec. 17b-262-607. Scope

Sections 17b-262-607 through 17b-262-618 inclusive set forth the Department of Social Services requirements for payment of nurse practitioner services provided by licensed advanced practice registered nurses for clients who are determined eligible to receive services under Connecticut's Medical Assistance Program pursuant to section 17b-262 of the Connecticut General Statutes (CGS).

(Effective August 10, 1998)

Sec. 17b-262-608. Definitions

For the purposes of sections 17b-262-607 through 17b-262-618 the following definitions shall apply:

(1) “Acute” means having rapid onset, severe symptoms, and a short course.

(2) “Allied Health Professional (AHP)” means a professional or paraprofessional individual who is qualified by special training, education, skills, and experience in providing health care and treatment and shall include, but shall not be limited to: licensed practical nurses, certified nurse assistants, and other qualified therapists.

(3) “By or Under the Supervision” means the nurse practitioner shall assume professional responsibility for the service performed by the allied health professional, overseeing or participating in the work of the allied health professional including, but not limited to:

(A) availability of the nurse practitioner to the allied health professional in person and within five minutes;

(B) availability of the nurse practitioner on a regularly scheduled basis to review the practice, charts, and records of the allied health professional and to support the allied health professional in the performance of services; and

(C) a predetermined plan for emergency situations, including the designation of an alternate nurse practitioner in the absence of the regular nurse practitioner.

(4) “Child” means a person who is under twenty-one years of age.

(5) “Client” means a person eligible for goods or services under the department’s Medical Assistance Program.

(6) “Commissioner” means the Commissioner of Social Services appointed pursuant to subsection (a) of section 17b-1 of the Connecticut General Statutes.

(7) “Concurrent Review” means the review of the medical necessity and appropriateness of admission upon or within a short period following an admission and the periodic review of services provided during the course of treatment.

(8) “Consultation” means those services rendered by a nurse practitioner whose opinion or advice is requested by the client’s nurse practitioner or agency in the evaluation or treatment of the client’s illness.

(9) “CPT or Physician’s Current Procedural Terminology” means a listing of descriptive terms and identifying codes for reporting medical services and procedures performed by licensed practitioners as published by the American Medical Association, as amended from time to time.

(10) “Criteria” means the predetermined measurement variables on which judgment or comparison of necessity, appropriateness, or quality of health services shall be made.

(11) “Department” means the Department of Social Services or its agent.

(12) “Emergency” means a medical condition, including labor and delivery, manifesting itself by acute symptoms of sufficient severity, including severe pain, such that the absence of immediate medical attention could reasonably be expected to result in placing the client’s health in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part.

(13) “Family Planning Services” means any medically approved diagnostic procedure, treatment, counseling, drug, supply, or device which is prescribed or furnished by a provider to individuals of childbearing age for the purpose of enabling such individuals to freely

determine the number and spacing of their children.

(14) "Fees" means the rates for services, treatments, and drugs administered by nurse practitioners which shall be established by the commissioner and contained in the department's fee schedules.

(15) "HealthTrack Services" means the services described in subsection (r) of section 1905 of the Social Security Act.

(16) "HealthTrack Special Services" means medically necessary and medically appropriate health care, diagnostic services, treatment, or other measures necessary to correct or ameliorate disabilities and physical and mental illnesses and conditions discovered as a result of a periodic comprehensive health screening or interperiodic encounter. Such services are provided in accordance with subdivision (5) of subsection (r) of section 1905 of the Social Security Act, and are:

(A) services not covered under the State Plan or contained in a fee schedule published by the department; or

(B) services covered under the State Plan and contained in a fee schedule published by the department which exceed the limit on the amount of services established by the department that are contained in regulation.

(17) "Home" means the client's place of residence which includes a boarding home or home for the aged. Home does not include a hospital or long-term care facility; long-term care facility includes a nursing facility, chronic disease hospital, and intermediate care facility for the mentally retarded (ICF/MR).

(18) "Hospital" means a facility licensed by the Department of Public Health as a general short-term hospital or a hospital for mental illness as defined in section 17a-495 of the Connecticut General Statutes, or a chronic disease hospital as defined in subdivision (2) of subsection (b) of section 19-13-D1 of the Regulations of Connecticut State Agencies, which is part of the Public Health Code.

(19) "Inpatient" means a client who has been admitted to a general hospital for the purpose of receiving medically necessary and appropriate medical, dental, and other health related services and is present at midnight for the census count.

(20) "Institution" means the definition contained in Title 42 of the CFR, Part 435, section 435.1009.

(21) "Interperiodic Encounter" means any medically necessary visit to a Connect-icut Medical Assistance provider, other than for the purpose of performing a periodic comprehensive health screening. Such encounters include, but are not limited to, physician's office visits, clinic visits, and other primary care visits.

(22) "Legend Device" means the definition contained in section 20-571 of the Connecticut General Statutes.

(23) "Legend Drug" means the definition contained in section 20-571 of the Connecticut General Statutes.

(24) "Licensed Practitioner" means any Connecticut medical professional granted prescriptive powers within the scope of his or her professional practice as defined and

limited by federal or state law.

(25) "Licensed Practitioner of the Healing Arts" means a professional person providing health care pursuant to a license issued by the Department of Public Health (DPH).

(26) "Long-Term Care Facility" means a medical institution which provides, at a minimum, skilled nursing services or nursing supervision and assistance with personal care on a daily basis. Long-term care facilities include:

(A) nursing facilities,

(B) chronic disease hospitals—inpatient, and

(C) intermediate care facilities for the mentally retarded (ICFs/MR).

(27) "Medical Appropriateness or Medically Appropriate" means health care that is provided in a timely manner and meets professionally recognized standards of acceptable medical care; is delivered in the appropriate medical setting; and is the least costly of multiple, equally-effective, alternative treatments or diagnostic modalities.

(28) "Medical Assistance Program" means the medical assistance provided pursuant to Chapter 319v of the Connecticut General Statutes and authorized by Title XIX of the Social Security Act. The program is also referred to as Medicaid.

(29) "Medical Necessity or Medically Necessary" means health care provided to correct or diminish the adverse effects of a medical condition or mental illness; to assist an individual in attaining or maintaining an optimal level of health; to diagnose a condition; or to prevent a medical condition from occurring.

(30) "Medical Record" means the definition contained in section 19a-14-40 of the Regulations of Connecticut State Agencies, which is also the Public Health Code.

(31) "Nurse Practitioner" means an advanced practice registered nurse (APRN) who holds a current license as such issued by the Department of Public Health (DPH) under Chapter 378 of the Connecticut General Statutes, and who performs within the scope of practice for APRNs established pursuant to the Connecticut General Statutes and all relevant regulations.

(32) "Panel or Profile Tests" means certain multiple tests performed on a single specimen of blood or urine. They are distinguished from the single or multiple tests performed on an individual, immediate, or "stat" reporting basis.

(33) "Physician" means an individual licensed under Chapter 370 or 371 of the Connecticut General Statutes as a doctor of medicine or osteopathy.

(34) "Plan of Care" means the definitions contained in Title 42 of the CFR, Part 441, sections 441.102, 441.103, 441.155, and 441.156.

(35) "Prescription" means an order issued by a licensed practitioner that is documented in writing and signed by the practitioner issuing the order. The prescription needs to be renewed six months from the date of issuance. In long-term care facilities the signed order of a licensed practitioner shall be accepted in lieu of a written or oral prescription. The written prescription shall include:

(A) the date of the prescription;

(B) the name and address of the client;

(C) the client's date of birth;
(D) the diagnosis;
(E) the item prescribed;
(F) the quantity prescribed and strength, when applicable;
(G) the timeframe for the product's use;
(H) the number of refills, if any:
(I) the name and address of the prescribing practitioner and his or her Drug Enforcement Act number when appropriate;
(J) the dated signature of the licensed practitioner prescribing; and
(K) directions for the use of the medication and any cautionary statements required.
(36) "Prior Authorization" means approval for the provision of a service or delivery of goods from the department before the provider actually provides the service or delivers the goods.
(37) "Provider" means a nurse practitioner who is enrolled in the Medical Assistance Program.
(38) "Provider Agreement" means the signed, written, contractual agreement between the department and the provider of services or goods.
(39) "Quality of Care" means the evaluation of medical care to determine if it meets the professionally recognized standards of acceptable medical care for the condition and the client under treatment.
(40) "Retrospective Review" means the review conducted after services are provided to a client, to determine the medical necessity, appropriateness, and quality of the services provided.
(41) "Routine Medical Visits" means visits intended to check a client's general medical condition rather than visits which are medically necessary to treat a specific medical problem. For clients under twenty-one years of age, this can mean a Health-Track interperiodic encounter or a periodic comprehensive health screening.
(42) "State Plan" means the document which contains the services covered by the Connecticut Medical Assistance Program in compliance with Part 430, Subpart B, of Title 42 of the Code of Federal Regulations (CFR).
(43) "Utilization Review" means the evaluation of the necessity, appropriateness, and quality of the use of medical services, procedures, and facilities. Utilization review evaluates the medical necessity and medical appropriateness of admissions, the services performed or to be performed, the length of stay, and the discharge practices. It is conducted on a concurrent, prospective, or retrospective basis.

(Effective August 10, 1998)

Sec. 17b-262-609. Provider participation

In order to enroll in the Medical Assistance Program and receive payment from the department, providers shall meet the following requirements:

(a) **General:**

(1) meet and maintain all applicable licensing, accreditation, and certification requirements;

(2) meet and maintain all departmental enrollment requirements; and

(3) have a valid provider agreement on file which is signed by the provider and the department upon application for enrollment into the Medical Assistance Program. This agreement, which shall be periodically updated, shall continue to be in effect for the duration of the agreement or for the stated period in the agreement. The provider agreement specifies conditions and terms which govern the program and to which the provider is mandated to adhere in order to participate in the program.

(b) **Specific:**

In order to qualify for payment under the Medical Assistance Program for laboratory procedures, a nurse practitioner shall be in compliance with the provisions of the Clinical Laboratory Improvement Amendments of 1988 (CLIA), as amended from time to time.

(Effective August 10, 1998)

Sec. 17b-262-610. Eligibility

Payment for nurse practitioner services shall be available on behalf of all persons eligible for the Medical Assistance Program subject to the conditions and limitations which apply to these services.

(Effective August 10, 1998)

Sec. 17b-262-611. Services covered and limitations

(a) Except for the limitations and exclusions listed below, the department shall pay for:

(1) medically necessary and medically appropriate professional services of a nurse practitioner which conform to accepted methods of diagnosis and treatment;

(2) services provided in the practitioner's office, client's home, hospital, long-term care facility, or other medical care facility;

(3) family planning services as described in the Regulations of Connecticut State Agencies;

(4) unless defined elsewhere, CPT descriptive terms used by the department as standards;

(5) medical and surgical supplies used by the provider in the course of treatment of a client;

(6) injectable drugs which are payable by the department and administered by a provider; and

(7) HealthTrack Services and HealthTrack Special Services.

(b) **Limitations on covered services shall be as follows:**

(1) The department reserves the right to review the medical necessity and medical appropriateness of visits and to disallow payment for those visits it determines are not medically necessary or medically appropriate.

(2) A nurse practitioner who is fully or partially salaried by a general hospital, public or private institution, group practice, or clinic shall not receive payment from the department

unless the nurse practitioner maintains an office for private practice at a separate location from the hospital, institution, group, or clinic in which the nurse practitioner is employed. Nurse practitioners who are solely hospital, institution, group, or clinic based, either on a full- or part-time salary are not entitled to payment from the department for services rendered to Medical Assistance Program clients.

(3) Nurse practitioners who maintain an office for private practice separate from the hospital, institution, group, or clinic, shall be able to bill for services provided at the private practice location or for services provided to the nurse practitioner's private practice clients in the hospital, institution, group, or clinic.

(4) The department shall pay nurse practitioners for drugs or devices which are administered or dispensed directly to a client under the following conditions:

(A) excluding oral medications, payment shall be made to a nurse practitioner for the estimated acquisition cost as determined by the department for the amount of the drugs or devices which are administered directly to the client; and

(B) for legend drugs or legend devices which shall be administered by a nurse practitioner, the department shall pay the nurse practitioner for the estimated acquisition cost as determined by the department for the amount of the drug or device which is administered.

(5) The fee for routine care of a newborn in the hospital shall be all inclusive and shall be billed only once per child. The fee includes initiation of diagnostic and treatment programs, preparation of hospital records, history and physical examination of the baby, and conferences with the parents. Subsequent hospital care for evaluation and management of a normal newborn is paid per day.

(6) Admission or annual exams for long-term care facility residents shall meet the following criteria:

(A) the exam shall be performed in the facility;

(B) the admission examination shall be performed within forty-eight hours of admission to the facility and shall be limited to one per client, per provider, regardless of the number of admissions. However, if the nurse practitioner who attended the client in an acute or chronic care hospital is the same nurse practitioner who shall attend the client in the facility, a copy of a hospital discharge summary completed within five working days of admission and accompanying the client may serve in lieu of this requirement. An additional admission exam shall be performed only when a new medical record is opened for the client; and

(C) the annual comprehensive medical examination shall be limited to one per client per calendar year.

(7) When billing allergy procedures the nurse practitioner shall bill for followup visits which include intracutaneous tests only if subsequent visits require testing. If follow-up visits do not include testing, regular office visit codes for established clients shall be used.

(8) Payment for panel or profile tests shall be made according to the fees listed in the department's fee schedule for panel tests and not at the rate for each separate test included in the panel or profile.

(9) Payment for any laboratory service shall be limited to services provided by Medical Assistance Program providers who are in compliance with the provisions of the Clinical Laboratory Improvement Amendments of 1988 (CLIA).

(10) The fees listed in the department's fee schedule shall be payable only when these services are provided by or under the supervision of a nurse practitioner.

(11) The department shall not pay a higher rate for any procedure which is performed in an emergency department.

(12) The department shall pay for an initial visit by a nurse practitioner in the office, home, or long-term care facility only once per client. Initial visits refer to the provider's first contact with the client and reflect higher fees for the additional time required for setting up records and developing past history. The exception to this is when the nurse practitioner-client relationship has been discontinued for three or more years and is then reinstated.

(13) The department shall pay for an initial visit once per inpatient hospitalization.

(14) The fee for a consultation shall apply only when the opinions and advice of a consultant nurse practitioner are requested by the client's nurse practitioner or agency in the evaluation or treatment of the client's illness. In a consultation the client's nurse practitioner carries out the plan of care. In a referral a second provider provides direct service to the client.

(15) When the consultant nurse practitioner assumes the continuing care of the client, any service subsequent to the initial consultation rendered by the consultant provider shall no longer be a consultation and shall be paid according to the fee listed for the procedure.

(16) A consultation initiated by a client or family, and not requested by a nurse practitioner, shall not be billed as an initial consultation, but shall be billed as a confirmatory consultation or as an office visit, whichever is appropriate.

(17) If a consultant nurse practitioner, subsequent to the consultation, assumes responsibility for management of a portion, or all of the client's medical condition, consultation codes shall not be billed. A specifically identifiable procedure, identified with a specific CPT code, performed on, or subsequent to the date of the initial consultation, shall be billed separately.

(18) When a newborn requires other than routine care following delivery, the nurse practitioner shall bill for the appropriate critical care. The department shall not pay both critical care and routine care for the same child.

(Effective August 10, 1998)

Sec. 17b-262-612. Services not covered

The department shall not pay for the following:

(a) any procedures or services of an unproven, educational, social, research, experimental, or cosmetic nature; for any diagnostic, therapeutic, or treatment procedures in excess of those deemed medically necessary and medically appropriate by the department to treat the client's condition; or for services not directly related to the client's diagnosis, symptoms, or medical history;

(b) any examinations, laboratory tests, biological products, immunizations, or other products which are furnished free of charge;

(c) information or services provided to a client by a provider over the telephone;

(d) an office visit for the sole purpose of the client obtaining a prescription where the need for the prescription has already been determined;

(e) cancelled office visits and appointments not kept;

(f) cosmetic surgery;

(g) services provided in an acute care hospital if the department determines the admission does not, or retrospectively did not, fit the department's utilization review requirements pursuant to section 17-134d-80 of the Regulations of Connecticut State Agencies;

(h) services provided by the admitting provider in an acute care hospital shall not be made or may be recouped if it is determined by the department's utilization review, either prospectively or retrospectively, that the admission did not fulfill the accepted professional criteria for medical necessity, medical appropriateness, appropriateness of setting, or quality of care;

(i) a laboratory charge for laboratory services performed by a laboratory outside of the nurse practitioner's office—the laboratory shall bill the department for services rendered when a nurse practitioner refers a client to a private laboratory;

(j) the following routine laboratory tests which shall be included in the fee for an office visit and shall not be billed on the same date of service: urinalysis without microscopy, hemoglobin determination, and urine glucose; and

(k) transsexual surgery or for a procedure which is performed as part of the process of preparing an individual for transsexual surgery, such as hormone treatment and electrolysis.

(Effective August 10, 1998)

Sec. 17b-262-613. Need for service

The department shall pay for an initial office visit and continuing services which the department deems are medically necessary and medically appropriate, in relation to the diagnosis for which care is required, provided that:

(a) the services are within the scope of the provider's practice, and

(b) the services are made part of the client's medical record.

(Effective August 10, 1998)

Sec. 17b-262-614. Prior authorization

(a) Prior authorization, on forms and in a manner as specified by the department, is required for the following services:

(1) more than one visit on the same day for the same client by the same provider. Authorization for additional visits need not be submitted in advance of the service, but providers shall submit the authorization request prior to billing for the second or subsequent visits;

(2) admissions to acute care hospitals pursuant to section 17-134d-80 of the Regulations

of Connecticut State Agencies;

(3) electrolysis epilation;

(4) physical therapy services in excess of two treatments per calendar week per client per provider;

(5) physical therapy services in excess of nine treatments per calendar year per client per provider, involving the following primary diagnoses:

(A) all mental disorders including diagnoses related to mental retardation and specific delays in development covered by the International Classification of Diseases (ICD), as amended from time to time;

(B) cases involving musculoskeletal system disorders covered by ICD, as amended from time to time; and

(C) cases involving symptoms related to nutrition, metabolism, and development covered by ICD, as amended from time to time;

(6) reconstructive surgery, including breast reconstruction following mastectomy;

(7) plastic surgery;

(8) transplant procedures; and

(9) HealthTrack Special Services.

(A) HealthTrack Special Services are determined medically necessary and medically appropriate on a case-by-case basis; and

(B) the request for HealthTrack Special Services shall include:

(i) a written statement from the prescribing physician, or other licensed practitioner of the healing arts, performing such services within his or her respective scope of practice as defined under state law, justifying the need for the item or service required;

(ii) a description of the outcomes of any alternative measures tried; and

(iii) if applicable and requested by the department, any other documentation required in order to render a decision.

(b) The procedure or course of treatment authorized shall be initiated within six months of the date of authorization.

(c) The initial authorization period shall be up to three months.

(d) If prior authorization is needed beyond the initial authorization period, requests for continued treatment beyond the initial authorization period shall be considered up to six months per request.

(e) For services requiring prior authorization, a nurse practitioner shall be required to provide pertinent medical or social information adequate for evaluating the client's medical need for services. Except in emergency situations, or when authorization is being requested for more than one visit in the same day, approval shall be received before services are rendered.

(f) In an emergency situation which occurs after working hours or on a weekend or holiday, the provider shall secure verbal approval on the next working day for the services provided. This applies only to those services which normally require prior authorization.

(g) In order to receive payment from the department a provider shall comply with all

prior authorization requirements. The department in its sole discretion determines what information is necessary in order to approve a prior authorization request. Prior authorization does not, however, guarantee payment unless all other requirements for payment are met.

(Effective August 10, 1998)

Sec. 17b-262-615. Billing procedures

(a) Claims from nurse practitioners shall be submitted on the department's designated form or electronically transmitted to the department's fiscal agent and shall include all information required by the department to process the claim for payment.

(b) The amount billed to the department shall represent the nurse practitioner's usual and customary charge for the services delivered.

(c) When a Medical Assistance Program client is referred to a provider for consultation, the consultant provider shall include the referring practitioner's provider number and name. If no provider number has been assigned, the consultant provider shall enter the entire name as well as the state license number of the referring provider on the billing form.

(d) Injectables shall be billed according to the number of units administered to the client by the nurse practitioner.

(e) When billing for anesthesia services, providers shall include the name of the primary surgeon on the bill and enter the total number of minutes in units.

(f) Providers shall bill for drugs or devices which are dispensed directly to the client as separate line items.

(g) All charges billed for supplies and materials provided by a provider, except glasses, shall be reviewed by the department.

(Effective August 10, 1998)

Sec. 17b-262-616. Payment

(a) Payment rates shall be the same for in-state and out-of-state providers.

(b) Payment shall be made at the lowest of:

(1) the provider's usual and customary charge to the general public;

(2) the lowest Medicare rate;

(3) the amount in the applicable fee schedule as published by the department;

(4) the amount billed by the provider; or

(5) the lowest price charged or accepted for the same or substantially similar goods or services by the provider from any person or entity.

(Effective August 10, 1998)

Sec. 17b-262-617. Payment rate and limitations

(a) The commissioner establishes the fees contained in the department's fee schedule pursuant to section 4-67c of the Connecticut General Statutes.

(b) Nurse practitioner rates for each procedure shall be set at 90% of the department's fees for physician procedure codes.

(c) The fees listed apply only when services are directly performed by the nurse practitioner or provided under the supervision of the nurse practitioner.

(d) Payment shall be made for panel or profile tests according to the fees listed in the department's fee schedule for panel tests and not at the rate for each separate test included in the panel or profile.

(e) Fees for surgical and medical procedures shall include the fee for an emergency room visit. The department shall not pay a provider at a higher rate for any surgical or medical procedure which is performed in an emergency room.

(f) The department shall pay nonhospital based providers for evaluation and management services provided to the provider's private practice clients in the emergency room.

(g) If a client is referred to a provider for advice and treatment of a condition which the referring provider does not usually treat, the fee for a consultation shall not be paid.

(h) If a client's medical condition necessitates the concurrent services and skills of two or more providers, each nurse practitioner provider shall be entitled to the listed fee for the service.

(i) When a Medical Assistance Program applicant visits a provider for the purpose of determining eligibility, the department shall pay only for the test required to establish eligibility as requested by the department. No other procedures shall be paid.

(j) Newborn resuscitation may be billed in addition to billing for routine care of a newborn or billing for critical care.

(k) The admission and annual comprehensive medical examination, in a long-term care facility, shall be performed by or under the direct supervision of a provider.

(*l*) The admission examination, in a long-term care facility, shall be performed within forty-eight hours of admission to the long-term care facility and shall be limited to one per client, per provider, regardless of the number of admissions.

(Effective August 10, 1998)

Sec. 17b-262-618. Documentation

(a) Nurse Practitioners shall maintain a specific record for all services rendered for each client eligible for Medical Assistance Program payment including, but not limited to: name, address, birth date, Medical Assistance Program identification number, pertinent diagnostic information, a current treatment plan signed by the nurse practitioner, documentation of services provided, and the dates the services were provided.

(b) All required documentation shall be maintained for at least five years in the nurse practitioner's file subject to review by authorized department personnel. In the event of a dispute concerning a service provided, documentation shall be maintained until the end of the dispute or five years, whichever is greater.

(c) Failure to maintain all required documentation shall result in the disallowance and recovery by the department of any amounts paid to the nurse practitioner for which the required documentation is not maintained or provided to the department upon request.

(Effective August 10, 1998)

Requirements for Payment of Podiatric Services

Sec. 17b-262-619. Scope

Sections 17b-262-619 to 17b-262-629, inclusive, of the Regulations of Connecticut State Agencies set forth the Department of Social Services requirements for payment of podiatric services on behalf of clients who are determined eligible to receive services under the Connecticut Medicaid program pursuant to section 17b-261 of the Connecticut General Statutes.

(Adopted effective February 11, 2009)

Sec. 17b-262-620. Definitions

As used in section 17b-262-619 to section 17b-262-629, inclusive, of the Regulations of Connecticut State Agencies:

(1) "Acute" means symptoms that are severe and have a rapid onset and short course;

(2) "Admission" means the formal acceptance by a hospital of a client who is to receive health care services while lodged in an area of the hospital reserved for continuous nursing services;

(3) "Border provider" means an out-of-state provider who routinely serves clients and is deemed a border provider by the department on a provider by provider basis;

(4) "Chronic disease hospital" means "chronic disease hospital" as defined in section 19-13-D1 of the Regulations of Connecticut State Agencies;

(5) "Client" means a person eligible for goods or services under the department's Medicaid program;

(6) "Commissioner" means the Commissioner of Social Services or his or her designee;

(7) "Consultation" means those services rendered by a podiatrist or other practitioner whose opinion or advice is requested by the client's podiatrist or other appropriate source in the evaluation or treatment of the client's illness;

(8) "Customized item" means an item or material adapted through modification to meet the specific needs of a particular client;

(9) "Department" means the Department of Social Services or its agent;

(10) "Early and Periodic Screening, Diagnostic and Treatment services" or "EPSDT" means the services provided in accordance with section 1905(r) of the Social Security Act, as amended from time to time;

(11) "Emergency" means a medical condition, including labor and delivery, manifesting itself by acute symptoms of sufficient severity, including severe pain, such that the absence of immediate medical attention could reasonably be expected to result in placing the client's health in serious jeopardy, serious impairment to bodily functions or serious dysfunction of any bodily organ or part;

(12) "Freestanding clinic" means "freestanding clinic" as defined in section 171B of the department's Medical Services Policy for clinic services;

(13) "General hospital" means "general hospital" as defined in section 17-134d-80 of the Regulations of Connecticut State Agencies;

(14) "Home" means the client's place of residence, including, but not limited to, a boarding home, community living arrangement or residential care home. "Home" does not include facilities such as hospitals, chronic disease hospitals, nursing facilities, intermediate care facilities for the mentally retarded (ICFs/MR) or other facilities that are paid an all-inclusive rate directly by Medicaid for the care of the client;

(15) "Intermediate care facility for the mentally retarded" or "ICF/MR" means a residential facility for persons with mental retardation licensed pursuant to section 17a-227 of the Connecticut General Statutes and certified to participate in the Medicaid program as an intermediate care facility for the mentally retarded pursuant to 42 CFR 442.101, as amended from time to time;

(16) "Legend device" means "legend device" as defined in section 20-571 of the Connecticut General Statutes;

(17) "Legend drug" means "legend drug" as defined in section 20-571 of the Connecticut General Statutes;

(18) "Medicaid" means the program operated by the department pursuant to section 17b-260 of the Connecticut General Statutes and authorized by Title XIX of the Social Security Act, as amended from time to time;

(19) "Medical appropriateness" or "medically appropriate" means health care that is provided in a timely manner and meets professionally recognized standards of acceptable medical care; is delivered in the appropriate setting; and is the least costly of multiple, equally-effective alternative treatments or diagnostic modalities;

(20) "Medical necessity" or "medically necessary" means health care provided; to correct or diminish the adverse effects of a medical condition or mental illness; to assist an individual in attaining or maintaining an optimal level of health; to diagnose a condition; or to prevent a medical condition from occurring;

(21) "Medical record" means "medical record" as defined in section 19a-14-40 of the Regulations of Connecticut State Agencies;

(22) "Nursing facility" means "nursing facility" as defined in 42 USC 1396r(a), as amended from time to time;

(23) "Out-of-state provider" means a provider that is located outside Connecticut and is not a border provider;

(24) "Physician" means a person licensed pursuant to chapter 370 of the Connecticut General Statutes;

(25) "Podiatric Services" means services provided by a podiatrist within the scope of practice as defined by state law, including chapter 375 of the Connecticut General Statutes;

(26) "Podiatrist" means a doctor of podiatric medicine licensed pursuant to section 20-54 of the Connecticut General Statutes;

(27) "Prior authorization" means approval for the provision of a service or the delivery of goods from the department before the provider actually provides the service or delivers the goods;

(28) "Provider" means a podiatrist or a podiatrist group enrolled in Medicaid;

(29) "Quality of care" means the evaluation of medical care to determine if it meets the professionally recognized standards of acceptable medical care for the condition and the client under treatment;

(30) "Routine foot care" means clipping or trimming of normal or mycotic toenails; debridement of the toenails that do not have onychogryposis or onychauxis; shaving, paring, cutting or removal of keratoma, tyloma or heloma; and nondefinitive shaving or paring of plantar warts except for the cauterization of plantar warts;

(31) "Simple foot hygiene" means self-care including, but not limited to: observation and cleansing of the feet; use of skin creams to maintain skin tone of both ambulatory and bedridden patients; nail care not involving professional attention; and prevention and reduction of corns, calluses and warts by means other than cutting, surgery or instrumentation;

(32) "Systemic condition" means the presence of a metabolic, neurologic, or peripheral vascular disease, including, but not limited to: diabetes mellitus, arteriosclerosis obliterans, Buerger's disease, chronic thrombophlebitis and peripheral neu-ropathies involving the feet, which would justify coverage of routine foot care;

(33) "Usual and customary charge" means the amount that the provider charges for the service or procedure in the majority of non-Medicaid cases. If the provider varies the charges so that no one amount is charged in the majority of cases, "usual and customary" shall be defined as the median charge. Token charges for charity patients and other exceptional charges are to be excluded; and

(34) "Utilization review" means the evaluation of the necessity and appropriateness of medical services and procedures as defined in section 17-134d-80 of the Regulations of Connecticut State Agencies.

(Adopted effective February 11, 2009)

Sec. 17b-262-621. Provider participation

To enroll in Medicaid and receive payment from the department, providers shall comply with sections 17b-262-522 to 17b-262-533, inclusive, of the Regulations of Connecticut State Agencies.

(Adopted effective February 11, 2009)

Sec. 17b-262-622. Eligibility

Payment for podiatric services shall be available on behalf of all persons eligible for Medicaid subject to the conditions and limitations that apply to these services.

(Adopted effective February 11, 2009)

Sec. 17b-262-623. Services covered and limitations

Subject to the limitations and exclusions identified in sections 17b-262-619 to 17b-262-629, inclusive, of the Regulations of Connecticut State Agencies, the department shall pay providers for podiatric services provided by podiatrists:

(1) for only for those procedures listed in the provider's fee schedule that are medically necessary and medically appropriate to treat the client's condition;

(2) for podiatric services provided in an office, a general hospital, the client's home, a chronic disease hospital, nursing facility, ICF/MR or other medical care facility;

(3) for laboratory services provided by a podiatrist in compliance with the provisions of the Clinical Laboratory Improvement Amendments (CLIA) of 1988;

(4) for medical and surgical supplies used by the podiatrist in the course of treatment of a client;

(5) for drugs and supplies administered by a podiatrist;

(6) for a second opinion for surgery when requested voluntarily by the client or when required by the department. The department shall pay for a second opinion according to the established fees for consultation; and

(7) for EPSDT services including, but not limited to, treatment services which are indicated following screening but not otherwise covered, provided that prior authorization is obtained.

(Adopted effective February 11, 2009)

Sec. 17b-262-624. Services not covered

The department shall not pay a podiatrist:

(1) for information or services provided to a client by a podiatrist over the telephone;

(2) for any product available to podiatrists free of charge;

(3) for more than one visit per day per client to the same podiatrist;

(4) for cosmetic surgery;

(5) for simplified tests requiring minimal time or equipment and employing materials nominal in cost, including, but not limited to, urine testing for glucose, albumin and blood;

(6) for simple foot hygiene;

(7) for repairs to devices judged by the department to be necessitated by willful or malicious abuse on the part of the client;

(8) for repairs to devices under guarantee or warranty. The podiatrist shall first seek payment from the manufacturer;

(9) for an office visit for the sole purpose of the client obtaining a prescription where the need for the prescription has already been determined;

(10) for cancelled services and appointments not kept;

(11) for services provided in a general hospital if the department determines the admission does not, or retrospectively did not, fit the department's utilization review requirements pursuant to section 17-134d-80 of the Regulations of Connecticut State Agencies; or

(12) for any procedures or services of an unproven, educational, social, research, experimental or cosmetic nature; for any diagnostic, therapeutic or treatment services in excess of those deemed medically necessary and medically appropriate by the department to treat the client's condition; or for services not directly related to the client's diagnosis,

symptoms or medical history.

(Adopted effective February 11, 2009)

Sec. 17b-262-625. Need for service

Payment for an initial office visit and continuing services which the department deems medically necessary and medically appropriate, in relation to the diagnosis for which care is required, is available provided that:

(1) the services are within the scope of the podiatrist's practice; and

(2) the services are made part of the client's medical record.

(Adopted effective February 11, 2009)

Sec. 17b-262-626. Prior authorization

(a) To receive payment from the department, a podiatrist shall comply with the prior authorization requirements described in section 17b-262-528 of the Regulations of Connecticut State Agencies. The department, in its sole discretion, shall determine what information is necessary in order to approve a prior authorization request. Prior authorization does not, however, guarantee payment unless all other requirements for payment are met.

(b) Prior authorization, on forms and in the manner specified by the department, shall be required for:

(1) physical therapy services in excess of two visits per calendar week per client per podiatrist;

(2) physical therapy services in excess of nine visits per calendar year per client per podiatrist, when the therapy is for the treatment of the following diagnoses:

(A) cases involving musculoskeletal system disorders of the spine covered by the ICD, as amended from time to time; and

(B) cases involving symptoms related to nutrition, metabolism and development covered by the ICD, as amended from time to time;

(3) reconstructive surgery;

(4) plastic surgery;

(5) EPSDT services that are identified during a periodic screening as medically necessary and which are not listed on the existing fee schedule; and

(6) other services and supplies identified as requiring prior authorization on the fee schedule.

(c) Prior authorization is required for payment of all hospital admissions as required and described in section 17-134d-80 of the Regulations of Connecticut State Agencies.

(d) The authorization period shall be for a period not to exceed six months.

(e) If prior authorization is needed beyond the initial authorization period, requests for continued treatment beyond the initial authorization period shall be considered for up to an additional six month period per request.

(f) Except in emergency situations, prior authorization shall be received before services are rendered.

(g) In an emergency situation that occurs after working hours or on a weekend or holiday, the podiatrist shall secure verbal prior authorization on the next working day for the services provided. This applies only to those services that normally require prior authorization.

(Adopted effective February 11, 2009)

Sec. 17b-262-627. Billing procedures

(a) Claims from podiatrists shall be submitted on the department's designated form or electronically transmitted to the department, in a form and manner as specified by the department, and shall include all information required by the department to process the claim for payment.

(b) The amount billed to the department shall represent the podiatrist's usual and customary charge for the services delivered.

(c) When a client is referred to a podiatrist for consultation, the consultant podiatrist shall include the referring practitioner's name.

(d) Laboratory services performed in the podiatrist's office shall be payable to the podiatrist and shall be billed as separate line items. When a podiatrist refers a client to a private laboratory for services, the laboratory shall bill directly and no laboratory charge shall be paid to the podiatrist.

(e) All charges billed for supplies and materials provided by a podiatrist may be reviewed by the department.

(f) When services are provided by more than one member of a group, the authorization request shall be submitted prior to billing as described in the billing instructions in the provider manual.

(Adopted effective February 11, 2009)

Sec. 17b-262-628. Payment

(a) The commissioner shall establish, and may periodically update, the fees for covered services in the department's fee schedule pursuant to section 4-67c of the Connecticut General Statutes.

(b) Fees shall be the same for in-state, border and out-of-state podiatrists.

(c) Payment shall be made at the lowest of:

(1) the podiatrist's usual and customary charge;

(2) the lowest Medicare rate;

(3) the amount in the applicable fee schedule as published by the department pursuant to section 4-67c of the Connecticut General Statutes; or

(4) the amount billed by the podiatrist.

(d) Notwithstanding the provisions of the regulations of connecticut state agencies or any of the Medical Services Policies to the contrary, the department shall not pay any podiatrist under sections 17b-262-619 through 17b-262-629, inclusive, of the regulations of connecticut state agencies for a client seen at a freestanding clinic enrolled in Medicaid. Only the clinic may bill for such services. As an exception to the foregoing, a podiatrist

may bill for covered services for a client seen at an outpatient surgical facility. a podiatrist who is enrolled with medicaid at a location separate from the clinic may bill the department for clients seen at the separate practice location.

(e) The department shall not pay interns or residents for their services nor shall the department pay for assistant surgeons in general or chronic disease hospitals staffed by interns and residents, unless the procedure is significantly complicated to justify a full surgeon acting as an assistant. If the surgery is performed by a resident or intern and the supervising surgeon assists, only the assistant's fee shall be paid to the surgeon. The regular surgical fee shall not be paid.

(f) If a resident or intern performs the surgery and the supervising surgeon is not present while the procedure is performed, no fee shall be paid to the surgeon even when the surgeon is on call.

(g) **Payment limitations**

(1) Fees for initial fittings and adjustments shall be included in the cost of the item or device.

(2) The department shall pay a podiatrist for physical therapy only if the podiatrist personally provides the physical therapy.

(3) Payment shall be made for a customized item for a client who dies, or is not otherwise eligible on the date of delivery, provided the client was eligible:

(A) on the date prior authorization was given by the department; or

(B) on the date the client ordered the item, if the item does not require prior authorization. For purposes of this section, the date the client orders the item means the date on which the podiatrist presents the order to the manufacturer or supplier. The podiatrist shall verify to the department the date the client ordered the item.

(4) The department shall pay for routine foot care only if the client has a systemic condition. Services are limited to one treatment every sixty days.

(5) The fees listed in the department's fee schedule shall be payable only when the services are performed by the podiatrist.

(6) The department shall pay for an initial visit by a podiatrist in an office, home, ICF/MR or nursing facility visit only once per client. Initial visits refer to the podiatrist's first contact with the client and reflect higher fees for the additional time required for setting up records and developing past history. The only exception to this is when the podiatrist-client relationship has been discontinued for three or more years and is then reinstated.

(7) Fees for consultations shall apply only when the opinions and advice of a consultant podiatrist are requested by the referring provider or other appropriate source in the evaluation and treatment of the client's illness. After the consultation is provided, the consultant shall prepare a written report of his or her findings and provide a copy of the report to the referring podiatrist or physician. In a consultation, the client's referring provider carries out the plan of care. In a referral, a second provider provides direct service to the client.

(h) **Surgery**

(1) When a claim is submitted by a podiatrist for multiple surgical procedures performed on the same date of service, the department will pay for the primary surgical procedure at the Medicaid allowed amount for podiatrists or the billed amount, whichever is lower. The department shall pay for additional surgical procedures performed on that day at fifty percent of the Medicaid allowed amount for podiatrists.

(2) When an assistant surgeon, in addition to staff provided by the hospital, is required, the amount payable by the department to the assistant surgeon shall be as indicated on the fee schedule.

(3) Subsequent to the decision for surgery, fees for surgical procedures include one related evaluation and management encounter on the date immediately prior to, or on, the date of the procedure, including history and physical.

(4) The listed fees for all surgical procedures include the surgery and typical postoperative follow-up care while in the general or chronic disease hospital. Followup visits related to the surgery shall not be payable as office visits.

(5) The listed fees for surgery on the musculoskeletal system shall include payment for the application of the first cast or traction device.

(i) **Radiology**

(1) The listed fees for all diagnostic radiology procedures shall include consultation and a written report to the referring provider.

(2) The listed fees for all diagnostic radiology procedures shall apply only when the podiatrist's own equipment is being used. If the equipment used to perform the procedure is owned directly or indirectly by the general or chronic disease hospital or a related entity, or if a hospital includes the operating expenses of the equipment in its cost reports, the podiatrist shall not be paid for the technical component of the listed fee.

(j) **Laboratory**

(1) The following routine laboratory tests shall be included in the fee for an office visit and shall not be payable on the same date of service: urinalysis without microscopy, hemoglobin determination and urine glucose determination.

(2) No payment shall be made for tests which are provided free of charge.

(3) Payment shall be made for panel or profile tests according to the fees listed in the department's fee schedule for panel tests and not according to the fee for each separate test included in the panel or profile.

(k) **Drugs**

(1) The department shall pay the actual acquisition costs for oral medications incident to an office visit as billed by the podiatrist.

(2) The department shall pay for legend drugs and legend devices administered by the podiatrist based on a fee schedule determined by the department.

(3) No payment shall be made for drugs provided free of charge.

(*l*) **Admission to a general hospital**

Payment for services provided by the admitting podiatrist in a general hospital shall not be made available if it is determined by the department's utilization review program, either

prospectively or retrospectively, that the admission did not fulfill the accepted professional criteria for medical necessity, medical appropriateness, appropriateness of setting or quality of care. Specific requirements are described in section 17-134d-80 of the Regulations of Connecticut State Agencies.

(Adopted effective February 11, 2009)

Sec. 17b-262-629. Documentation and audit requirements

(a) Podiatrists shall maintain a specific record for all services received by each client eligible for Medicaid payment including, but not limited to: name, address, birth date, Medicaid identification number, pertinent diagnostic information, a current treatment plan and treatment notes signed by the podiatrist, documentation of services provided and the dates the services were provided and a signed receipt for all devices dispensed. The receipt for any dispensed device, regardless of the format used, shall, at a minimum, contain the following elements:

(1) the podiatrist's name;
(2) the client's name;
(3) the delivery address;
(4) the date of delivery; and
(5) itemization of the device delivered, including:
(A) a product description;
(B) a brand name;
(C) a model name and number, if applicable;
(D) a serial number, if applicable;
(E) the quantity delivered; and
(F) the amount billed per device.

(b) All required documentation shall be maintained in its original form for at least five years or longer by the podiatrist in accordance with statute or regulation, subject to review by the department. In the event of a dispute concerning a service provided, documentation shall be maintained until the end of the dispute, five years or the length of time required by statute or regulation, whichever is longest.

(c) Failure to maintain and provide all required documentation to the department upon request shall result in the disallowance and recovery by the department of any future or past payments made to the podiatrist for which the required documentation is not maintained and not provided to the department upon request.

(d) The department retains the right to audit any and all relevant records and documentation and to take any other appropriate quality assurance measures it deems necessary to assure compliance with these and other regulatory and statutory requirements.

(e) Podiatrists shall maintain documentation supporting all prior authorization requests.

(Adopted effective February 11, 2009)

Requirements for Payment of Services Provided by Independent Licensed Audiologists, Physical Therapists, Occupational Therapists and Speech Pathologists

Sec. 17b-262-630. Scope

Sections 17b-262-630 to 17b-262-640, inclusive, of the Regulations of Connecticut State Agencies set forth the Department of Social Services requirements for payment of services provided by independent licensed audiologists, physical therapists, occupational therapists and speech pathologists for clients who are determined eligible to receive services under Connecticut's Medicaid program pursuant to section 17b-261 of the Connecticut General Statutes. Sections 17b-262-630 to 17b-262-640, inclusive, of the Regulations of Connecticut State Agencies shall not apply to therapy services provided by home health agencies, clinics, rehabilitation centers, hospitals or other health care providers.

(Adopted effective December 1, 2000; Amended September 6, 2012)

Sec. 17b-262-631. Definitions

For the purposes of sections 17b-262-630 to 17b-262-640, inclusive, of the Regulations of Connecticut State Agencies the following definitions shall apply:

(1) "Advanced practice registered nurse" or "APRN" means a person licensed pursuant to section 20-94a of the Connecticut General Statutes;

(2) "Audiologist" means a person licensed to practice audiology pursuant to chapter 397a of the Connecticut General Statutes and who meets the definition of "qualified audiologist" in 42 CFR 440.110(c)(3);

(3) "Audiology" means evaluation and treatment provided by an audiologist;

(4) "Border provider" has the same meaning as provided in section 17b-262-523 of the Regulations of Connecticut State Agencies;

(5) "Chronic disease hospital" has the same meaning as provided in section 19a-550 of the Connecticut General Statutes;

(6) "Client" means a person eligible for goods or services under Medicaid;

(7) "Commissioner" means the Commissioner of Social Services or the commissioner's agent;

(8) "Department" means the Department of Social Services or its agent;

(9) "Early and Periodic Screening, Diagnostic and Treatment Special Services" or "EPSDT Special Services" means services that are not otherwise covered under Medicaid but which are nevertheless covered as EPSDT services for Medicaid-eligible children pursuant to 42 USC 1396d(r)(5) when the service is medically necessary, the need for the service is identified in an EPSDT screen, the service is provided by a participating provider and the service is a type of service that may be covered by a state Medicaid agency and qualifies for federal reimbursement under 42 USC 1396d;

(10) "Home" means the client's place of residence, which includes a boarding home or residential care home. Home does not include a hospital or long-term care facility;

(11) "Hospital" means a "short-term hospital" as defined in section 19-13-D1 of the Regulations of Connecticut State Agencies. It shall also include an out-of-state hospital or

a hospital that is a border provider;

(12) "Independent therapist" means an audiologist, physical therapist, occupational therapist or speech pathologist practicing in the community independently and not associated with a hospital, long-term care facility, clinic, home health agency or any other health care provider;

(13) "Independent therapy" means those services provided by an independent therapist, a physical therapy assistant or an occupational therapy assistant;

(14) "Intermediate Care Facility for the Mentally Retarded" or "ICF/MR" means a residential facility for individuals with intellectual disabilities licensed pursuant to section 17a-227 of the Connecticut General Statutes and certified to participate in Medicaid as an intermediate care facility for the mentally retarded pursuant to 42 CFR 442.101, as amended from time to time;

(15) "International Classification of Diseases" or "ICD" means the most recent system of disease classification established by the World Health Organization or such other disease classification system that the department requires providers to use when submitting Medicaid claims;

(16) "Licensed practitioner" means a physician, a physician assistant, an advanced practice registered nurse or a podiatrist providing services within the licensed practitioner's scope of practice under state law;

(17) "Long-term care facility" means a medical institution which provides, at a minimum, skilled nursing services or nursing supervision and assistance with personal care on a daily basis. Long-term care facilities include:

(A) nursing facilities;

(B) inpatient chronic disease hospitals; and

(C) intermediate care facilities for the mentally retarded;

(18) "Medicaid" means the program operated by the department pursuant to section 17b-260 of the Connecticut General Statutes and authorized by Title XIX of the Social Security Act, as amended from time to time;

(19) "Medical necessity" or "medically necessary" have the same meaning as provided in section 17b-259b of the Connecticut General Statutes;

(20) "Nursing facility" has the same meaning as provided in 42 USC 1396r(a) and is licensed pursuant to section 19-13-D8t of the Regulations of Connecticut State Agencies as a chronic and convalescent home or a rest home with nursing supervision;

(21) "Occupational therapist" has the same meaning as provided in section 20-74a(2) of the Connecticut General Statutes;

(22) "Occupational therapy" means services provided by an occupational therapist or an occupational therapy assistant and that meet the definition of occupational therapy in 42 CFR 440.110(b);

(23) "Occupational therapy assistant" has the same meaning as provided in section 20-74a(3) of the Connecticut General Statutes;

(24) "Physical therapist" has the same meaning as provided in section 20-66 of the

Connecticut General Statutes;

(25) "Physical therapy assistant" has the same meaning as provided in section 20-66 of the Connecticut General Statutes;

(26) "Physical therapy" means the evaluation and treatment provided by a physical therapist or physical therapy assistant in accordance with 42 CFR 440.110(a);

(27) "Physician" means a person licensed pursuant to section 20-13 of the Connecticut General Statutes;

(28) "Physician assistant" has the same meaning as provided in section 20-12a(5) of the Connecticut General Statutes;

(29) "Podiatrist" means a person licensed to practice podiatric medicine pursuant to chapter 375 of the Connecticut General Statutes;

(30) "Prior authorization" means approval from the department for the provision of a service or the delivery of goods before the provider actually provides the service or delivers the goods;

(31) "Provider" means an independent therapist enrolled with Medicaid;

(32) "Provider agreement" means the signed, written agreement between the department and the provider for enrollment in Medicaid;

(33) "Speech pathologist" means a "licensed speech and language pathologist" as defined in section 20-408 of the Connecticut General Statutes;

(34) "Speech pathology services" means the evaluation and treatment provided by a speech pathologist in accordance with 42 CFR 440.110(c); and

(35) "Usual and customary charge" means the amount that the provider charges for the service or procedure in the majority of non-Medicaid cases. If the provider varies the charges so that no one amount is charged in the majority of cases, "usual and customary" means the median charge. Token charges for charity patients and other exceptional charges shall be excluded when calculating the usual and customary charge.

(Adopted effective December 1, 2000; Amended September 6, 2012)

Sec. 17b-262-632. Provider participation

In order to participate in Medicaid and receive payment from the department, providers shall:

(a) Comply with all applicable licensing, accreditation and certification requirements;

(b) comply with all departmental enrollment requirements, including sections 17b-262-522 to 17b-262-532, inclusive, of the Regulations of Connecticut State Agencies;

(c) comply with sections 17b-262-630 to 17b-262-640, inclusive, of the Regulations of Connecticut State Agencies; and

(d) have a valid provider agreement on file with the department.

(Adopted effective December 1, 2000; Amended September 6, 2012)

Sec. 17b-262-633. Eligibility

Payment for independent therapy services prescribed by a licensed practitioner is

available on behalf of all clients who have a need for such services and which are medically necessary subject to the conditions and limitations which apply to such services.

(Adopted effective December 1, 2000; Amended September 6, 2012)

Sec. 17b-262-634. Services covered and limitations

Subject to the limitations and exclusions in this section, the department shall pay for independent therapy which conforms to accepted methods of diagnosis and treatment, but shall not pay for anything of an unproven, educational, social, research, experimental or cosmetic nature; for services in excess of those deemed medically necessary by the department to treat the client's condition; or for services not directly related to the client's diagnosis, symptoms or medical history.

(a) The department shall pay for the following:

(1) Services provided in the provider's office or the client's home; and

(2) EPSDT Special Services.

(b) Limitations on covered services shall be as follows:

(1) Evaluation services for physical therapy, speech therapy, occupational therapy and audiology shall be limited to one of each type per day, per client regardless of the length of time it takes to complete the evaluation;

(2) for physical therapy and occupational therapy services, the department shall pay per modality as listed on the fee schedule;

(3) for speech therapy and audiology services, the department shall not pay for more than one and one half hours of treatment per day;

(4) the fee for evaluation shall include all treatment when evaluation and treatment are provided on the same day; and

(5) group speech therapy services shall include a maximum of three persons per group, per session regardless of each participant's payment source.

(c) The department shall not pay for the following independent therapy:

(1) Independent therapy when the client is concurrently receiving the same therapy services from a hospital, chronic disease hospital, clinic, rehabilitation clinic, home health agency or any other health care provider;

(2) services provided to clients who are residents of a hospital, long-term care facility or any other facility that is required to include independent therapy in its rates;

(3) cancelled office visits or appointments not kept; and

(4) information or services provided to a client by a provider electronically or over the telephone.

(Adopted effective December 1, 2000; Amended September 6, 2012)

Sec. 17b-262-635. Need for service

(a) The department shall pay for independent therapy that is medically necessary when a licensed practitioner prescribes the client's need for the service.

(b) A licensed practitioner shall reestablish the need for service by performing an

evaluation not more than twelve months after the previous evaluation.

(c) The provider shall document the initial and subsequent need for service in the client's record.

(Adopted effective December 1, 2000; Amended September 6, 2012)

Sec. 17b-262-636. Prior authorization

(a) Prior authorization, on forms and in a manner as specified by the department, is required for:

(1) All audiology, physical therapy, occupational therapy and speech pathology evaluation services in excess of one evaluation per calendar year, per client, per provider;

(2) all audiology, physical therapy, occupational therapy and speech pathology treatment services in excess of nine treatments per calendar year per provider per client, involving the following primary diagnoses:

(A) All mental disorders including diagnoses relating to mental retardation and specific delays in development covered by the ICD;

(B) cases involving musculoskeletal system disorders of the spine covered by the ICD; and

(C) cases involving symptoms related to nutrition, metabolism and development covered by the ICD;

(3) all audiology, physical therapy, occupational therapy and speech pathology treatment services in excess of two services per calendar week, per client, per provider;

(4) EPSDT Special Services, as follows:

(A) EPSDT Special Services are determined medically necessary on a case-by-case basis; and

(B) the request for EPSDT Special Services shall include:

(i) A written statement from a licensed practitioner justifying the need for the item or services requested; and

(ii) any other documentation required by the department in order to render a decision; and

(5) any service that is not on the department's fee schedule.

(b) The length of the initial authorization period is at the department's discretion, but shall be for no longer than three months;

(c) If prior authorization is needed beyond the initial authorization period, requests for continued treatment beyond the initial authorization period shall be considered up to six months per request or longer if determined appropriate by the department on a case- by-case basis.

(d) For services requiring prior authorization, a provider shall provide pertinent medical or social information adequate to evaluate the client's medical need for the services.

(e) In order to receive payment from the department, a provider shall comply with all prior authorization requirements. The department, in its sole discretion, determines what information is necessary in order to approve a prior authorization request. Prior authorization

does not guarantee payment unless all other requirements for payment are met.

(Adopted effective December 1, 2000; Amended September 6, 2012)

Sec. 17b-262-637. Billing procedures

Providers shall submit claims on a hard copy invoice or by electronic transmission to the department in a form and manner specified by the department, together with all information required by the department to process the claim for payment.

(Adopted effective December 1, 2000; Amended September 6, 2012)

Sec. 17b-262-638. Payment

(a) Payment rates shall be the same for in-state, border and out-of-state providers.

(b) Payment shall be made at the lowest of:

(1) The provider's usual and customary charge;

(2) the lowest Medicare rate;

(3) the amount in the independent therapy fee schedule as published by the department;

(4) the amount billed by the provider; or

(5) the lowest price charged or accepted for the same or substantially similar goods or services by the provider from any person or entity.

(c) Notwithstanding the provisions of subsection (b)(5) of this section and subject to the approval of the department, a provider may charge or accept a lesser amount based on a showing by the provider of financial hardship to an individual without affecting the amount paid by the department for the same or substantially similar goods or services.

(Adopted effective December 1, 2000; Amended September 6, 2012)

Sec. 17b-262-639. Payment rates

The commissioner shall establish the fees contained in the department's fee schedule pursuant to section 4-67c of the Connecticut General Statutes.

(Adopted effective December 1, 2000; Amended September 6, 2012)

Sec. 17b-262-640. Documentation

(a) Providers shall maintain a specific record for all services provided to each client including, but not limited to: name, address, birth date, Medicaid identification number, pertinent diagnostic information, a current treatment plan and treatment notes signed by the provider, documentation of services provided and the dates the services were provided.

(b) The provider shall maintain all required documentation in its original form, paper or electronic, for at least five years or longer, as required by applicable statutes and regulations in the provider's file, subject to review by authorized department personnel. In the event of a dispute concerning a service provided, the provider shall maintain the documentation until the end of the dispute or five years, whichever is greater.

(c) The department may disallow and recover any amounts paid to the provider for which the required documentation is not maintained and not provided to the department upon

request.

(d) The department may audit any relevant records and documentation and take any other appropriate quality assurance measures it deems necessary to assure compliance with all regulatory and statutory requirements.

(Adopted effective December 1, 2000; Amended September 6, 2012)

Requirements for Payment of Laboratory Services

Sec. 17b-262-641. Scope

Sections 17b-262-641 through 17b-262-650, inclusive, of the Regulations of Connecticut State Agencies set forth the Department of Social Services requirements for payment of laboratory services provided by licensed clinical laboratories, in settings other than hospital inpatient or outpatient departments or a physician's, nurse-midwife's, or nurse practitioner's office, for clients who are determined eligible to receive services under Connecticut's Medicaid Program pursuant to section 17b-262 of the Connecticut General Statutes (CGS).

(Adopted effective May 10, 2000)

Sec. 17b-262-642. Definitions

For the purposes of sections 17b-262-641 through 17b-262-650, inclusive, of the Regulations of Connecticut State Agencies the following definitions shall apply:

(1) **"Client"** means a person eligible for goods or services under the department's Medicaid Program.

(2) **"Commissioner"** means the Commissioner of Social Services appointed pursuant to section 17b-1(a) of the Connecticut General Statutes.

(3) **"Department"** means the Department of Social Services or its agent.

(4) **"HealthTrack Services"** means the services described in section 1905(r) of the Social Security Act.

(5) **"HealthTrack Special Services"** means medically necessary and medically appropriate health care, diagnostic services, treatment, or other measures necessary to correct or ameliorate disabilities and physical and mental illnesses and conditions discovered as a result of a periodic comprehensive health screening or interperiodic encounter. Such services are provided in accordance with section 1905(r)(5) of the Social Security Act, and are:

(A) services not covered under the State Plan or contained in a fee schedule published by the department; or

(B) services covered under the State Plan and contained in a fee schedule published by the department which exceed the limit on the amount of services established by the department that are contained in regulation.

(6) **"Interperiodic Encounter"** means any medically necessary visit to a Connecticut Medicaid provider, other than for the purpose of performing a periodic comprehensive health screening. Such encounters include, but are not limited to, physician's office visits,

clinic visits, and other primary care visits.

(7) **"Laboratory"** means a licensed clinical laboratory as defined in section 19a-30 of the Connecticut General Statutes and which is independent of a physician's, nurse-midwife's, or nurse practitioner's office, or an inpatient or outpatient hospital department or clinic.

(8) **"Licensed Practitioner of the Healing Arts"** means a professional person providing health care pursuant to a license issued by the Department of Public Health (DPH).

(9) **"Medical Appropriateness or Medically Appropriate"** means health care that is provided in a timely manner and meets professionally recognized standards of acceptable medical care; is delivered in the appropriate medical setting; and is the least costly of multiple, equally-effective, alternative treatments or diagnostic modalities.

(10) **"Medicaid"** means the program operated by the department pursuant to section 17b-260 of the Connecticut General Statutes and authorized by Title XIX of the Social Security Act.

(11) **"Medical Necessity or Medically Necessary"** means health care provided to correct or diminish the adverse effects of a medical condition or mental illness; to assist an individual in attaining or maintaining an optimal level of health; to diagnose a condition; or prevent a medical condition from occurring.

(12) **"Panel or Profile Tests"** means certain multiple tests performed on a single specimen or material derived from the human body which are related to a condition, disorder, or family of disorders, which when combined mathematically or otherwise, comprise a finished identifiable laboratory study or studies.

(13) **"Prior Authorization"** means approval for the provision of a service or the delivery of goods from the department before the provider actually provides the service or delivers the goods.

(14) **"Provider"** means a laboratory which provides testing and analysis services and which is independent of a physician's, nurse-midwife's, or nurse practitioner's office, or an inpatient or outpatient hospital department.

(15) **"Provider Agreement"** means the signed, written, contractual agreement between the department and the provider of services or goods.

(16) **"State Plan"** means the document which contains the services covered by the Connecticut Medicaid Program in compliance with 42 CFR 430(B).

(Adopted effective May 10, 2000)

Sec. 17b-262-643. Provider participation

In order to enroll in the Medicaid Program and receive payment from the department, providers shall:

(1) be in compliance with the provisions of the Clinical Laboratories Improvement Amendments (CLIA) of 1988 for the procedures performed at the laboratory for which claims are submitted, including but not limited to, 42 CFR 493.1809;

(2) meet and maintain all applicable licensing, accreditation, and certification

requirements;

(3) meet and maintain all departmental enrollment requirements; and

(4) have a valid provider agreement on file which is signed by the provider and the department upon application for enrollment into the Medicaid Program. This agreement, which shall be periodically updated, shall continue to be in effect for the duration of the agreement or for the stated period in the agreement. The provider agreement specifies conditions and terms which govern the program and to which the provider is mandated to adhere in order to participate in the program.

(Adopted effective May 10, 2000)

Sec. 17b-262-644. Eligibility

Payment for independent clinical laboratory services shall be available on behalf of all persons eligible for the Medicaid Program subject to the conditions and limitations which apply to these services.

(Adopted effective May 10, 2000)

Sec. 17b-262-645. Services covered and limitations

(a) The department shall pay for the following:

(1) medically appropriate and medically necessary clinical laboratory services, for which the laboratory holds certification according to the provisions of CLIA, which are listed in the department's fee schedule; and

(2) for HealthTrack and HealthTrack Special Services.

(b) Limitations on covered services shall be as follows:

(1) payment shall not be made for laboratory fees to the physician, nurse-midwife, nurse practitioner, or referring laboratories for services performed in a separate private laboratory;

(2) when laboratory services are performed in a private laboratory, billing for the service shall be made by the laboratory. Payment shall not be made to the referring physician, nurse-midwife, nurse practitioner, or to another laboratory which has referred the specimen to the performing laboratory for testing;

(3) payment shall not be made for testing and analysis which is available free of charge; and

(4) payment shall not be made for any procedures or services of an unproven, educational, social, research, experimental, or cosmetic nature; for services in excess of those deemed medically necessary and medically appropriate to treat the client's condition; or for services not directly related to the client's diagnosis, symptoms, or medical history.

(Adopted effective May 10, 2000)

Sec. 17b-262-646. Need for service

The department shall pay for medically necessary and medically appropriate testing and analysis services only when ordered by a licensed physician or other licensed practitioner

of the healing arts.

(Adopted effective May 10, 2000)

Sec. 17b-262-647. Prior authorization

(a) Prior authorization, on forms and in a manner as specified by the department, is required for HealthTrack Special Services. HealthTrack Special Services are determined medically necessary and medically appropriate on a case-by-case basis. The request for HealthTrack Special Services shall include:

(1) a written statement from the prescribing physician, or other licensed practitioner of the healing arts, performing such services within his or her respective scope of practice as defined under state law, justifying the need for the item or service requested;

(2) a description of the outcomes of any alternative measures tried; and

(3) if applicable and requested by the department, any other documentation required in order to render a decision.

(b) In order to receive payment from the department a provider shall comply with all prior authorization requirements. The department in its sole discretion determines what information is necessary in order to approve a prior authorization request. Prior authorization does not, however, guarantee payment unless all other requirements for payment are met.

(Adopted effective May 10, 2000)

Sec. 17b-262-648. Billing procedures

(a) Claims from providers shall be submitted on the department's designated form or electronically transmitted to the department's fiscal agent and shall include all information required by the department to process the claim for payment.

(b) Laboratory services performed in a physician's, nurse-midwife's, or nurse practitioner's office shall be payable pursuant to respective Regulations of Connecticut State Agencies which describe these services.

(c) Payment for services performed in a laboratory shall not be made to the referring physician, nurse-midwife, or nurse practitioner.

(d) Payment for the components of a panel or profile of tests consists of the following:

(1) the sum of any number of the components of a panel or profile of tests shall not exceed the total charged for the group offering, the panel or profile, whether done by automation or bench testing and whether or not the equipment is available in the facility where some Medicaid Program clients reside; and

(2) where multiple tests constitute a panel or profile, they shall be billed in that manner.

(Adopted effective May 10, 2000; Amended November 4, 2005)

Sec. 17b-262-649. Payment

(a) Payment shall be made at the lowest of:

(1) the provider's usual and customary charge to the general public;

(2) the lowest Medicare rate;

(3) the amount in the applicable fee schedule as published by the department;

(4) the amount billed by the provider; or

(5) the lowest price charged or accepted for the same or substantially similar goods or services by the provider from any person or entity.

(b) Notwithstanding the provisions of subsection (a) of this section and subject to the approval of the department, a provider may charge or accept a lesser amount based on a showing by the provider of financial hardship to an individual enrollee without affecting the amount paid by the department for the same or substantially similar goods or services.

(c) **Payment Rate**

The commissioner establishes the fees contained in the department's published fee schedule for independent clinical laboratories pursuant to section 4-67c of the Connecticut General Statutes.

(d) **Payment Limitations**

(1) A specimen collection fee by an independent clinical laboratory is limited to specimen collection by venipuncture or catherization.

(2) One specimen collection fee is permitted per encounter. A physician or duly authorized practitioner of the healing arts shall order the collection, and the order shall include the covered procedure or procedures from the independent clinical laboratory fee schedule. Payment shall be made to the provider performing the collection.

(Adopted effective May 10, 2000)

Sec. 17b-262-650. Documentation

(a) Independent clinical laboratory providers shall maintain a specific record for all services received for each client eligible for Medicaid Program payment including, but not limited to: name, address, birth date, Medicaid Program identification number, pertinent diagnostic information, documentation of services provided, and the dates the services were provided.

(b) All required documentation shall be maintained for at least five years in the provider's file subject to review by authorized department personnel. In the event of a dispute concerning a service provided, documentation shall be maintained until the end of the dispute or five years, whichever is greater.

(c) Failure to maintain all required documentation shall result in the disallowance and recovery by the department of any amounts paid to the provider for which required documentation is not maintained or provided to the department upon request.

(Adopted effective May 10, 2000)

Requirements for Payment of Dialysis Services

Sec. 17b-262-651. Scope

Sections 17b-262-651 through 17b-262-660, inclusive, of the Regulations of Connecticut State Agencies set forth the Department of Social Services requirements for payment of

dialysis services provided by physicians, general hospitals, and freestanding dialysis clinics for clients who are determined eligible to receive services under Connecticut's Medicaid Program pursuant to section 17b-262 of the Connecticut General Statutes (CGS).

(Adopted effective May 10, 2000)

Sec. 17b-262-652. Definitions

For the purposes of sections 17b-262-651 through 17b-262-660, inclusive, of the Regulations of Connecticut State Agencies the following definitions shall apply:

(1) **"Border Hospital"** means an out-of-state general hospital which has a common medical delivery area with the State of Connecticut and is deemed a border hospital by the department on a hospital by hospital basis.

(2) **"Client"** means a person eligible for goods or services under the department's Medicaid Program.

(3) **"Commissioner"** means the Commissioner of Social Services appointed pursuant to section 17b-1(a) of the Connecticut General Statutes.

(4) **"Department"** means the Department of Social Services or its agent.

(5) **"Dialysis"** means dialysis as defined in 42 CFR 405.2102.

(6) **"Freestanding Dialysis Clinic"** means those centers licensed by the Department of Public Health (DPH) and certified, pursuant to section 19-13-D55a of the Regulations of Connecticut State Agencies, to provide dialysis services.

(7) **"General Hospital"** means a short-term acute care hospital having facilities, medical staff, and all necessary personnel to provide diagnosis, care, and treatment of a wide range of acute conditions, including injuries. This includes a children's general hospital. It shall also include a border hospital.

(8) **"HealthTrack Services"** means the services described in section 1905(r) of the Social Security Act.

(9) **"HealthTrack Special Services"** means medically necessary and medically appropriate health care, diagnostic services, treatment, or other measures necessary to correct or ameliorate disabilities and physical and mental illnesses and conditions discovered as a result of a periodic comprehensive health screening or interperiodic encounter. Such services are provided in accordance with section 1905(r)(5) of the Social Security Act, and are:

(A) services not covered under the State Plan or contained in a fee schedule published by the department; or

(B) services covered under the State Plan and contained in a fee schedule published by the department which exceed the limit on the amount of services established by the department that are contained in regulation.

(10) **"Home"** means the client's place of residence which includes a boarding home or residential care home. Home does not include a hospital, chronic disease hospital, nursing facility or intermediate care facility for the mentally retarded (ICF/MR).

(11) **"Interperiodic Encounter"** means any medically necessary visit to a Connecticut

Medicaid provider, other than for the purpose of performing a periodic comprehensive health screening. Such encounters include, but are not limited to, physician's office visits, clinic visits, and other primary care visits.

(12) **"Licensed Practitioner of the Healing Arts"** means a professional person providing health care pursuant to a license issued by the Department of Public Health (DPH).

(13) **"Medical Appropriateness or Medically Appropriate"** means health care that is provided in a timely manner and meets professionally recognized standards of acceptable medical care; is delivered in the appropriate medical setting; and is the least costly of multiple, equally-effective, alternative treatments or diagnostic modalities.

(14) **"Medicaid"** means the program operated by the department pursuant to section 17b-260 of the Connecticut General Statutes and authorized by Title XIX of the Social Security Act.

(15) **"Medical Necessity or Medically Necessary"** means health care provided to correct or diminish the adverse effects of a medical condition or mental illness; to assist an individual in attaining or maintaining an optimal level of health; to diagnose a condition; or prevent a medical condition from occurring.

(16) **"Medical Record"** means medical record as defined in section 19a-14-40 of the Regulations of Connecticut State Agencies, which is part of the Public Health Code.

(17) **"Physician"** means a physician licensed pursuant to section 20-1 of the Connecticut General Statutes or a doctor of osteopathy licensed pursuant to section 20-17 of the Connecticut General Statutes.

(18) **"Prior Authorization"** means approval for the provision of a service or the delivery of goods from the department before the provider actually provides the service or delivers the goods.

(19) **"Provider"** means:

(A) a physician;

(B) a general hospital—inpatient or outpatient; or

(C) a freestanding dialysis clinic licensed by the Department of Public Health (DPH) and certified, pursuant to section 19-13-D55a of the Regulations of Connecticut State Agencies, to provide dialysis services.

(20) **"Provider Agreement"** means the signed, written, contractual agreement between the department and the provider of services or goods.

(21) **"State Plan"** means the document which contains the services covered by the Connecticut Medicaid Program in compliance with 42 CFR(430)(B).

(Adopted effective May 10, 2000)

Sec. 17b-262-653. Provider participation

In order to enroll in the Medicaid Program and receive payment from the department, providers shall:

(1) meet and maintain all applicable licensing, accreditation, and certification

requirements;

(2) meet and maintain all departmental enrollment requirements; and

(3) have a valid provider agreement on file which is signed by the provider and the department upon application for enrollment into the Medicaid Program. This agreement, which will be periodically updated, shall continue to be in effect for the duration of the agreement or for the stated period in the agreement. The provider agreement specifies conditions and terms which govern the program and to which the provider is mandated to adhere in order to participate in the program.

(Adopted effective May 10, 2000)

Sec. 17b-262-654. Eligibility

Payment for dialysis services shall be available on behalf of all persons eligible for the Medicaid Program subject to the conditions and limitations which apply to these services.

(Adopted effective May 10, 2000)

Sec. 17b-262-655. Services covered and limitations

Subject to the limitations and exclusions listed below and those set forth in the Regulations of Connecticut State Agencies dealing with physicians, general hospitals, and freestanding dialysis clinics, the department shall pay for dialysis services which conform to accepted methods of diagnosis and treatment.

(a) The department shall pay for the following:

(1) for services provided by an enrolled provider in a home, clinic, hospital, or institution having an organized and approved dialysis program; and

(2) for HealthTrack Services and HealthTrack Special Services.

(b) The department shall not pay for the following:

(1) cancelled office visits and appointments not kept;

(2) information or services provided to a client by a provider over the telephone;

(3) any examinations, laboratory tests, biological products, immunizations, or other products which are furnished free of charge; and

(4) for any procedures or services of an unproven, educational, social, research, experimental, or cosmetic nature; for any diagnostic, therapeutic, or treatment services in excess of those deemed medically necessary and medically appropriate by the department to treat the client’s condition; or for services not directly related to the client’s diagnosis, symptoms, or medical history.

(Adopted effective May 10, 2000)

Sec. 17b-262-656. Need for service and authorization process

(a) The department shall pay for medically necessary and medically appropriate dialysis services for Medicaid Program clients, in relation to the diagnosis for which care is required, provided that:

(1) the services are within the scope of the provider’s practice;

(2) a physician documents the need in writing and orders the service; and

(3) the services are made part of the client's medical record.

(b) Prior authorization, on forms and in a manner as specified by the department, is required for HealthTrack Special Services:

(1) HealthTrack Special Services are determined medically necessary and medically appropriate on a case-by-case basis; and

(2) the request for HealthTrack Services shall include:

(A) a written statement from the prescribing physician, or other licensed practitioner of the healing arts, performing such services within his or her scope of practice as defined under state law, justifying the need for the item or services requested;

(B) a description of the outcomes of any alternative measures tried; and

(C) if applicable and requested by the department, any other documentation required in order to render a decision.

(c) The procedure or course of treatment authorized shall be initiated within six months of the date of authorization.

(d) The initial authorization period shall be up to three months.

(e) If prior authorization is needed beyond the initial authorization period, requests for continued treatment beyond the initial authorization period shall be considered up to six months per request.

(f) For services requiring prior authorization, a provider shall be required to provide pertinent medical or social information adequate for evaluating the client's medical need for services. Except in emergency situations, or when authorization is being requested for more than one visits in the same day, approval shall be received before services are rendered.

(g) In an emergency situation which occurs after working hours or on a weekend or holiday, the provider shall secure verbal approval on the next working day for the services provided. This applies to only those services which normally require prior authorization.

(h) In order to receive payment from the department a provider shall comply with all prior authorization requirements. The department in its sole discretion determines what information is necessary in order to approve a prior authorization request. Prior authorization does not, however, guarantee payment unless all other requirements for payment are met.

(Adopted effective May 10, 2000)

Sec. 17b-262-657. Billing procedures

Claims from providers shall be submitted on the department's designated form or electronically transmitted to the department's fiscal agent and shall include all information required by the department to process the claim for payment.

(Adopted effective May 10, 2000)

Sec. 17b-262-658. Payment

(a) Payment shall be made at the lowest of:

(1) the provider's usual and customary charge to the general public;

(2) the lowest Medicare rate;
(3) the amount in the applicable fee schedule as published by the department;
(4) the amount billed by the provider; or
(5) the lowest price charged or accepted for the same or substantially similar goods or services by the provider from any person or entity.

(b) Notwithstanding the provisions of subsection (a) of this section and subject to the approval of the department, a provider may charge or accept a lesser amount based on a showing by the provider of financial hardship to an individual enrollee without affecting the amount paid by the department for the same or substantially similar goods or services.

(Adopted effective May 10, 2000)

Sec. 17b-262-659. Payment rate

(a) The commissioner establishes the fees contained in the provider's fee schedule pursuant to section 4-67c of the Connecticut General Statutes.

(b) Payment rates for physicians and physician groups are found in the department's fee schedule for physicians' services.

(c) Payment rates for dialysis services performed by freestanding dialysis clinics shall be based on the fee published by the department and contained in the department's fee schedule for clinics.

(d) Payment rates for dialysis services performed in a hospital on an inpatient basis are paid through the inpatient hospital interim per diem rate and published in the department's fee schedule for general hospital inpatient services.

(e) Payment rates for dialysis services performed in a hospital on an outpatient basis are paid as published in the department's fee schedule for general hospital outpatient services.

(Adopted effective May 10, 2000)

Sec. 17b-262-660. Documentation

(a) Providers shall maintain a specific medical record for all services received for each client eligible for Medicaid Program payment including, but not limited to: name, address, birth date, Medicaid identification number, pertinent diagnostic information, documentation of services provided, and the dates the services were provided.

(b) All required documentation shall be maintained for at least five years in the provider's file subject to review by authorized department personnel. In the event of a dispute concerning a service provided, documentation shall be maintained until the end of the dispute or five years, whichever is greater.

(c) Failure to maintain all required documentation shall result in the disallowance and recovery by the department of any amounts paid to the provider for which the required documentation is not maintained or provided to the department upon request.

(Adopted effective May 10, 2000)

Sec. 17b-262-661—17b-262-671. Reserved

Requirements for Payment of Durable Medical Equipment

Sec. 17b-262-672. Scope

Sections 17b-262-672 through 17b-262-682 of the Regulations of Connecticut State Agencies set forth the Department of Social Services requirements for the payment of durable medical equipment (DME) to providers, for clients who are determined eligible to receive services under Connecticut Medicaid pursuant to section 17b-262 of the Connecticut General Statutes (CGS).

(Adopted effective August 22, 2000)

Sec. 17b-262-673. Definitions

For the purposes of sections 17b-262-672 through 17b-262-682 of the Regulations of Connecticut State Agencies, the following definitions shall apply:

(1) "Chronic disease hospital" means an institution as defined in section 19-13-D1 of the Regulations of Connecticut State Agencies;

(2) "Client" means a person eligible for goods or services under the Medicaid program;

(3) "Certificate of Medical Necessity" or "CMN" means an approved Medicare form or a similar form which has been submitted to and approved by the department for use. This form shall contain all the documentation required for DME;

(4) "Commissioner" means the commissioner of social services;

(5) "Customized equipment" means devices or equipment prescribed by a licensed practitioner which is specifically manufactured to meet the special medical, physical, and psychosocial needs of the client. The equipment shall be individualized to preclude its use by any other person except the client for whom it was originally developed;

(6) "Department" means the department of social services or its agent;

(7) "Documented in writing" means that the prescription has been handwritten, typed, or computer printed;

(8) "Durable medical equipment" or "DME" means equipment that meets all of the following requirements:

(A) can withstand repeated use;

(B) is primarily and customarily used to serve a medical purpose;

(C) generally is not useful to a person in the absence of an illness or injury; and

(D) is nondisposable;

(9) "Equipment replacement" means any item that takes the place of original equipment lost, destroyed, or no longer medically useable or adequate;

(10) "Home" means the client's place of residence which includes a boarding home, community living arrangement, or residential care home. Home does not include facilities such as hospitals, chronic disease hospitals, nursing facilities, intermediate care facilities for the mentally retarded (ICFs/MR), or other facilities that are paid an all inclusive rate directly by Medicaid for the care of the client;

(11) "Hospital" means an institution as defined in Section 19-13-D1(b)(1) of the Regulations of Connecticut State Agencies;

(12) "Intermediate care facility for the mentally retarded" or "ICF/MR" means an institution licensed by, or operated by, the department of mental retardation (DMR) according to state law, and certified as a Medicaid intermediate care facility for the mentally retarded by the department of public health (DPH) to provide health or rehabilitative services for individuals with mental retardation or related conditions who, because of their mental or physical condition, require care and services, above the level of room and board, which can be made available to them only through a residential facility. Individuals residing in an ICF/MR shall be receiving active treatment pursuant to 42 CFR 483.440(a);

(13) "Licensed practitioner" means any person licensed by the state of Connecticut, any other state, District of Columbia, or the Commonwealth of Puerto Rico and authorized to prescribe treatments within the scope of his or her practice as defined and limited by federal and state law;

(14) "Manufactured" means constructed or assembled;

(15) "Medical appropriateness" or "medically appropriate" means health care that is provided in a timely manner and meets professionally recognized standards of acceptable medical care; is delivered in the appropriate setting; and is the least costly of multiple, equally-effective, alternative treatments or diagnostic modalities;

(16) "Medicaid" means the program operated by the department of social services pursuant to section 17b-260 of the Connecticut General Statutes and authorized by Title XIX of the Social Security Act;

(17) "Medical necessity" or "medically necessary" means health care provided to correct or diminish the adverse effects of a medical condition or mental illness; to assist an individual in attaining or maintaining an optimal level of health; to diagnose a condition; or to prevent a medical condition from occurring;

(18) "Nursing facility" or "NF" means an institution as defined in 42 USC 1396r(a);

(19) "Prescription" means an original order issued by a licensed practitioner that is documented in writing and signed by the practitioner issuing the order;

(20) "Prior authorization" or "PA" means approval for the service or the delivery of goods from the department before the provider actually provides the service or delivers the goods;

(21) "Provider" means the vendor or supplier of durable medical equipment who is enrolled with the department as a medical equipment, devices, and supplies supplier; and

(22) "Provider agreement" means the signed, written, contractual agreement between the department and the provider of services or goods.

(Adopted effective August 22, 2000)

Sec. 17b-262-674. Provider participation

In order to enroll in the Medicaid program and receive payment from the department, providers shall comply with sections 17b-262-522 to 17b-262-533, inclusive, of the

Regulations of Connecticut State Agencies.

(Adopted effective August 22, 2000)

Sec. 17b-262-675. Eligibility

Payment for DME and related equipment is available for Medicaid clients who have a medical need for such equipment which meets the department's definition of DME when the item is prescribed by a licensed practitioner, subject to the conditions and limitations set forth in sections 17b-262-672 to 17b-262-682, inclusive, of the Regulations of Connecticut State Agencies.

(Adopted effective August 22, 2000)

Sec. 17b-262-676. Services covered and limitations

(a) **Services Covered**

(1) The department shall pay for the purchase or rental and the repair of DME, except as limited by sections 17b-262-672 to 17b-262-682, inclusive, of the Regulations of Connecticut State Agencies, that conforms to accepted methods of diagnosis and treatment and is medically necessary and medically appropriate.

(2) DME services are available to all clients who live at home. Additionally, the department shall pay for ventilators, customized wheelchairs, and Group 2 Pressure Reducing Support Surfaces for residents of nursing facilities and ICFs/MR.

(3) The department shall maintain a non-exclusive fee schedule of items which it has already determined meet the department's definition of DME and for which coverage shall be provided to eligible clients, subject to the conditions and limitations set forth in sections 17b-262-672 to 17b-262-682, inclusive, of the Regulations of Connecticut State Agencies. This fee schedule includes, but is not limited to:

(A) wheelchairs and accessories;

(B) walking aides, such as walkers, canes, and crutches;

(C) bathroom equipment such as commodes and safety equipment;

(D) inhalation therapy equipment such as IPPB machines, suction machines, nebulizers, and related equipment;

(E) hospital beds and accessories; and

(F) enteral/parenteral therapy equipment.

(4) When the item for which Medicaid coverage is requested is not on the department's fee schedule, prior authorization is required by the department. The recipient requesting Medicaid coverage for a prescribed item not on the list shall submit such prior authorization request to the department through an enrolled provider of DME. Such request shall include a signed prescription and shall include documentation showing the recipient's medical need for the prescribed item. If the item for which Medicaid coverage is requested is not on the department's fee schedule, the provider shall also include documentation showing that the item meets the department's definition of DME and is medically appropriate for the client requesting coverage of such item.

(5) In the last quarter of each calendar year, the department shall make modifications to its non-exclusive DME fee schedule. In deciding which items to add to this schedule, the department shall give consideration to:

(A) items requested for individual consideration through the process described in subdivision (4) of this subsection;

(B) input from the provider community; and

(C) input from the consumer community.

Providers and consumers who wish to provide input may make suggestions to the department's Medical Operations unit. Any suggestions shall be considered during the department's annual modification of its fee schedule.

(b) **Limitations**

(1) The department shall not pay for anything of an unproven, experimental or research nature or for services in excess of those deemed medically necessary by the department to treat the recipient's condition or for services not directly related to the recipient's diagnosis, symptoms, or medical history.

(2) Notwithstanding any other provisions of the Regulations of Connecticut State Agencies, the department shall pay for customized wheelchairs for clients of nursing facilities and ICFs/MR only when such customized wheelchairs are medically necessary in accordance with section 17-134d-46 or section 17-134d-47 of the Regulations of Connecticut State Agencies. The department shall pay for the purchase, modification or repair of these customized wheelchairs. The customized wheelchair may or may not be motorized. The need for the customized wheelchair shall be documented in accordance with section 17-134d-46 or section 17-134d-47 of the Regulations of Connecticut State Agencies.

(Adopted effective August 22, 2000)

Sec. 17b-262-677. Services not covered

The Department shall not pay DME providers for:

(1) standard or stock DME items prescribed and ordered for a client who:

(A) dies prior to delivery of the item, or

(B) is not otherwise eligible on the date of delivery. It shall be the provider's responsibility to verify that the client is eligible on the date the item is delivered;

(2) the purchase or repair of DME necessitated by inappropriate, willful, or malicious misuse on the part of the client as determined by the department;

(3) the repairs and maintenance of DME furnished on a rental basis. The rental fee shall cover the services necessary to maintain the equipment in working order;

(4) DME supplied to clients in hospitals or chronic disease hospitals; and

(5) any service or item not identified as covered in sections 17b-262-672 to 17b-262-682, inclusive, of the Regulations of Connecticut State Agencies, unless it is approved in accordance with section 17b-262-676(a)(4) of the Regulations of Connecticut State Agencies.

(Adopted effective August 22, 2000)

Sec. 17b-262-678. Prior authorization

(a) In order to receive reimbursement from the department a provider shall comply with all prior authorization requirements. The department in its sole discretion determines what information is necessary in order to approve a prior authorization request. Prior authorization does not, however, guarantee payment unless all other requirements are met.

(b) The department requires prior authorization for: 1) any item identified on the department's published fee schedule as requiring prior authorization; and 2) any item requested under section 17b-262-676(a)(4) of the Regulations of Connecticut State Agencies.

(c) A PA request, on forms and in a manner as specified by the department, shall include documentation of medical need and shall be signed by the prescribing licensed practitioner and the supplier. A copy of the prescription from the licensed practitioner may be attached to the completed PA request in lieu of the actual signature of the licensed practitioner on the PA request form. The licensed practitioner's original prescription shall be on file with the provider and subject to review by the department.

(d) A provider may FAX in prior authorization requests that are medically necessary to: 1) facilitate institutional discharge, or 2) avoid imminent hospitalization. Specifics that substantiate the nature of the request need to be clearly documented. Other PA requests for DME shall be submitted by mail.

(e) The initial authorization period for the rental of DME is determined by the department. If the medical need continues beyond the initial authorization period, a request for the extension of the authorization shall be submitted to the department with documentation by a licensed practitioner that service continues to be medically necessary. Such request and documentation shall arrive at the department prior to the start date of the extension or prior authorization shall be denied.

(f) Providers shall include an estimated delivery date when submitting a request for prior authorization, allowing for the department to take up to four weeks to process the request. The department shall share such estimated date with the client so that expectations for service delivery can be clear. Prior authorizations that do not include an estimated delivery date shall be denied.

(Adopted effective August 22, 2000)

Sec. 17b-262-679. Billing procedure

(a) Claims from DME providers shall be submitted on a hard copy invoice or electronically transmitted to the department or its agent, in a form and manner as specified by the department, and shall include all information required by the department to process the claim for payment.

(b) Claims submitted for DME not requiring prior authorization shall include the name of the licensed practitioner or clinic making the referral. A licensed practitioner's original prescription for these items shall be on file with the provider and shall be subject to review by the department.

(c) DME providers shall bill and the department shall pay at the lowest of:
(1) the usual and customary charge to the general public;
(2) the lowest Medicare rate;
(3) the amount in the applicable fee schedule as published by the department;
(4) the amount prior authorized in writing by the department; or
(5) the lowest price charged or accepted for the same or substantially similar goods or services by the provider from any person or entity.
(d) Notwithstanding the provisions of subsection (c)(5) of this section and subject to the approval of the department, a provider may charge or accept a lesser amount based on a showing by the provider of financial hardship to an individual without affecting the amount paid by the department for the same or substantially similar goods or services.

(Adopted effective August 22, 2000)

Sec. 17b-262-680. Payment limitations

(a) Payment shall be made for customized DME for a client who dies or is not otherwise eligible on the date of delivery providing the client was eligible:
(1) on the date prior authorization was given by the department; or
(2) on the date the client ordered the item, if the item does not require prior authorization. For purposes of this section, the date the client orders the item means the date on which the written medical order for the item is presented to the provider. The provider shall verify to the department the date the client ordered the item.
(b) If the cost of repairs to any item exceeds its replacement cost, the item shall be replaced.
(c) The price for any item listed in the fee schedule published by the department shall include:
(1) fees for initial fittings and adjustments and related transportation costs;
(2) labor charges;
(3) delivery costs, fully prepaid by the provider, including any and all manufacturer's delivery charges with no additional charges to be made for packing or shipping;
(4) travel to the client's home, postage and handling, and set up or installation charges;
(5) technical assistance to the client to teach the client, or his or her family, the proper use and care of the equipment; and
(6) information furnished by the provider to the client over the telephone.
(d) Payment for servicing, repairs, or replacement of DME that are purchased by the department shall be contingent upon the exhaustion of any manufacturer's or dealer's warranty. The supplier shall first utilize existing warranties covering required servicing, repairs, and replacement.
(e) The department may pay for the rental of a wheelchair, for a period not to exceed three (3) months, in situations involving the pending delivery of a customized model to a client who resides in his or her own home.
(f) The department has the authority to determine the maximum rental period for DME,

at which time the item shall be considered purchased. Such maximum rental periods shall be published on the fee schedule.

(Adopted effective August 22, 2000)

Sec. 17b-262-681. Documentation

(a) All required documentation shall be maintained for at least five (5) years in the DME provider's file subject to review by the department. In the event of a dispute concerning a service or an item provided, documentation shall be maintained until the end of the dispute or five (5) years, whichever is greater.

(b) Failure to maintain all required documentation shall result in the disallowance and recovery by the department of any amounts paid to the DME provider for the item or service for which the required documentation is not maintained or provided to the department upon request.

(c) The licensed practitioner's original prescription for DME shall be on file with the DME provider and shall be subject to review by the department. Such prescription shall specify the items ordered.

(d) The department requires that DME providers maintain fiscal and medical records to fully disclose services and goods rendered or delivered to Medicaid clients. A new prescription is required prior to replacement of DME.

(e) A signed receipt is required for all deliveries of DME, documenting that the client or, if the client is unable to sign, a designated representative other than the DME provider or the DME provider's employees, took delivery of the item. The receipt for DME, regardless of format used, shall, at a minimum, contain the following elements:

(1) provider's name;

(2) client's name;

(3) itemization of DME delivered, including:

(A) product description;

(B) brand name;

(C) model name and number;

(D) serial number (if applicable);

(E) quantity delivered;

(F) amount billed per item; and

(4) date of delivery.

(f) All prescriptions for DME regardless of format used (e.g., CMN, prescription pad, or letter) shall, at a minimum, contain the following elements:

(1) the client's name, address, and date of birth;

(2) diagnosis for which the DME is required;

(3) detailed description of the DME, including quantities and any special options or add-ons;

(4) length of need for the DME use;

(5) name and address of prescribing practitioner; and

(6) prescribing practitioner's signature and date signed.

(g) All requests for purchase of DME to replace an item shall be fully explained, documenting the continuing medical necessity and including reasons for the replacement and the reason that repairs are not feasible or are more costly than replacement.

(Adopted effective August 22, 2000)

Sec. 17b-262-682. Other

(a) All equipment or devices purchased by the department shall be new and shall become the property of the client as of the date of delivery to the client.

(b) Where brand names or stock or model numbers are specified on the prescription or the PA, no substitution shall be permitted without the written approval of the department.

(c) Used equipment when rented shall be completely refurbished and in proper condition to meet the client's specific medical need.

(d) The provider shall instruct the client, or his or her family, on the proper use and care of the equipment. This instruction shall be provided as a part of the cost of the item. Additionally, the services and items shall be appropriate to both the environment and the client's current medical necessity.

(e) When the DME item is delivered, the provider shall ensure that proper assembly occurs and that the item meets the client's needs.

(f) DME providers shall notify the department of returns of DME items delivered to a client. Providers shall initiate necessary reimbursement adjustments resulting from such returns.

(g) It shall be the department's decision to rent or purchase DME, except in cases where the rental or payment option is determined by the primary payor source.

(Adopted effective August 22, 2000)

Sec. 17b-262-683. Reserved

Requirements for Payment Under the Connecticut Pharmaceutical Assistance Contract to the Elderly and the Disabled (ConnPACE)

Sec. 17b-262-684. Scope

Sections 17b-262-684 to 17b-262-692, inclusive, of the Regulations of Connecticut State Agencies set forth the Department of Social Services requirements for payment for pharmacy services provided to enrollees determined eligible under provisions of sections 17b-490 to 17b-498, inclusive, of the Connecticut General Statutes, the Connecticut Pharmaceutical Assistance Contract to the Elderly and the Disabled (ConnPACE) Program.

(Adopted effective January 1, 2002)

Sec. 17b-262-685. Definitions

As used in sections 17b-262-684 to 17b-262-692, inclusive, of the Regulations of Connecticut State Agencies the following definitions shall apply:

(1) “Administrative lock-in” means the restriction by the department of an enrollee to a provider of the enrollee’s choice pursuant to section 17b-275 of the Connecticut General Statutes;

(2) “Average wholesale price” or “AWP” means the published wholesale price as listed by one or more national drug databases which obtain their pricing information either directly from the manufacturer or by surveying drug wholesalers;

(3) “Brand name” means “brand name” as defined in section 20-619 of the Connecticut General Statutes;

(4) “Commissioner” means the Commissioner of the Department of Social Services or his or her agent;

(5) “ConnPACE” means the Connecticut Pharmaceutical Assistance Contract to the Elderly and the Disabled Program as described in section 17b-491 of the Connecticut General Statutes;

(6) “Copayment” means the dollar amount which is required under section 17b-491 of the Connecticut General Statutes to be paid to providers by enrollees for each prescription;

(7) “Department” means the Department of Social Services or its agent;

(8) “Dispensing fee” means an amount of money paid to a pharmacy for rendering a professional service involving the preparation and dispensing of a prescribed drug ordered by a prescribing practitioner;

(9) “Drug efficacy study implementation” or “DESI” means the review through which the United States Food and Drug Administration has identified certain products which lack sufficient evidence of their effectiveness for the approved indication(s);

(10) “Drug utilization review program” or “DUR” means the prospective and retrospective utilization review as mandated by the Omnibus Budget Reconciliation Act (OBRA) of l990 (P.L. 101-508);

(11) “Enrollee” means a person who meets the relevant requirements specified in the department’s Uniform Policy Manual, section 8075 and whose application for enrollment in the ConnPACE program has been approved by the department;

(12) “Estimated acquisition cost” or “EAC” means the department’s best estimate of the price as related to the average wholesale price generally and currently paid by providers for a drug marketed or sold by a particular manufacturer or labeler, as identified by the national drug code (NDC);

(13) “Experimental drug” means a drug currently being administered under an investigational new drug application as required by the United States Food and Drug Administration under 21 CFR 312;

(14) “Federal upper limit” or “FUL” means the listing of multiple source drugs and pricing according to criteria set forth in 42 CFR 447.332;

(15) “Generic name” means “generic name” as defined in section 20-619 of the Connecticut General Statutes;

(16) “Generically equivalent drug” means a therapeutically equivalent generic drug product which may be substituted for a brand name drug under section 20-619(b) of the

Connecticut General Statutes;

(17) "Legend drug" means "legend drug" as defined in section 20-571 of the Connecticut General Statutes;

(18) "Manufacturer rebate program" means the program as described in section 17b-491(d) of the Connecticut General Statutes;

(19) "Medicaid" means the program operated by the department pursuant to section 17b-260 of the Connecticut General Statutes and authorized by Title XIX of the Social Security Act;

(20) "Medical appropriateness" or "medically appropriate" means health care that is provided in a timely manner and meets professionally recognized standards of acceptable medical care; is delivered in the appropriate setting; and is the least costly of multiple, equally-effective alternative treatments or diagnostic modalities;

(21) "Medical necessity" or "medically necessary" means health care provided to correct or diminish the adverse effects of a medical condition or mental illness; to assist an individual in attaining or maintaining an optimal level of health; to diagnose a condition; or prevent a medical condition from occurring;

(22) "National drug code" or "NDC" means the numeric characters identifying a drug product by labeler code, product name and package size;

(23) "Pharmaceutical manufacturer" means any entity holding legal title to or possession of a national drug code issued by the United States Food and Drug Administration;

(24) "Pharmacy" means "pharmacy" as defined in section 20-571 of the Connecticut General Statutes;

(25) "Prescribing practitioner" means "prescribing practitioner" as defined in section 20-571 of the Connecticut General Statutes;

(26) "Prescription" means "prescription" as defined in section 20-571 of the Connecticut General Statutes;

(27) "Prescription drugs" means "prescription drugs" as defined in section 17b-490 of the Connecticut General Statutes;

(28) "Provider" means a pharmacy that is enrolled with the department as a ConnPACE provider;

(29) "Unit" means the lowest identifiable amount of a drug, for example: tablet or capsule for solid dosage forms, milliliter for liquid forms, gram for ointments or creams; and

(30) "Usual and customary charge" means an enrolled provider's charge to the general public for a prescription drug, in a specific strength and quantity on the day the prescription is dispensed. In determining such charges all charges made to third party payers shall be excluded.

(Adopted effective January 1, 2002)

Sec. 17b-262-686. Provider participation

In order to receive payment from the department under the ConnPACE program, a

pharmacy shall meet the following requirements:

(a) meet and maintain all departmental enrollment requirements for a pharmacy participating in Medicaid as described in sections 17b-262-522 to 17b-262-533, inclusive, with the exception of section 17b-262-526(12) of the Regulations of Connecticut State Agencies. A ConnPACE provider does not need to be enrolled as a provider under Medicaid; and

(b) be located in the State of Connecticut.

(Adopted effective January 1, 2002)

Sec. 17b-262-687. Eligibility

In order to be eligible for ConnPACE a person must meet all relevant requirements specified in the department's Uniform Policy Manual, section 8075.

(Adopted effective January 1, 2002)

Sec. 17b-262-688. Services covered and limitations

(a) The department shall pay for prescription drugs dispensed under the Conn-PACE program:

(1) that are medically necessary and appropriate and listed in section 17b-490(b) of the Connecticut General Statutes; and

(2) that do not exceed the recommended dosage level and duration as approved by the United States Food and Drug Administration and presented in the manufacturer's literature, and as monitored and operationalized in the department's drug utilization review program.

(b) The department shall pay for any number of authorized refills by the prescribing practitioner for a maximum period of six (6) months. The exception is controlled substances that are regulated by 21 USC 829(b) and section 21a-249(h) of the Connecticut General Statutes.

(c) A provider shall substitute a therapeutically equivalent generic drug product for a prescribed drug product unless the prescribing practitioner has written on the prescription "brand medically necessary" in accordance with sections 17b-274 and 17b-493 of the Connecticut General Statutes.

(d) The department shall pay at the estimated acquisition cost for the generic drug only when available but not yet on the federal upper limit list.

(Adopted effective January 1, 2002)

Sec. 17b-262-689. Services not covered

The department shall not pay providers for:

(1) the replacement of lost or destroyed prescription drugs;

(2) any prescription drug of a manufacturer that does not participate in the manufacturer rebate program, unless the department determines the prescription drug is medically necessary and medically appropriate for the program enrollees;

(3) any drugs excluded pursuant to section 17b-490(b). The department shall pay for

amphetamines and amphetamine-like drugs for specific diagnoses as specified in the billing instructions;

(4) over the counter preparations;

(5) DESI drugs;

(6) prescriptions dispensed but not received by the enrollee;

(7) drugs for an administrative lock-in enrollee who is not locked in to the billing pharmacy;

(8) anything of an unproven, experimental or research nature or for services in excess of those deemed medically necessary and medically appropriate by the department to meet the enrollee's condition or for services not directly related to the enrollee's diagnosis, symptoms or medical history;

(9) claims of quantities which exceed 120 oral dosage units or a 30 day supply, whichever is greater; and

(10) claims for services which are covered by other insurance.

(Adopted effective January 1, 2002)

Sec. 17b-262-690. Payment rate

(a) The provider shall bill the usual and customary charge and the department shall pay the lowest of:

(1) the estimated acquisition cost (EAC) plus the dispensing fee minus the copayment;

(2) the federal upper limit (FUL) plus the dispensing fee minus the copayment;

(3) the billed amount to the department, i.e. ingredient cost plus the dispensing fee, minus the copayment;

(4) the usual and customary charge of the provider minus the copayment.

(b) The commissioner shall determine the dispensing fee for each prescription.

(c) The provider shall collect the full copayment as described in section 17b-491 of the Connecticut General Statutes.

(d) The department shall pay at the federal upper limit price for brand name drugs that appear on the federal upper limit list when the prescribing practitioner has indicated "brand medically necessary" in accordance with section 17b-493 of the Connecticut General Statutes.

(e) If an enrollee requests the brand name product and the prescribing practitioner has not specified "brand medically necessary" in accordance with section 17b-493 of the Connecticut General Statutes, then the enrollee is responsible for paying for the full amount of the prescription and the claim may not be billed to ConnPACE.

(f) Providers are prohibited from seeking reimbursement for covered drugs from enrollees with the exception of the co-payment.

(Adopted effective January 1, 2002)

Sec. 17b-262-691. Documentation

(a) The pharmacy shall maintain the original prescription which shall conform to the

documentation requirements described in section 20-614(c) of the Connecticut General Statutes.

(b) The pharmacy shall maintain patient profiles as required in section 17b-494(5) of the Connecticut General Statutes.

(c) In addition, prescriptions transmitted by facsimile machine shall meet all requirements of sections 20-164-1 to 20-164-5, inclusive, of the Regulations of Connecticut State Agencies.

(d) For any prescription for a brand name drug for which a generically equivalent drug exists, there shall be a prescription on file on which, in the prescribing practitioner's handwriting, the phrase "brand medically necessary" is written and signed by the prescribing practitioner in accordance with section 17b-493 of the Connecticut General Statutes.

(e) Prescriptions for controlled substances shall also meet the requirements of sections 21a-244-1 to 21a-244-6, inclusive, of the Regulations of Connecticut State Agencies.

(f) The provider shall maintain all required documentation for at least five years, or longer in accordance with statute or regulation, in the provider's file subject to review by the department. In the event of a dispute concerning a service or item provided, documentation shall be maintained until the end of the dispute, five years, or the length of time required by statute or regulation, whichever is longest.

(g) Failure to maintain and provide all required documentation to the department upon request shall result in the disallowance and recovery by the department of any future or past payments made to the provider.

(Adopted effective January 1, 2002)

Sec. 17b-262-692. Manufacturer rebate program

Pharmaceutical manufacturers must apply to participate in a rebate program with the department in order to have their prescription drugs covered by the ConnPACE program. All prescription drugs allowed by the program of a pharmaceutical manufacturer that participates in the manufacturer rebate program shall be immediately available. The cost of such drugs shall be reimbursed in accordance with sections 17b-262-684 to 17b-262-692, inclusive, of the Regulations of Connecticut State Agencies.

(Adopted effective January 1, 2002)

Requirements for Payment of Public Health Dental Hygienist Services

Sec. 17b-262-693. Scope

Sections 17b-262-693 to 17b-262-700, inclusive, set forth the requirements for payment of public health dental hygienist services for persons determined eligible for Connecticut's Medicaid Program pursuant to Section 17b-262 of the Connecticut General Statutes.

(Adopted effective July 10, 2001)

Sec. 17b-262-694. Definitions

As used in sections 17b-262-693 to 17b-262-700, inclusive, the following definitions shall apply:

(1) "Client" means a person eligible for services under the department's Medicaid program;

(2) "Clinic" means an "outpatient clinic" as defined in section 19-13-D45 of the Regulations of Connecticut State Agencies;

(3) "Commissioner" means the Commissioner of Social Services or his or her agent;

(4) "Community health center" means a "community health center" as defined in section 19a-490a of the Connecticut General Statutes;

(5) "Dental examination" means inspecting and charting of the oral structures;

(6) "Dental hygienist" means a dental hygienist licensed to practice dental hygiene pursuant to sections 20-126h to 20-126x, inclusive, of the Connecticut General Statutes;

(7) "Dental hygienist services" means "the practice of dental hygiene" as defined in section 20-126l(a)(3) of the Connecticut General Statutes;

(8) "Dentist" means a dentist licensed to practice dentistry pursuant to section 20-108 of the Connecticut General Statutes or who is licensed to practice dentistry in another state;

(9) "Department" means the Department of Social Services or its agent;

(10) "Group home" means a "community residential facility" as defined in section 17a-220 of the Connecticut General Statutes or a "community residence" as defined in section 19a-507a of the Connecticut General Statutes;

(11) "Hospital" means a "general hospital" or "special hospital" as defined in section 19-13-D1(b)(1) of the Regulations of Connecticut State Agencies;

(12) "Intermediate care facility for the mentally retarded" or "ICF/MR" means a residential facility for persons with mental retardation licensed pursuant to section 17a-227 of the Connecticut General Statutes and certified to participate in Medicaid as an intermediate care facility for the mentally retarded pursuant to 42 CFR 442.101 as amended from time to time;

(13) "Medicaid" means the program operated by the department pursuant to section 17b-260 of the Connecticut General Statutes and authorized by Title XIX of the Social Security Act;

(14) "Medical appropriateness" or "medically appropriate" means health care that is provided in a timely manner and meets professionally recognized standards of acceptable medical care; is delivered in the appropriate setting; and, is the least costly of multiple, equally effective alternative treatments or diagnostic modalities;

(15) "Medical necessity" or "medically necessary" means health care provided to correct or diminish the adverse effects of a medical condition or mental illness; to assist an individual in attaining or maintaining an optimal level of health; to diagnose a condition; or to prevent a medical condition from occurring;

(16) "Medical record" means a medical record as set forth in section 19a-14-40 of the Regulations of Connecticut State Agencies;

(17) "Nursing facility" means an institution as defined in 42 USC 1396(r)(a), as amended from time to time;

(18) "Provider" means a "public health dental hygienist" as defined in subsection (19) of this section;

(19) "Public health dental hygienist" means a dental hygienist who is providing services in accordance with section 20-1261(b)(1)(B) of the Connecticut General Statutes;

(20) "School" means any preschool, elementary or secondary school or any college, vocational, professional or graduate school; and

(21) "Usual and customary charge" means the amount that the provider charges for the service or procedure in the majority of non-Medicaid cases. If the provider varies the charges so that no one amount is charged in the majority of cases, "usual and customary" means the median charge. Token charges for charity patients and other exceptional charges are to be excluded.

(Adopted effective July 10, 2001)

Sec. 17b-262-695. Provider participation

(a) In order to participate in Medicaid and receive payment from the department, all providers shall meet and maintain all departmental enrollment requirements as set forth in sections 17b-262-522 to 17b-262-533, inclusive, of the Regulations of Connecticut State Agencies.

(b) All dental hygienists who participate in Medicaid shall be public health dental hygienists.

(Adopted effective July 10, 2001)

Sec. 17b-262-696. Eligibility

Payment for public health dental hygienist services shall be available on behalf of all persons eligible for Medicaid subject to the conditions and limitations that apply to these services.

(Adopted effective July 10, 2001)

Sec. 17b-262-697. Services covered and limitations

(a) **Services Covered**

(1) The department shall pay for medically necessary and medically appropriate public health dental hygienist services provided to clients subject to the limitations listed in subsection (b) of this section.

(2) The department shall pay providers only for those procedures listed in the provider's fee schedule.

(b) **Limitations**

(1) Dental examination is limited to one (1) every six (6) calendar months per client.

(2) The department shall not pay for fluoride treatment except for the following clients, and shall limit treatment to one (1) time every six (6) calendar months per client:

(A) clients under age twenty one (21); and
(B) clients over age twenty one (21):
(i) using radiology services as oncology treatment on a regularbasis; or
(ii) residing in nursing facilities or intermediate care facilities for the mentally retarded who have six (6) or more natural teeth.
(3) Pit and fissure sealant is limited to:
(A) clients between the ages of five (5) through sixteen (16), inclusive;
(B) first and second permanent molars that are decay and restoration free; and
(C) one every five (5) calendar years per tooth.
(4) A public health dental hygienist who is salaried at a practice location shall not bill the department for dental hygienist services for clients seen at this location.
(5) Payment for dental hygienist services is available to all clients who have a need for these services, subject to the limitations in this subsection, when provided at the following locations only:
(A) a nursing facility;
(B) an ICF/MR;
(C) a group home;
(D) a school that does not have a dental clinic on site;
(E) a clinic or community health center that does not have a dental clinic on site; or
(F) a hospital outpatient department that does not have a dental clinic on site.

(Adopted effective July 10, 2001)

Sec. 17b-262-698. Services not covered

The department shall not pay for:
(1) anything not explicitly allowed pursuant to section 17b-262-697 of the Regulations of Connecticut State Agencies;
(2) information provided to the client over the telephone;
(3) cancelled visits or services not provided;
(4) any services provided by a public health dental hygienist free of charge to non-Medicaid clients;
(5) anything of an unproven, experimental or research nature, or for services in excess of those deemed medically necessary or medically appropriate by the department to treat a client's condition, or for services not directly related to the client's diagnosis, symptoms, or medical history; or
(6) any services provided by a public health dental hygienist in a dental office, a dental clinic or a location other than those set forth in section 17b-262-697(b)(5) of the Regulations of Connecticut State Agencies.

(Adopted effective July 10, 2001)

Sec. 17b-262-699. Payment rate and billing procedure

(a) The provider may sign claims and bill directly and shall submit claims to the

department in accordance with the procedures set forth in section 17b-262-529 of the Regulations of Connecticut State Agencies and the billing instructions specific to a public health dental hygienist.

(b) The commissioner shall establish the fees for dental hygienist services performed by the public health dental hygienist pursuant to section 4-67c of the Connecticut General Statutes;

(c) The provider shall bill the usual and customary charge and the department shall pay the lowest of:

(1) the usual and customary charge;

(2) the amount billed by the provider to the department; or

(3) the amount in the applicable fee schedule as published by the department.

(Adopted effective July 10, 2001)

Sec. 17b-262-700. Documentation

(a) The provider shall maintain a client file that shall include, but not be limited to, the following information:

(1) identifying data:

(A) name of client;

(B) address;

(C) date of birth;

(D) gender; and

(E) Medicaid identification number;

(2) name, address, telephone number and license number of the public health dental hygienist responsible for the dental care;

(3) pertinent past and current health history of the client; and

(4) the medical record for the client.

(b) All notes and reports in the client's medical record shall be type written or legibly written in ink or maintained electronically, dated and signed by the recording person with his or her full first name or first initial, surname and title. Electronic signatures shall be permissible in accordance with state and federal law.

(c) Each public health dental hygienist shall document action taken to:

(1) refer for treatment any client with needs outside the public health dental hygienist's scope of practice;

(2) coordinate such referral for treatment to dentists; and

(3) provide meaningful medical and dental information to dentists to whom clients are referred.

(d) For fluoride treatments provided to a client pursuant to section 17b-262-697(b)(2)(B)(i) of the Regulations of Connecticut State Agencies, the provider shall maintain documentation substantiating that the client is using radiology services as oncology treatment on a regular basis.

(e) All required documentation shall be maintained for at least five (5) years or longer

as required by state or federal law in the provider's file and shall be subject to review by the authorized department personnel. In the event of a dispute concerning a service provided, documentation shall be maintained until the end of the dispute, for five (5) years, or the length of time required by state or federal law, whichever is greatest.

(f) Failure to maintain and provide all required documentation to the department upon request may result in the disallowance and recovery by the department of any future or past payments made to the provider.

(Adopted effective July 10, 2001)

Requirements for Payment of Nursing Facilities

Sec. 17b-262-701. Scope

Sections 17b-262-701 to 17b-262-711, inclusive, set forth the Department of Social Services requirements for payment to nursing facilities for services to clients eligible to receive such services under Connecticut's Medicaid program pursuant to section 17b-262 of the Connecticut General Statutes.

(Adopted effective March 1, 2002)

Sec. 17b-262-702. Definitions

For the purposes of sections 17b-262-701 to 17b-262-711, inclusive, the following definitions shall apply:

(1) "Applied income" means the amount of income that each client receiving nursing facility services is expected to pay each month toward the cost of his or her care, calculated according to the department's Uniform Policy Manual, section 5045.20;

(2) "Client" means a person eligible for goods or services under the department's Medicaid program;

(3) "Chronic disease hospital" means "chronic disease hospital" as defined in section 19-13-D1 of the Regulations of Connecticut State Agencies;

(4) "Commissioner" means the Commissioner of Social Services, or the commissioner's designee;

(5) "Department" means the Department of Social Services or its agent;

(6) "DMHAS" means the Department of Mental Health and Addiction Services or its agent;

(7) "DMR" means the Department of Mental Retardation or its agent;

(8) "Home leave" means an absence from the nursing facility for any reason other than admission to a hospital. It is taken at the discretion of the resident;

(9) "Hospital" means "hospital" as defined in section 19a-537 of the Connecticut General Statutes;

(10) "Institution for Mental Diseases" or "IMD" means "institution for mental diseases" as defined in 42 CFR 435.1009, as amended from time to time;

(11) "Licensed practitioner" means any person licensed by the state of Connecticut, any

other state, District of Columbia, or the Commonwealth of Puerto Rico and authorized to prescribe treatments within the scope of his or her practice as defined and limited by federal and state law;

(12) “Medical appropriateness” or “medically appropriate” means health care that is provided in a timely manner and meets professionally recognized standards of acceptable medical care; is delivered in the appropriate medical setting; and, is the least costly of multiple, equally-effective, alternate treatments or diagnostic modalities;

(13) “Medicaid” means the program operated by the Department of Social Services pursuant to section 17b-260 of the Connecticut General Statutes and authorized by Title XIX of the Social Security Act;

(14) “Medical necessity” or “medically necessary” means health care provided to correct or diminish the adverse effects of a medical condition or mental illness; to assist an individual in attaining or maintaining an optimal level of health; to diagnose a condition; or to prevent a medical condition from occurring;

(15) “Nursing facility” or “NF” means “nursing facility” as defined in 42 USC 1396r(a), as amended from time to time;

(16) “Preadmission screening and resident review” or “PASRR” means the program defined in 42 USC 1396r(e)(7) and 42 CFR Part 483, Subpart C, as amended from time to time;

(17) “Preadmission MI/MR screen” means the level I screen required under the PASRR program and described in 42 CFR 483.106 and 42 CFR 483.128, as amended from time to time. It shall be completed on the forms and in the manner prescribed by the department;

(18) “Preadmission screening level II evaluation” means the level II screen as described in 42 CFR 483.112 and 42 CFR 483.128, as amended from time to time. It shall be completed on the forms and in the manner prescribed by the department;

(19) “Provider” means a nursing facility that is enrolled in the Medicaid program;

(20) “Provider agreement” means the signed, written, contractual agreement between the department and the provider;

(21) “Reserve bed day” means a day when a nursing facility client is temporarily absent from the nursing facility and for which payment is made by the department in accordance with section 19a-537 of the Connecticut General Statutes;

(22) “Resident” means a person living in a nursing facility; and

(23) “Usual and customary charge” means the amount that the provider charges for the service or procedure in the majority of non-Medicaid cases. If the provider varies the charges so that no one amount is charged in the majority of cases, usual and customary shall be defined as the median charge. Token charges for charity patients and other exceptional charges are to be excluded.

(Adopted effective March 1, 2002)

Sec. 17b-262-703. Provider participation

In order to enroll in the Medicaid program and receive payment from the department, a

nursing facility shall comply with sections 17b-262-522 through 17b-262-533, inclusive, of the Regulations of Connecticut State Agencies. Licensing and certification requirements for nursing facilities referenced in sections 17b-262-701 to 17b-262-711, inclusive, of the Regulations of Connecticut State Agencies include, but are not limited to, the criteria described in section 19-13-D8t of the Regulations of Connecticut State Agencies and the criteria described in 42 CFR Part 483, subpart B, as amended from time to time.

(Adopted effective March 1, 2002)

Sec. 17b-262-704. Eligibility

Payment for nursing facility services is available to all persons eligible for the Medicaid program subject to the conditions and limitations that apply to these services.

(Adopted effective March 1, 2002)

Sec. 17b-262-705. Services covered and limitations

The department shall pay an all-inclusive per diem rate, computed in accordance with section 17b-340 of the Connecticut General Statutes and sections 17-311-1 to 17-311-120, inclusive, and sections 17-311-200 to 17-311-209, inclusive, of the Regulations of Connecticut State Agencies, to the provider for each Medicaid resident. This rate represents payment for the following goods and services:

(a) all services as required by section 19-13-D8t of the Regulations of Connecticut State Agencies and 42 CFR Part 483, subpart B, as amended from time to time, including, but not limited to:

(1) medical direction in accordance with sections 19-13-D8t(h) and (i) of the Regulations of Connecticut State Agencies;

(2) nursing service in accordance with 42 CFR 483.30, as amended from time to time, and sections 19-13-D8t(j),(k),(m) and (n) of the Regulations of Connecticut State Agencies;

(3) social services in accordance with 42 CFR 483.15(g), as amended from time to time, and section 19-13-D8t(s) of the Regulations of Connecticut State Agencies;

(4) therapeutic recreation in accordance with 42 CFR 483.15(f), as amended from time to time, and section 19-13-D8t(r) of the Regulations of Connecticut State Agencies;

(5) specialized rehabilitative services in accordance with 42 CFR 483.45, as amended from time to time;

(6) room and board in accordance with 42 CFR 483.10(c)(8)(i)(D), 42 CFR 483.35, and 42 CFR 483.70, as amended from time to time, and sections 19-13-D8t(q) and 19-13-D8t(v) of the Regulations of Connecticut State Agencies;

(7) consultation and assistance to residents in obtaining other needed services including:

(A) vision and hearing services in accordance with 42 CFR 483.25(b), as amended from time to time;

(B) services to address mental and psychosocial functioning in accordance with 42 CFR 483.25(f), as amended from time to time;

(C) dental services in accordance with 42 CFR 483.55, as amended from time to time;

and

(D) pharmacy services in accordance with 42 CFR 483.60(b) and (c), as amended from time to time;

(b) routine personal hygiene items as defined in 42 CFR 483.10(c)(8)(i)(E), as amended from time to time;

(c) over the counter medications except insulin;

(d) durable medical equipment except those items listed in section 17b-262-676(a)(2) of the Regulations of Connecticut State Agencies that are payable separately for nursing facility clients;

(e) supplies used in the routine care of the Medicaid resident that are included on the department's medical and surgical fee schedule including:

(1) antiseptics and solutions;
(2) bandages and dressing supplies;
(3) catheters and urinary incontinent supplies;
(4) diabetic supplies;
(5) diapers and underpads;
(6) compression, burns and specialized medical garments;
(7) ostomy supplies;
(8) respiratory and tracheotomy supplies;
(9) enteral and parenteral supplies; and
(10) miscellaneous supplies;

Some of these supplies are covered by and should be billed to Part B of the Medicare program. Such supplies are not included in the per diem rate as per section 17b-340(f)(1) of the Connecticut General Statutes.

(f) services related to the provision or arrangement for provision of customized wheelchairs that are the responsibility of the nursing facility as described in sections 17-134d-46(m) and (n) of the Regulations of Connecticut State Agencies;

(g) oxygen concentrators as described in section 17b-281 of the Connecticut General Statutes and the regulations promulgated thereunder;

(h) prescription drugs for those providers that have approval from the department to include prescription drug costs in the per diem rate; and

(i) transportation services necessary to transport a client to and from any service included in the per diem rate as described in this section. Transportation to services listed in subdivision (a)(7) of this section, which the nursing facility shall help obtain but not provide directly, is not included in the per diem rate. Nursing facilities shall follow the customary authorization procedure in arranging for such transpor tation.

(Adopted effective March 1, 2002)

Sec. 17b-262-706. Service limitations

(a) the department shall pay to reserve a bed in a nursing facility for a Medicaid resident during a temporary absence in a hospital or a temporary absence for home leave in

accordance with the provisions of section 19a-537 of the Connecticut General Statutes.

(b) Payment shall be made for the date of admission and not for the date of discharge. Exceptions to this are:

(1) Payment may be made for the date of death when the resident dies in the nursing facility. If the resident dies while in the hospital or on home leave, the date of death may be paid as a reserve bed day, provided all other bed reservation requirements as described in section 19a-537 of the Connecticut General Statutes are met; and

(2) In the case of a resident admitted and discharged on the same day, payment shall be made for one day of care.

(c) The department shall not pay nursing facilities that are characterized as institutions for mental diseases (IMD) except for services to clients aged 65 and older or under age 22 in accordance with section 17-134d-68 of the Regulations of Connecticut State Agencies and 42 CFR 435.1008.

(Adopted effective March 1, 2002)

Sec. 17b-262-707. Need for service and authorization process

(a) The department shall pay for an admission that is medically necessary and medically appropriate as evidenced by the following:

(1) certification by a licensed practitioner that a client admitted to a nursing facility meets the criteria outlined in section 19-13-D8t(d)(1) of the Regulations of Connecticut State Agencies. This certification of the need for care shall be made prior to the department's authorization of payment. The licensed practitioner shall use and sign all forms specified by the department;

(2) the department's evaluation and written authorization of the client's need for nursing facility services as ordered by the licensed practitioner;

(3) a health screen for clients eligible for the Connecticut Home Care Program for Elders as described in section 17b-342-4(a) of the Regulations of Connecticut State Agencies;

(4) a preadmission MI/MR screen signed by the department; or an exemption form, in accordance with 42 CFR 483.106(b), as amended from time to time, for any hospital discharge, readmission or transfer for which a preadmission MI/MR screen was not completed; and

(5) a preadmission screening level II evaluation for any individual suspected of having mental illness or mental retardation as identified by the preadmission MI/MR screen.

(b) The department shall pay a provider only when the department has authorized payment for the client's admission to that nursing facility.

(c) A nursing facility may admit a client on an emergency basis only if:

(1) the Office of Protection and Advocacy, established in accordance with section 46a-10 of the Connecticut General Statutes, in conjunction with DMHAS or DMR authorizes the emergency admission of a client with mental illness or mental retardation to a nursing facility for up to seven (7) days in accordance with 42 CFR 483.130(d)(5), as amended from time to time; or

(2) the commissioner of public health authorizes an emergency transfer as prescribed in section 19a-534 of the Connecticut General Statutes.

(d) if a client is admitted on an emergency basis, the nursing facility is not required to meet:

(1) the waiting list requirements of section 19a-533 of the Connecticut General Statutes and sections 17-311-200 to 17-311-209, inclusive, of the Regulations of Connecticut State Agencies, as long as emergency admissions are uniformly and consistently made without regard to source of payment; and

(2) the requirements of subsections (a)(3) to (a)(5) of this section.

(e) A client who requires admission after hours is not considered an emergency admission.

(Adopted effective March 1, 2002)

Sec. 17b-262-708. Applied income

(a) The department is responsible for calculating the applied income. The department shall notify the nursing facility of the amount of any applied income that the nursing facility is responsible for collecting. Applied income shall be deducted from what otherwise would have been the department's monthly payment to the nursing facility.

(b) The nursing facility shall notify the department's caseworker of any errors in the amount of applied income processed against the claim using the form specified by the department. Payment adjustments resulting from retroactive applied income corrections shall be processed periodically.

(c) In any month that a resident returns to the community or dies, and the cost of care is less than the applied income, the department shall adjust the applied income as follows: the applied income shall equal the number of days that the resident was in the nursing facility multiplied by the per diem rate.

(d) Applied income is not pro rated. It is used to cover the cost of care until it is expended.

(Adopted effective March 1, 2002)

Sec. 17b-262-709. Billing and payment procedures

(a) The nursing facility shall submit claims to the department as described in section 17b-262-529 of the Regulations of Connecticut State Agencies and the billing instructions specific to nursing facilities established by the department.

(b) The nursing facility is responsible for:

(1) completing the daily admission and discharge forms in accordance with the department's instructions;

(2) notifying the department caseworker if the nursing facility is aware that the Medicaid resident's asset level exceeds the established resource limit. The report shall be made on the form specified by the department;

(3) notifying the convalescent payment unit of the department of any and all credits due the department on the form specified by the department; and

(4) exhausting other payment sources of which the nursing facility is aware before billing the department.

(Adopted effective March 1, 2002)

Sec. 17b-262-710. Rates

(a) The per diem rates for nursing facilities services are determined annually pursuant to section 17b-340 of the Connecticut general statutes and sections 17-311-1 to 17-311-209, inclusive, of the Regulations of Connecticut State Agencies.

(b) the department shall reimburse the nursing facility at the lower of:

(1) the per diem rate minus the applied income; or

(2) the usual and customary charge minus the applied income.

(Adopted effective March 1, 2002)

Sec. 17b-262-711. Documentation

(a) The nursing facility shall maintain all documentation required for rate setting purposes in accordance with section 17-311-56 of the Regulations of Connecticut State Agencies, including all documentation required to support the billing for bed reserve days described in subsection (e)(5) of this section. This documentation is subject to review and audit by the department.

(b) The nursing facility shall maintain all other documentation required by this section for at least five (5) years or longer as required by statute or regulation, subject to review by authorized department personnel. In the event of a dispute concerning a service provided, the nursing facility shall maintain all documentation until the end of the dispute, for five (5) years, or for the length of time required by statute or regulation, whichever is longest.

(c) Failure to maintain all required documentation may result in the disallowance and recovery by the department of any amounts paid to the nursing facility for which the required documentation is not maintained and provided to the department upon request. Documentation requirements are described in detail in the Provider Agreement for Nursing Facilities and sections 17b-262-522 to 17b-262-533, inclusive, of the Regulations of Connecticut State Agencies.

(d) The department requires that nursing facilities maintain fiscal and medical records to fully disclose services and goods rendered or delivered to Medicaid residents. Records shall be maintained in accordance with the department's Provider Agreement for nursing facilities.

(e) Required documentation includes:

(1) certification for nursing facility admission as required by the department. The form shall be signed by the licensed practitioner;

(2) the department's written authorization of the client's need for nursing facility care;

(3) a health screen signed by the department for clients eligible for the Connecticut Home Care Program for Elders;

(4) all admission and discharge forms supporting the claim;

(5) all documentation required to support the nursing facility's billing for and the department's payment of bed reserve days as described in section 19a-537 of the Connecticut General Statutes;

(6) all documentation required by the PASRR process including:

(A) a preadmission MI/MR screen signed by the department or an exemption letter, in the form and manner prescribed by the department, for any hospital discharge, readmission or transfer for which a preadmission MI/MR screen is not on file; and

(B) a preadmission screening level II evaluation, signed by DMHAS or DMR, for any resident suspected of having mental illness or mental retardation, respectively, as identified on the preadmission MI/MR screen.

(7) medical records in accordance with section 19-13-D8t(o) of the Regulations of Connecticut State Agencies.

(Adopted effective March 1, 2002)

Requirements for Payment for Medical and Surgical Supplies

Sec. 17b-262-712. Scope

Sections 17b-262-712 to 17b-262-722, inclusive, of the Regulations of Connecticut State Agencies set forth the Department of Social Services' requirements for payment to providers of medical and surgical supplies provided to eligible Medicaid clients residing at home.

(Adopted effective May 11, 2009)

Sec. 17b-262-713. Definitions

As used in sections 17b-262-712 to 17b-262-722, inclusive, of the Regulations of Connecticut State Agencies:

(1) "Chronic disease hospital" means "chronic disease hospital" as defined in section 19-13-D1 of the Regulations of Connecticut State Agencies;

(2) "Client" means a person eligible for goods or services under the Medicaid program;

(3) "Commissioner" means the Commissioner of Social Services or his or her designee;

(4) "Department" means the Department of Social Services or its agent;

(5) "Documented in writing" means handwritten, typed or computer printed;

(6) "EPSDT (Early & Periodic Screening & Diagnostic Treatment) special services" means services provided in accordance with subdivision 1905 (r) of the Social Security Act;

(7) "Home" means the client's place of residence, including a boarding home, community living arrangement or residential care home. Home does not include facilities such as hospitals, chronic disease hospitals, nursing facilities, intermediate care facilities for the mentally retarded or other facilities that are paid an all-inclusive rate directly by Medicaid for the care of the client;

(8) "Hospital" means "short-term hospital" as defined in section 19-13-D1(b)(1) of the Regulations of Connecticut State Agencies;

(9) "Intermediate care facility for the mentally retarded" or "ICF/MR" means a

residential facility for the mentally retarded licensed pursuant to section 17a-227 of the Connecticut General Statutes and certified to participate in the Medicaid program as an intermediate care facility for the mentally retarded pursuant to 42 CFR 442.101, as amended from time to time;

(10) “Licensed practitioner” means an individual who is licensed by the Connecticut Department of Public Health, another state, District of Columbia or the Commonwealth of Puerto Rico and is acting within his or her scope of practice under Connecticut state law in prescribing a medical or surgical supply;

(11) “Medical and surgical supplies” or “supply” means treatment products that:

(A) are fabricated primarily and customarily to fulfill a medical or surgical purpose;

(B) are used in the treatment or diagnosis of specific medical conditions;

(C) are generally not useful in the absence of illness or injury; and

(D) are generally not reusable and are disposable.

(12) “Medicaid” means the program operated by the Department of Social Services pursuant to section 17b-260 of the Connecticut General Statutes and authorized by Title XIX of the Social Security Act, as amended from time to time;

(13) “Medical appropriateness” or “medically appropriate” means health care that is provided in a timely manner and meets professionally recognized standards of acceptable medical care; is delivered in the appropriate setting; and is the least costly of multiple, equally-effective, alternative treatments or diagnostic modalities;

(14) “Medical necessity” or “medically necessary” means health care needed to correct or diminish the adverse effects of a medical condition or mental illness; to assist an individual in attaining or maintaining an optimal level of health; to diagnose a condition; or to prevent a medical condition from occurring;

(15) “Nursing facility” means “nursing facility” as defined in 42 USC 1396r(a), as amended from time to time;

(16) “Prescription” means an original order issued by a licensed practitioner that is documented in writing and signed and dated by the licensed practitioner issuing the order;

(17) “Prior authorization” or “PA” means approval from the department for the provision of a service or the delivery of goods before the provider actually provides the service or delivers the goods;

(18) “Provider” means a vendor or supplier of medical and surgical supplies who is enrolled with the department as a supplier of medical and surgical supplies;

(19) “Provider agreement” means the signed, written contractual agreement between the department and the provider; and

(20) “Usual and customary charge” means the amount that the provider charges for the service or procedure in the majority of non-Medicaid cases. If the provider varies the charges so that no one amount is charged in the majority of cases, usual and customary shall be defined as the median charge. Token charges for charity patients and other exceptional charges are to be excluded.

(Adopted effective May 11, 2009)

Sec. 17b-262-714. Provider participation

To enroll in Medicaid and receive payment from the department, providers shall comply with sections 17b-262-522 to 17b-262-533, inclusive, of the Regulations of Connecticut State Agencies.

(Adopted effective May 11, 2009)

Sec. 17b-262-715. Eligibility

Payment for medical and surgical supplies is available for clients who have a medical necessity for such supplies, when the supplies are prescribed by a licensed practitioner, subject to the conditions and limitations set forth in sections 17b-262-712 to 17b-262-722, inclusive, of the Regulations of Connecticut State Agencies.

(Adopted effective May 11, 2009)

Sec. 17b-262-716. Supplies covered and limitations

(a) **Supplies covered**

(1) The department shall pay for the purchase of medical and surgical supplies, except as limited by sections 17b-262-712 to 17b-262-722, inclusive, of the Regulations of Connecticut State Agencies, that conform to accepted methods of diagnosis and treatment and are medically necessary and medically appropriate.

(2) Payment for medical and surgical supplies is available only to clients who live at home.

(3) The department shall maintain a non-exclusive fee schedule of supplies which it has determined meet the department's definition of medical and surgical supplies and for which coverage shall be provided to eligible clients, subject to the conditions and limitations set forth in sections 17b-262-712 to 17b-262-722, inclusive, of the Regulations of Connecticut State Agencies.

(4) When the supply for which coverage is requested is not on the department's fee schedule, prior authorization is required for that supply. The provider requesting coverage for a prescribed supply not on the list shall submit a prior authorization request to the department through an enrolled provider of medical and surgical supplies. Such request shall include a prescription and documentation showing the client's medical necessity for the prescribed supply. The provider also shall include documentation showing that the supply meets the department's definition of a medical and surgical supply and is medically appropriate for the client requesting coverage of such supply.

(5) The department shall pay for medical and surgical supplies for EPSDT special services.

(b) **Limitations**

(1) The department shall not pay for anything of an unproven, experimental or research nature or for supplies in excess of those deemed medically necessary by the department to treat the client's condition or for supplies not directly related to the client's diagnosis, symptoms or medical history.

(2) A prescription shall be valid for no longer than one year.
(3) The department may set maximum allowable quantity limitations at levels that it determines to be reasonable.
(4) Automatic shipment of goods and products shall not be allowed. Any refills shall be made only at the request of the client or the client's authorized representative with a valid prescription.

(Adopted effective May 11, 2009)

Sec. 17b-262-717. Supplies not covered

The department shall not pay providers for:
(1) standard or stock medical and surgical supplies prescribed and ordered for a client who:
(A) dies prior to delivery of the supply; or
(B) is not otherwise eligible on the date of delivery. It shall be the provider's responsibility to verify that the client is eligible on the date the supply is delivered;
(2) medical and surgical supplies provided to clients in hospitals, chronic disease hospitals, nursing facilities or ICF/MRs;
(3) drugs and supplements, including, but not limited to, over-the-counter supplies such as cough medicines, herbal remedies and laxatives; and
(4) any supply routinely used for personal hygiene.

(Adopted effective May 11, 2009)

Sec. 17b-262-718. Prior authorization

(a) To receive payment from the department, providers shall comply with all prior authorization requirements. The department in its sole discretion determines what information is necessary in order to approve a prior authorization request. Prior authorization does not guarantee payment unless all other requirements are met.
(b) The department requires prior authorization for any supply identified on the department's published fee schedule as requiring prior authorization or any supply not on the department's fee schedule.
(c) A prior authorization request, on forms and in a manner as specified by the department, shall include documentation of medical necessity and shall be signed by the prescribing licensed practitioner and the supplier. A copy of the prescription from the licensed practitioner may be attached to the completed PA request in lieu of the actual signature of the licensed practitioner on the PA request form. The licensed practitioner's original prescription shall be on file with the provider and be subject to review by the department.

(Adopted effective May 11, 2009)

Sec. 17b-262-719. Billing procedure

(a) Claims from providers shall be submitted on a hard copy invoice or electronically

transmitted to the department or its agent, in a form and manner that the department shall specify and shall include all information that the department shall require to process the claim for payment.

(b) Claims submitted for medical and surgical supplies not requiring prior authorization shall include the name of the licensed practitioner prescribing the supplies. A licensed practitioner's original prescription for the supplies shall be on file in the client's record with the provider and shall be subject to review by the department.

(c) Providers shall use the Healthcare Common Procedure Coding System (HCPCS), as maintained and distributed by the United States Department of Health and Human Services, for billing for medical and surgical supplies. Providers shall consult the Medicare SADMERC (Statistical Analysis Durable Medical Equipment Regional Carrier) if necessary to determine the proper billing code. A miscellaneous HCPCS code shall not be used unless a specific HCPCS code is not available for a supply. If a provider submits a prior authorization request to the department using a miscellaneous code for a supply that has a specific HCPCS code, the authorization request shall be denied.

(d) Providers shall bill the usual and customary charge.

(e) The department shall pay the lowest of:

(1) the lowest Medicare rate;

(2) the amount in the applicable fee schedule as published by the department;

(3) the provider's usual and customary charge; or

(4) the amount previously authorized in writing by the department.

(Adopted effective May 11, 2009)

Sec. 17b-262-720. Payment limitations

The price for any supply listed in the fee schedule published by the department shall include and the department shall pay the lowest:

(1) fees for initial measurements, fittings and adjustments and related transportation costs;

(2) labor charges;

(3) delivery costs, fully prepaid by the provider, including any and all manufacturer's delivery charges with no additional charges to be made for packing or shipping;

(4) travel to the client's home;

(5) technical assistance to the client to teach the client, or his or her family, the proper use and care of the supplies;

(6) information furnished by the provider to the client over the telephone; and

(7) the provider shall accept the department's payment as payment in full.

(Adopted effective May 11, 2009)

Sec. 17b-262-721. Documentation

(a) All required documentation shall be maintained for at least five years or the length of time required by statute in the provider's file subject to review by the department. In the event of a dispute concerning a service or a supply provided, documentation shall be

maintained until the end of the dispute, five years or the length of time required by statute, whichever is longest.

(b) Failure to maintain all required documentation shall result in the disallowance of payment and recovery by the department of any amounts paid to the provider for supplies for which the required documentation is not maintained or provided to the department upon request.

(c) The licensed practitioner's original prescription for medical and surgical supplies shall be on file with the provider and shall be subject to review by the department.

(d) The department requires that providers maintain fiscal and medical records to fully disclose services and goods rendered or delivered to clients.

(e) A signed receipt is required for all deliveries of medical and surgical supplies documenting that the client or, if the client is unable to sign, a designated representative or adult other than the provider or the provider's employee, took delivery of the supply. The receipt for medical and surgical supplies, regardless of format used, shall, at a minimum, contain the following elements:

(1) provider's name;

(2) client's name;

(3) delivery address;

(4) date of delivery; and

(5) itemization of the medical and surgical supplies delivered, including:

(A) product description;

(B) brand name;

(C) quantity delivered; and

(D) amount billed per supply.

(f) All orders for medical and surgical supplies, regardless of format used, which includes verbal, telephone and faxed orders, shall, at a minimum, contain the following:

(1) client's name, address and date of birth;

(2) diagnosis for which the medical and surgical supplies are required;

(3) detailed description of the medical and surgical supplies, including quantities and directions for usage, when appropriate;

(4) length of need for the medical and surgical supplies prescribed;

(5) name and address of prescribing practitioner; and

(6) prescribing practitioner's signature and date signed.

(g) Original prescriptions for medical and surgical supplies shall be obtained from the prescribing practioner prior to submitting claims for payment.

(h) The department retains the right to audit any and all relevant records and documentation and to take any other appropriate quality assurance measures it deem necessary to assure compliance with these and other regulatory and statutory requirements.

(Adopted effective May 11, 2009)

Sec. 17b-262-722. Other

(a) Where brand names or stock numbers are specified on the prescription or the PA, no substitution shall be permitted without the written approval of the department.

(b) The provider shall instruct the client or his or her family, designated representative or adult, on the proper use and care of the supply. This instruction shall be provided as a part of the cost of the supply.

(c) Providers shall notify the department of returns of medical and surgical supplies delivered to a client. Providers shall initiate necessary reimbursement adjustments resulting from such returns.

(d) The provider shall maintain a current usual and customary price list.

(Adopted effective May 11, 2009)

Sec. 17b-262-723. Reserved

Requirements for Payment of Home Health Care Services

Sec. 17b-262-724. Scope

Sections 17b-262-724 to 17b-262-735, inclusive, of the Regulations of Connecticut State Agencies set forth the Department of Social Services requirements for the payment of home health care services on behalf of clients who are determined eligible to receive services under the Connecticut Medicaid program pursuant to section 17b-262 of the Connecticut General Statutes.

(Adopted effective March 7, 2007)

Sec. 17b-262-725. Definitions

As used in section 17b-262-724 to section 17b-262-735, inclusive, of the Regulations of Connecticut State Agencies:

(1) "Activity of daily living" or "ADL" means any activity necessary for self care including bathing, dressing, toileting, transferring and feeding;

(2) "Acute" means symptoms that are severe and have a rapid onset and a short course;

(3) "Care plan" means the patient care plan as set forth in section 19-13-D73 of the Regulations of Connecticut State Agencies;

(4) "Chronic disease hospital" means "chronic disease hospital" as defined in section 19-13-D1(b)(2) of the Regulations of Connecticut State Agencies;

(5) "Client" means a person eligible for goods or services under Medicaid;

(6) "Commissioner" means the Commissioner of Social Services or his or her designee;

(7) "Concurrent" means in the same time period covered by the care plan;

(8) "Department" means the Department of Social Services or its agent;

(9) "Early and periodic screening, diagnostic, and treatment services" or "EPSDT" means the services provided in accordance with section 1905(r) of the Social Security Act, as amended from time to time;

(10) "Emergency" means a medical condition, including labor and delivery, manifesting

itself by acute symptoms of sufficient severity, including severe pain, such that the absence of immediate medical attention could reasonably be expected to result in placing the client's health in serious jeopardy, serious impairment to bodily functions or serious dysfunction of any bodily organ or part;

(11) "Extended nursing services" means nursing care services that are required for more than two continuous, consecutive hours on any given day;

(12) "Hands on care" means the assistance with activities of daily living provided most often, but not exclusively, by home health aides. The assistance includes the prompting and cueing necessary for a client to perform an activity of daily living;

(13) "Home" means the client's place of residence, including, but not limited to, a boarding home, residential care home or community living arrangement. "Home" does not include facilities such as hospitals, nursing facilities, chronic disease hospitals, intermediate care facilities for the mentally retarded (ICFs/MR) or other facilities that are paid an all-inclusive rate directly by Medicaid for the care of the client;

(14) "Home health aide" means "homemaker-home health aide" as defined in section 19-13-D66 of the Regulations of Connecticut State Agencies;

(15) "Home health care agency" means "home health care agency" as defined in section 19a-490 of the Connecticut General Statutes and which:

(A) is licensed by the Department of Public Health pursuant to sections 19-13-D66 to 19-13-D79, inclusive, of the Regulations of Connecticut State Agencies;

(B) meets the requirements of 42 CFR Parts 440, 441 and 484, as amended from time to time; and

(C) is enrolled in Medicaid;

(16) "Home health care services" means the services provided by a licensed home health care agency on a part-time or intermittent basis in the client's home;

(17) "Hospice" means "hospice" as defined in section 19-13-D1(b)(1)(C) of the Regulations of Connecticut State Agencies;

(18) "Hospital" means "short-term hospital" as defined in section 19-13-D1(b)(1) of the Regulations of Connecticut State Agencies;

(19) "Household" means a situation where two or more people are living: (A) in a group home, a residential care home or other group living situation; (B) at the same street address if it is a single family house that is not divided into apartments or units; or (C) at the same apartment number or unit number if clients live in a building that is divided into apartments or units;

(20) "Instrumental activity of daily living" or "IADL" means any activity related to a person's ability to function in the home, including, but not limited to, meal preparation, housework, laundry and use of the telephone;

(21) "Intermediate care facility for the mentally retarded" or "ICF/MR" means a residential facility for persons with mental retardation licensed pursuant to section 17a-227 of the Connecticut General Statutes, if applicable, and certified to participate in Medicaid as an intermediate care facility for the mentally retarded pursuant to 42 CFR 442.101, as

amended from time to time;

(22) "Intermittent" means less than twenty-four hour care within a twenty-four hour period;

(23) "Licensed practical nurse" or "LPN" means "licensed practical nurse" as defined in chapter 378 of the Connecticut General Statutes;

(24) "Licensed practitioner" means a physician who orders home health care services in accordance with sections 19-13-D66 to 19-13-D79, inclusive, of the Regulations of Connecticut State Agencies;

(25) "Licensed practitioner order" means an order that directs the home health care agency to provide services according to the licensed practitioner's care plan;

(26) "Medicaid" means the program operated by the department pursuant to section 17b-260 of the Connecticut General Statutes and authorized by Title XIX of the Social Security Act, as amended from time to time;

(27) "Medical appropriateness" or "medically appropriate" means health care that is provided in a timely manner and meets professionally recognized standards of acceptable medical care; is delivered in the appropriate setting; and is the least costly of multiple, equally-effective alternative treatments or diagnostic modalities;

(28) "Medical necessity" or "medically necessary" means health care provided to correct or diminish the adverse effects of a medical condition or mental illness; to assist an individual in attaining or maintaining an optimal level of health; to diagnose a condition; or to prevent a medical condition from occurring;

(29) "Medical record" means "medical record" as defined in section 19a-14-40 of the Regulations of Connecticut State Agencies;

(30) "Medication administration" means the administration of oral, intramuscular or subcutaneous medication and also those procedures used to assess the client's medical or behavioral health status as ordered by the prescribing practitioner. Such procedures include, but are not limited to, glucometer readings, pulse rate checks, blood pressure checks or brief mental health assessments;

(31) "Normal life activities" means any activity that the client attends or in which he participates in the community including, but not limited to, school, work and day care;

(32) "Nursing care services" means the services provided by a registered nurse or a licensed practical nurse;

(33) "Nursing facility" means "nursing facility" as defined in 42 USC 1396r(a), as amended from time to time;

(34) "Occupational therapy" means the services provided by an occupational therapist or an occupational therapy assistant as set forth in section 20-74a of the Connecticut General Statutes;

(35) "Physical therapy" means the services provided by a physical therapist or a physical therapy assistant as set forth in section 20-66 of the Connecticut General Statutes;

(36) "Physician" means a physician or surgeon licensed pursuant to sections 20-8 to 20-14k, inclusive, of the Connecticut General Statutes;

(37) "Postpartum" means the sixty-day time period immediately following childbirth;

(38) "Prenatal" means the time period between the beginning of a pregnancy and the end of a pregnancy;

(39) "Prior authorization" or "PA" means the approval for the provision of a service or delivery of goods from the department before the provider actually provides the service or delivers the goods;

(40) "Provider" means a home health care agency;

(41) "Registered nurse" means "registered nurse" as defined in chapter 378 of the Connecticut General Statutes;

(42) "Speech therapy" or "speech pathology" means the services provided by a speech pathologist as set forth in section 20-408 of the Connecticut General Statutes;

(43) "Usual and customary charge" means the amount that the provider charges for the service or procedure in the majority of non-Medicaid cases. If the provider varies the charges so that no one amount is charged in the majority of cases, "usual and customary" shall be defined as the median charge. Token charges for charity patients and other exceptional charges are to be excluded; and

(44) "Week" means a calendar week beginning on Sunday and ending on Saturday.

(Adopted effective March 7, 2007)

Sec. 17b-262-726. Provider participation

To enroll in Medicaid and receive payment from the department, providers shall comply with sections 17b-262-522 to 17b-262-533, inclusive, and sections 17b-262-1 to 17b-262-9, inclusive, of the Regulations of Connecticut State Agencies.

(Adopted effective March 7, 2007)

Sec. 17b-262-727. Eligibility

Payment for home health care services provided to persons eligible for Medicaid shall be available subject to the conditions and limitations that apply to these services as identified in sections 17b-262-724 to 17b-262-735, inclusive, of the Regulations of Connecticut State Agencies.

(Adopted effective March 7, 2007)

Sec. 17b-262-728. Services covered and limitations

(a) Subject to the limitations and exclusions identified in sections 17b-262-724 to 17b-262-735, inclusive, of the Regulations of Connecticut State Agencies, the department shall pay for medically necessary and medically appropriate home health care services provided by home health care agencies that are directly related to the client's diagnosis, symptoms or medical history. These services include:

(1) nursing care services limited to the following:

(A) physical nursing care or the teaching of nursing care, including, but not limited to, direct services such as enemas, irrigations, dressing changes, treatments and administration

and supervision of medication;

(B) admission of clients to agency services; development of the initial care plan; and subsequent reviews of the care plan, no more than one every 60 days;

(C) diabetic teaching for thirty consecutive days per diabetic client;

(D) pregnancy-related preventive prenatal and postpartum nursing care services to women at high risk of negative pregnancy outcome that are performed during the prenatal or postpartum period of pregnancy for the purpose of, but not limited to:

(i) evaluation of medical health status, obstetrical history, present and past pregnancy related problems and psychosocial factors such as emotional status, inadequate resources, supportive helping networks and parenting skills; and

(ii) the provision of general health education and counseling, referral, instruction, suggestions, support or observation to monitor for any untoward changes in the condition of a prenatal or postpartum woman at high risk so that other medical or social services, if necessary, can be instituted during the prenatal or postpartum stage of childbearing;

(2) hands on care provided by a home health aide;

(3) home health aide assistance with an IADL provided in conjunction with hands on care;

(4) physical therapy services;

(5) speech therapy or speech pathology services;

(6) occupational therapy services; and

(7) EPSDT

(b) Limitations on covered services shall be as follows:

(1) The department shall pay for home health care services only when these services are provided in the client's home. However, the department shall pay for medically necessary and medically appropriate nursing care services for clients who leave their place of residence to engage in normal life activities. The total number of hours of nursing care services shall be limited to those hours to which the client would be entitled if services were provided exclusively at the client's place of residence. Such services shall not be provided in hospitals, nursing facilities, chronic disease hospitals, intermediate care facilities for the mentally retarded or other facilities that are paid an all-inclusive rate directly by Medicaid for the care of the client.

(2) The department shall pay for only those services that are listed in the department's fee schedule for home health care services.

(3) The department shall pay for pregnancy-related preventive postpartum nursing care services only for high risk women as described in section 17b-262-731 of the Regulations of Connecticut State Agencies. Such payment shall be limited to services provided during the sixty-day time period immediately following childbirth.

(4) Home health aide services in excess of fourteen hours per week must be cost effective, as described in section 17b-262-730 of the Regulations of Connecticut State Agencies, for Medicaid payment to be available.

(5) Extended nursing services shall be cost effective as described in section 17b-262-

730 of the Regulations of Connecticut State Agencies.

(6) The fee for medication administration shall include the administration of medication(s) while the nurse is present as well as the pre-pouring of additional doses, less than a one week supply, that the client will self administer at a later time and the teaching of self administration of the medication that has been pre-poured.

(7) When the purpose of the visit is to pre-pour medication for a week or more, the skilled nursing visit codes for either a registered nurse or a licensed practical nurse shall be used. The skilled nursing visit is provided for a client who has a documented need for this service because of his or her inability to correctly count out or draw up the medication for self-administration. Documentation shall include a full assessment of the client's medical and behavioral status as well as notes addressing the client's understanding of the drug therapy and his or her continued ability to self-administer the medications.

(8) If during the course of a scheduled medication administration visit, there is a change in the client's condition and the client's prescribing practitioner is notified, the medication administration visit may become a skilled nursing visit. This may occur even if a revision to the client's plan of care is not required. The client's medical record shall be fully updated to reflect the change in medical and behavioral health observed during the visit, the additional skilled services provided to the client and the revisions, if any, made to the plan of care. If this situation occurs and the services have been prior authorized, the provider shall contact the department to request modification of the prior authorization.

(Adopted effective March 7, 2007)

Sec. 17b-262-729. Services not covered

The department shall not pay a home health care agency:

(1) for services provided to a client who is receiving the same service concurrently from an individual therapist, clinic, hospital, practitioner, rehabilitation center or other health care provider;

(2) for services provided by or through another agency or facility as part of its licensing requirements. For example, the department shall not pay for home health aide services if the client lives in a facility that provides home health aide services as part of its licensing requirements;

(3) when the client is in a hospital, nursing facility, chronic disease hospital, ICF/MR or other facility that is paid an all-inclusive rate directly by Medicaid for the care of the client;

(4) when the client is receiving the same home health care services concurrently from another home health care agency. This limitation does not preclude a home health care agency from contracting with another agency as described in section 19-13-D70 of the Regulations of Connecticut State Agencies;

(5) for well child care or for prenatal or postpartum care that is not high risk;

(6) for medical and surgical supplies or durable medical equipment used by the nurse, home health aide or therapist as part of the course of treatment for a client;

(7) for cancelled visits, appointments not kept or services not provided;

(8) for information or services provided to a client over the telephone; or

(9) for anything of an unproven, experimental or research nature or for services in excess of those deemed medically necessary and medically appropriate by the department to treat the client's condition or for services not directly related to the client's diagnosis, symptoms or medical history.

(Adopted effective March 7, 2007)

Sec. 17b-262-730. Cost effectiveness test

(a) The department shall apply a cost effectiveness test for all prior authorization requests for: (1) home health aide services in excess of fourteen hours per week; and (2) all extended nursing services. The purpose of said test is to ensure that the services requiring PA, when combined with other services provided and within the home health care agency's scope of practice, whether or not provided by the home health agency, are not more expensive than the cost of the care would be for the client if the client were to be placed in the appropriate institution.

(b) In determining whether the home health care services are cost effective, the department shall compare the monthly cost of the home health care services with the monthly rate at the appropriate institution. The monthly cost of service in the appropriate institution means the average monthly Medicaid rate, calculated by the department, for a particular type of institution, for example, a nursing facility or ICF/MR. The monthly cost of home health care services is defined as the projected costs of providing these services for the client.

(c) The department shall total the costs of the following services to determine the cost of the home health care services: nursing, home health aide, physical therapy, speech therapy and occupational therapy. All costs of providing these services shall be included whether provided by a single home health care agency or multiple Medicaid providers including any other entity that the department reimburses for these services.

(d) The department shall determine whether a nursing facility, ICF/MR, chronic disease hospital or hospice is the appropriate institutional placement. Such determination shall depend on the criteria for admission to the institution and the client's care needs.

(e) The department shall approve PA requests for home health aide services for more than fourteen hours per week or extended nursing services only if:

(1) the total monthly cost of the home health care services as described in subsection (c) of this section is less than the monthly cost of services provided at the appropriate institution as described in subsection (d) of this section; and

(2) all other requirements of sections 17b-262-724 to 17b-262-735, inclusive, of the Regulations of Connecticut State Agencies are met.

(f) Notwithstanding subsections (a) and (e) of this section, the department shall not apply the cost-effectiveness test for a PA request for home health aide services or extended nursing services provided during the first week after a hospital discharge. However, said services

shall require prior authorization.

(Adopted effective March 7, 2007)

Sec. 17b-262-731. Need for service

(a) The department shall pay for medically necessary and medically appropriate home health care services only under orders of a licensed practitioner as part of a care plan.

(b) The department shall pay for pregnancy-related preventive prenatal or postpartum nursing care services only if the woman has one, or a combination of, high risk indicators including, but not limited to, the following, which, in the opinion of her licensed practitioner, places the woman at high risk for negative pregnancy outcomes:

(1) an age under 20;

(2) an age over 39;

(3) a late registration for prenatal care that starts after the sixteenth week of gestation;

(4) no prenatal care;

(5) a serious weight loss or inadequate weight gain of seven pounds or less;

(6) a prenatal weight of more than eighty percent above the standard for height and age;

(7) more than one abortion, or an abortion within three months before the current pregnancy;

(8) a previous neonatal or fetal death;

(9) a previous preterm birth;

(10) an infant with a significant congenital anomaly or central nervous system damage;

(11) violence or deprivation that was abusive or damaging to the woman or her children;

(12) active substance abuse or an addiction, or a history of substance abuse or addiction, such as alcohol, drugs or nicotine;

(13) an active sexually transmitted disease or a history of such a disease;

(14) diseases or conditions including, but not limited to:

(A) human immunodeficiency virus (HIV), including related conditions such as acquired immune deficiency syndrome (AIDS) or AIDS related complex (ARC);

(B) cancer;

(C) acute or chronic cardiac disease;

(D) chronic renal disease;

(E) a seizure disorder;

(F) hypertension, either pre-existing or gestational;

(G) mental disorder without social or psychiatric supervision;

(H) mental retardation without supervision or support;

(I) endocrine or metabolic disorder;

(J) hepatitis;

(K) multiple sclerosis; or

(L) nutritional deficiency; and

(15) an infant up to sixty days of age with one or a combination of diseases or conditions such as:

(A) HIV, including related conditions such as AIDS or ARC;
(B) a birth before thirty-six weeks of gestation or a birth weight under two thousand five hundred grams;
(C) central nervous system damage;
(D) a failure to thrive or a significant infant feeding problem;
(E) an admission to a neonatal intensive care unit;
(F) a sibling who required treatment for recurring apnea or had sudden infant death syndrome;
(G) mental retardation;
(H) neonatal asphyxia;
(I) a seizure disorder;
(J) a significant congenital anomaly; or
(K) a supervising relative under sixteen years of age.

(Adopted effective March 7, 2007)

Sec. 17b-262-732. Prior authorization

(a) To receive payment from the department the provider shall comply with the prior authorization requirements described in section 17b-262-528 of the Regulations of Connecticut State Agencies and this section. The department, in its sole discretion, shall determine what information is necessary to approve a prior authorization request. Prior authorization does not, however, guarantee payment unless all other requirements for payment are met.

(b) Prior authorization, on forms and in a manner as specified by the department, shall be required for:
(1) nursing care services in excess of an initial evaluation and two visits per week;
(2) all extended nursing services;
(3) pregnancy-related preventive prenatal nursing care services in excess of two visits during the prenatal period;
(4) pregnancy-related preventive postpartum nursing care services in excess of two visits during the postpartum period;
(5) home health aide services in excess of fourteen hours per week;
(6) physical therapy services in excess of an initial evaluation and two visits per week;
(7) speech therapy services in excess of an initial evaluation and two visits per week;
(8) occupational therapy services in excess of an initial evaluation and one visit per week;
(9) physical therapy, occupational therapy or speech therapy services in excess of nine visits per therapy type per calendar year per provider per client, when the therapy is for the treatment of the following diagnoses:
(A) all mental disorders including diagnoses relating to mental retardation and specific delays in development covered by the International Classification of Diseases (ICD), as amended from time to time;
(B) cases involving musculoskeletal system disorders of the spine covered by the ICD,

as amended from time to time; or

(C) cases involving symptoms related to nutrition, metabolism and development covered by the ICD, as amended from time to time; and

(10) Early and periodic screening, diagnostic and treatment services requested under section 1905(r)(5) of the Social Security Act, as amended from time to time.

(c) The provider shall obtain, and the department may give, the initial prior authorization either verbally or by mail. The length of the initial authorization is at the department's discretion, but shall be for no longer than a three-month period. The provider shall submit subsequent prior authorization requests in writing by mail at least thirty days in advance of providing services or delivering goods beyond the period of initial approval. If there is a need to change the prior authorization request, the provider shall notify the department not more than two working days after the modification was made. Any authorization period for home health aide services shall be for at least one month.

(d) If continued treatment is needed beyond an initial or subsequent authorization period, the department shall consider, and may approve, an additional prior authorization request that shall be for a period of up to twelve months. The provider shall submit subsequent prior authorization requests in writing by mail at least thirty days in advance.

(e) The provider shall present pertinent medical or social information adequate for evaluating the client's medical need for services when requesting prior authorization. The home health care agency shall maintain a valid practitioner's order on file. Except in emergency situations, the provider shall obtain approval from the department before services are rendered.

(f) In an emergency situation that occurs after working hours or on a weekend or holiday, the provider shall secure verbal authorization on the next working day for the services provided. This applies only to those services that normally require prior authorization. If verbal authorization is obtained, the provider shall submit a written request not more than ten days after the date of service.

(Adopted effective March 7, 2007)

Sec. 17b-262-733. Billing procedures

(a) Claims from home health care agencies shall be submitted on the department's designated form or electronically transmitted to the department or its agent, in a form and manner as specified by the department, and shall include all information required by the department to process the claim for payment.

(b) The provider shall bill the usual and customary charge and the department shall pay the lowest of:

(1) the provider's usual and customary charge;

(2) the lowest non-managed care Medicare rate;

(3) the amount in the applicable fee schedule as published by the department; or

(4) the amount billed by the provider to the department.

(Adopted effective March 7, 2007)

Sec. 17b-262-734. Payment

(a) **Payment**

(1) The commissioner shall establish the fees for home health care services in the department's fee schedule pursuant to section 17b-242 of the Connecticut General Statutes.

(2) The department shall pay for home health aide services based on each unit of service the aide spends providing the services as described in the fee schedule.

(3) The department shall pay therapists as described in the fee schedule.

(4) The department shall pay for nursing services based on each visit or unit of service the nurse spends providing the services as described in the fee schedule.

(b) **Payment Limitations**

(1) The department shall reimburse a provider when all of the requirements of sections 17b-262-726 to 17b-262-735, inclusive, of the Regulations of Connecticut State Agencies have been met.

(2) When two or more clients in the same household are receiving nursing care services, except extended nursing services, the department shall pay the full unit fee for the primary client and a reduced fee for each subsequent client. The procedure code and modifier used for billing shall reflect the purpose of the visit for each subsequent client.

(3) The following limitations shall apply when extended nursing services are required to care for multiple clients in the same household:

(A) If one nurse is required, the department shall pay the full unit fee for the primary client and a reduced unit fee for the unit of time during which the nurse is providing care to one subsequent client. No payment shall be made for additional subsequent clients. The billing instructions for home health agencies shall include a detailed description of the billing process. The care plans shall support the ability of one nurse to provide services safely to multiple clients.

(B) If more than one nurse is required, the department shall pay the fee as described in section 17b-262-734(b)(3)(A) of the Regulations of Connecticut State Agencies for each nurse. The care plans shall support the need for multiple nurses.

(4) When home health aides are caring for multiple clients in the same household, the department shall pay each aide the full unit fee. The department shall pay for the home health aide to care for one client for any one 15-minute unit of time.

(5) The fee for home health care services shall include transportation.

(6) The fee for home health aide services shall include supervision of the home health aide by a registered nurse.

(7) The department shall pay the same fee for out-of-state providers as for instate providers.

(Adopted effective March 7, 2007)

Sec. 17b-262-735. Documentation

(a) All required documentation shall be maintained for at least five years, or longer by the provider in accordance with statute or regulation, subject to review by the department.

Documentation as set forth in sections 19-13-D75 and 19-13-D77 of the Regulations of Connecticut State Agencies shall be maintained for seven years. In the event of a dispute concerning a service provided, documentation shall be maintained until the end of the dispute, five years or the length of time required by statute or regulation, whichever is longest.

(b) Failure to maintain and provide all required documentation to the department upon request shall result in the disallowance and recovery by the department of any future or past payments made to the provider for which the required documentation is not maintained and not provided to the department upon request.

(c) The following information shall be documented in writing or electronically, consistent with the requirements described in the Provider Enrollment Agreement and maintained on file with the home health care agency for each Medicaid client:

(1) initial and subsequent care plans signed and dated by the licensed practitioner in accordance with section 19-13-D73 of the Regulations of Connecticut State Agencies;

(2) verbal and telephone orders signed and dated by a licensed practitioner in accordance with section 17b-242 of the Connecticut General Statutes;

(3) Medicaid identification number;

(4) pertinent diagnostic information;

(5) documentation of each service provided and its duration;

(6) dates of services provided;

(7) for pregnancy-related preventive prenatal or postpartum nursing care services, evidence that the client is high risk as described in section 17-262-731 of the Regulations of Connecticut State Agencies;

(8) time sheets documenting all home health aide hours worked and duties performed that are signed by the client or his or her representative. A client representative shall not be an employee of, or under contract to, the home health care agency. All signatures shall be accompanied by a printed name; and

(9) all information described in section 19-13-D75(b) of the Regulations of Connecticut State Agencies.

(d) Each home health care agency shall maintain fiscal and medical records that fully disclose services and goods rendered or delivered to Medicaid clients.

(e) The licensed practitioner order shall include the projected number of hours needed for home health care services. The actual number of hours provided may be less than, or the same as, the projected number of hours, but the actual number of hours provided may not exceed the projected number of hours.

(f) Providers shall maintain documentation supporting all prior authorization requests.

(Adopted effective March 7, 2007)

Requirements for Payment to Providers of Orthotic and Prosthetic Devices

Sec. 17b-262-736. Scope

Sections 17b-262-736 to 17b-262-746, inclusive, of the Regulations of Connecticut State Agencies set forth the Department of Social Services requirements for payment to providers of orthotic and prosthetic devices that are prescribed by a licensed practitioner on behalf of clients who are determined to be eligible to receive such goods and services under Medicaid pursuant to section 17b-262 of the Connecticut General Statues.

(Adopted effective January 1, 2003)

Sec. 17b-262-737. Definitions

As used in sections 17b-262-736 to 17b-262-746, inclusive, of the Regulations of Connecticut State Agencies the following definitions shall apply:

(1) "Chronic disease hospital" means a "chronic disease hospital" as defined in section 19-13-D1 of the Regulations of Connecticut State Agencies;

(2) "Client" means a person eligible for goods or services under the Medicaid program;

(3) "Customized orthotic or prosthetic device" means a device prescribed by a licensed practitioner that is specifically manufactured to meet the special medical, physical or psychosocial needs of a client. A customized orthotic or prosthetic device requires special construction, the plans for which are taken from an exact model of a particular client's body part;

(4) "Department" means the Department of Social Services or its agent;

(5) "Documented in writing" means that the prescription has been handwritten, typed or computer printed;

(6) "Home" means the client's place of residence and includes a boarding home, community living arrangement or residential care home. Home does not include a facility such as a hospital, chronic disease hospital, nursing facility, intermediate care facility for the mentally retarded (ICF/MR) or other facilities that are paid an all-inclusive rate directly by Medicaid for the care of the client;

(7) "Hospital" means a "short-term hospital" as defined in section 19-13-D1 of the Regulations of Connecticut State Agencies;

(8) "Intermediate care facility for the mentally retarded" or "ICF/MR" means a residential facility for the mentally retarded licensed pursuant to section 17a-227 of the Connecticut General Statutes and certified to participate in the Medicaid program as an intermediate care facility for the mentally retarded pursuant to 42 CFR 442.101, as amended from time to time;

(9) "Licensed practitioner" means an individual who is either licensed by the Connecticut Department of Public Health, another state, District of Columbia or the Commonwealth of Puerto Rico and is acting within his or her scope of practice under Connecticut state law in prescribing an orthotic or prosthetic device;

(10) "Medical appropriateness" or "medically appropriate" means health care that is provided in a timely manner and meets professionally-recognized standards of acceptable

medical care; is delivered in the appropriate setting; and is the least costly of multiple, equally-effective, alternative treatments or diagnostic modalities;

(11) "Medicaid" means the program operated by the Department of Social Services pursuant to section 17b-260 of the Connecticut General Statutes and authorized by Title XIX of the Social Security Act, as amended from time to time;

(12) "Medical necessity" or "medically necessary" means health care provided to correct or diminish the adverse effects of a medical condition or mental illness, to assist an individual in attaining or maintaining an optimal level of health, to diagnose a condition or to prevent a medical condition from occurring;

(13) "Nursing facility" means an institution as defined in 42 USC 1396r(a), as amended from time to time;

(14) "Orthotic or prosthetic device" or "device" means a corrective or supportive device prescribed by a licensed practitioner, within the scope of his or her practice as defined by federal and state law, to:

(A) artificially replace a missing portion of the body;

(B) prevent or correct physical deformity or malfunction; or

(C) support a weak or deformed portion of the body;

(15) "Prescription" means an original order issued by a licensed practitioner that is documented in writing and signed and dated by the licensed practitioner issuing the order;

(16) "Prior authorization" or "PA" means approval from the department for the provision of a service or the delivery of goods from the department before the provider actually provides the service or delivers the goods;

(17) "Provider" means the vendor or supplier of an orthotic or prosthetic device who is enrolled with the department as a medical equipment, devices, and supplies supplier; and

(18) "Usual and customary charge" means the amount that the provider charges for the service or procedure in the majority of non-Medicaid cases. If the provider varies the charges so that no one amount is charged in the majority of cases, usual and customary shall be defined as the median charge. Token charges for charity patients and other exceptional charges are to be excluded.

(Adopted effective January 1, 2003)

Sec. 17b-262-738. Provider participation

To enroll in the Medicaid program and receive payment from the department, providers shall comply with sections 17b-262-522 to 17b-262-533, inclusive, of the Regulations of Connecticut State Agencies.

(Adopted effective January 1, 2003)

Sec. 17b-262-739. Eligibility

A provider may receive reimbursement from the department for the provision of an orthotic and prosthetic device to a client. No reimbursement shall be made unless a licensed practitioner has prescribed the orthotic or prosthetic device subject to the conditions and

limitations set forth in sections 17b-262-736 to 17b-262-746, inclusive, of the Regulations of Connecticut State Agencies.

(Adopted effective January 1, 2003)

Sec. 17b-262-740. Services covered and limitations

(a) **Services Covered**

(1) The department shall pay for the purchase or repair of a medically necessary and medically appropriate orthotic or prosthetic device, except as limited by sections 17b-262-736 to 17b-262-746, inclusive, of the Regulations of Connecticut State Agencies, provided such device is prescribed by a licensed practitioner in conformance with accepted methods of diagnosis and treatment.

(2) The department shall pay for an orthotic or prosthetic device for a client who lives at home or in a nursing facility, ICF/MR, hospital or chronic disease hospital, except as limited by sections 17b-262-736 to 17b-262-746, inclusive, of the Regulations of Connecticut State Agencies.

(3) The department shall maintain a fee schedule for orthotic and prosthetic devices, subject to the conditions and limitations set forth in sections 17b-262-736 to 17b-262-746, inclusive, of the Regulations of Connecticut State Agencies. This fee schedule is designed to meet the needs of most Medicaid clients. An item is not covered unless it is on the fee schedule. A provider or client may request that an item be added to the fee schedule. The department, at its discretion, may decide to add requested items during its regular revisions to the fee schedule, as published by the department.

(4) The department shall pay for early and periodic screening, diagnostic and treatment services (EPSDT) described in subsection 1905(r) of the Social Security Act, as amended from time to time.

(b) **Limitations**

(1) The department shall pay for replacement of a device only if the device is lost, destroyed or is no longer medically usable or adequate due to a measurable change in the client's condition. A new prescription shall be required for a replacement item. All requests for purchases of orthotic or prosthetic devices to replace a device shall be fully explained, and shall document the continuing medical necessity and include reasons for the replacement and the reason that repairs are not feasible or are more costly than replacement.

(2) The department shall not pay for an orthotic or prosthetic device for a client in a nursing facility, ICF/MR, chronic disease hospital or hospital if the device is included in the facility's per diem Medicaid rate.

(3) The department shall not pay for an orthotic or prosthetic device that can be billed to another payor.

(Adopted effective January 1, 2003)

Sec. 17b-262-741. Goods and services not covered

The department shall not pay providers for:

(1) any orthotic or prosthetic device that is of an unproven, experimental or research nature or for services in excess of those deemed medically necessary by the department to treat the client's condition or for services not directly related to the client's diagnosis, symptoms or medical history;

(2) any non-customized orthotic or prosthetic device that does not require prior authorization and that is prescribed and ordered for a client who:

(A) dies prior to delivery of the device; or

(B) is not otherwise eligible on the date of delivery. It shall be the provider's responsibility to verify that the client is eligible on the date the device is delivered; or

(3) the purchase or repair of an orthotic or prosthetic device necessitated by inappropriate, willful or malicious misuse on the part of the client as determined by the department.

(Adopted effective January 1, 2003)

Sec. 17b-262-742. Prior authorization

(a) The department shall require PA for any orthotic or prosthetic device identified on the department's published fee schedule as requiring PA.

(b) To receive reimbursement from the department a provider shall comply with all prior authorization requirements. The department in its sole discretion shall determine what information is necessary to approve a prior authorization request. Prior authorization does not, however, guarantee payment unless all other requirements are met.

(c) A PA request, on a form and in a manner specified by the department, shall include documentation of medical necessity and shall be signed by the prescribing licensed practitioner and the provider. A copy of the prescription from the licensed practitioner may be attached to the completed PA request in lieu of the actual signature of the licensed practitioner on the PA request form. The licensed practitioner's original prescription shall be on file with the provider and be subject to review by the department.

(d) A provider may send a prior authorization request to the department via facsimile if the request is medically necessary to: (1) facilitate institutional discharge or (2) avoid imminent hospitalization. Specifics that substantiate the nature of the request shall be clearly identified in the facsimile. All other PA requests for an orthotic or prosthetic device shall be submitted by mail.

(Adopted effective January 1, 2003)

Sec. 17b-262-743. Billing procedure

(a) Claims from providers shall be submitted on a hard copy invoice or electronically transmitted to the department or its agent in a form and in a manner specified by the department and shall include all information required by the department to process the claim for payment.

(b) A claim submitted for an orthotic or prosthetic device that did not require prior authorization shall include the name of the licensed practitioner prescribing the device. A licensed practitioner's original prescription for the device shall be on file with the provider

and shall be subject to review by the department.

(c) Providers shall bill and the department shall pay at the lowest of:

(1) the usual and customary charge;

(2) the lowest Medicare rate;

(3) the amount in the applicable fee schedule as published by the department;

(4) the amount billed by the provider to the department; or

(5) the amount the department indicates in writing in a prior authorization.

(Adopted effective January 1, 2003)

Sec. 17b-262-744. Payment limitations

(a) The department shall reimburse a provider when all requirements of sections 17b-262-736 to 17b-262-746, inclusive, of the Regulations of Connecticut State Agencies have been met.

(b) The department shall pay for a customized orthotic or prosthetic device for a client who dies or is not otherwise eligible on the date of delivery provided the client was eligible:

(1) on the date prior authorization was given by the department; or

(2) on the date the client ordered the device, if the device does not require prior authorization. For purposes of this section, the date the client orders the device means the date on which the written medical order for the device is presented to or received by the provider. The provider shall verify to the department the date the client ordered the device.

(c) If the cost of repairs to any orthotic or prosthetic device exceeds its replacement cost, the device shall be replaced.

(d) The price for any device listed in the fee schedule published by the department shall include:

(1) fees for initial fittings and all related subsequent adjustments;

(2) labor charges;

(3) delivery costs, fully prepaid by the provider, including any manufacturer's delivery charges, postage, packing and shipping;

(4) all travel costs incurred by the provider associated with measurements, fittings, adjustments or repairs;

(5) technical assistance fees related to teaching the client, his or her family or the designated representative the proper use and care of the equipment; and

(6) fees for providing information to the client over the telephone.

(e) The department shall pay for the servicing, repair or replacement of an orthotic or prosthetic device that is purchased by the department, provided that any manufacturer's or dealer's warranty has been exhausted. The provider shall first utilize existing warranties that cover required servicing, repairs and replacement.

(Adopted effective January 1, 2003)

Sec. 17b-262-745. Documentation

(a) All required documentation shall be maintained for at least five (5) years in the

provider's primary place of business and shall be subject to review by the department. In the event of a dispute concerning a service or a device provided, documentation shall be maintained until the end of the dispute or five (5) years, whichever is longer.

(b) Failure to maintain all required documentation shall result in the disallowance and recovery by the department of any amounts paid to the provider for the device or service for which the required documentation is not maintained or provided to the department upon request.

(c) The licensed practitioner's original prescription for an orthotic or prosthetic device and documentation of all notes related to fittings and adjustments shall be kept at the provider's primary place of business and shall be subject to review by the department.

(d) Providers shall maintain all fiscal and medical records related to services and goods rendered or delivered to Medicaid clients.

(e) Providers shall require and retain a signed receipt for all deliveries of orthotic and prosthetic devices, documenting that the client or, if the client is unable to sign, a designated representative other than the provider or the provider's employee, took delivery of the device. The receipt for an orthotic or prosthetic device, regardless of the format used, shall, at a minimum, contain the following elements:

(1) the provider's name;

(2) the client's name;

(3) the delivery address;

(4) the date of delivery; and

(5) itemization of the orthotic and prosthetic devices delivered, including:

(A) a product description;

(B) a brand name;

(C) a model name and number, if applicable;

(D) a serial number, if applicable;

(E) the quantity delivered; and

(F) the amount billed per device.

(f) A prescription for an orthotic or prosthetic device, regardless of the format used, shall, at a minimum, contain the following elements:

(1) the client's name, address and date of birth;

(2) the diagnosis for which the orthotic or prosthetic device is required;

(3) a detailed description of the orthotic or prosthetic device, including the quantity and any special options or add-ons, and, if needed, directions for usage;

(4) the length of need for the orthotic or prosthetic device prescribed;

(5) the name and address of the prescribing licensed practitioner; and

(6) the prescribing licensed practitioner's signature and date of his or her signature.

(Adopted effective January 1, 2003)

Sec. 17b-262-746. Other

(a) Where brand names or stock or model numbers are specified on the prescription or

the PA, no substitution shall be permitted without the written approval of the department.
(b) The provider shall instruct the client, his or her family or a designated representative on the proper use and care of the device.
(c) Providers shall initiate necessary reimbursement adjustments to the department resulting from returns of non-customized orthotic and prosthetic devices delivered to a client.
(d) The provider shall maintain a written usual and customary price list that details individual product and service charges. This list, including updates along with any required manufacturer's list pricing, shall be available for review by authorized department personnel.
(e) An orthotic or prosthetic device purchased by the department shall be new and shall become the property of the client on the date of delivery to the client.

(Adopted effective January 1, 2003)

Requirements for Payment of Services Provided by Private Non-Medical Institutions

Sec. 17b-262-747. Scope

Sections 17b-262-747 to 17b-262-757, inclusive, of the Regulations of Connecticut State Agencies set forth the Department of Social Services' requirements for payment of rehabilitative services provided by private non-medical institutions to children who are determined eligible for Connecticut's Medicaid program pursuant to section 17b-261 of the Connecticut General Statutes.

(Adopted effective March 11, 2003)

Sec. 17b-262-748. Definitions

As used in sections 17b-262-747 through 17b-262-757, inclusive, of the Regulations of Connecticut State Agencies the following definitions shall apply:
(1) "Billing provider" means the Connecticut Department of Children and Families.
(2) "Child" means a person who is under twenty-one (21) years of age.
(3) "Department" or "DSS" means the Department of Social Services or its agent.
(4) "DCF" means the Department of Children and Families.
(5) "Individual treatment plan" means a written plan developed by the performing provider in accordance with section 17b-262-749(a)(5) of the Regulations of Connecticut State Agencies.
(6) "Licensed clinical staff" means:
(A) a doctor of medicine or osteopathy licensed under chapter 370 of the Connecticut General Statutes;
(B) a psychologist who is licensed under chapter 383 of the Connecticut General Statutes;
(C) a marriage and family therapist who is licensed under chapter 383a of the

Connecticut General Statutes;

(D) a clinical social worker who is licensed under chapter 383b of the Connecticut General Statutes;

(E) an alcohol and drug counselor who is licensed under chapter 376b of the Connecticut General Statutes;

(F) an advanced practice registered nurse who is licensed under chapter 378 of the Connecticut General Statues; or

(G) a registered nurse who is licensed under chapter 378 of the Connecticut General Statutes and who has a minimum of one year of experience in the mental health field.

(7) "Medicaid" means the program operated by the department pursuant to Section 17b-260 of the Connecticut General Statutes and authorized by Title XIX of the Social Security Act.

(8) "Medically necessary" or "medically appropriate" means health care provided to correct or diminish the adverse effects of a medical condition or mental illness; to assist an individual in attaining or maintaining an optimal level of health; to diagnose a medical condition or mental illness; or to prevent a condition from occurring.

(9) "Monthly rate" means the amount the department pays for each PNMI client for PNMI program services for each month of service.

(10) "Performing provider" means an entity that participates in the Medicaid program as a provider of PNMI children's rehabilitative services and that is a state licensed or approved (A) residential treatment facility; group home; maternity home; or similar institution; or (B) child placing agency that offers a therapeutic foster care or professional parent program.

(11) "PNMI client" or "client" means a client who is a child that (A) has been placed with a PNMI performing provider by a state agency and (B) determined by the department to be eligible for Medicaid.

(12) "Private Non-Medical Institution" or "PNMI" means an entity that is not a health insuring organization, hospital, nursing home, or a community health care center, but which (A) provides residential services for children and is licensed or approved by the state of Connecticut as (i) a residential treatment facility, group home, maternity home, or similar institution or (ii) a child placing agency that offers a therapeutic foster care or a professional parent program or (B) is an out-of-state facility determined by the Commissioner of the Department of Children and Families to meet comparable licensure standards or requirements.

(13) "Residential treatment facility" means a 24 hour mental health facility that is licensed or approved by the Department of Children and Families and that operates for the purpose of effecting positive change and normal growth and development for emotionally disturbed, behavior disordered and socially maladjusted children.

(14) "Group home" means a community based residential facility with a homelike environment that is licensed or approved by the Department of Children and Families; provides board and care, counseling, life-skill training and recreation; and arranges for or

helps residents access educational, vocational and therapy services that are offered in the community.

(15) "Maternity home" means a maternity home that (A) is licensed by DCF as a group home; (B) is a 24 hour facility that provides board, care, treatment and the therapeutic environment required to promote positive change and growth in pregnant adolescents and young mothers; and (C) has neonatal and postnatal programs that are designed to assess client needs and develop skills in parenting, socialization and independent living.

(16) "Therapeutic foster care" means a program offered by a DCF approved or licensed child placing agency that recruits, trains and supports foster parents who provide family foster care to children with emotional and behavioral needs.

(17) "Professional parent program" means a program provided by a DCF approved or licensed child placing agency that (A) recruits, trains and supports foster parents who provide family foster care to children with multiple needs and (B) serves children who need a greater level of care than those children who are served in a therapeutic foster care agency program.

(18) "Provider agreement and contract" means the signed, written contractual agreement between the department and the performing provider and the billing provider of PNMI children's rehabilitative services.

(19) "Rehabilitative services" means those services described in 42 C.F.R. 440.130(d), as amended from time to time, and include those services identified in section 17b-262-752 of the Regulations of Connecticut State Agencies.

(20) "Title V Agency" means the Department of Public Health, which administers Title V of the Social Security Act, known as the Maternal and Child Health Services Block Grant.

(21) "PNMI program" means the component part of the state's Title V program, which is administered through agreement among the billing provider, the department and the Title V Agency.

(Adopted effective March 11, 2003)

Sec. 17b-262-749. Provider and billing provider requirements

To participate in the Medicaid program and provide PNMI rehabilitative services that are eligible for Medicaid reimbursement from the department, the following requirements shall be met:

(1) The performing provider shall:

(A) Enroll with the department and have on file a valid provider agreement.

(B) Be licensed or approved by DCF or another state agency as (A) a residential treatment facility, group home, maternity home, or similar institution; or (B) a child placing agency that offers therapeutic foster care or a professional parent program.

(C) Comply with all Medicaid record keeping, documentation and other requirements, including, but not limited to, those delineated in the department's administrative manuals, provider agreements and memoranda of understanding.

(D) Follow all laws, rules, regulations, policies and amendments that govern the Medicaid

program as they relate to reimbursement for PNMI rehabilitative services.

(E) Develop an individual treatment plan for each PNMI client in accordance with section 17a-145-94 of the Regulations of Connecticut State Agencies not later than thirty days after the PNMI client's admission to the program. The individual treatment plan shall be developed in conjunction with DCF, the child and the child's family, whenever possible, and shall be signed and dated by a licensed clinical staff member employed by or under contract with the performing provider. Such plan shall contain specific behavioral health goals and objectives that are based on an evaluation and diagnosis for the maximum reduction of a client's behavioral health problems and shall identify the type, amount, frequency and duration of services to be provided.

(F) Ensure that a licensed clinical staff member employed by or under contract with the performing provider reviews and signs the individual treatment plan within each six month calendar period following the date of a PNMI client's admission.

(G) Keep current service and progress notes in a permanent case record for each PNMI client in accordance with sections 17a-145-94 and 17a-145-98 of the Regulations of Connecticut State Agencies. Such entries shall be made on at least a monthly basis.

(H) Furnish information and documentation to the billing provider that is sufficient to allow the billing provider to prepare PNMI claims for rehabilitative services.

(I) Cooperate with the department and the billing provider in the rate setting process; licensing; or any quality assurance reviews or periodic audits to ensure compliance with PNMI program requirements.

(J) Assign billing responsibilities related to the claiming of federal financial participation for state PNMI Medicaid costs to the billing provider.

(2) The billing provider shall:

(A) Have a valid provider agreement and contract on file that is signed by the performing provider, the billing provider and the department that assigns responsibility for the claiming of federal financial participation to the department. The agreement shall be updated periodically in accordance with Medicaid requirements.

(B) Ensure that the performing provider meets and maintains all applicable licensing, accreditation and certification requirements in accordance with federal and state laws.

(C) Comply with all Medicaid record keeping, documentation, and other requirements, including, but not limited to, those delineated in department PNMI rehabilitative service administrative manuals, provider agreements and memoranda of understanding.

(D) Follow all laws, rules, regulations, policies and amendments that govern the Medicaid program as they relate to PNMI rehabilitative services.

(E) Carry out regular licensing and quality assurance reviews of performing providers.

(F) Assist the department in establishing PNMI rates that are based upon Medicaid eligible activities that are not otherwise being claimed for federal financial participation.

(Adopted effective March 11, 2003)

Sec. 17b-262-750. Eligibility

Payment for PNMI rehabilitative services shall be subject to available appropriations and shall be available for services rendered to PNMI clients under the conditions and limitations that are set forth in sections 17b-262-747 to 17b-262-757, inclusive, of the Regulations of Connecticut State Agencies.

(Adopted effective March 11, 2003)

Sec. 17b-262-751. Need for services

Payment for PNMI rehabilitative services shall be made by the department only if all of the following conditions are met:

(1) The client shall be assessed by the billing provider or its agent to determine that the PNMI rehabilitative services are medically necessary or medically appropriate.

(2) For up to 30 days of a PNMI client's initial stay in a PNMI program, the PNMI rehabilitative services shall be provided in accordance with an initial assessmentof need that is completed by DCF and signed by a licensed clinical staff member of the performing provider. This assessment shall, for up to 30 days of a PNMI client's initial stay, be deemed to meet the PNMI requirements for an individual treatment plan set forth in section 17b-262-749(a)(5) of the Regulations of Connecticut State Agencies.

(3) After the first 30 days of a client's stay in a PNMI program, the PNMI rehabilitative services shall be provided in accordance with a written individual treatment plan developed in accordance with section 17b-262-749(a)(5) of the Regulations of Connecticut State Agencies. Within each 90 day period thereafter, the individual treatment plan shall be reviewed by the licensed, clinical staff employed by or under contract with the performing provider.

(Adopted effective March 11, 2003)

Sec. 17b-262-752. Covered services

PNMI rehabilitative services shall include the following services:

(1) Assessment, treatment planning and support activities that assist the client in gaining access to authorized services. These services include:

(A) Intake and assessment, which means assessing and reassessing the client's behavioral health needs in the context of medical, social, educational and other needs through face-to-face contact with the client, the client's family and through consultation with other professionals; and

(B) Development of an individual treatment plan in accordance with sections 17b-262-749(a)(5) and 17b-262-751 of the Regulations of Connecticut State Agencies; and

(C) Care coordination, which means facilitating the child's access to behavioral health services identified in the individual treatment plan, including:

(i) Arranging for services;

(ii) Assuring that prescribed services are received;

(iii) Assessing the effectiveness of those services;

(iv) Attending case conferences to review and modify individual treatment plans as necessary; and

(v) Arranging home visits, discharge and aftercare services.

(2) Socialization skills development, which means client-centered activities that are provided to support the goals and objectives in the PNMI client's individual treatment plan and that are directed at reducing mental disabilities of children in care, restoring them to their best possible functioning level and assisting clients in becoming responsible for their own actions.

(3) Counseling and therapy, which includes (A) individual, group and family counseling and (B) therapy or consultation that is necessary to improve problems and to restore children to their optimal functioning level.

(Adopted effective March 11, 2003)

Sec. 17b-262-753. Limitations

Coverage of PNMI rehabilitative services shall be subject to the following limitations:

(1) PNMI rehabilitative services shall be pre-authorized by DCF based on a written service recommendation.

(2) The PNMI rehabilitative service shall be based on the individual treatment plan developed pursuant to section 17b-262-749(a)(5) of the Regulations of Connecticut State Agencies and shall be performed by the performing provider or under the supervision of licensed clinical staff employed by or under contract to the performing provider.

(3) The department shall not pay for programs, services or components of services that are of an unproven, experimental, cosmetic or research nature.

(4) The department shall not pay for programs, services or components of services that do not relate to the client's diagnosis, symptoms or medical history.

(5) The department shall not pay for programs, services or components of services, which are not included in the fee schedule established by the department.

(6) The department shall not pay for programs, services that are academic in nature such as tutoring, study sessions or instruction in English, science, history, mathematics or foreign languages.

(7) The department shall not pay for programs, services or components of services that are intended solely to prepare individuals for paid or unpaid employment or for vocational equipment and uniforms.

(8) The department shall not pay for programs, services or components of services designed to provide socialization or recreational activities for clients unless such services are provided to meet a client's need for motivational, diversionary or behavior management activities for which specific goals and objectives are identified in the client's individual treatment plan.

(9) The department shall not pay for costs associated with room and board for clients.

(10) The department shall not pay PNMI rehabilitative services that are provided out-of-state unless the services are pre-authorized by a placing state agency and are not available

within Connecticut.

(11) The department shall not pay any organization that is directly under contract to a performing provider for services covered under this regulation.

(12) The department shall not pay for care coordination services that are provided within a PNMI program if such services duplicate Medicaid-reimbursed case management services that are provided outside the facility. PNMI program staff providing care coordination services shall coordinate with any Medicaid-reimbursed case management services provided outside of the program so that such duplication does not occur.

(13) The department shall not pay other providers for services to PNMI clients that if the services are not part of a client's individual treatment plan developed pursuant to section 17b-262-749(a)(5) of the Regulations of Connecticut State Agencies.

(Adopted effective March 11, 2003)

Sec. 17b-262-754. Documentation and record retention requirements

PNMI rehabilitative services shall be reimbursed by the department when documentation of compliance with the following requirements is on file with the billing provider or the performing providers:

(1) Individual treatment plan requirement.

(A) An individual treatment plan shall be maintained.

(B) An initial assessment of need completed by DCF in conformance with section 17b-262-751 of the Regulations of Connecticut State Agencies is maintained.

(2) Permanent case record requirement.

(A) A permanent case record, as required by section 17a-145-98 of the Regulations of Connecticut State Agencies, is maintained and includes, at a minimum, identifying information including the name of the client, date of birth, gender, Medicaid identification number, LINK person number; the client's family, social and health history; the reason for admission to the PNMI program; the individual treatment plan; identification of the care and services provided; the progress of the child in the program; and the plan for discharge and disposition of the PNMI client.

(B) All documentation shall be physically placed into the eligible PNMI client's permanent case record in a complete, prompt and accurate manner. All documents shall be made available to authorized Department personnel upon request.

(3) Other documentation and record retention requirements.

(A) The performing provider shall maintain a current record of the applicable licenses and certificates of practice of all licensed or certified individuals furnishing PNMI rehabilitative services.

(B) The performing provider shall be substantially in compliance with all documentation requirements in its most recent licensure review and relevant state agency quality assurance reviews.

(C) The performing provider shall maintain all required records for at least five (5) years or longer as required by statutes or regulation subject to review by the department. In the

event of a dispute concerning a service provided, documentation shall be maintained until the end of the dispute or five (5) years, whichever is greater.

(Adopted effective March 11, 2003)

Sec. 17b-262-755. Billing requirements

(a) Claims for payment of PNMI rehabilitation services shall be submitted by the billing provider on the department's uniform billing form or electronically transmitted to the Department's fiscal agent and shall include all information required by the Department to process the claim for payment.

(b) All claims submitted to the department for payment of services covered under sections 17b-262-747 to 17b-262-757, inclusive, of the Regulations of Connecticut State Agencies shall be substantiated by documentation in the PNMI client's permanent case record.

(Adopted effective March 11, 2003)

Sec. 17b-262-756. Payment

Payment by the department for PNMI rehabilitative services shall be made in accordance with the following provisions.

(1) The department shall make payments on the basis of monthly rates for each of three types of PNMI programs: (A) residential treatment centers, (B) group homes or maternity homes and (C) therapeutic foster care and professional parent programs. The Department shall establish interim PNMI rates each year based upon the cost to the public agency for the purchase of PNMI services during the most recently completed year. These rates shall be adjusted based upon actual cost experience of the public agency at the close of the fiscal year by adjusting the interim rate for the subsequent year accordingly. To identify costs not covered by the Medicaid program, the Department shall establish a method for cost allocation acceptable to the Centers for Medicare and Medicaid Services.

(2) The calculation of the PNMI rates shall not include any services that have been reimbursed by Medicaid under other service categories.

(3) The PNMI rates shall exclude payment for non-Medicaid covered services, such as room and board.

(4) Payments shall not be made if the recipient has been absent from the program for the entire calendar month.

(5) The billing provider shall seek payment from any other resources that are available for payment of rendered services prior to billing the Department.

(6) The billing provider shall provide the non-federal match funds required for the PNMI program.

(Adopted effective March 11, 2003)

Sec. 17b-262-757. Audit and compliance review

All supporting accounting and business records, statistical data and all other records

relating to the provision of PNMI rehabilitative services paid for by the department shall be subject to audit or compliance review by authorized personnel. All documentation shall be made available to authorized personnel upon request in accordance with 42 C.F.R. section 431. The Department of Children and Families shall take full financial responsibility for any Medicaid claims disallowed due to inadequate documentation by any performing provider or failure to comply with requirements set forth in statute or regulations.

(Adopted effective March 11, 2003)

Requirements for Payment of Mental Health Rehabilitation Services for Adults Provided by Private Non-Medical Institutions

Sec. 17b-262-758. Scope

Sections 17b-262-758 to 17b-262-769, inclusive, of the Regulations of Connecticut State Agencies set forth the Department of Social Services' requirements for payment of rehabilitative services provided by private non-medical institutions to adults who are determined eligible for Connecticut's Medicaid program pursuant to section 17b-261 of the Connecticut General Statutes.

(Adopted effective December 1, 2005)

Sec. 17b-262-759. Definitions

As used in sections 17b-262-758 to 17b-262-769, inclusive, of the Regulations of Connecticut State Agencies:

(1) "Adult" means a person who is 18 years of age or older;

(2) "Department" or "DSS" means the Department of Social Services or its agent;

(3) "DMHAS" means the Department of Mental Health and Addiction Services;

(4) "DPH" means the Department of Public Health;

(5) "Group home" means a privately operated, community-based residential facility that serves sixteen or fewer adult clients, is licensed by the Department of Public Health as either a private freestanding mental health residential living center or a private freestanding community residence pursuant to sections 19a-495-551 or 19a-495-560 of the Regulations of Connecticut State Agencies, is certified by the Department of Mental Health and Addiction Services as a provider of mental health rehabilitation services pursuant to section 17a-485d of the Connecticut General Statutes, and meets the requirements of section 17b-262-760 of the Regulations of Connecticut State Agencies for participation in the Medicaid program as a provider of PNMI rehabilitative services;

(6) "Licensed clinician" means:

(A) a doctor of medicine or osteopathy licensed under chapter 370 of the Connecticut General Statutes;

(B) a psychologist who is licensed under chapter 383 of the Connecticut General Statutes;

(C) a marriage and family therapist who is licensed under chapter 383a of the

Connecticut General Statutes;

(D) a clinical social worker who is licensed under chapter 383b of the Connecticut General Statutes;

(E) an advanced practice registered nurse who is licensed under chapter 378 of the Connecticut General Statutes;

(F) a registered nurse who is licensed under chapter 378 of the Connecticut General Statutes and who has a minimum of one year of experience in the mental health field; or

(G) a professional counselor who is licensed under chapter 383c of the Connecticut General Statutes;

(7) "Medicaid" means the program operated by the department pursuant to section 17b-260 of the Connecticut General Statutes and authorized by Title XIX of the Social Security Act;

(8) "Medically appropriate" means medical care that is provided in a timely manner and meets professionally recognized standards of acceptable medical care and is delivered in the appropriate medical setting;

(9) "Medically necessary" means health care provided to correct or diminish the adverse effects of a medical condition or mental illness; to assist an individual in attaining or maintaining an optimal level of health; to diagnose a medical condition or mental illness; or to prevent a condition from occurring;

(10) "Monthly rate" means the amount the department pays for each PNMI client for PNMI program services for each month of service in which there is a qualifying billable unit of service provided;

(11) "Provider" means an entity that participates in the Medicaid program as a qualified group home provider of PNMI adult rehabilitative services as evidenced by an executed provider agreement with DSS;

(12) "PNMI client" or "client" means a Medicaid-eligible adult who resides in a participating group home and who receives covered PNMI rehabilitative services in accordance with sections 17b-262-758 to 17b-262-769, inclusive, of the Regulations of Connecticut State Agencies;

(13) "Prior authorization" means approval for the provision of service from the department before the provider actually provides the service;

(14) "Private Non-Medical Institution" or "PNMI" means an entity that is a qualified group home provider of adult rehabilitative services under sections 17b-262-758 to 17b-262-769, inclusive, of the Regulations of Connecticut State Agencies and is not a health insuring organization, hospital, nursing home, or a community health care center;

(15) "Provider agreement" means the signed, written contractual agreement between the department and the provider of PNMI rehabilitative services;

(16) "Qualifying billable unit of service" means forty hours of rehabilitative services during a calendar month or the prorated equivalent based on the number of days the client is in residence at the group home during that month. For purposes of calculation, the forty hours, or the prorated equivalent, may be made up of fifteen minute sub-units, using a

rounding convention to be determined by the department;

(17) “Rehabilitative services” means those services identified in section 17b-262-763 of the Regulations of Connecticut State Agencies when provided by a qualified provider on behalf of a PNMI client;

(18) “Residential rehabilitation plan” means a written plan developed by the performing provider in accordance with section 17b-262-760(5) of the Regulations of Connecticut State Agencies; and

(19) “Under the supervision” means that a licensed clinician provides periodic supervision of the work performed by unlicensed clinical staff and accepts primary responsibility for the rehabilitative services performed by the unlicensed staff.

(Adopted effective December 1, 2005)

Sec. 17b-262-760. Provider participation

In order to participate in the Medicaid program and provide PNMI rehabilitative services that are eligible for Medicaid reimbursement from the department, the provider shall:

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

(2) Be certified by DMHAS as a group home provider of rehabilitation services;

(3) Comply with all Medicaid record keeping, documentation and other requirements, including, but not limited to, those delineated in the department’s administrative manuals, provider agreements and memoranda of understanding;

(4) Follow all laws, rules, regulations, policies and amendments that govern the Medicaid program as they relate to reimbursement for PNMI rehabilitative services;

(5) Develop an individual residential rehabilitation plan for each PNMI client in accordance with section 19a-495-551(k)(3) of the Regulations of Connecticut State Agencies not later than thirty days after the PNMI client’s admission to the program. Such plan shall contain specific behavioral health goals and objectives that are based on each client’s mental health diagnosis and diagnostic and functional evaluation and are targeted toward the maximum reduction of a client’s behavioral health symptoms, restoration of functioning, and recovery, and shall identify the type, amount, frequency and duration of services to be provided;

(6) Ensure that a licensed clinician employed by, or under contract with, the performing provider reviews and signs the individual residential rehabilitation plan. The first review and signature shall occur not more than thirty days after admission;

(7) Keep current service and progress notes in a permanent case record for each PNMI client in accordance with section 19a-495-551(k)(3)(H) of the Regulations of Connecticut State Agencies;

(8) Cooperate with the department in the rate setting process including, but not limited to, time studies, licensing or any quality assurance reviews or periodic audits to ensure compliance with PNMI program requirements;

(9) Provide an initial orientation, training and periodic supervision to direct service staff related to the provision of rehabilitative services;

(10) Ensure that all group home staff are certified in first aid and cardiopulmonary resuscitation;

(11) Conduct ongoing assessment and service planning;

(12) Promote independent management of medication including the supervision and monitoring of self-administration as appropriate;

(13) Be licensed by the Department of Public Health as either a private freestanding mental health residential living center or a private freestanding community residence pursuant to sections 19a-495-551 or 19a-495-560 of the Regulations of Connecticut State Agencies;

(14) Ensure that the facility director holds a bachelor's degree in a human service discipline and a minimum of three years of experience in a mental health services related position;

(15) Ensure that the facility director (or other manager) is accessible after-hours, by telephone or pager, to staff on duty; and

(16) Ensure that direct service staff hold either a bachelor's degree in a behavioral health related specialty or have two years experience in the provision of mental health services.

(Adopted effective December 1, 2005)

Sec. 17b-262-761. Eligibility

Payment for PNMI rehabilitative services shall be available for services rendered to PNMI clients under the conditions and limitations that are set forth in sections 17b-262-758 to 17b-262-769, inclusive, of the Regulations of Connecticut State Agencies.

(Adopted effective December 1, 2005)

Sec. 17b-262-762. Need for services

Payment for PNMI rehabilitative services shall be made by the department only if all of the following conditions are met:

(1) For up to thirty days of a PNMI client's initial stay in a PNMI program, the PNMI rehabilitative services shall be provided in accordance with an initial assessment of need that is completed and signed by a licensed clinician. This assessment shall, for up to thirty days of a PNMI client's initial stay, be utilized as the individual residential rehabilitation plan;

(2) After the first thirty days of a client's stay in a PNMI program, the PNMI rehabilitative services shall be provided in accordance with a written individual residential rehabilitation plan developed in accordance with section 17b-262-760(5) of the Regulations of Connecticut State Agencies. This plan shall be reviewed and signed by the licensed clinical staff employed by, or under contract with, the performing provider at least every ninety days thereafter;

(3) The group home has provided one qualifying billable unit of service for that month;

(4) The client's mental illness is so serious and disabling as to require care in a group home setting;

(5) The client is sufficiently stable to be able to function outside of a twenty-four hour medically managed setting and participate in community-based treatment services; and

(6) The client has functional disabilities secondary to serious and persistent mental illness and such disabilities are so great as to require that the client reside in a non-medical residential setting with rehabilitative services and supports.

(Adopted effective December 1, 2005)

Sec. 17b-262-763. Covered services

PNMI rehabilitative services are services designed to assist individuals with a serious and persistent mental illness to achieve their highest degree of independent functioning and recovery. These services include the following services, depending upon the particular needs of each client and the individual rehabilitation plan:

(1) Intake and assessment, which means assessing and reassessing the client's behavioral health needs in the context of medical, social, educational and other needs through face-to-face contact with the client, the client's family and through consultation with other professionals;

(2) Development of an individual residential rehabilitation plan in accordance with sections 17b-262-760(5) and 17b-262-762 of the Regulations of Connecticut State Agencies;

(3) Socialization skills development, which means client-centered skills development activities that are provided to support the goals and objectives in the PNMI client's individual residential rehabilitation plan and that are directed at reducing mental disabilities of clients in care, restoring them to their best possible functioning level and assisting clients in becoming responsible for their own actions;

(4) Behavior management training and intervention;

(5) Supportive counseling directed at solving daily problems related to community living and interpersonal relationships;

(6) Psycho-educational groups pertaining to the alleviation and management of psychiatric disorders;

(7) Teaching, coaching and assisting with daily living and self-care skills such as the use of transportation, meal planning and preparation, personal grooming, management of financial resources, shopping, use of leisure time, interpersonal communication and problem solving;

(8) Assistance in developing skills necessary to support a full and independent life in the community;

(9) Support with connecting individuals to natural community supports;

(10) Orientation to, and assistance with, accessing self help and advocacy resources;

(11) Development of self-advocacy skills;

(12) Health education;

(13) Teaching of recovery skills in order to prevent relapse;

(14) Other rehabilitative support necessary to develop or maintain social relationships, to provide for independent participation in social, interpersonal or community activities and

to achieve full community reintegration; and

(15) Individual, family, and group counseling.

(Adopted effective December 1, 2005)

Sec. 17b-262-764. Limitations

Coverage of PNMI rehabilitative services shall be subject to the following limitations:

(1) PNMI rehabilitative services shall be pre-authorized by the department or its agent based on a written service recommendation.

(2) PNMI rehabilitative services shall be based on the individual residential rehabilitation plan developed pursuant to section 17b-262-760(5) of the Regulations of Connecticut State Agencies and the requirements of sections 17b-262-758 to 17b-262-769, inclusive, of the Regulations of Connecticut State Agencies, and shall be performed by, or under the supervision of, a licensed clinician employed by, or under contract to, the performing provider.

(3) The department shall not pay for programs, services or components of services that are of an unproven, experimental, cosmetic or research nature.

(4) The department shall not pay for programs, services or components of services that do not relate to the client's diagnosis, symptoms, functional limitations or medical history.

(5) The department shall not pay for programs, services or components of services that are not included in the fee established by the department.

(6) The department shall not pay for programs, services or components of services that are intended solely to prepare individuals for paid or unpaid employment or for vocational equipment and uniforms.

(7) The department shall not pay for programs, services or components of services designed to provide socialization or recreational activities for clients.

(8) The department shall not pay for time spent by the provider transporting clients.

(9) The department shall not pay for services that are solely, educational or vocational.

(10) The department shall not pay for costs associated with room and board for clients.

(11) The department shall not pay for PNMI rehabilitative services that are provided out-of-state unless the services are pre-authorized and are not available within Connecticut.

(12) The department shall not pay any organization or individual for services covered under sections 17b-262-758 to 17b-262-769, inclusive, of the Regulations of Connecticut State Agencies, if such organization or individual is directly under contract to a provider for services covered under sections 17b-262-758 to 17b-262-769, inclusive, of the Regulations of Connecticut State Agencies.

(Adopted effective December 1, 2005)

Sec. 17b-262-765. Prior authorization

(a) Prior authorization of the need for PNMI adult rehabilitative services is required in order for Medicaid payment to be available for the services. Prior authorization shall be obtained on forms and in the manner specified by the department.

(b) The initial authorization period shall be for up to six months.

(c) If authorization is needed beyond the initial authorization period, requests for continued treatment beyond the initial authorization period shall be submitted prior to the end of the existing authorization and shall be considered for up to six months per request.

(d) Except in emergency situations, approval shall be received before services are rendered.

(e) In an emergency situation that occurs after working hours or on a weekend or holiday, the provider shall secure approval on the next working day for the admission to the PNMI.

(f) In order to receive payment from the department, a provider shall comply with all prior authorization requirements. The department or its agent in its sole discretion determines what information is necessary in order to approve a prior authorization request. Prior authorization does not, however, guarantee payment unless all other requirements for payment are met.

(Adopted effective December 1, 2005)

Sec. 17b-262-766. Documentation and record retention requirements

Providers shall comply with the following documentation and record retention requirements:

(1) An initial residential rehabilitation plan and all updated versions, including the current plan, shall be maintained.

(2) A case record, as required by section 19a-495-551(k) (3) of the Regulations of Connecticut State Agencies, shall be maintained and shall include, at a minimum: identifying information; social and health history; the reason for admission to the PNMI program; copies of the initial and all subsequent orders for PNMI rehabilitative services; the individual residential rehabilitation plan; identification of the care and services provided; a current list of all medications; and the plan for discharge and disposition of the PNMI client.

(3) Encounter notes shall be maintained for each rehabilitative service provided. The notes shall include the service rendered, actual time the service was rendered, location of service, the goal and objective that is the focus of the intervention, a general description of the content of the intervention to provide evidence that it is a rehabilitative service as described in section 17b-262-763 of the Regulations of Connecticut State Agencies and the client's response to the intervention. Encounter notes shall be signed, dated and indicate the credentials of the staff member who provided the service. Shift notes are not a substitute for encounter notes.

(4) At least monthly, a progress note shall be prepared that describes the services the client has received over the past month, the client's overall response, and the client's specific progress toward the goals and objectives listed on the residential rehabilitation plan. The note shall be signed or co-signed by the program director or the licensed clinician. The note shall discuss any variance between the services listed on the residential rehabilitation plan and the services actually delivered. The note shall also discuss suggested changes, if any,

to the residential rehabilitation plan.

(5) Other documentation and record retention requirements:

(A) The provider shall maintain a current record of the applicable licenses and certificates of practice of all licensed or certified individuals furnishing PNMI rehabilitative services.

(B) The provider shall be substantially in compliance with all documentation requirements in its most recent licensure review and relevant state agency quality assurance reviews.

(C) The provider shall maintain all required records for at least five years or longer as required by statutes or regulation. All required records shall be subject to review by the department. In the event of a dispute concerning a service provided, documentation shall be maintained until the end of the dispute or five years, whichever is longer.

(D) All documentation shall be physically placed into the eligible PNMI client's case record in a complete, prompt and accurate manner. All documents shall be made available to authorized personnel of the department upon request.

(6) Failure to maintain all required documentation shall result in the disallowance and recovery by the department of any amounts paid to the provider for which the required documentation is not maintained and not provided to the department upon request.

(Adopted effective December 1, 2005)

Sec. 17b-262-767. Billing requirements

(a) Claims for payment of PNMI rehabilitation services shall be on the department's uniform billing form or electronically transmitted to the department's fiscal agent and shall include all information required by the department to process the claim for payment.

(b) All claims submitted to the department for payment of services covered under sections 17b-262-758 to 17b-262-769, inclusive, of the Regulations of Connecticut State Agencies shall be substantiated by documentation in the recipient's permanent case record.

(Adopted effective December 1, 2005)

Sec. 17b-262-768. Payment

Payment by the department for PNMI rehabilitative services shall be made in accordance with the following provisions.

(a) The department shall make payments on the basis of monthly rates for PNMI programs.

(b) A statewide capitated monthly rate will be established annually and applied uniformly to all facility providers and to all Medicaid eligible recipients provided with a qualified billable unit of service.

(c) The statewide capitated rate shall be based upon annual audited cost reports filed by licensed and certified service providers to include cost allocations based upon semi-annual time studies of facility staff hours related to rehabilitative services.

(d) The Department shall establish interim PNMI rates for the first and second year of service coverage based upon estimated costs. The interim rates will be replaced based upon

cost report filings for the period and related payment adjustments will be made accordingly.

(e) Prospective rates for subsequent periods will be based upon allowable costs for the cost period ending twelve months prior to the start of the rate period. These rates will be updated, within available appropriations, by the projected increase or decrease in the consumer price index for urban consumers for the twenty-four months between the mid-point of the cost period and the mid-point of the rate year.

(1) Allowable costs for purposes of establishing the statewide capitated rate are the reasonable and necessary costs attributable to the provision of rehabilitative services covered under this regulation but shall exclude any other costs such as transportation, recreation or vocational services that are not part of rehabilitative services. Allowable costs will be determined based on a survey of all group homes covered under this regulation.

(f) The calculation of the PNMI rates shall not include any services that have been reimbursed by Medicaid under other service categories.

(g) The PNMI rates shall exclude payment for non-Medicaid covered services, such as room and board.

(h) Payments shall not be made if the recipient has been absent from the program for the entire calendar month.

(i) The provider shall seek payment from any other resources that are available for payment of rendered services prior to billing the Department.

(j) Claims for payment shall be supported by documentation of required services.

(Adopted effective December 1, 2005)

Sec. 17b-262-769. Audit and compliance review

All supporting accounting and business records, statistical data and all other records relating to the provision of PNMI rehabilitative services paid for by the department shall be subject to audit or compliance review by authorized personnel. All documentation shall be made available, upon request, to authorized representatives of DPH, DMHAS, and DSS.

(Adopted effective December 1, 2005)

Sec. 17b-262-770. Scope

Sections 17b-262-770 to 17b-262-773, inclusive, of the Regulations of Connecticut State Agencies set forth the Department of Social Services requirements for the establishment by Medicaid entities of policies and procedures for the education of employees regarding false claims recoveries and methodologies for oversight of entities' compliance with these requirements.

(Adopted effective August 30, 2007)

Sec. 17b-262-771. Definitions

As used in sections 17b-262-770 to 17b-262-773, inclusive, of the Regulations of Connecticut State Agencies:

(1) "Entity" means a government agency, organization, unit, corporation, partnership,

or other business arrangement, including any Medicaid managed care organization, irrespective of the form of business structure or arrangement by which it exists, whether for-profit or not-for profit, which furnishes directly, or otherwise authorizes the furnishing of, the delivery of Medicaid health services where payments made with respect to those services are received, or made, under a State Plan approved under Title XIX, or under any waiver of such plan totaling at least $5,000,000 annually. If an entity furnishes items or services at more than a single location, or under more than one contractual or other payment arrangement, the provisions of sections 17b-262-770 to 17b-262-773, inclusive, of the Regulations of Connecticut State Agencies apply if the aggregate payments to that entity meet the $5,000,000 annual threshold whether the entity submits claims for payments using one or more provider identification or tax identification numbers. An entity meets the $5,000,000 annual threshold as of January 1, 2007, if it received or made payments in that amount in federal fiscal year 2006. Future determinations regarding an entity's responsibility stemming from the requirements of section 1902(a)(68) of the Social Security Act, P.L. 109-171, § 6032, will be made by January 1 of each subsequent year, based upon the amount of payments an entity either received or made under the State Plan under Title XIX of the Social Security Act during the preceding federal fiscal year. A government component serving as a provider for which Medicaid payments are made (e.g., a state mental health facility or school district providing school-based health services) is an "entity" as defined in this subsection. A government agency which merely administers the Medicaid program, in whole or in part (e.g., managing the claims processing system or determining beneficiary eligibility), is not an "entity" as defined in this subsection;

(2) "Employee" means any officer or employee of an entity and includes management;

(3) "Contractor" or "agent" means any contractor, subcontractor, agent or other person which or who, on behalf of the entity, furnishes, or otherwise authorizes the furnishing of, the delivery of Medicaid health care items or services, performs billing or coding functions, or is involved in the monitoring of health care provided by the entity;

(4) "Department" means the Department of Social Services or its agent; and

(5) "Medicaid" means the program operated by the Department pursuant to section 17b-260 of the Connecticut General Statutes and authorized by Title XIX of the Social Security Act, as amended from time to time.

(Adopted effective August 30, 2007)

Sec. 17b-262-772. Provider participation

To receive payment from the Department for the provision of goods or services to Medicaid clients, entities shall comply with sections 17b-262-770 to 17b-262-773, inclusive, of the Regulations of Connecticut State Agencies.

(Adopted effective August 30, 2007)

Sec. 17b-262-773. Establishment and dissemination of written policies

(a) An entity shall establish and disseminate written policies, which shall also be adopted

by its contractors or agents. Written policies may be on paper or in electronic form, but shall be readily available to all employees, contractors and agents. An entity need not create an employee handbook if none already exists.

(b) An entity shall establish written policies for all employees and for any contractor or agent of the entity, that includes, but is not limited to, detailed information about the federal False Claims Act and other provisions named in section 1902(a)(68)(A) of the Social Security Act and detailed information about the entity's policies and procedures for detecting and preventing waste, fraud and abuse. An entity shall include in any employee handbook a specific discussion of the laws described in the written policies, the rights of employees to be protected as whistleblowers and a specific discussion of the entity's policies and procedures for detecting and preventing fraud, waste and abuse.

(c) In addition to the education requirements concerning the federal laws set forth above, an entity shall reference in its written polices and handbook the following sections of the Connecticut General Statutes: 53a-290 et seq. (Vendor Fraud); 53-440 et seq. (Health Insurance Fraud); 53a-118 et seq. (Larceny); 53a-155 (Tampering with or Fabricating Physical Evidence); 53a-157b (False Statement Intending to Mislead Public Servant); 17b-25a (Toll Free Vendor Fraud Telephone Hotline); 17b-99 (Vendor Fraud); and 17b-102 (Financial Incentive for Reporting Vendor Fraud); 4-61dd (Whistleblowing); 31-51m (Protection of Employee Who Discloses Employer's Illegal Activities or Unethical Practices); and 31-51q (Liability of Employer for Discipline or Discharge of Employee on Account of Employee's Exercise of Certain Constitutional Rights).

(d) An entity shall reference in its written policies and handbook the following sections of the Regulations of Connecticut State Agencies: 17-83k-1 et seq. (Administrative Sanctions); 17b-102-01 et seq. (Financial Incentive for Reporting Vendor Fraud and Requirements for Payment for Reporting Vendor Fraud); and 4-61dd-1 et seq. (Rules of Practice for Contested Case Proceedings under the Whistleblower Protection Act).

(e) The Department shall require that all entities, upon re-enrollment or contract amendment subsequent to January 1, 2007, include an addendum to their Medicaid Provider Agreement or contract which describes the requirements of this section. All entities that met the $5,000,000 threshold in federal fiscal year 2006 and annually thereafter must provide an attestation of their compliance with this section to the Department's Office of Quality Assurance by August 31st of each year. The Department's Office of Quality Assurance shall verify compliance with this section.

(Adopted effective August 30, 2007)

Sec. 17b-262-774—17b-262-778. Reserved

Payment to Chronic Disease Hospitals

Sec. 17b-262-779. Scope

Sections 17b-262-779 to 17b-262-791, inclusive, of the Regulations of Connecticut State Agencies, set forth the department of social services' requirements for payment to chronic

disease hospitals for services to clients who are determined eligible to receive services under the Connecticut Medicaid program pursuant to section 17b-262 of the Connecticut General Statutes.

(Adopted effective October 6, 2009)

Sec. 17b-262-780. Definitions

As used in sections 17b-262- 779 to 17b-262- 791, inclusive, of the Regulations of Connecticut State Agencies:

(1) "Applied income" means the amount of income that each client receiving chronic disease hospital services is expected to pay each month toward the cost of his or her care, calculated according to the department's Uniform Policy Manual, section 5045.20;

(2) "Assessment" means a comprehensive written evaluation of an individual's functional performance in relation to a set of measurable medical or physical criteria;

(3) "Client" means a person eligible for goods or services under the department's Medicaid program;

(4) "Chronic disease" means a disease having one or more of the following characteristics:

(a) is permanent;

(b) leaves residual disability;

(c) is caused by non-reversible pathological alteration;

(d) requires special training of the client for rehabilitation; or

(e) is expected to require a long period of supervision, observation or care;

(5) "Chronic disease hospital" means "chronic disease hospital" as defined in section 19-13-D1 of the Regulations of Connecticut State Agencies;

(6) "Commissioner" means the commissioner of social services or his or her designee;

(7) "Department" means the department of social services or its agent;

(8) "Durable medical equipment" means equipment that meets all of the following requirements:

(a) can withstand repeated use;

(b) is primarily and customarily used to serve a medical purpose;

(c) is generally not useful to a person in the absence of an illness or injury; and

(d) is non-disposable;

(9) "Institution for mental diseases" means "institution for mental diseases" as defined in 42 CFR 435.1009, as amended from time to time;

(10) "Licensed practitioner" means any person licensed by the state of Connecticut, any other state, the District of Columbia or the Commonwealth of Puerto Rico and authorized to prescribe treatments within the scope of his or her practice as defined and limited by federal and state law;

(11) "Medicaid" means the program operated by the Department of Social Services pursuant to section 17b-260 of the Connecticut General Statutes and authorized by Title XIX of the Social Security Act;

(12) "Medical appropriateness" or "medically appropriate" means health care that is provided in a timely manner and meets professionally recognized standards of acceptable medical care; is delivered in the appropriate medical setting; and is the least costly of multiple, equally-effective, alternate treatments or diagnostic modalities;

(13) "Medical necessity" or "medically necessary" means health care provided to correct or diminish the adverse effects of a medical condition or mental illness; to assist an individual in attaining or maintaining an optimal level of health; to diagnose a condition; or to prevent a medical condition from occurring;

(14) "Preadmission assessment" means a clinical assessment of ongoing needs and prognosis as necessary to determine the chronic disease hospital's ability to provide for a client's expected needs;

(15) "Provider" means a chronic disease hospital that is enrolled in Medicaid;

(16) "Provider agreement" means the signed, written, contractual agreement between the department and the provider;

(17) "Physician" means a physician licensed pursuant to section 20-10 of the Connecticut General Statutes;

(18) "Rehabilitation" means any medical or remedial services recommended by a physician or other licensed practitioner for maximum reduction of physical or mental disability and restoration of an individual to his or her best possible functional level;

(19) "Resident" means a client living in a chronic disease hospital;

(20) "Team" means a group of individuals employed by or under contract to the chronic disease hospital and may include physiatrists, specialized skilled nurses, physical therapists, occupational therapists or other rehabilitation specialists, such as speech therapists, respiratory specialists, prosthetists, orthotists, physiatrists or respiratory specialists. Other practitioners, including but not limited to, mental health practitioners, may be part of the team as appropriate;

(21) "Team conference" means a meeting of the team to develop a treatment plan of care;

(22) "Treatment plan of care" means the written description of services designed to meet a resident's medical, nursing and rehabilitation needs that are identified in the resident's assessment. The treatment plan of care shall include measurable objectives and a specific timetable; and

(23) "Usual and customary charge" means the amount that the provider charges for the service or procedure in the majority of non-Medicaid cases. If the provider varies the charges so that no one amount is charged in the majority of cases, "usual and customary" shall be defined as the median charge. Token charges for charity patients and other exceptional charges are to be excluded.

(Adopted effective October 6, 2009)

Sec. 17b-262-781. Provider participation

(a) To enroll in Medicaid and receive payment from the department, a chronic disease hospital shall comply with the provider participation requirements of sections 17b-262-522

through 17b-262-533, inclusive, of the Regulations of Connecticut State Agencies.

(b) In order to enroll in Medicaid and to receive payment from the department, a chronic disease hospital shall meet the requirements for state licensure described in section 19-13-D5 of the Regulations of Connecticut State Agencies, the requirements for federal certification to participate in the Medicaid program that are described in 42 CFR Part 482, as amended from time to time, and the requirements stated in sections 17b-262-779 to 17b-262-791, inclusive, of these regulations.

(c) In addition to the requirements in subsections (a) and (b) of this section, in order to participate in the Medicaid program, a chronic disease hospital shall be federally certified as either:

(1) a long term care hospital that meets the criteria of 42 CFR 412.23(e);

(2) a rehabilitation hospital that meets the criteria of 42 CFR 412.23(b); or

(3) an acute care hospital with a psychiatric unit excluded from the prospective payment system that meets the criteria of 42 CFR 412.25.

(Adopted effective October 6, 2009)

Sec. 17b-262-782. Eligibility

Payment for chronic disease hospital services is available on behalf of all clients subject to the conditions and limitations that apply to these services.

(Adopted effective October 6, 2009)

Sec. 17b-262-783. Need for service

In order for a client to be approved for admission to a chronic disease hospital, the client shall meet the criteria for admission as either a chronic disease client or a rehabilitation client. All care shall be medically necessary and medically appropriate.

(a) The criteria for admission as a chronic disease client are as follows:

(1) Each chronic disease client shall require services that can be provided safely and effectively at a chronic disease hospital level, shall be ordered by a physician and documented in the client's medical record, and shall include at least a daily physician visit and assessment or the 24-hour availability of medical services and equipment available only in a hospital setting; and

(2) The client's medical condition and treatment needs are such that no effective, safe, less costly alternative placement is available to the client.

(b) The criteria for admission as a rehabilitation client are as follows:

(1) Each rehabilitation client shall require an intensive rehabilitation program at the level of a chronic disease hospital level of care that includes a multi-disciplinary approach to improve the client's ability to function to his or her maximum potential. Factors shall be present in the client's condition that indicate the potential for functional improvement or freedom from pain. A client who requires therapy solely to maintain function shall not be considered an appropriate rehabilitation candidate;

(2) Each client's medical condition and treatment needs are such that no effective, safe,

less costly alternative placement is available to the client;

(3) A preadmission assessment shall be developed, prior to admission by specialized skilled nurses, physical therapists, occupational therapists or other rehabilitation specialists, such as speech therapists, prosthetists or orthotists;

(4) The treatment plan of care shall be directed by a physician who is board certified or eligible for board certification in an appropriate specialty; and

(5) The treatment plan of care shall be designed to achieve specific goals within a specified timeframe.

(c) Team conferences shall be conducted for each client. The first team conference shall occur not later than seven calendar days after the client's admission.

(d) For rehabilitation clients, subsequent conferences shall occur at least once every fourteen calendar days. All team members, or a designee within the same specialty, shall be in attendance. The purpose of the conference shall be to conduct an assessment of the client's progress, make adjustments to the established goals as indicated or terminate the program when the expected goal has been reached or determined to be no longer attainable.

(e) For chronic disease clients, subsequent conferences shall occur at least once every 90 days. The depth of the periodic review shall be appropriate to the client's clinical status and prognosis.

(f) The department may use nationally recognized guidelines applicable to chronic disease hospitals or inpatient rehabilitation hospitals in determining if the admission is medically necessary and medically appropriate.

(g) The department shall authorize payment for any individual who meets the criteria set forth in subsections (a) or (b) of this section when he or she:

(1) is a client seeking admission to a chronic disease hospital;

(2) is an individual who applies for Medicaid while in the chronic disease hospital; or

(3) is a client seeking an extension of treatment at a chronic disease hospital.

(h) The department shall pay a provider only when the department has authorized the client's admission to that chronic disease hospital and all other requirements for payment are met.

(Adopted effective October 6, 2009)

Sec. 17b-262-784. Services covered

The department shall pay an all-inclusive per diem rate to the provider for each resident for whom payment has been authorized pursuant to section 17b-262-783 of the Regulations of Connecticut State Agencies. This per diem rate represents payment for the following goods and services:

(a) all services as required by section 19-13-D5 of the Regulations of Connecticut State Agencies and 42 CFR Part 482, as amended from time to time, including, but not limited to:

(1) medical direction in accordance with section 19-13- D5(c) of the Regulations of Connecticut State Agencies and 42 CFR 482.22;

(2) nursing services in accordance with section 19-13- D5(e) of the Regulations of Connecticut State Agencies and 42 CFR 482.23, as amended from time to time;

(3) therapeutic recreation in accordance with section 19-13- D5(k) of the Regulations of Connecticut State Agencies;

(4) rehabilitation services in accordance with section 19-13-D5(k) of the Regulations of Connecticut State Agencies and 42 CFR 482.56, as amended from time to time;

(5) room and board in accordance with sections 19-13-D5(h) and (i) of the Regulations of Connecticut State Agencies and 42 CFR 482.28 and 482.41 as amended from time to time;

(6) diagnostic and therapeutic services in accordance with section 19-13-D5(f) of the Regulations of Connecticut State Agencies and 42 CFR 482.26, as amended from time to time;

(7) pharmacy services in accordance with section 19-13-D5(g) and 42 CFR 482.25, as amended from time to time;

(8) laboratory services in accordance with 42 CFR 482.27, as amended from time to time;

(9) respiratory services in accordance with 42 CFR 482.57, as amended from time to time; and

(10) consultation and assistance to residents in obtaining other needed services including, but not limited to, dental services, vision services, hearing services and services to address mental and psychosocial functioning;

(b) all services required as conditions of participation for certification under 42 CFR 412, Subpart B, Subpart O or Subpart P as applicable;

(c) all physical therapy, occupational therapy, speech therapy and respiratory therapy included in the treatment plan of care;

(d) routine personal hygiene items required to meet the needs of the resident including, but not limited to, hair hygiene supplies, soaps and other cleansing agents to treat skin problems, shaving supplies, dental and denture supplies, lotions, incontinence supplies, bathroom supplies and over the counter drugs;

(e) prescription drugs;

(f) durable medical equipment including customized equipment;

(g) supplies used in the care of the resident including, but not limited to:

(1) antiseptics and solutions;

(2) bandages and dressing supplies;

(3) catheters and urinary incontinent supplies;

(4) diabetic supplies;

(5) diapers and underpads;

(6) compression, burn and specialized medical garments;

(7) ostomy supplies;

(8) respiratory and tracheotomy supplies;

(9) enteral and parenteral supplies; and

(10) miscellaneous supplies;
(h) all oxygen supplies including oxygen concentrators; and
(i) transportation services necessary to transport a resident to and from any service included in the per diem rate as described in this section.

(Adopted effective October 6, 2009)

Sec. 17b-262-785. Service limitations

Payment shall be made for the date of admission but not for the date of discharge. Exceptions to this are:
(a) payment shall be made for the date of death when the resident dies in the chronic disease hospital.
(b) in the case of a resident admitted and discharged on the same day, payment shall be made for one day of care.

(Adopted effective October 6, 2009)

Sec. 17b-262-786. Services not covered

(a) The department shall not pay a chronic disease hospital that is characterized as an institution for mental diseases except for services to clients aged 65 and older or under age 22 in accordance with section 17-134d-68 of the Regulations of Connecticut State Agencies and 42 CFR 435.1009.
(b) The department shall not reimburse any provider for any costs incurred before the authorized length-of-stay period or after the expiration of the specified length-of-stay period.

(Adopted effective October 6, 2009)

Sec. 17b-262-787. Authorization process

(a) The department shall pay a provider only when the department has authorized payment for the client's admission to that chronic disease hospital.
(b) The provider shall comply with the authorization requirements described in section 17b-262-528 of the Regulations of Connecticut State Agencies and sections 17b-262-779 to 17b-262-791, inclusive, of the Regulations of Connecticut State Agencies. The department, in its sole discretion, shall determine what information is necessary to approve an authorization request. Authorization does not, however, guarantee payment unless all other requirements for payment are met.
(c) An authorization request, on forms and in a manner as specified by the department, shall include documentation of medical need and shall be signed by the licensed practitioner. For individuals who become clients while in the chronic disease hospital, this authorization request shall include, but not be limited to, a treatment plan of care under the direction of a physician that is designed to achieve specified goals within a specified timeframe and developed by a team.
(d) Initial authorizations for treatment shall be authorized by the department for up to 30 days. Subsequent requests for the extension of authorization for the same client may be

made for up to three months or longer, on a case-by-case basis.

(e) If a safe discharge is not possible from the chronic disease hospital, the department shall authorize a continued stay and payment at the current Medicaid rate for up to three months or longer, on a case by case basis.

(f) The department shall act on prior authorization requests for readmissions to a chronic disease hospital from an acute care hospital within one business day so that clients do not remain at the acute care hospital level longer than necessary.

(g) No chronic disease hospital shall be required to admit a client if such hospital has not received an authorization for treatment from the department.

(h) The department will process a request for authorization for treatment, and deliver a decision on such request within two full business days from the date a chronic disease hospital notifies the department that a client who is a patient of such hospital has exhausted his or her other third party insurance or whose coverage by such insurance has been denied.

(Adopted effective October 6, 2009)

Sec. 17b-262-788. Applied income

(a) A client who receives chronic disease hospital services is responsible for paying applied income to the chronic disease hospital.

(b) The department shall calculate the applied income. The department shall notify the chronic disease hospital of the amount of any applied income that the chronic disease hospital is responsible for collecting. Applied income shall be deducted from what otherwise would have been the department's monthly payment to the chronic disease hospital.

(c) The chronic disease hospital shall notify the department's caseworker of any errors in the amount of applied income processed against the claim using the form specified by the department. Payment adjustments resulting from retroactive applied income corrections shall be processed periodically.

(d) In any month that a resident returns to the community or dies, and the cost of care is less than the applied income, the department shall adjust the applied income as follows: the applied income shall equal the number of days that the resident was in the chronic disease hospital multiplied by the per diem rate.

(e) Applied income is not pro rated. It is used to cover the cost of care until it is expended.

(Adopted effective October 6, 2009)

Sec. 17b-262-789. Billing and payment procedures

(a) Claims from providers shall be submitted on the department's designated form or electronically transmitted to the department's fiscal agent and shall include all information required by the department to process the claim for payment.

(b) The chronic disease hospital is responsible for:

(1) completing the daily admission and discharge forms in accordance with the department's instructions;

(2) notifying the department's caseworker if the chronic disease hospital is aware that

the resident's asset level exceeds the established resource limit. The report shall be made on the form specified by the department;

(3) notifying the department of any and all credits due the department on the form specified by the department; and

(4) exhausting other payment sources of which the chronic disease hospital is aware before billing the department.

(Adopted effective October 6, 2009)

Sec. 17b-262-790. Rates

(a) The per diem rate for a chronic disease hospital is determined annually pursuant to section 17b-239 of the Connecticut General Statutes for freestanding chronic disease hospitals or section 17b-340 of the Connecticut general statutes for chronic disease hospitals associated with chronic and convalescent nursing homes.

(b) the department shall reimburse the chronic disease hospital at the lower of:

(1) the per diem rate minus the applied income; or

(2) the usual and customary charge minus the applied income.

(Adopted effective October 6, 2009)

Sec. 17b-262-791. Documentation

(a) The chronic disease hospital shall maintain all documentation required for rate setting purposes in accordance with section 17-311-56 of the Regulations of Connecticut State Agencies. This documentation is subject to review and audit by the department.

(b) The chronic disease hospital shall maintain all other documentation required by this section for at least five (5) years or longer as required by statute or regulation, subject to review by authorized department personnel. In the event of a dispute concerning a service provided, the chronic disease hospital shall maintain all documentation until the end of the dispute, for five (5) years, or for the length of time required by statute or regulation, whichever is longest.

(c) Failure to maintain all required documentation may result in the disallowance and recovery by the department of any amounts paid to the chronic disease hospital for which the required documentation is not maintained and provided to the department upon request. Documentation requirements are described in detail in the provider agreement and sections 17b-262-522 to 17b-262-533, inclusive, of the Regulations of Connecticut State Agencies.

(d) The department requires that each chronic disease hospital maintain fiscal and medical records to fully disclose services and goods rendered to residents. Records shall be maintained in accordance with the department's Provider Enrollment Agreement as signed by the chronic disease hospital.

(e) Required documentation includes:

(1) certification for chronic disease hospital admission as required by the department. The form shall be signed by a licensed practitioner;

(2) the department's written authorization of the client's need for chronic disease hospital

care;

(3) all admission and discharge forms supporting the claim;

(4) medical records in accordance with section 19-13-D5(d) of the Regulations of Connecticut State Agencies and 42 CFR 482.24 that contains all pertinent diagnostic information and documentation of each service provided;

(5) the initial and all subsequent treatment plans of care signed and dated by a licensed practitioner; and

(6) For clients in the rehabilitation level of care, a record that includes:

(A) each team member's goals for the client and progress notes from each team conference;

(B) all decisions reached; and

(C) the reason for any lack of progress in reaching a specific goal.

(Adopted effective October 6, 2009)

Sec. 17b-262-792. Scope

Sections 17b-262-792 to 17b-262-803, inclusive, of the Regulations of Connecticut State Agencies set forth the Department of Social Services requirements for payment to providers of hearing aids and supplies that are medically necessary and that are provided to clients who are determined to be eligible to receive such goods and services under Medicaid pursuant to section 17b-262 of the Connecticut General Statutes.

(Adopted effective July 11, 2011)

Sec. 17b-262-793. Definitions

As used in sections 17b-262-792 to 17b-262-803, inclusive, of the Regulations of Connecticut State Agencies:

(1) "Actual acquisition cost" means the price paid to a manufacturer by a hearing aid provider for a hearing aid or accessory, as documented on the manufacturer's invoice, less any applicable discounts or rebates. The actual acquisition cost shall be verified by a copy of the manufacturer's invoice;

(2) "Advanced practice registered nurse" means a person who is licensed pursuant to section 20-94a of the Connecticut General Statutes;

(3) "Audiologist" means a person who is licensed under Chapter 399 of Connecticut General Statutes as an audiologist;

(4) "Audiometric report" means a written report that describes the results of measurement of overall performance in hearing, understanding and responding to speech for a general assessment of hearing and an estimate of the degree of practical handicap. The results are recorded on a graph or grid, also called an audiogram, to show the results and the impact of the hearing loss;

(5) "Chronic disease hospital" means "chronic disease hospital" as defined in section 19-13-D1(b)(2) of the Regulations of Connecticut State Agencies;

(6) "Client" means a person eligible for goods or services under the Medicaid program;

(7) "Commissioner" means the Commissioner of Social Services or his or her designee;

(8) "Department" means the Department of Social Services or its agent;

(9) "Dispensing fee" means a one-time fee pertaining to the selection, orientation, training in proper use, fittings and adjustments required within the first year of service;

(10) "Documented in writing" means handwritten, typed or computer printed;

(11) "Early Periodic Screening, Diagnosis and Treatment special services" or "EPSDT special services" means services that are not otherwise covered under Connecticut's Medicaid program but which are nevertheless covered as EPSDT services for Medicaid-eligible children pursuant to the requirements of 42 U.S.C. 1396d(r)(5) when the service is medically necessary, the need for the service is identified in an EPSDT screen, the service is provided by a participating provider, and the service is a type of service that may be covered by a state Medicaid agency and qualify for federal reimbursement under 42 U.S.C. 1396b and 42 U.S.C. 1396d;

(12) "Ear specialist" means any licensed physician who specializes in diseases of the ear and is medically trained to identify the symptoms of deafness in the context of the total health of the patient, and is qualified by special training to diagnose and treat hearing loss. Such physicians are also known as otolaryngologists, otologists and otorhinolaryngologists;

(13) "Hearing aid" means any wearable instrument designed or offered for the purpose of aiding or compensating for impaired human hearing and any parts, attachments or accessories, excluding batteries and ear molds;

(14) "Hearing aid dealer" means a "licensed hearing instrument specialist" as defined in section 20-396 of the Connecticut General Statutes or a "hearing aid dealer" as described in section 20-406-1 to 20-406-15, inclusive, of the Regulations of Connecticut State Agencies;

(15) "Hearing aid supplies" means those items purchased by the provider that are necessary for the proper operation of the hearing aid;

(16) "Hearing testing" means the measurement of an individual's level of hearing, as set forth in section 20-406-9(f) of the Regulations of Connecticut State Agencies, for the purpose of determining if a hearing aid is medically necessary;

(17) "Home" means the client's place of residence including, but not limited to, a boarding home, community living arrangement or residential care home. "Home" does not include facilities such as hospitals, chronic disease hospitals, nursing facilities, intermediate care facilities for the mentally retarded or other facilities that are paid an all-inclusive rate directly by Medicaid for the care of the client;

(18) "Hospital" means a "short-term hospital" as defined in section 19-13-D1(b)(1) of the Regulations of Connecticut State Agencies;

(19) "Intermediate care facility for the mentally retarded" or "ICF/MR" means a residential facility for the mentally retarded licensed pursuant to section 17a-227 of the Connecticut General Statutes and certified to participate in the Medicaid program as an intermediate care facility for the mentally retarded pursuant to 42 CFR 442.101, as amended from time to time;

(20) "Licensed practitioner" means a physician, a physician assistant or an advanced practice registered nurse;

(21) "Medicaid" means the program operated by the department pursuant to section 17b-261 of the Connecticut General Statutes and authorized by Title XIX of the Social Security Act;

(22) "Medical evaluation" means an examination to ensure that all medically treatable conditions that may affect hearing are identified and treated first and the client is an appropriate candidate for a hearing aid;

(23) "Medical necessity" or "medically necessary" has the same meaning as in section 17b-259b of the Connecticut General Statutes;

(24) "Nursing facility" means "nursing facility" as defined in 42 USC 1396r(a), as amended from time to time and licensed according to section 19-13-D8t(b) of the Regulations of Connecticut State Agencies as a chronic and convalescent home or rest home with nursing supervision;

(25) "Physician" means a person licensed pursuant to section 20-10 of the Connecticut General Statutes;

(26) "Physician assistant" means "physician assistant" as defined in section 20-12a(5) of the Connecticut General Statutes;

(27) "Practice of fitting hearing aids" means "practice of fitting hearing aids" as defined in section 20-396 of the Connecticut General Statutes;

(28) "Prescription" means an original, written order documenting medical necessity that is signed and dated by the licensed practitioner who issued the order;

(29) "Prior authorization" or "PA" means approval from the department for the provision of a service or the delivery of goods before the provider actually provides the service or delivers the goods;

(30) "Provider" means the vendor or supplier of a hearing aid and supplies who is enrolled with the department as a hearing aid dealer;

(31) "Replacement of a hearing aid" means any occasion in which a new hearing aid is to take the place of a prior hearing aid; and

(32) "Usual and customary charge" means the amount that the provider accepts for the service or procedure in the majority of non-Medicaid cases. If the provider varies the charges so that no one amount is accepted in the majority of cases, usual and customary shall be defined as the median charge. Token charges for charity patients and other exceptional charges are to be excluded.

(Adopted effective July 11, 2011)

Sec. 17b-262-794. Provider participation

To enroll in the Medicaid program and receive payment from the department, providers shall comply with sections 17b-262-792 to 17b-262-803, inclusive, of the Regulations of Connecticut State Agencies and sections 17b-262-522 to 17b-262-532, inclusive, of the

Regulations of Connecticut State Agencies.

(Adopted effective July 11, 2011)

Sec. 17b-262-795. Need for service

(a) The department shall pay for the purchase or repair of a medically necessary hearing aid or supply, subject to the conditions and limitations described in sections 17b-262-792 to 17b-262-803, inclusive, of the Regulations of Connecticut State Agencies.

(b) All clients who have been identified as having a hearing loss, such as through the performance of a hearing screening, shall receive a medical evaluation by a licensed practitioner, preferably an ear specialist, before a hearing aid is considered to ensure that all medically treatable conditions that affect hearing are identified and treated first. The medical evaluation shall have taken place within the six-month period prior to the date in which the client receives the first hearing aid and may, at the licensed practitioner's discretion, be accompanied by a prescription for a hearing aid.

(c) Medical necessity shall be documented by the provider and shall include:

(1) An estimate of the client's ability to benefit from the use of a hearing aid as demonstrated by improvement in speech discrimination or environmental awareness of sound;

(2) test results showing the client's current hearing level and an estimate of improvement in speech discrimination or environmental awareness of sound;

(3) evidence of a medical evaluation signed by a licensed practitioner; and

(4) a written prescription signed by a licensed practitioner or an order by an audiologist or hearing aid dealer.

(d) In addition the provider shall document:

(1) The commitment on the part of the appropriate caregiver to assist the client in the use and care of the hearing aid, if the client is incapable of caring for the hearing aid on his or her own; and

(2) the status of any previous hearing aid used by the client.

(e) The department shall pay for hearing aids and supplies for a client who lives at home or in a nursing facility, ICF/MR, hospital or chronic disease hospital, except as limited by sections 17b-262-792 to 17b-262-803, inclusive, of the Regulations of Connecticut State Agencies.

(f) All hearing aids dispensed to a child under eighteen years of age shall meet the requirements of section 20-406-10 of the Regulations of Connecticut State Agencies.

(g) Hearing testing shall meet the requirements of section 20-406-9(f) of the Regulations of Connecticut State Agencies.

(h) There shall be a thirty-day trial period for a hearing aid in accordance with section 20-402a of the Connecticut General Statutes; the cancellation fee applies to the total acquisition cost and dispensing fee.

(i) An audiometric report to support medical necessity is required for the purchase of all hearing aids.

(j) A hearing aid shall be replaced only when the prior hearing aid no longer meets the client's needs, has been lost, stolen or damaged beyond repair.

(k) For a hearing aid that has been lost, stolen or damaged beyond repair, the provider shall document:

(1) The disposition of the prior hearing aid and statement of circumstances of loss or damage;

(2) in the case of damage, a statement from the hearing aid dealer or audiologist that the hearing aid cannot be repaired;

(3) the measures to be taken by the client, family or other caregiver, to prevent future loss or damage.

(*l*) For a hearing aid that is no longer meets the client's needs, the provider shall document the significant change in the client's hearing loss to warrant the replacement.

(Adopted effective July 11, 2011)

Sec. 17b-262-796. Eligibility

Payment to a provider for hearing aids and related supplies is available for clients who have a need for such products and services which meets the department's definition of a hearing aid when the items are medically necessary, subject to the conditions and limitations set forth in sections 17b-262-792 to 17b-262-803, inclusive, of the Regulations of Connecticut State Agencies.

(Adopted effective July 11, 2011)

Sec. 17b-262-797. Services covered and limitations

(a) The department shall maintain a fee schedule for hearing aids and supplies, subject to the conditions and limitations set forth in sections 17b-262-792 to 17b-262-803, inclusive, of the Regulations of Connecticut State Agencies. This fee schedule is designed to meet the needs of most Medicaid clients.

(b) The department shall pay for the servicing, repair or replacement of hearing aids and supplies, provided that any manufacturer's or dealer's warranty has been exhausted. The provider shall first utilize existing warranties that cover required servicing, repairs and replacement.

(c) The department shall pay for one hearing test provided by either:

(1) A hearing aid provider, who is not an audiologist; or

(2) an audiologist, ear specialist or any other physician under contract to, or employed by a hearing aid provider, who does not separately bill the department for any other hearing test or audiological examination.

(Adopted effective July 11, 2011)

Sec. 17b-262-798. Goods and services not covered

The department shall not pay providers for:

(a) Any hearing aid that is of an unproven, experimental or research nature or for services

in excess of those deemed medically necessary by the department to treat the client's condition or for services not directly related to the client's diagnosis, symptoms or medical history;

(b) any hearing aid prescribed and ordered for a client who:

(1) Dies prior to delivery of the item; or

(2) is not otherwise eligible on the date of delivery. It shall be the provider's responsibility to verify that the client is eligible on the date the item is delivered;

(c) the purchase or repair of a hearing aid necessitated by inappropriate, willful or malicious misuse on the part of the client, as determined by the department;

(d) any hearing aid or supply provided for cosmetic reasons;

(e) a hearing aid for a client in a nursing facility, ICF/MR, chronic disease hospital, hospital or other facility if the hearing aid is included in the facility's per diem Medicaid rate; or

(f) a hearing aid that can be billed to another payer.

(Adopted effective July 11, 2011)

Sec. 17b-262-799. Payment and payment limitations

(a) Fees shall be the same for in-state, border-state and out-of-state providers.

(b) Payment shall be made at the lowest of:

(1) The provider's usual and customary charge;

(2) the lowest Medicare rate;

(3) the amount in the applicable fee schedule as published by the department pursuant to section 4-67c of the Connecticut General Statutes; or

(4) the amount billed by the provider.

(c) The department shall reimburse a provider when all the requirements of sections 17b-262-792 to 17b-262-803, inclusive, of the Regulations of Connecticut State Agencies have been met.

(d) The fee for a hearing aid includes an initial one-year manufacturer's warranty against loss, theft or damage.

(e) Hearing aids provided shall be new and guaranteed against all defects in workmanship and materials for at least one year from the date of delivery of the hearing aid to the client.

(f) The department shall pay providers for:

(1) The actual acquisition cost of a hearing aid to the provider up to the maximum amount allowed by the department's fee schedule;

(2) a dispensing fee up to the maximum allowed by the department's fee schedule; and

(3) hearing testing for the purpose of fitting a hearing aid.

(g) The department shall pay for custom ear molds for a client who dies or is not otherwise eligible on the date of delivery provided the client was eligible on the date the item was ordered.

(h) If the cost of repairs to any hearing aid exceeds its replacement cost, the hearing aid

shall be replaced.

(i) The provider shall meet the exact specifications of a hearing aid selected by an audiologist, ear specialist or licensed practitioner.

(Adopted effective July 11, 2011)

Sec. 17b-262-800. Prior authorization

(a) The department shall require PA for:

(1) Any hearing aid that is identified on the department's fee schedule as requiring PA;

(2) EPSDT special services; and

(3) any service or device that is not on the department's fee schedule.

(b) To receive reimbursement from the department, a provider shall comply with all prior authorization requirements. The department, in its sole discretion, shall determine what information is necessary to approve a prior authorization request. Prior authorization does not, however, guarantee payment unless all other requirements are met.

(c) A PA request, on a form and in the manner specified by the department, shall include documentation of medical necessity and shall be signed by the provider.

(d) A prescription is required from a licensed practitioner for all services and goods provided as EPSDT special services. A copy of the prescription from the licensed practitioner may be attached to the completed PA request in lieu of the actual signature of the licensed practitioner on the PA request form. The licensed practitioner's original prescription shall be on file with the provider and be subject to review by the department.

(Adopted effective July 11, 2011)

Sec. 17b-262-801. Billing procedure

(a) Claims from providers shall be submitted on a hard copy invoice or electronically transmitted to the department in a form and in a manner specified by the department and shall include all information required by the department to process the claim for payment.

(b) A claim submitted for hearing aids and supplies that does not require prior authorization shall include the national provider identifier number of the licensed practitioner or audiologist prescribing the hearing aid, if applicable.

(Adopted effective July 11, 2011)

Sec. 17b-262-802. Documentation

(a) Providers shall maintain all fiscal and medical records related to services and goods rendered or delivered to clients.

(b) All required documentation, including evidence of a medical evaluation for a hearing aid, results of audiometric evaluations, results of any testing to support the need for a hearing aid and expected hearing improvement and notes related to fittings and adjustments shall be maintained for at least five years in the provider's primary place of business and shall be subject to review by the department.

(c) The department shall accept, when feasible, faxed or electronic medical evaluations

and other orders. If evidence indicates that the documentation being reviewed has been falsified or the provider is unable to provide adequate assurance of the medical necessity of the items or services, the department may request additional information, including an original signature, in order to obtain that assurance.

(d) Any documentation, including a medical evaluation, that is electronically submitted to a vendor shall identify the sender and display the sender's fax number and date. The department may request the original medical evaluation and results of the hearing test whenever medical necessity is in question.

(e) In the event of a dispute concerning a service or a hearing aid provided, documentation shall be maintained until the end of the dispute or five years, whichever is longer.

(f) Failure to maintain all required documentation shall result in the disallowance and recovery by the department of any amounts paid to the provider for the hearing aid or service for which the required documentation is not maintained or provided to the department upon request.

(g) The provider shall have on file the manufacturer's purchase invoice for any hearing aid dispensed to a client, for any repairs or servicing and for any processing charges associated with replacement of a hearing aid under warranty.

(h) Providers shall maintain signed receipts for all goods and services that are provided to a client regardless of whether the item is delivered or picked up by the client or client's representative. The receipt for hearing aids, services and supplies shall at a minimum, contain the following:

(1) The provider's name;

(2) the client's name;

(3) the client's address;

(4) the date of delivery; and

(5) itemization of the hearing aid, service or supplies delivered, including, but not limited to:

(A) Product description;

(B) brand name;

(C) model name and number, if applicable;

(D) serial number, if applicable;

(E) the quantity delivered;

(F) the amount billed per hearing aid; and

(G) any warranty in effect.

(i) A prescription or order for hearing aids and supplies, regardless of the format used, shall, at a minimum, contain the following:

(1) The client's name, address and date of birth; and

(2) the diagnosis for which the hearing aid is required.

(j) Evidence of the medical evaluation shall, at a minimum, include the following:

(1) The client's name, address and date of birth;

(2) the date of the physician's medical evaluation;
(3) the prescribing physician's signature and date of his or her signature; and
(4) a statement that the client's hearing loss has been medically evaluated and that the client may be considered a candidate for a hearing aid.
(k) All required documentation shall be subject to review by authorized department personnel upon the department's request.

(Adopted effective July 11, 2011)

Sec. 17b-262-803. Other

(a) Where brand names or stock or model numbers are specified on the prescription or the PA, no substitution shall be permitted without the written approval of the department.
(b) The provider shall instruct the client, his or her family or a designated representative on the proper use and care of the hearing aid.
(c) The provider shall maintain a written usual and customary price list that details individual product and service charges. This list, including updates along with any required manufacturer's list pricing, shall be available for review by the department.
(d) A hearing aid purchased by the department shall become the property of the client on the date of delivery to the client.

(Adopted effective July 11, 2011)

Requirements for Payment of Services Provided by Psychiatric Residential Treatment Facilities Providers

Sec. 17b-262-804. Scope

Sections 17b-262-804 to 17b-262-816, inclusive, of the Regulations of Connecticut State Agencies set forth the Department of Social Services' requirements for payment for Psychiatric Residential Treatment Facilities (PRTF) services provided to clients who are determined eligible for Connecticut's Medicaid Program pursuant to section 17b-261 of the Connecticut General Statutes.

(Adopted effective September 4, 2009)

Sec. 17b-262-805. Definitions

As used in section 17b-262-804 to section 17b-262-816, inclusive, of the Regulations of Connecticut State Agencies:
(1) "Active treatment" means "active treatment" as defined in 42 CFR, Part 441, section 441.154;
(2) "Acute" means having rapid onset, severe symptoms and a short course;
(3) "Allied Health Professional" or "AHP" means a licensed individual who is qualified by special training, education, skills and experience in behavioral health care and treatment and shall include, but shall not be limited to: psychologists, social workers, psychiatric nurses, professional counselors and other qualified therapists as defined in Title 20 of the

Connecticut General Statutes;

(4) "Authorization" means the approval of payment for services or goods by the department based on a determination of medical necessity and appropriateness. For elective admissions, authorization also serves as the certification of need as defined in this section;

(5) "CMS" means the Centers for Medicare and Medicaid Services;

(6) "Certification of need" means an evaluation process for clients who are under consideration for admission to a PRTF;

(7) "Client" means a person eligible for goods or services under Medicaid who is under age twenty-one at the time services are received. If a client received services immediately before reaching age twenty-one, payment shall be available for services received before the earlier of the date that the client no longer requires the services or the date that the client reaches age twenty-two;

(8) "Department" means the Department of Social Services or its agent;

(9) "Elective admission" means any admission to a PRTF that is non-emergent, including, but not limited to, transfers from one PRTF to another;

(10) "Independent team" means a team that meets the requirements set forth in 42 CFR, Part 441, section 441.153(a). The independent team may not include anyone who is related, in any way, to the admitting facility, or who is directly responsible for the care of patients whose care is being reviewed or has a financial interest in the admitting facility. The department performs the functions of the independent team;

(11) "Individual plan of care" or "plan of care" means a written plan that meets the criteria set forth in 42 CFR, Part 441, Section 441.155;

(12) "Inpatient" means "inpatient" as defined in 42 CFR, Part 440, section 440.2;

(13) "Interdisciplinary team" means a team that meets the requirements set forth in section 42 CFR, Part 441, section 441.156;

(14) "Medicaid" means the program operated by the department pursuant to section 17b-260 of the Connecticut General Statutes and authorized by Title XIX of the Social Security Act;

(15) "Medical appropriateness" or "medically appropriate" means health care that is provided in a timely manner and meets professionally recognized standards of acceptable medical care; is delivered in the appropriate medical setting; and is the least costly of multiple, equally-effective, alternative treatments or diagnostic modalities;

(16) "Medical necessity" or "medically necessary" means health care provided to correct or diminish the adverse effects of a medical condition or mental illness; to assist an individual in attaining or maintaining an optimal level of health; to diagnose a condition or to prevent a medical condition from occurring;

(17) "Medical record" means "medical record" as described in 42 CFR, Part 482, section 482.6l and subsection (d) of section 19-13-D3 of the Regulations of Connecticut State Agencies;

(18) "Overnight pass" means a conditional release to the client's proposed residence on discharge of not more than two days duration, after admission and prior to the day of

discharge, in which the client has been permitted by the attending physician to be absent from the facility premises and in accordance with the client's treatment needs and goals as specified in the plan of care;

(19) "Provider" means a PRTF that is enrolled in Medicaid;

(20) "Provider agreement" means the signed, written contractual agreement between the department and the provider;

(21) "Psychiatric emergency" means a sudden onset of a psychiatric condition, as determined by a physician, that manifests itself by acute symptoms of such severity that the absence of immediate medical care and treatment in an inpatient psychiatric facility could reasonably be expected to result in serious dysfunction, disability or death of the client or harm to self or another person by the client. Court commitments and clients admitted on a physician emergency certificate are not automatically deemed to qualify as a psychiatric emergency;

(22) "Psychiatric Residential Treatment Facility" or "PRTF" means a facility that meets all the requirements in 42 CFR Part 441, Subpart D and 42 CFR Part 483, Subpart G;

(23) "Quality of care" means the evaluation of medical care to determine if it meets the professionally recognized standard of acceptable medical care for the condition and the client under treatment;

(24) "Retrospective review" means the review conducted after services are provided to a client, to determine the medical necessity, medical appropriateness and quality of the services provided;

(25) "Transfer" means that a client is discharged from a PRTF and directly admitted to another;

(26) "Under the direction of a physician" means that health services may be provided by allied health professionals or paraprofessionals whether or not the physician is physically present at the time that the services are provided; and

(27) "Utilization management" means the prospective, retrospective or concurrent assessment of the medical necessity and appropriateness of the allocation of health care resources and services given, or proposed to be given, to a client.

(Adopted effective September 4, 2009)

Sec. 17b-262-806. Provider participation

In order to enroll in Medicaid and receive payment from the department, a provider shall meet the following requirements:

(a) **General:**

(1) meet and maintain all applicable licensing, accreditation and certification requirements;

(2) meet and maintain all departmental enrollment requirements; and

(3) have a valid provider agreement on file which is signed by the provider and the department upon application for enrollment into Medicaid. This agreement, which shall be periodically updated, shall continue to be in effect for the duration of the agreement or for

the stated period in the agreement. The provider agreement specifies conditions and terms which govern the program and to which the provider is mandated to adhere in order to participate in the program.

(b) **Specific:**

(1) be accredited in accordance with 42 CFR 441.151(a)(2);

(2) satisfy all federal and state requirements governing the use of restraint and seclusion including, but not limited to, a written attestation of facility compliance with CMS standards governing the use of restraint and seclusion and filed annually with the department no later than July 1st of each year; and

(3) if located outside of Connecticut, meet all of the provider requirements in subsections (a) and (b) of this section and be an enrolled Medicaid provider in the provider's state of residence, when that state participates in the optional Medicaid of inpatient psychiatric facility services provided for clients.

(Adopted effective September 4, 2009)

Sec. 17b-262-807. Eligibility

Payment for PRTF services shall be available, subject to the conditions and limitations set forth in sections 17b-262-804 to17b-262-816, inclusive, of the Regulations of Connecticut State Agencies, for services rendered to clients.

(Adopted effective September 4, 2009)

Sec. 17b-262-808. Services covered

(a) The department shall pay a per diem rate, which is an inclusive payment for all services that are required to be provided by the facility as a condition for participation as a PRTF, including, but not limited to:

(1) therapeutic services provided by PRTF staff;

(2) active treatment services including, but not limited to, individual, group and family therapy;

(3) diagnostic testing and assessment;

(4) room and board; and

(5) case management, discharge planning.

(b) The department shall pay for authorized PRTF services for clients provided by an enrolled provider.

(Adopted effective September 4, 2009)

Sec. 17b-262-809. Services not covered

The department shall not pay for the following PRTF services that are not covered under Medicaid:

(a) procedures or services of an unproven, educational, social, research, experimental or cosmetic nature or for any diagnostic, therapeutic or treatment procedures in excess of those deemed medically necessary and appropriate by the department to treat the client's

condition;

(b) services or items furnished for which the provider does not usually charge;

(c) services that do not directly relate to the client's diagnosis, symptoms or medical history;

(d) the day of discharge;

(e) a PRTF admission or a day of care that does not meet all the department's requirements for inpatient services;

(f) a day when the client is absent from the PRTF at the midnight census, unless the absence is a medically authorized overnight pass and part of the treatment plan; or

(g) costs associated with the education or vocational training of the client which shall be excluded from Medicaid payments.

(Adopted effective September 4, 2009)

Sec. 17b-262-810. Certification of need requirements

(a) In order to receive payment for PRTF services for an individual, admissions shall have a certification of need as required in 42 CFR 441 Subpart D, as amended from time to time.

(b) The certification of need shall be based on a determination that:

(1) ambulatory care resources available in the community do not meet the treatment needs of the client;

(2) proper treatment of the client's psychiatric condition requires services on an inpatient basis under the direction of a physician; and

(3) the services shall reasonably be expected to improve the client's condition or prevent further regression so that inpatient services shall no longer be needed.

(c) When the admission of a client is elective, an independent team shall perform the certification of need. The facility shall maintain written documentation of the independent team's certification of need as evidenced by the signature of a member of the independent team on a certification of need form or letter(s) of authorization by the independent team.

(d) When the admission is of a person who is not Medicaid eligible and who applies for Medicaid while in the PRTF, the certification of need shall be conducted at the time of application for or by the first day of Medicaid eligibility. The interdisciplinary team responsible for the individual plan of care shall perform the certification of need, which shall cover any period prior to application for which Medicaid claims are made. The facility shall maintain written documentation of the certification of need.

(e) For psychiatric emergency admissions, the certification of need shall be performed by the interdisciplinary team responsible for the plan of care not later than fourteen days after the day of admission. The facility shall maintain written documentation of the certification of need as evidenced by the signature of a member of the independent team on a certification of need form.

(f) When the client is admitted from a PRTF to a hospital and, upon discharge, is

readmitted to the PRTF, a new certification of need shall be performed.

(Adopted effective September 4, 2009)

Sec. 17b-262-811. Individual plan of care requirements

(a) PRTF services for clients shall involve active treatment, as documented in the professionally developed and supervised individual plan of care.

(b) A physician shall:

(1) assume professional responsibility for the services provided under the plan of care;

(2) assure that the services are medically appropriate;

(3) certify in writing that the services provided are necessary in the setting in which they will be provided; and

(4) be readily available in person or by phone but not necessarily on the premises.

(c) Not later than seven days after admission, the interdisciplinary team shall establish a written plan of care for each client, designed to achieve the client's discharge from the PRTF at the earliest possible time. This plan shall:

(1) be based on a diagnostic evaluation that includes examinations of the medical, psychological, social, behavioral and developmental aspects of the client's situation and thereby reflect the need for PRTF services;

(2) be developed by the interdisciplinary team of professionals in consultation with the client and his or her parents, legal guardian, or others into whose care he or she will be released after discharge;

(3) state the treatment objectives;

(4) prescribe an integrated program of therapies, activities and experiences designed to meet the treatment objectives;

(5) include, at an appropriate time, post-discharge plans and coordination of PRTF services with partial discharge plans and related community services to ensure continuity of care with the client's family, school and community upon discharge; and

(6) be a recorded document which is maintained in the client's medical record.

(d) The individual plan of care shall be reviewed every thirty days by the interdisciplinary team, starting on the date of admission. The purpose of the review is to determine whether services being provided are currently required, or were required on an inpatient basis, and to recommend any changes to the plan that are indicated by the client's overall progress towards the treatment goals.

(Adopted effective September 4, 2009)

Sec. 17b-262-812. Utilization review program

(a) The department conducts utilization review activities for services delivered by the PRTF for clients where Medicaid has been determined to be the appropriate payer.

(b) To determine whether admission to a PRTF is medically necessary and medically appropriate, the department or the Administrative Service Organization shall:

(1) authorize each PRTF admission, unless the department notifies the providers that a

specific admission or diagnosis does not require such authorization; and

(2) perform retrospective reviews, at the department's discretion, which may be a random or targeted sample of the admissions and services delivered. The review may be focused on the appropriateness, necessity or quality of the health care services provided.

(c) All claims for payment for admission and all days of stay and services that are provided shall be documented. Lack of said documentation may be adequate grounds for the department, in its discretion, to deny or recoup payment for the admission for some or all of the days of stay or services provided.

(d) The department may conduct medical reviews and inspections of care in PRTFs.

(Adopted effective September 4, 2009)

Sec. 17b-262-813. Billing procedures

Claims from providers shall be submitted on the department's uniform billing form or electronically transmitted to the department's fiscal agent and shall include all information required by the department to process the claim for payment.

(Adopted effective September 4, 2009)

Sec. 17b-262-814. Documentation and record retention

(a) A provider shall meet the medical record requirements for a PRTF and shall maintain records to support claims made for payment. All documentation shall be made available upon request by and to authorized department, state or federal personnel in accordance with state and federal laws. Documentation shall be retained by the provider for a period of at least five years, except if otherwise required by law or, if any dispute arises concerning a service, until such dispute has been finally resolved.

(b) Failure to maintain all required documentation or to provide it to the department upon request may result in the disallowance and recovery by the department of any amounts paid out for which the required documentation is not maintained or provided.

(Adopted effective September 4, 2009)

Sec. 17b-262-815. Payment

The Department shall reimburse PRTFs at a negotiated per diem rate.

(Adopted effective September 4, 2009)

Sec. 17b-262-816. Audit and compliance review

All supporting accounting and business records, statistical data and all other records relating to the provision of PRTF services paid for by the department shall be subject to audit or compliance review by authorized personnel. All documentation shall be made available, upon request, to authorized representatives of the department.

(Adopted effective September 4, 2009)

Sec. 17b-262-817—17b-262-828. Reserved

Requirements for Payment of Hospice

Sec. 17b-262-829. Scope

Sections 17b-262-829 to 17b-262-848, inclusive, of the Regulations of Connecticut State Agencies set forth the Department of Social Services requirements for the payment of hospice services on behalf of clients who are determined eligible to receive services under the Connecticut Medicaid program pursuant to section 17b-262 of the Connecticut General Statutes.

(Adopted effective July 7, 2009)

Sec. 17b-262-830. Definitions

As used in section 17b-262-829 to section 17b-262-848, inclusive, of the Regulations of Connecticut State Agencies:

(1) "Advanced practice registered nurse" or "APRN" means an advanced practice registered nurse as defined in section 20-87a of the Connecticut General Statutes;

(2) "Applied income" means the amount of income that each client receiving hospice care is expected to pay each month toward the cost of care, calculated according to the department's Uniform Policy Manual, section 5045.20;

(3) "Attending physician" means a physician who is identified by the client at the time he or she elected to receive hospice care as having the most significant role in the determination and delivery of the individual's medical care;

(4) "Bereavement counseling" means emotional, psychosocial, and spiritual support and services provided before and after the client's death to the client and the client's family to assist with issues related to grief, loss and adjustment;

(5) "Client" means a person eligible for goods or services under Medicaid;

(6) "Commissioner" means the Commissioner of Social Services or his or her designee;

(7) "Concurrent" means in the same time period covered by the care plan;

(8) "Counseling" means services, including dietary counseling, provided for the purpose of helping the client and caregivers to adjust to the client's approaching death;

(9) "Date of terminal diagnosis" means the date on which a physician first diagnoses the client as terminally ill;

(10) "Department" means the Department of Social Services or its agent;

(11) "Election period" means one of three or more periods of care a client may choose to receive the hospice benefit. The periods consist of an initial 90-day period, a subsequent 90 day period and an unlimited number of subsequent 60-day periods;

(12) "Home" means the client's place of residence, including, but not limited to, a boarding home, residential care home or community living arrangement. "Home" does not include facilities such as hospitals, nursing facilities, chronic disease hospitals, intermediate care facilities for the mentally retarded (ICF/MR) or other facilities that are paid an all-inclusive rate directly by Medicaid for the care of the client;

(13) "Home health aide" means an individual who has completed the homemaker-home health aide services training and competency evaluation program in accordance with Sec.19-13-D69 of the Regulations of Connecticut State Agencies;

(14) "Home health care agency" means "home health care agency" as defined in section 19a-490 of the Connecticut General Statutes and licensed pursuant to sections 19-13-D66 to 19-13-D79, inclusive, of the Regulations of Connecticut State Agencies;

(15) "Hospice" means an agency that is primarily engaged in providing care to terminally ill individuals and meets the requirements of section 19-13-D72(b)(2) of the Regulations of Connecticut State Agencies. The hospice model of care is based on a coordinated program of home and inpatient care, employing an interdisciplinary team to meet the special needs of terminally ill individuals;

(16) "Hospice aide and homemaker" means a "hospice aide and homemaker" as defined in 42 CFR 418.76;

(17) "Hospital" means "general hospital" as defined in section 19-13-D1(b)(1) of the Regulations of Connecticut State Agencies;

(18) "Interdisciplinary team" means a group of hospice personnel to include, but not be limited to, a physician, a registered nurse, a pharmacist, a social worker and a counselor that is responsible for providing services to meet the physical, psychosocial, spiritual and emotional needs of a terminally ill client or family members, as delineated in a specific plan of care. The interdisciplinary team is responsible for participating in the establishment of a plan of care for each client, supervising hospice services and reviewing and updating the plan of care as necessary;

(19) "Intermediate care facility for the mentally retarded" or "ICF/MR" means a residential facility for persons with mental retardation licensed pursuant to section 17a-227 of the Connecticut General Statutes and certified to participate in Medicaid as an intermediate care facility for the mentally retarded pursuant to 42 CFR 442.101, as amended from time to time;

(20) "Legal representative" means an individual who has been authorized under Connecticut state law to direct medical care or to elect or revoke the election of hospice care on behalf of a terminally ill individual who is mentally or physically incapacitated;

(21) "Licensed practical nurse" or "LPN" means "licensed practical nurse" as defined in section 20-87a of the Connecticut General Statutes;

(22) "Medicaid" means the program operated by the department pursuant to section 17b-260 of the Connecticut General Statutes and authorized by Title XIX of the Social Security Act, as amended from time to time;

(23) "Medical appropriateness" or "medically appropriate" means health care that is provided in a timely manner and meets professionally recognized standards of acceptable medical care; is delivered in the appropriate setting; and is the least costly of multiple, equally-effective alternative treatments or diagnostic modalities;

(24) "Medical necessity" or "medically necessary" means health care provided to correct or diminish the adverse effects of a medical condition or mental illness; to assist an

individual in attaining or maintaining an optimal level of health; to diagnose a condition; to prevent a medical condition from occurring; or to alleviate suffering through the palliation of symptoms at the end of life;

(25) "Medical record" means "medical record" as defined in section 19a-14-40 of the Regulations of Connecticut State Agencies;

(26) "Nursing care" means the services provided by a registered nurse or a licensed practical nurse;

(27) "Nursing facility" means "nursing facility" as defined in 42 USC 1396r(a), as amended from time to time, and licensed pursuant to section 19-13-D8t of the Regulations of Connecticut State Agencies;

(28) "Occupational therapy" means the services provided by an occupational therapist or an occupational therapy assistant as set forth in section 20-74a of the Connecticut General Statutes;

(29) "Palliative care" means care that addresses physical, intellectual, emotional, social and spiritual needs and facilitating patient autonomy, access to information and choice;

(30) "Physical therapy" means the services provided by a physical therapist or a physical therapy assistant as set forth in section 20-66 of the Connecticut General Statutes;

(31) "Physician" means a physician or surgeon licensed pursuant to section 20-10 or 20-12, inclusive, of the Connecticut General Statutes;

(32) "Plan of care" means a comprehensive assessment of the client's needs that identifies the types and frequency of services necessary to manage the client's discomfort and relieve the symptoms of the terminal illness as well as to identify any services necessary to meet the needs of the family that meet the requirements of 42 CFR 418.54;

(33) "Prior authorization" or "PA" means the approval for the provision of a service or delivery of goods from the department before the provider actually provides the service or delivers the goods;

(34) "Provider" means a hospice that is certified by Medicare as a hospice, is licensed by the Connecticut Department of Public Health as a hospice and is enrolled with Medicaid;

(35) "Registered nurse" means "registered nurse" as defined in section 20-87a of the Connecticut General Statutes;

(36) "Social worker" means an individual licensed pursuant to section 20-195n of the Connecticut General Statutes;

(37) "Speech therapy" or "speech pathology" means the services provided by a speech pathologist as set forth in section 20-408 of the Connecticut General Statutes; and

(38) "Terminally ill" means a condition in which the patient has a medical prognosis of a life expectancy of six months or less if the illness runs its normal course.

(Adopted effective July 7, 2009)

Sec. 17b-262-831. Provider participation

To enroll in Medicaid and receive payment from the department, providers shall comply with sections 17b-262-522 to 17b-262-533, inclusive, of the Regulations of Connecticut

State Agencies, shall be certified as a provider of hospice services under the Medicare program as described in 42 CFR 418.50 through 418.100, inclusive, and shall be licensed as a hospice by the State Department of Public Health in accordance with section 19a-122b of the Connecticut General Statutes and section 19-13D72(b)(2) of Regulations of Connecticut State Agencies.

(Adopted effective July 7, 2009)

Sec. 17b-262-832. Eligibility

Payment for hospice services is provided to persons who meet all of the following conditions:

(1) the individual is eligible for Medicaid; and

(2) the individual is certified by a physician as being terminally ill.

(Adopted effective July 7, 2009)

Sec. 17b-262-833. Refusal to serve

No hospice enrolled as a Medicaid provider shall select a service area or refuse to serve any person, based on the geographical location of the service to be provided unless the hospice has a legitimate, non-discriminatory reason for its choice of service area or its refusal to serve as provided in section 17b-262-5 to 17b-262-8, inclusive, of the Regulations of Connecticut State Agencies. Providers shall designate service areas, document any refusals to serve and be subject to the sanctions in section 17b-262-9 of the Regulations of Connecticut State Agencies.

(Adopted effective July 7, 2009)

Sec. 17b-262-834. Certification of terminal illness

(a) The provider shall obtain an initial certification of the client's terminal illness jointly from the medical director of the hospice or a physician member of the hospice interdisciplinary group and the client's attending physician, if an attending physician is identified, prior to the beginning of hospice services.

(b) The initial certification shall state that the client's life expectancy is six months or less and shall include clinical information to support this medical prognosis. The initial certification is valid for the first 90 days of hospice care.

(c) At the end of the first 90-day period, a second 90-day period may be certified by the medical director of the hospice or the physician member of the hospice interdisciplinary group. The certification shall include clinical information to support this medical prognosis;

(d) An unlimited number of 60-day periods may be certified following the first two 90-day periods by the medical director of the hospice or the physician member of the hospice interdisciplinary group. The certification shall include clinical information to support this medical prognosis

(e) An APRN may not certify or recertify a terminally ill diagnosis.

(Adopted effective July 7, 2009)

Sec. 17b-262-835. Plan of care

(a) The interdisciplinary team in conjunction with the attending physician shall establish an initial written plan of care for each client within 48 hours of the client's election of hospice. Services may not be billed until the plan is established.

(b) The interdisciplinary team, in collaboration with the individual's attending physician, if any, must review, revise and document the individualized plan as frequently as the client's condition requires, but no less frequently than every 14 calendar days.

(c) The plan of care shall specify the care and services necessary to meet the client's and family's needs identified in the comprehensive assessment.

(Adopted effective July 7, 2009)

Sec. 17b-262-836. Election of hospice

(a) A client who meets the eligibility requirement of 42 CFR 418.20 may file an election statement with a particular hospice. If the individual is physically or mentally incapacitated, his or her legal representative may file the election statement. The election statement must indicate;

(1) that the individual is electing a hospice benefit and identify which hospice he has chosen;

(2) the effective date of the election;

(3) that the individual understands that hospice services are palliative rather than curative and waives all rights to Medicaid payment for services to cure the terminal illness and related condition. Medicaid shall continue to pay for covered benefits that are not related to the terminal illness; and

(4) that the individual is eligible to receive hospice services only through the provider he has designated.

(b) The election statement shall include the following information:

(1) name of client;

(2) address and telephone number of client;

(3) client's Medicaid number and Medicare number, if applicable;

(4) primary terminal diagnosis;

(5) client's date of birth;

(6) name of parent, guardian or legal representative, if applicable;

(7) sex of client;

(8) name, telephone number and Medicaid number of provider;

(9) name and Medicaid number of attending physician;

(10) date of physician's certification of terminal illness;

(11) date the diagnosis is terminal; and

(12) name and Medicaid number of the nursing facility or ICF/MR, if applicable.

(c) A client may revoke election of hospice services at any time during the election period by signing and dating a statement to this effect. The revocation shall be in writing and shall not be retroactive. When a client revokes the hospice benefit, he resumes coverage for any

services waived when he elected hospice. The client may re-elect hospice at any time for the next 60 or 90 day election period.

(d) A client may change hospice agencies once during any election period by signing and dating a statement to this effect.

(e) A client who is eligible for Medicare in addition to Medicaid shall elect the hospice benefit in both the Medicare and Medicaid programs simultaneously.

(Adopted effective July 7, 2009)

Sec. 17b-262-837. Discharge from hospice

(a) The provider may discharge a client if:

(1) the client moves out of the provider's service area or transfers to another hospice;

(2) the client is no longer terminally ill;

(3) the client revokes the hospice benefit;

(4) the client dies; or

(5) the provider determines that there is just cause because the client or other person living with the client is disruptive, abusive or uncooperative to the extent that delivery of care to the client or the ability of the hospice to operate effectively is seriously impaired. A discharge for just cause shall meet the criteria and follow the process described in 42 CFR 418.26(a)(3).

(b) No client shall be discharged for just cause or if he or she is considered no longer terminally ill without a review by the department. When the hospice advises the client that discharge is being considered either for good cause or because the physician believes the client is no longer terminally ill, a copy of that written communication shall be sent to the department and the attending physician.

(c) The hospice shall obtain a written physician discharge order consistent with 42 CFR 418(b) before discharging a client for any reason other than death.

(d) Upon discharge the client is no longer covered for hospice care for that election period and resumes the Medicaid benefit that had been waived unless the client is immediately transferred to another hospice. As long as the client is still eligible, he or she may re-elect the hospice benefit immediately and by so doing shall enter the next election period.

(e) The provider shall have a discharge planning process in place that is consistent with 42 CFR 418.26(d).

(Adopted effective July 7, 2009)

Sec. 17b-262-838. Services covered

(a) The following documents shall be in place prior to the provision of hospice services:

(1) certification of terminal illness for the applicable election period. The certification may be in writing, electronically transmitted or verbal. A facsimile is acceptable provided the original is available on request. Verbal orders are acceptable provided a written order is received within 48 hours of the verbal order.

(2) a statement signed by the client or his or her legal representative electing the hospice benefit; and

(3) an initial plan of care within 48 hours following election of the hospice benefit.

(b) Subject to the limitations and exclusions identified in sections 17b-262-829 to 17b-262-848, inclusive, of the Regulations of Connecticut State Agencies, the department shall pay an all-inclusive per diem rate to the provider for each Medicaid client. This rate represents payment for the provision of the following goods and services:

(1) Physician services to include: the general supervisory duties of the medical director, participation in the establishment of plans of care, supervision of care and services, periodic review and updating of plans of care and establishment of governing policies by the interdisciplinary group;

(2) nursing service provided by or under the supervision of a registered nurse;

(3) home health aide and hospice aide and homemaker services under the supervision of a registered nurse, as ordered by the physician-led interdisciplinary group;

(4) physical therapy, occupational therapy and speech-language pathology to control symptoms or to enable the client to maintain activities of daily living and basic functional skills;

(5) medical equipment, supplies, biologicals and appliances that are a part of the written plan of care and not included in the payment to facilities for room & board;

(6) drugs which are used primarily for the relief of pain and symptom control related to the client's terminal illness and that are included in the provider's formulary, subject to review and approval by the department;

(7) social work services based on the client's psychosocial assessment and the client's and family's needs and acceptance of these services;

(8) dietary counseling, when identified in the plan of care and performed by a qualified individual, including dietitians as well as nutritionists and registered nurses, who are able to address and assure that the dietary needs of the client are met;

(9) spiritual counseling in accordance with the client's and family's acceptance of this service, and in a manner consistent with patient and family beliefs and desires;

(10) bereavement, grief and loss counseling, to reflect the needs of the bereaved;

(11) short term care inpatient care according to 42 CFR 418.108 for pain control and symptom management;

(12) respite care;

(13) supervision of volunteers; and

(14) any covered medically necessary and reasonable services related to the terminal illness as identified by the interdisciplinary team.

(c) The professional component of physician and APRN services reasonable and necessary for the treatment and management of the hospice client's terminal illness not described in subsection (b)(1) of this section shall be paid in addition to the per diem amount according to the department's fee schedule for physician services.

(d) Hospice services are provided at one of the following four levels of care:

(1) Routine home care is furnished to a client who is at home, in a nursing facility, or ICF/MR; is under the care of a hospice; and is not receiving continuous care.

(2) Continuous home care is furnished during brief periods of crisis as described in 42 CFR 418.204(a) in order to maintain a client at home. A minimum of eight hours of care, of which at least half is direct licensed nursing care, shall be provided in a 24-hour period to qualify for continuous home care to be billed on a hourly basis. The care does not need to be provided in successive blocks of time so long as a need for an aggregate of eight hours is required in a 24-hour period. All direct service hours shall be clearly documented. Services provided by other disciplines, such as social workers or counselors, are expected during periods of crisis but are not counted towards the total hours of continuous care. In addition, documentation of care, modification of the plan of care and supervision of home health aides by a nurse shall not qualify as direct client care.

(3) General inpatient care is furnished in an inpatient facility that meets the requirements in 42 CFR 418.108 when pain control or acute or chronic symptom management cannot be managed in other settings.

(4) Respite care is furnished for each day the client is in an approved inpatient facility in order to give the caregiver a rest. It is available for a maximum of five days in a 60-day period.

(e) The department shall pay a nursing facility or ICF/MR to hold the bed of a client who is hospitalized when the requirements of section 19a-537 of the Connecticut General Statutes are met.

(f) The provider shall routinely provide all nursing services, medical social work services and counseling. The provider may contract for physician services and the services of other personnel consistent with the requirements of 42 CFR 418.64.

(Adopted effective July 7, 2009)

Sec. 17b-262-839. Coordination of hospice and waiver services

(a) For clients who receive waiver services prior to electing the hospice benefit under Medicaid, waiver services shall continue to be available.

(b) It is the responsibility of hospice to develop a plan of care that coordinates the hospice and waiver services. It is the responsibility of the hospice to initiate coordination with the waiver program case manager so that the client receives all of the care and services necessary. The waiver program's case manger is responsible for adjusting the waiver services so there is no duplication of services provider by the hospice or the waiver. These objectives should be accomplished according to the following principles:

(1) The best interest of the client is the key consideration. In circumstances when the hospice and waiver program case managers cannot agree on what is best for the client they shall ask the department for assistance in this determination.

(2) Each program shall provide services consistent with the goals of their respective programs. The goal of hospice care is to keep the client as comfortable as possible while maintaining his or her dignity and quality of life; the goal of the waiver program is to keep

clients out of institutions.

(3) Services related to the terminal diagnosis are the responsibility of the hospice.

(4) Services provided prior to the date of terminal diagnosis are generally considered to be unrelated to the terminal diagnosis.

(5) Services unrelated to the terminal diagnosis may be billed in addition to the hospice reimbursement by the provider rendering the service.

(6) For the purpose of developing a plan of care, the presumption is that waiver services provided prior to the date of the terminal diagnosis should continue to be provided as waiver services. It is presumed that services initiated after the date of the terminal diagnosis are the responsibility of the hospice although this is subject to review and reconsideration by the hospice as approved by the department.

(Adopted effective July 7, 2009)

Sec. 17b-262-840. Volunteers

The provider shall maintain a volunteer program consistent with 42 CFR 418.78.

(Adopted effective July 7, 2009)

Sec. 17b-262-841. Service limitations

(a) The department shall pay only for services listed in its fee schedule.

(b) the department shall not pay separately for any services that are related to the treatment of the terminal condition for which hospice services were elected.

(c) Hospice services are covered in a nursing facility only if the nursing facility has a written agreement with the provider such that the provider takes full responsibility for the professional management of the client's hospice care and the nursing facility agrees to provide room and board to the client. The agreement shall meet the requirements of 42 CFR 418.112.

(d) For a client eligible for both Medicare and Medicaid, the only service payable by Medicaid is the room and board charge for a client in a nursing facility. Room and board means the facility's per diem rate that includes the services described in section 17b-262-705 of the Regulations of Connecticut State Agencies.

(e) The department shall pay for only one level of care on any day.

(f) Respite care is not available for a client who resides in a nursing facility, hospital or ICF/MR.

(g) Bereavement counseling shall be available for the family for up to 13 months following the client's death but is not separately reimbursable.

(h) Home health agency services are not covered unless they are unrelated to the terminal illness and prior authorized by the department.

(Adopted effective July 7, 2009)

Sec. 17b-262-842. Services not covered

(a) When a client elects the hospice benefit, the client waives his or her right to receive

the following services under Medicaid:

(1) treatment intended to cure the terminal illness;

(2) treatment related to the terminal illness except for the treatment provided by the designated hospice;

(3) hospice services provided by a provider other than the one designated by the client on the hospice form submitted to the department. However, the provider may subcontract with another hospice for services as described is section. 17b-262-838(f); and

(4) any services that are duplicative of any service provided by the hospice provider with the exception of services of the client's attending physician.

(b) In order for charges to be billed separately, the provider shall first demonstrate that the service is not related to the terminal illness.

(c) The department shall not pay for services that are not medically necessary and medically appropriate.

(Adopted effective July 7, 2009)

Sec. 17b-262-843. Prior authorization

(a) Prior authorization, on forms and in the manner specified by the department shall be required for:

(1) general inpatient days beyond the fifth day; and

(2) any service which the department indicates on its fee schedule requires prior authorization.

(b) The department, in its sole discretion, shall determine what information is necessary to approve a prior authorization request. Prior authorization does not, however, guarantee payment unless all other requirements for payment are met.

(Adopted effective July 7, 2009)

Sec. 17b-262-844. Billing procedures

(a) Claims from providers shall be submitted on the department's designated form or electronically transmitted to the department, in a form and manner as specified by the department and shall include all information required by the department to process the claim for payment.

(b) The provider is responsible for:

(1) completing any admission and discharge forms consistent with the department's instructions; and

(2) exhausting other payment sources of which the provider is aware before billing the department.

(Adopted effective July 7, 2009)

Sec. 17b-262-845. Payment

(a) The Commissioner shall establish fees that are consistent with section 1902(a)(13)(B) of the Social Security Act.

(b) the Commissioner may increase any fee payable to a hospice upon the application of such an agency evidencing extraordinary costs related to providing escort services. In no case shall any rate or fee exceed the charge to the general public for similar services.

(c) The department shall reimburse the provider at the per diem rate for the appropriate level of care.

(d) The department shall reimburse a provider when all of the requirements of sections 17b-262-829 to 17b-262-848, inclusive, of the Regulations of Connecticut State Agencies have been met.

(e) The fee for routine, inpatient or respite services represents the per diem reimbursement for the client and is payment for all services provided by the provider on that day. Only one level of care may be billed on any day.

(f) The fee for continuous hospice care is paid on an hourly basis. A minimum of eight hours must be medically necessary in a 24-hour period to qualify for continuous hospice care.

(g) The department shall pay the fee for the routine, inpatient or respite level of care for each day the client is within an election period, regardless of the volume or intensity of services provided on that day.

(h) The department shall pay the same fee for border providers as for in-state providers.

(i) When a client who has elected hospice resides in a nursing facility or ICF/MR, the department shall make a payment equal to the department's rate for the nursing facility or ICF/MR. This payment represents payment for room and board services and is payable to the provider. It is the responsibility of the provider to reimburse the nursing facility or ICF/MR for room and board expenses. Applied income shall be deducted from the room and board payment.

(Adopted effective July 7, 2009)

Sec. 17b-262-846. Payment limitations

(a) It is expected that the provider shall provide bereavement counseling to the client's family after the client's death; however the department shall not pay the provider for such bereavement counseling.

(b) For a twelve month period beginning November 1 of each year and ending October 31, the aggregate number of inpatient days, both general inpatient and respite, shall not exceed twenty percent of the aggregate number of days of hospice care provided to all hospice clients during that same period. At the department's discretion, the days of inpatient care provided to individuals with AIDS may be excluded from the days counted toward the twenty percent limitation.

(c) Payment for inpatient care is limited as follows:

(1) The total payment to the provider for inpatient care, general and respite, is subject to a limitation that total inpatient care days for Medicaid clients not exceed 20 percent of the total days for which these clients had elected hospice care.

(2) At the end of a twelve-month period specified in subsection (b) of this section, the

department calculates a limitation on payment for inpatient care to ensure that Medicaid payment is not made for days of inpatient care in excess of 20 percent of the total number of days of hospice care furnished to Medicaid clients. Payments to nursing facilities and ICF/MRs where Medicaid is the secondary payer to Medicare shall be excluded from the calculation.

(3) If the number of days of inpatient care furnished to Medicaid clients is equal to or less than 20 percent of the total days of hospice care to Medicaid clients, no adjustment is necessary. Overall payments to a provider are subject to the cap amount specified in 42 CFR 418.309. Any provider that has received an exemption as specified in 42 CFR 418.108(e) shall be exempt from this provision.

(4) If the number of days of inpatient care furnished to Medicaid clients exceeds 20 percent of the total days of hospice care to Medicaid clients, the total payment for inpatient care is determined in accordance with subsection (c)(5) of this section. That amount is compared to actual payments for inpatient care and any excess reimbursement shall be refunded by the provider or recouped from subsequent claims. Overall payments to the provider are subject to the cap amount specified in 42 CFR 418.309.

(5) If a provider exceeds the number of inpatient care days described in subsection (c)(4) of this section, the total payment for inpatient care is determined as follows:

(A) calculate the ratio of the maximum number of allowable inpatient days to the actual number of inpatient care days furnished by the provider to Medicaid clients;

(B) multiply this ratio by the total reimbursement for inpatient care made by the department;

(C) multiply the number of actual inpatient days in excess of the limitation by the routine home care rate;

(D) add the amounts calculated in subsections (c)(5)(B) and (C) of this section.

(E) compare the amount in section 5(D) of this section with the total reimbursement to the hospice provider for inpatient care during that period. The amount that total reimbursement to the hospice exceeds the amount calculated in section 5(D) of this section is the amount due from the hospice provider.

(d) Applied income shall be calculated and deducted from the department's payment to the provider for a client living in a nursing facility or a hospice facility as follows:

(1) Clients who receive hospice services while residing in a hospice facility or in a nursing facility pursuant to a room and board arrangement with a hospice are responsible for paying applied income to the hospice provider.

(2) The department shall calculate the applied income liability and shall inform the client and the provider of the amount that the client is required to contribute towards the cost of care each month. The client's applied income liability shall be deducted from the amount that the department would otherwise pay to the hospice provider each month.

(3) The provider and the nursing facility may assign responsibility for collecting the client's applied income and may assign the risk of loss for nonpayment in their agreement, depending on the result of their negotiations. In no event shall the department be liable to

a hospice or to a nursing facility in the event that a client fails to pay his or her applied income obligation.

(4) The provider shall notify the department's caseworker of any errors in the amount of applied income processed against the claim using the form specified by the department. Payment adjustments resulting from retroactive applied income corrections shall be processed periodically.

(5) In any month that a resident returns to the community or dies, and the cost of care is less than the applied income, the department shall adjust the applied income as follows: the applied income shall equal the number of days that the resident was in the hospice multiplied by the per diem rate.

(6) Applied income is not pro rated. It is used to cover the cost of care until it is expended.

(e) A nursing facility that enters into an agreement with a hospice to provide room and board services for clients shall accept the amount paid by the hospice, if any, pursuant to the contractual agreement between the hospice and the nursing facility as payment in full. In no event may a nursing facility assert a claim against a client, or against the department, in the event that the hospice fails to pay the nursing facility in accordance with their agreement, except that a nursing facility may assert a claim against a client for nonpayment of the client's applied income amount only when the agreement between the hospice and the nursing facility assigns responsibility for collecting the client's applied income liability to the nursing facility.

(Adopted effective July 7, 2009)

Sec. 17b-262-847. Review process

(a) a client or client representative may request a review with the hospice whenever a requested good or service is denied.

(b) **Review Process:**

(1) The hospice shall have a timely and organized review process. The review process shall be available whenever:

(A) the hospice denies a requested good or service; or

(B) the hospice fails to respond to a client's request for goods and services within five working days of such request.

(2) The results of the review shall be in writing and shall include a brief statement of the reasons for the decision and shall state that the client may request review by the department and how to obtain such review.

(3) The hospice's review process shall allow for an expedited review within one business day when the standard time frames for determining a review could jeopardize the comfort of the client.

(c) **Department review:**

(1) A client who is denied a good or service by the hospice provider may request a review by the department in accordance with the following procedures:

(A) The client shall file a written or verbal request for a review within fifteen days from

the date of the hospice denial of the good or service.

(B) The request shall state the reasons the client believes he or she should receive the goods or services and include any additional documentation in support of his or her case.

(C) Within five days of the request, the department shall make a finding based on an evaluation of the evidence submitted and shall notify the client in writing.

(2) If the standard timeframe for the department's review could jeopardize the comfort of the client, an expedited review shall be completed by the department within one business day of the request.

(Adopted effective July 7, 2009)

Sec. 17b-262-848. Documentation

(a) All required documentation shall be maintained for at least five years, or longer, by the provider in accordance with statute or regulation, subject to review by the department. In the event of a dispute concerning a service provided, documentation shall be maintained until the end of the dispute, five years or the length of time required by statute or regulation, whichever is longest.

(b) Failure to maintain and provide all required documentation to the department upon request shall result in the disallowance and recovery by the department of any future or past payments made to the provider for which the required documentation is not maintained and not provided to the department upon request.

(c) The following information shall be documented in writing or electronically, consistent with the requirements described in the Provider Enrollment Agreement and maintained on file with the provider for each Medicaid client:

(1) signed and dated physician orders;

(2) initial and subsequent plans of care signed and dated by the licensed practitioner or interdisciplinary team;

(3) Medicaid identification number;

(4) pertinent diagnostic information;

(5) documentation of each service provided and its duration;

(6) dates of services provided;

(7) all election forms signed by the client indicating that he has elected the hospice benefit and which hospice he has elected to provide services;

(8) the initial certification of terminal illness signed by the attending physician and the medical director of the hospice;

(9) subsequent certifications of terminal illness signed by the medical director of the hospice or the physician member of the interdisciplinary team;

(10) forms signed and dated by the client indicating any change in the designation of the hospice, if applicable; and

(11) revocation statements signed and dated by the client, if applicable.

(d) All clinical records shall be maintained in accordance with 42 CFR 418.104.

(e) Each provider shall maintain fiscal and medical records that fully disclose services

and goods rendered or delivered to Medicaid clients.

(f) Providers shall maintain documentation supporting all prior authorization requests.

(Adopted effective July 7, 2009)

Requirements for Payment of Rehabilitation Services for Individuals Under Age 21 with Behavioral Health Disorders

Sec. 17b-262-849. Scope

Sections 17b-262-849 to 17b-262-861, inclusive, of the Regulations of Connecticut State Agencies set forth the Department of Social Services' requirements for Medicaid coverage of rehabilitation services for individuals with behavioral health conditions who are determined eligible for Connecticut's Medicaid program pursuant to section 17b-261 of the Connecticut General Statutes.

(Effective February 2, 2012)

Sec. 17b-262-850. Definitions

As used in sections 17b-262-849 to 17b-262-861, inclusive, of the Regulations of Connecticut State Agencies:

(1) "Admission" means an individual's initial participation in a rehabilitation services program;

(2) "Allied health professional" or "AHP" means:

(A) a licensed or certified practitioner performing within his or her scope of practice in any of the professional and occupational license or certification categories pertaining to behavioral health covered in Title 20 of the Connecticut General Statutes; or

(B) a license or certification-eligible individual whose education, training, skills and experience satisfy the criteria for any of the professional and occupational licensure or certification categories pertaining to behavioral health covered in Title 20 of the Connecticut General Statutes;

(3) "Authorization" means the approval of payment for services or goods by the department;

(4) "Behavioral health condition" means one or more mental disorders as defined in the most recent edition of the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders*, but excludes mental retardation, dementia and conditions designated with V codes;

(5) "Behavioral health services" means health care that is necessary to diagnose, correct or diminish the adverse effects of a behavioral health condition;

(6) "Commissioner" means the Commissioner of Social Services or the commissioner's agent;

(7) "Complex behavioral health service needs" means behavioral health needs that require specialized, coordinated behavioral health services across several service systems; for example, school, mental health and court;

(8) "DCF" means the Department of Children and Families or its agent;

(9) "Department" or "DSS" means the Department of Social Services or its agent;

(10) "Early and Periodic Screening, Diagnostic and Treatment services" or "EPSDT services" means the services provided in accordance with the requirements of 42 USC 1396a(a)(43), 42 USC 1396d (r) and 42 USC 1396d(a)(4)(B) and implementing federal regulations found in 42 CFR 441, Subpart B and section 17b-261(i) of the Connecticut General Statutes;

(11) "Emergency" means a psychiatric or substance abuse condition manifesting itself by acute symptoms of sufficient severity, including severe distress, such that a prudent lay person, who possesses an average knowledge of health and medicine, could reasonably expect that the absence of immediate psychiatric attention may result in placing the health of the individual in serious jeopardy due to harm to self, harm to others or grave disability;

(12) "Emergency Mobile Psychiatric Services" or "EMPS" means rehabilitation services provided by a DCF-certified provider of such services in the home or other community setting to an individual in response to a psychiatric or substance abuse related crisis in order to reduce disability, restore functioning and achieve full community integration and recovery;

(13) "Extended day treatment program" or "EDT" means "extended day treatment" as defined in section 17a-147-1 of the Regulations of Connecticut State Agencies;

(14) "Home and community-based rehabilitation services" means services provided by a DCF-certified provider of such services in the home or other community setting to an individual with psychiatric or substance abuse needs in order to reduce disability, restore functioning and achieve full community integration and recovery. Services may be provided in settings appropriate to the achievement of the rehabilitation goals and objectives, and as mutually agreed upon with the child and family. For example, service locations may include a local neighborhood community center, police substation, social service office or any other public or private community setting;

(15) "Individual" means a Medicaid-eligible person under age 21 who receives covered rehabilitation services in accordance with sections 17b-262-849 to 17b-262-861, inclusive, of the Regulations of Connecticut State Agencies;

(16) "Licensed clinician" means:

(A) a doctor of medicine or osteopathy who is licensed under chapter 370 of the Connecticut General Statutes;

(B) a psychologist who is licensed under chapter 383 of the Connecticut General Statues;

(C) a marital and family therapist who is licensed under chapter 383a of the Connecticut General Statutes;

(D) a clinical social worker who is licensed under chapter 383b of the Connecticut General Statutes;

(E) an advanced practice registered nurse who is licensed under chapter 378 of the Connecticut General Statutes;

(F) a registered nurse who is licensed under chapter 378 of the Connecticut General

Statutes and who has a minimum of one year of experience in the mental health field;

(G) a professional counselor who is licensed under chapter 383c of the Connecticut General Statutes; or

(H) an alcohol and drug counselor who is licensed under chapter 376b of the Connecticut General Statutes;

(17) "Medicaid program" means the program operated by DSS pursuant to section 17b-260 of the Connecticut General Statutes and authorized by Title XIX of the Social Security Act;

(18) "Medical necessity" or "medically necessary" has the same meaning as defined in section 17b-259b of the Connecticut General Statutes;

(19) "Office-based, off-site rehabilitation services" means services provided by a DCF-licensed outpatient psychiatric clinic operating within its scope of practice to an individual in a primary care, school or office setting other than a primary or satellite office as provided for on the clinic's license;

(20) "Prior authorization" means approval for the provision of service from the department before the provider actually provides the service;

(21) "Provider" means a person, entity or organization that meets the requirements for participation specified in section 17b-262-851 of the Regulations of Connecticut State Agencies as a DCF-licensed or DCF-certified entity that provides office-based, off-site rehabilitation services, extended day treatment, emergency mobile psychiatric services or home and community-based rehabilitation services and participates in the Medicaid program as a qualified provider of rehabilitation services as evidenced by an executed provider agreement with the department;

(22) "Provider agreement" means the signed, written contractual agreement between the department and the provider;

(23) "Provider network" means the providers enrolled or contracted with the department;

(24) "Quality management" means the process of reviewing, measuring and continually improving the processes and outcomes of care delivered;

(25) "Registration" means the process of notifying the department of the initiation or continuation of a behavioral health service that includes information regarding the evaluation findings and plan of treatment. Registration may serve in lieu of authorization if a service is designated by the department as requiring registration only;

(26) "Rehabilitation plan" means a written individualized plan of care developed by the performing provider in accordance with the applicable licensing requirements and section 17b-262-851(7) of the Regulations of Connecticut State Agencies;

(27) "Rehabilitation services" means those services identified in section 17b-262-854 of the Regulations of Connecticut State Agencies when provided by a qualified provider to an individual with a behavioral health condition;

(28) "Trainee" means a person enrolled in an educational program or acquiring the supervisory experience necessary to obtain licensure or certification in any of the professional and occupational license or certification categories pertaining to behavioral

health covered in Title 20 of the Connecticut General Statutes;

(29) "Under the direct supervision" means that a licensed clinician operating within his or her scope of practice provides periodic supervision of the work performed by unlicensed clinical staff and accepts primary responsibility for the rehabilitation services performed by the unlicensed staff; and

(30) "Utilization management" means the prospective, retrospective or concurrent assessment of the medical necessity of the allocation of health care resources and services given, or proposed to be given, to an individual.

(Effective February 2, 2012)

Sec. 17b-262-851. Provider participation

In order to participate in the Medicaid program and provide rehabilitation services that are eligible for Medicaid reimbursement from the department, the provider shall:

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

(2) be licensed by DCF as an Outpatient Psychiatric Clinic for Children, as defined in section 17a-20-11 of the Regulations of Connecticut State Agencies, if providing office-based off-site rehabilitation services;

(3) be licensed by DCF as an extended day treatment program under section 17a-147-1 to 17a-147-36, inclusive, of the Regulations of Connecticut State Agencies, if providing extended day treatment program services;

(4) comply with any applicable DCF certification requirements necessary to be qualified to provide home and community-based rehabilitation services or emergency mobile psychiatric services;

(5) comply with all Medicaid record keeping, documentation and other requirements including, but not limited to, those delineated in the department's administrative manuals, provider agreements and memoranda of understanding;

(6) comply with all laws, rules, regulations, policies and amendments that govern the Medicaid program as they relate to reimbursement for rehabilitation services;

(7) except as noted below in subdivision (G) of this subsection, develop a written rehabilitation plan for each individual in accordance with section 17a-20-42 of the Regulations of Connecticut State Agencies not later than thirty days after the individual's admission to the program. This rehabilitation plan requirement applies to all providers of Medicaid-funded rehabilitation services for individuals, not just DCF psychiatric clinics, which are the specific subject of section 17a-20-42 of the Regulations of Connecticut State Agencies. Such plan shall be developed by the provider, with input from the individual, the individual's family or the individual's legal representative and shall:

(A) Specify the behavioral health disorder to be addressed;

(B) specify reasonable, individualized behavioral health goals and objectives based on each individual's behavioral health diagnosis and diagnostic and functional evaluation and be targeted toward the reduction of an individual's behavioral health symptoms, restoration of functioning and recovery;

(C) identify the type, amount, frequency and duration of services to be provided;

(D) document that the services provided have been determined to be rehabilitation services consistent with section 17b-262-854 of the Regulations of Connecticut State Agencies;

(E) ensure the active participation of the individual and his or her family or the legal representative of the individual;

(F) contain a timeline, based upon the individual's assessed and anticipated needs, for reevaluation of the plan, which should occur not later than one year after the date of the prior plan; and

(G) providers of EMPS to individuals are not required to develop an individualized rehabilitation plan that meets the requirements of section 17a-20-42 of the Regulations of Connecticut State Agencies unless the services are provided for a period of more than 45 days. The Statewide Uniform Crisis Plan shall serve as the rehabilitation plan for the EMPS until an individual rehabilitation plan for EMPS is developed;

(8) ensure that a licensed clinician operating within his or her scope of practice and employed by or under contract with the provider reviews and signs the individual rehabilitation plan. The first review and signature shall occur not later than thirty days after admission;

(9) ensure that rehabilitation plans are reassessed by a licensed clinician at 90-day intervals, as well as when a significant change in condition or diagnosis occurs. Reassessed rehabilitation plans shall be reviewed and signed by the supervising licensed clinician;

(10) keep current service and progress notes in a permanent case record for each client in accordance with section 17a-20-54 of the Regulations of Connecticut State Agencies;

(11) cooperate with the department in the rate-setting process including, but not limited to, licensing or any quality assurance reviews or periodic audits to ensure compliance with rehabilitation service requirements defined in section 17b-262-849 to section 17b-262-861, inclusive, of the Regulations of Connecticut State Agencies;

(12) provide an initial orientation, training and periodic supervision to direct service staff responsible for the provision of rehabilitation services;

(13) conduct ongoing assessment and service planning;

(14) ensure that the program director is a licensed clinician operating within his or her scope of practice and has a minimum of three years of experience in a behavioral-health-services-related position;

(15) ensure that the program director, or the program director's designee who shall be a licensed clinician, is accessible after hours, by telephone or pager, to staff on duty;

(16) ensure that direct service staff of providers of office-based off-site rehabilitation services are physicians, allied health professionals or trainees;

(17) ensure that direct service staff of providers of extended day treatment meet the minimum requirements established in sections 17a-147-1 to 17a-147-36, inclusive, of the Regulations of Connecticut State Agencies;

(18) ensure that direct service staff of providers of home and community-based

rehabilitation services and EMPS are physicians, allied health professionals or trainees or persons who hold either a bachelor's degree in a behavioral-health-related specialty or have two years of experience in the provision of behavioral health services, provided such individuals meet the minimum requirements of any applicable certification authority;

(19) ensure that all unlicensed staff work under the direct supervision of licensed clinical staff; and

(20) ensure that direct service staff of providers of home and community-based rehabilitation services and EMPS are accessible to clients after hours, whether face-to-face or by telephone.

(Effective February 2, 2012)

Sec. 17b-262-852. Eligibility

Medicaid coverage for the cost of rehabilitation services is available for individuals with behavioral health conditions when the service is medically necessary and is provided by a provider to an individual with a behavioral health condition, subject to all of the qualifications, conditions and limitations contained in sections 17b-262-849 to 17b-262-861, inclusive, of the Regulations of Connecticut State Agencies.

(Effective February 2, 2012)

Sec. 17b-262-853. Need for services

Payment for rehabilitation services shall be made by the department only if all of the following conditions are met:

(1) Medicaid payment for rehabilitation services may be made only to the extent that a covered rehabilitation service is provided by a qualified participating provider of such services and the service is medically necessary for the client. Where a service is subject to prior authorization requirements in accordance with section 17b-262-855 or 17b-262-857 of the Regulations of Connecticut State Agencies, eligibility for Medicaid payment is conditioned upon compliance with such requirements. Furthermore, all Medicaid payments, including payments for services that are prior authorized or for which registration is required, are subject to record keeping and post-payment review and audit requirements, and are subject to subsequent recoupment if it is subsequently determined that the service was not medically necessary or if record keeping or other requirements for payment are not satisfied;

(2) For no more than thirty days after an individual's admission, rehabilitation services shall be provided in accordance with an initial assessment of need that is signed by a licensed clinician operating within his or her scope of practice. This assessment shall, for no more than thirty days after an individual's admission, be utilized as the individual's rehabilitation plan;

(3) Not later than thirty days after an individual's admission, the rehabilitation services shall be provided in accordance with the rehabilitation plan developed in accordance with section 17a-20-42 of the Regulations of Connecticut State Agencies. The rehabilitation plan

shall include a progress note that describes the services that the individual has received to date; the individual's overall response; the individual's specific progress toward the goals and objectives listed in the rehabilitation plan and justification of the need for continued treatment. The progress note shall include discussion of any variance between the services listed on the rehabilitation plan and the services actually delivered. The progress note shall also include discussion of suggested changes, if any, to the rehabilitation plan. The rehabilitation plan shall be reviewed and signed by the licensed clinician employed by or under contract with the provider at least every ninety days thereafter; and

(4) The individual is sufficiently stable to be able to function outside of a twenty-four hour medically managed setting and participate in community-based treatment services.

(Effective February 2, 2012)

Sec. 17b-262-854. Covered services

(a) Rehabilitation services shall be recommended by a physician or other licensed clinician operating within his or her scope of practice.

(b) Rehabilitation services are services designed to assist individuals in reaching an achievable level of independent functioning.

(c) Rehabilitation services include office-based off-site rehabilitation services, home and community-based rehabilitation services and EMPS when provided by a qualified and enrolled provider of such services.

(d) Depending upon the particular needs of each individual and the rehabilitation plan, office-based off-site services may include any of the routine outpatient services listed on the department's fee schedule for behavioral health clinics.

(e) Depending upon the particular needs of each individual and the rehabilitation plan, home and community-based rehabilitation services, extended day treatment program services and EMPS may include the following components:

(1) Intake and assessment, which means assessing and reassessing the individual's behavioral health needs in the context of medical, social, educational and other needs through face-to-face contact with the individual, the individual's family and through consultation with other professionals;

(2) development of an individual rehabilitation plan in accordance with sections 17b-262-851(7) and 17b-262-858 of the Regulations of Connecticut State Agencies;

(3) individual and group psychotherapy or counseling;

(4) family therapy or training;

(5) socialization skills development, which means individual-centered skill development activities that are provided to support the goals and objectives in the rehabilitation plan and that are directed at reducing individuals' psychiatric and substance abuse symptoms, restoring individuals to an achievable functioning level;

(6) behavior modification or management training and intervention;

(7) supportive counseling directed at solving daily problems related to community living and interpersonal relationships;

(8) psycho-educational services pertaining to the alleviation and management of psychiatric or substance abuse disorders;

(9) teaching, coaching and assisting with daily living and self-care skills such as the use of transportation, meal planning and preparation, personal grooming, management of financial resources, shopping, use of leisure time, interpersonal communication and problem solving;

(10) therapeutic recreation and other skill development activities directed at reducing disability; restoring individual functioning and achieving independent participation in social, interpersonal or community activities and full community reintegration and independence as identified in the rehabilitation plan;

(11) support with connecting individuals to natural community supports;

(12) orientation to, and assistance with, accessing self-help and advocacy resources;

(13) development of self-advocacy skills;

(14) health education;

(15) teaching of recovery skills in order to prevent relapse;

(16) crisis response services, either face-to-face or telephonic only, when provided as part of a home and community-based rehabilitation service; and

(17) consultation for persons responsible for the development of healthy social relationships and the promotion of successful interpersonal and community experiences.

(Effective February 2, 2012)

Sec. 17b-262-855. Coverage limitations

(a) Coverage of services shall be subject to the following limitations:

(1) Services that do not meet medical necessity requirements or any applicable authorization or certification requirements are not eligible for Medicaid payment.

(2) Services shall be based on the rehabilitation plan developed pursuant to section 17b-262-851(7) of the Regulations of Connecticut State Agencies and the requirements of sections 17b-262-849 to 17b-262-861, inclusive, of the Regulations of Connecticut State Agencies, and shall be performed by or under the supervision of a licensed clinician employed by or under contract with the provider.

(3) Home and community-based services and EMPS may be provided in a facility, home, hospital or other setting, except as follows:

(A) When an individual resides in a facility or institution, the services may not duplicate services included in the facility's or institution's rate; or

(B) if the provider operates a clinic or practice for the provision of outpatient services, no more than 10 visits may be provided at the site of the outpatient clinic or practice per individual per episode of care, other than the initial assessment, which may occur off-site. The services rendered under this exception are considered reimbursable services only if the services rendered are part of a rehabilitation plan.

(4) EDT programs shall meet the following requirements:

(A) Provide time-limited, active services within a clinic or off-site community setting;

(B) employ an integrated, comprehensive and complementary schedule of treatment approaches;

(C) serve individuals with significant functional impairments resulting from a behavioral health condition in order to avert hospitalization or increase the client's level of independent functioning;

(D) provide an adult escort to support the transportation of individuals under 16 years of age, transported by a Medicaid non-emergency medical transportation provider, unless the parent or guardian of the individual between the ages of 12 to 15 years consents, in writing, to transportation of the individual to the EDT program without an escort; and

(E) provide a minimum of three hours of scheduled, documented programming of which at least two and one half hours are services.

(5) Services may be provided indirectly through counseling of parents, other family members or other persons responsible for the care of the individual, regardless of the Medicaid eligibility of these persons, only to the extent that the provision of such indirect treatment service is necessary and is intended to primarily benefit the individual.

(6) The department shall not pay for the following:

(A) Programs, services or components of services that are of an unproven, experimental, cosmetic or research nature;

(B) programs, services or components of services that do not relate to the individual's diagnosis, symptoms, functional limitations or medical history;

(C) programs, services or components of services that are not included in the fee established by the department;

(D) programs, services or components of services that are intended solely to prepare individuals for paid or unpaid employment or for vocational equipment and uniforms;

(E) programs, services or components of services provided solely for social or recreational purposes not in compliance with section 17b-262-854(e)(5) or 17b-262-854(e)(10) of the Regulations of Connecticut State Agencies;

(F) time spent by the provider solely for the purpose of transporting clients;

(G) services that are solely educational or vocational;

(H) costs associated with room and board for individuals; and

(I) services that are provided out-of-state unless the services are not available within Connecticut.

(b) Notwithstanding subparagraph (a)(3)(B) of this section, services that are provided at the primary or satellite site of a DCF-licensed clinic, as indicated on the clinic's license, do not qualify as rehabilitation services and may be reimbursed by the Medicaid program only to the extent that such services otherwise qualify for Medicaid reimbursement, for example, as covered clinic services.

(Effective February 2, 2012)

Sec. 17b-262-856. Non-billable activities

The following activities are not billable:

(1) Telephone contact with the department for the purpose of requesting or reviewing authorization;

(2) documentation of progress notes or billing documentation;

(3) individual or group supervision, routine case reviews and rounds; ad hoc consultation with supervisors; and discussion or consultation among participants of the rehabilitation team, including those conducted for the purpose of treatment planning;

(4) travel to an appointment with an individual or family; travel to and from collateral appointments (e.g. school planning meeting, court appearance); or transportation of the individual to or from meetings or appointments, unless the provider is also engaged in an activity that otherwise qualifies as a service;

(5) time on-call that does not otherwise qualify as a rehabilitation service;

(6) time spent performing routine services, such as cleaning, cooking, shopping or child care designed to provide relief or respite for the family;

(7) time spent waiting for individuals at their homes when they have a scheduled appointment and the individual has not arrived;

(8) no shows, missed or cancelled appointments;

(9) services of less than eight minutes duration for rehabilitation procedures whose billing codes are defined in 15-minute increments; and

(10) time spent engaged in activities required by a credentialing or oversight entity such as gathering and submitting care plan or service data or other information.

(Effective February 2, 2012)

Sec. 17b-262-857. Authorization

(1) Services are subject to prior authorization or registration requirements to the extent required by this section. Where a service is subject to authorization or registration requirements, Medicaid payment for such service is not available unless the provider complies with such requirements.

(2) Services that require authorization or registration will be designated as such on the provider's fee schedule or authorization and registration schedule published at www.ctdssmap.com.

(3) The following requirements shall apply to all services that require authorization or registration under subdivision (1) or (2) of this subsection:

(A) The initial authorization or registration period shall be based on the needs of the individual.

(B) If authorization or registration is needed beyond the initial or current authorization period, such requests for continued treatment shall be submitted prior to the end of the current authorization period.

(C) Except in emergency situations or for the purpose of initial assessment, providers shall obtain authorization or shall register, as appropriate, before services are rendered.

(D) In order to receive payment from the department, a provider shall comply with all prior authorization and registration requirements. The department or its agent in its sole

discretion determines what information is necessary in order for a provider to register or to approve a prior authorization request. Registration or prior authorization does not, however, guarantee payment unless all other requirements for payment are met.

(E) A provider shall present medical or social information adequate for evaluating medical necessity when registering or requesting authorization. The provider shall maintain documentation adequate to support requests for authorization and registration including, but not limited to, medical or social information adequate for evaluating medical necessity.

(F) Registration or requests for authorization for the continuation of services shall include the progress made to date with respect to established treatment goals, the future gains expected from additional treatment and medical or social information adequate for evaluating medical necessity.

(G) The provider shall maintain documentation adequate to support registration or requests for continued authorization including, but not limited to, progress made to date with respect to established treatment goals, the future gains expected from additional treatment, and medical or social information adequate for evaluating medical necessity.

(H) The department may require a review of the discharge plan and actions taken to support the successful implementation of the discharge plan as a condition of registration or authorization.

(I) A provider may register or request authorization from the department after a service has been provided for individuals who are granted eligibility retroactively or in cases where it was not possible to determine eligibility at the time of service.

(J) For individuals who are granted retroactive eligibility, the department may conduct retroactive medical necessity reviews. The provider shall be responsible for initiating this review to enable registration or authorization and payment for services.

(K) The department may deny authorization or registration based on non-compliance by the provider with utilization management policies and procedures.

(Effective February 2, 2012)

Sec. 17b-262-858. Documentation and record retention requirements

(a) Providers shall comply with the following documentation and record retention requirements:

(1) An initial rehabilitation plan and all updated versions, including the current plan, shall be maintained.

(2) All rehabilitation service providers are required to develop a rehabilitation plan that meets the requirements of section 17a-20-42 of the Regulations of Connecticut State Agencies, except as provided for under subsection 17b-262-851(7) of the Regulations of Connecticut State Agencies. The rehabilitation plan shall include a medication plan, if the rehabilitation service includes medication management. The medication plan shall include an order and instructions for administration for each medication prescribed by a provider staff member and a list of other medications that the individual is taking that may be prescribed by non-clinic practitioners.

(3) A case record that meets the requirements of section 17a-20-54 of the Regulations of Connecticut State Agencies, shall be maintained and shall include, at a minimum: identifying information; social and health history; the reason for admission to the rehabilitation program; copies of the initial and all subsequent orders for rehabilitation services; the rehabilitation plan; identification of the care and services provided; a current list of all medications; and the plan for discharge and disposition of the individual. This case record requirement applies to all providers of rehabilitation services for individuals, not just to DCF-licensed psychiatric clinics that are subject to section 17b-20-54 of the Regulations of Connecticut State Agencies.

(4) Encounter notes shall be maintained for each rehabilitative service provided. The notes shall include the service rendered; actual time the service was rendered; location of service; the goal and objective that is the focus of the intervention; a general description of the content of the intervention to provide evidence that it is a rehabilitative service, as described in section 17b-262-854 of the Regulations of Connecticut State Agencies; and the individual's response to the intervention. Encounter notes shall be signed and dated and shall indicate the credentials of the staff member who provided the service.

(5) For EDT programs the encounter notes shall document the duration of each distinct therapeutic session or activity and progress toward treatment goals.

(6) For the purpose of documenting the supervision of services provided by unlicensed direct care staff, licensed clinical staff shall document in the case record that they have reviewed the encounter notes corresponding to services provided by such unlicensed direct care staff at least once every 30 days. Documentation shall include the signature and credentials of the licensed clinical staff that reviewed the encounter notes.

(b) Other documentation and record retention requirements:

(1) The provider shall maintain a current record of the applicable licenses and certificates of practice of all licensed or certified persons furnishing rehabilitation services.

(2) The provider shall be substantially in compliance with all documentation requirements in its most recent licensure review and relevant state agency quality assurance reviews.

(3) The provider shall maintain all required records for at least five years or longer as required by statutes or regulation. All required records shall be subject to review by the department. In the event of a dispute concerning a service provided, documentation shall be maintained until the end of the dispute or five years, whichever is longer.

(4) All documentation shall be recorded in the eligible individual's case record in a complete, prompt and accurate manner. All documents shall be made available to authorized personnel of the department upon request.

(5) Failure to maintain all required documentation shall result in the disallowance and recovery by the department of any amounts paid to the provider for which the required documentation is not maintained and not provided to the department upon request.

(Effective February 2, 2012)

Sec. 17b-262-859. Billing requirements

(a) Claims for office-based off-site rehabilitation services shall be billed with routine outpatient procedure codes and an off-site modifier or appropriate place of service code as designated by the department.

(b) For home and community-based rehabilitation services that are delivered by more than one staff member, each staff member may bill for time spent engaged in rehabilitative services, whether the staff members are working together or independently. When more than one staff member is in the home at the same time co-facilitating a family therapy or crisis intervention, each staff member may bill for the time spent engaged in this activity. The staff members may co-sign a single note that documents the rehabilitation service that was conducted by the team. If the staff members worked with different family members, each staff member shall write an encounter note in accordance with section 17b-262-858(a)(4) of the Regulations of Connecticut State Agencies.

(c) A single per diem fee shall be billed for EDT inclusive of all medication evaluation or management services, treatment and rehabilitative services, administrative services and coordination with or linkages to other health care services. The provider may bill separately for medically necessary individual psychotherapy clinic services while the individual continues to receive extended day treatment services, if such services are rendered outside of the EDT program hours of operation, are provided by persons other than EDT program staff and are necessary for the individual's transition or continuity of care.

(d) For EDT if the individual is present for up to half of the program day and attends at least one therapy session, the provider may bill for half of their fee on file. If the individual is present for more than half of the program day but less than a full day and attends at least two therapy sessions, the provider may bill the full day charge on file. If the individual does not attend at least one therapy session the clinic is not entitled to any payment from the department.

(e) Claims for payment of rehabilitation services shall be on the department's uniform billing form or electronically transmitted to the department's fiscal agent and shall include all information required by the department to process the claim for payment. All claims submitted to the department for payment of services covered under section 17b-262-854 of the Regulations of Connecticut State Agencies shall be substantiated by documentation in the individual's permanent case record.

(Effective February 2, 2012)

Sec. 17b-262-860. Payment

(a) In order to receive payment from the department, the provider shall be enrolled in the Connecticut Medical Assistance Program and comply with the requirements of sections 17b-262-522 through 17b-262-533, inclusive, of the Regulations of Connecticut State Agencies.

(b) The department shall establish rates for rehabilitation services. By enrolling in the program and providing covered rehabilitation services to individuals, the provider agrees

to accept the department's rate as payment in full for rehabilitation services provided to individuals.

(c) Office-based off-site rehabilitation services provided by a provider that is not a Federally Qualified Health Center shall be reimbursed at the same rate applicable to such services when provided at a primary or satellite site as provided for on the clinic's DCF license.

(d) Office-based off-site rehabilitation services provided by Federally Qualified Health Centers shall be reimbursed at the Federally Qualified Health Center's psychiatric encounter rate.

(e) Home and community-based rehabilitation services and EMPS provided by Federally Qualified Health Centers shall be reimbursed at the same rates paid to non-Federally Qualified Health Center providers.

(f) Rates for rehabilitation services include any associated travel costs.

(g) Payment shall be made at the lowest of:

(1) The provider's usual and customary charge;

(2) the lowest Medicare rate; or

(3) the amount in the provider's rate letter or the amount on the applicable fee schedule as published by the department.

(Effective February 2, 2012)

Sec. 17b-262-861. Audit and compliance reviews

All supporting accounting and business records, statistical data and all other records relating to the provision of rehabilitation services paid for by the department shall be subject to audit or compliance review by authorized personnel. All documentation shall be made available, upon request, to authorized representatives of the department.

(Effective February 2, 2012)

Requirements for Payment of Services Provided by Licensed Behavioral Health Clinicians in Independent Practice

Sec. 17b-262-912. Scope

Sections 17b-262-912 to 17b-262-925, inclusive, of the Regulations of Connecticut State Agencies set forth the Department of Social Services' requirements for payment of services performed by licensed behavioral health clinicians in independent practice for HUSKY C and HUSKY D clients under age twenty-one and HUSKY A clients of any age who are determined eligible to receive services under Connecticut's Medicaid program pursuant to sections 17b-261, 17b-261n and 17b-277 of the Connecticut General Statutes.

(Effective December 28, 2012)

Sec. 17b-262-913. Definitions

As used in sections 17b-262-912 to 17b-262-925, inclusive, of the Regulations of

Connecticut State Agencies:

(1) "Advanced practice registered nurse" or "APRN" means an individual licensed pursuant to section 20-94a of the Connecticut General Statutes;

(2) "Behavioral health clinician services" means preventive, diagnostic, therapeutic, rehabilitative or palliative services provided by a licensed behavioral health clinician within the licensed behavioral health clinician's scope of practice under state law;

(3) "Client" means a person who is eligible for goods or services under Medicaid and is a HUSKY C or HUSKY D member under age twenty-one or a HUSKY A member of any age;

(4) "Commissioner" means the Commissioner of Social Services or the commissioner's agent;

(5) "Current treatment plan" means a treatment plan that has been reviewed and updated by the provider not more than six months before each treatment session;

(6) "Department" means the Department of Social Services or its agent;

(7) "Early and Periodic Screening, Diagnostic and Treatment Services" or "EPSDT Services" means the services described in 42 USC 1396d(r)(5);

(8) "Early and Periodic Screening, Diagnostic and Treatment Special Services" or "EPSDT Special Services" means services that are not covered under the Medicaid State Plan but are covered as EPSDT services for Medicaid-eligible children pursuant to 42 USC 1396d(r)(5) when the service is (A) medically necessary, (B) the need for the service is identified in an EPSDT screen, (C) the service is provided by a participating provider and (D) the service is a type of service that may be covered by a state Medicaid agency and qualifies for federal reimbursement under 42 USC 1396d;

(9) "Federally qualified health center" has the same meaning as provided in 42 USC 1396d(*l*);

(10) "Home" means a client's place of residence, including, but not limited to, a boarding house, community living arrangement, nursing facility or residential care home. "Home" does not include facilities such as hospitals, chronic disease hospitals, intermediate care facilities for the mentally retarded or other facilities that are paid an all-inclusive rate directly by Medicaid for the care of the client;

(11) "HUSKY A" means the Medicaid coverage groups for children, caretaker relatives and pregnant women authorized by Title XIX of the Social Security Act (Medicaid) and operated pursuant to sections 17b-261 and 17b-277 of the Connecticut General Statutes;

(12) "HUSKY C" means the Medicaid coverage groups for the aged, blind and disabled authorized by Title XIX of the Social Security Act (Medicaid) and operated pursuant to section 17b-261 of the Connecticut General Statutes;

(13) "HUSKY D" means the Medicaid coverage groups for low-income adults authorized by 42 USC 1396a(a)(10)(A)(i)(VIII) and operated pursuant to section 17b-261n of the Connecticut General Statues, formerly referred to as the State-Administered General Assistance program;

(14) "Licensed alcohol and drug counselor" means an individual licensed pursuant to

section 20-74s of the Connecticut General Statutes;

(15) "Licensed behavioral health clinician" means a licensed alcohol and drug counselor, licensed marital and family therapist, licensed clinical social worker or licensed professional counselor;

(16) "Licensed clinical social worker" means a person licensed pursuant to section 20-195n of the Connecticut General Statutes;

(17) "Licensed marital and family therapist" means an individual licensed pursuant to section 20-195c of the Connecticut General Statutes;

(18) "Licensed professional counselor" means an individual licensed pursuant to sections 20-195cc and 20-195dd of the Connecticut General Statutes;

(19) "Licensed practitioner" means a physician, APRN or physician assistant;

(20) "Medicaid" means the program operated by the department pursuant to section 17b-260 of the Connecticut General Statutes and authorized by Title XIX of the Social Security Act;

(21) "Medical necessity" or "medically necessary" has the same meaning as provided in section 17b-259b of the Connecticut General Statutes;

(22) "Physician" means an individual licensed pursuant to section 20-13 of the Connecticut General Statutes;

(23) "Physician assistant" means a person licensed pursuant to section 20-12b of the Connecticut General Statutes;

(24) "Prior authorization" means the department's approval for the provision of a service before a provider actually provides such service, except where section 17b-262-920 of the Regulations of Connecticut State Agencies specifically authorizes the department to grant prior authorization before paying for a service but after the provider has provided such service;

(25) "Provider" means a licensed behavioral health clinician enrolled in Medicaid pursuant to a valid provider agreement with the department;

(26) "Provider agreement" means the signed, written agreement between the department and the provider for enrollment in Medicaid;

(27) "Registration" means the process of notifying the department of the initiation of a behavioral health clinician service, including evaluation findings and plan of care information;

(28) "State Plan" means the current Medicaid coverage and eligibility plan established, submitted and maintained by the department and approved by the Centers for Medicare and Medicaid Services in accordance with 42 CFR 430, Subpart B;

(29) "Treatment plan" means a written individualized plan developed and updated in accordance with section 17b-262-919 of the Regulations of Connecticut State Agencies that contains the type, amount, frequency and duration of services to be provided, and measurable goals and objectives developed in collaboration with the client after evaluation, in order to improve the client's condition to the point that treatment by the licensed behavioral health clinician no longer becomes necessary, aside from occasional follow-up

or maintenance visits; and

(30) "Utilization management" means the prospective, retrospective or concurrent assessment of the medical necessity of services given, or proposed to be given, to a client.

(Effective December 28, 2012)

Sec. 17b-262-914. Provider participation

In order to enroll in Medicaid and receive payment from the department, a provider shall:

(1) Comply with all applicable licensing, accreditation and certification requirements;

(2) comply with all departmental enrollment requirements, including sections 17b-262-522 to 17b-262-532, inclusive, of the Regulations of Connecticut State Agencies;

(3) comply with sections 17b-262-912 to 17b-262-925, inclusive, of the Regulations of Connecticut State Agencies; and

(4) have a valid provider agreement on file with the department.

(Effective December 28, 2012)

Sec. 17b-262-915. Eligibility

The department shall pay for medically necessary behavioral health clinician services provided to clients eligible for such services, subject to the conditions and limitations that apply to these services.

(Effective December 28, 2012)

Sec. 17b-262-916. Services covered

The department shall pay only for behavioral health clinician services that are:

(1) Within the licensed behavioral health clinician's scope of practice as defined by chapters 376b, 383a, 383b or 383c of the Connecticut General Statutes, as applicable to the behavioral health clinician; and

(2) medically necessary to treat the client's condition.

(Effective December 28, 2012)

Sec. 17b-262-917. Service limitations

The department shall pay for covered services only in accordance with the treatment plan and with the following additional limits:

(1) Only one diagnostic interview in any twelve-month period per licensed behavioral health clinician per client;

(2) only one unit of individual counseling or individual psychotherapy per client, per day;

(3) only one unit of family counseling or family psychotherapy per client, per day;

(4) only one unit of group counseling or group psychotherapy per client, per day;

(5) group psychotherapy sessions shall include a maximum of twelve participants per group session, to the extent clinically appropriate, regardless of each participant's payment source, and the provider shall document the number of participants in each session in the

client's chart;

(6) family, group and multiple-family group psychotherapy sessions shall be at least forty-five minutes in length, and the provider shall document the length of time of each session in the client's chart;

(7) family and multiple-family group psychotherapy shall be reimbursable for one identified family member client per session, without regard to the number of family members in attendance or the presence of behavioral health conditions among other family members in attendance; and

(8) multiple-family group psychotherapy shall include a maximum of twenty-four participants per group regardless of each participant's payment source, shall include members of at least two unrelated families and the provider shall document the number of participants in each session in the client's chart.

(Effective December 28, 2012)

Sec. 17b-262-918. Services not covered

The department shall not pay for the following behavioral health clinician services:

(1) Information or services furnished by the licensed behavioral health clinician to the client electronically or over the telephone, except for case management services provided to clients age eighteen and under;

(2) case management services provided to clients age nineteen and older;

(3) evaluations, diagnostic interviews and therapy services performed in hospital inpatient or outpatient settings;

(4) concurrent services involving the same treatment modalities for the same client by different health professionals;

(5) cancelled office visits or appointments not kept;

(6) services, treatment or items for which the provider does not usually charge;

(7) behavioral health clinician services in excess of those medically necessary to treat the client's condition;

(8) services not directly related to the client's diagnosis, symptoms or medical history;

(9) services provided by anyone other than the provider; and

(10) services that are primarily for vocational or educational guidance.

(Effective December 28, 2012)

Sec. 17b-262-919. Need for service and treatment plan

The department shall pay for medically necessary behavioral health clinician services. The provider shall establish a treatment plan for each client based on the initial diagnostic evaluation before commencing treatment and shall regularly update the treatment plan in accordance with the client's progress as necessary and at least every six months. Notwithstanding section 17b-962-917 of the Regulations of Connecticut State Agencies, the department shall pay for an initial diagnostic evaluation in order to enable the licensed behavioral health clinician to develop the treatment plan. The treatment plan shall specify

the treatment modalities and frequency of care necessary to meet the client's needs, identify measurable outcomes to be achieved and identify any medical providers with whom the licensed behavioral health clinician is coordinating care.

(Effective December 28, 2012)

Sec. 17b-262-920. Prior authorization and registration

(a) Where a service requires prior authorization or registration under this section, the department shall not pay for such service unless the provider complies with this section and all of the department's requirements for prior authorization or registration, as applicable.

(b) The department shall designate services that require prior authorization or registration in the department's fee schedule or on the department's website or by other means accessible to providers, with advance notice given to providers before changing the prior authorization or registration requirements. Registration may serve in lieu of prior authorization only if the department designates a service as requiring registration but not prior authorization. Prior authorization is also required for:

(1) Any service that is not in the department's fee schedule; and

(2) EPSDT Special Services.

(c) The following requirements shall apply to all services that require prior authorization or registration under subsections (a) and (b) of this section:

(1) The initial prior authorization or registration period shall be based on the client's needs;

(2) if prior authorization is needed beyond the initial or current prior authorization period, the provider shall submit a request to the department to extend the prior authorization before the end of the current prior authorization period;

(3) except as provided in subdivision (9) of this subsection or for the purpose of initial assessment, the provider shall receive prior authorization before rendering services or submit complete registration information to the department within the timeframes established by the department and posted on the department's website;

(4) in order to receive payment from the department, a provider shall comply with all prior authorization and registration requirements. The department, in its sole discretion, determines what information is necessary to approve a prior authorization request. Prior authorization does not guarantee payment unless all other requirements for payment are met;

(5) a provider shall present medical or social information adequate to evaluate medical necessity when requesting prior authorization. The provider shall maintain documentation adequate to support requests for prior authorization and registration including, but not limited to, medical or social information adequate to evaluate medical necessity;

(6) requests for prior authorization for continued services shall include: progress made to date with respect to established treatment goals; future gains expected from additional treatment; and medical or social information adequate to evaluate medical necessity;

(7) the provider shall maintain documentation adequate to support requests for continued

prior authorization including, but not limited to: progress made to date with respect to established treatment goals; the future gains expected from additional treatment; and medical or social information adequate to evaluate medical necessity;

(8) the department may require a review of the discharge plan and actions taken to support successful implementation of the discharge plan as a condition of prior authorization;

(9) a provider may request retrospective prior authorization from the department before payment has been made but after a service has been provided for clients who are granted eligibility retroactively or in cases where it was not possible to determine eligibility at the time of service;

(10) for clients who are granted retroactive eligibility, the department may conduct retroactive medical necessity reviews. The provider shall initiate this review to enable authorization and payment for services;

(11) for all prior authorization requests for EPSDT Special Services, a provider shall attach a physical or electronic copy of a prescription signed by a licensed practitioner acting within the licensed practitioner's scope of practice under state law or an order signed by a licensed behavioral health clinician acting within the licensed behavioral health clinician's scope of practice under state law. The provider shall keep the original prescription or order on file and subject to the department's review; and

(12) the department may deny prior authorization or registration if the provider does not comply with utilization management policies and procedures.

(Effective December 28, 2012)

Sec. 17b-262-921. Billing procedures

(a) Providers shall submit claims on the department's designated form or by electronic transmission as established by the department and shall include all information required by the department to process the claim for payment.

(b) The amount billed to the department shall represent the licensed behavioral health clinician's usual and customary charge for the services provided.

(c) When a licensed behavioral health clinician is requested to attend a staff conference for a client, the name of the referring practitioner, clinic or agency shall be entered in the appropriate section of the claim form.

(Effective December 28, 2012)

Sec. 17b-262-922. Payment

(a) Licensed behavioral health clinicians who are fully or partially compensated by a Medicaid participating general hospital, public or private institution, freestanding clinic or federally qualified health center shall not receive payment from the department for services rendered at such entities unless the licensed behavioral health clinician maintains an office for private practice at a separate location from the entity referenced above where the licensed behavioral health clinician is employed. The licensed behavioral health clinician shall bill

the department only for a service provided to a client whose overall treatment is provided through the provider's private practice, although each individual service may be provided either at the practice, the client's home or in the community.

(b) Payment for services directly performed by a licensed behavioral health clinician in private practice shall be made at the lowest of:

(1) The provider's usual and customary charge;

(2) the lowest Medicare rate; or

(3) the amount in the department's applicable fee schedule.

(Effective December 28, 2012)

Sec. 17b-262-923. Payment rate

The commissioner shall establish, update and publish the department's fee schedule pursuant to section 4-67c of the Connecticut General Statutes.

(Effective December 28, 2012)

Sec. 17b-262-924. Payment limitations

(a) The fees for a diagnostic interview examination, as stipulated in the department's applicable fee schedule, represent one unit of service. The provider shall bill for only one unit of service for a diagnostic interview examination regardless of the number of days it takes to complete.

(b) If a session includes a combination of individual and family psychotherapy, the provider shall bill for the modality that comprises the greater part of the session. The provider shall not bill for both individual and family psychotherapy for the same date of service unless each modality individually meets the minimum time requirement for the modality specified in the department's fee schedule or in section 17b-262-917 of the Regulations of Connecticut State Agencies.

(Effective December 28, 2012)

Sec. 17b-262-925. Documentation

(a) Providers shall maintain (1) a specific record for all services provided to each client including, but not limited to: name, address, birth date, Medicaid identification number, pertinent diagnostic information, a current treatment plan signed by the licensed behavioral health clinician and (2) documentation of services provided, including, types of service or modalities, date of service, location of the service and the start and stop time of the service.

(b) For treatment services, the provider shall document the treatment intervention and progress with respect to the client's goals as identified in the treatment plan.

(c) Providers shall maintain all required documentation in its original form for a minimum of five years or longer if required by applicable statutes and regulations, subject to review by the department. In the event of a dispute concerning a service provided, the provider shall maintain documentation until the end of the dispute, five years or the time required by applicable statues and regulations, whichever is greater.

(d) The department may disallow and recover any amounts paid to the provider for which required documentation is not maintained and provided to the department upon request.

(e) The department may audit any relevant records and documentation and take any other appropriate quality assurance measures it deems necessary to assure compliance with these and other regulatory and statutory requirements.

(f) Providers shall make all entries in ink or electronically and shall incorporate all documentation into a client's permanent medical record in a complete, prompt and accurate manner.

(g) Providers shall make all documentation available to the department upon request in accordance with 42 CFR 431.107.

(Effective December 28, 2012)

Requirements for Payment to Birth Centers

Sec. 17b-262-956. Scope

Sections 17b-262-956 to 17b-262-965, inclusive, of the Regulations of Connecticut State Agencies set forth the Department of Social Services requirements for payment to birth centers that are medically necessary and are provided to clients who are determined to be eligible to receive such goods and services under Medicaid pursuant to section 17b-261 of the Connecticut General Statutes.

(Effective October 2, 2012)

Sec. 17b-262-957. Definitions

As used in sections 17b-262-956 to 17b-262-965, inclusive, of the Regulations of Connecticut State Agencies:

(1) "Birth center" means a free-standing, separately licensed health care facility that is not a hospital, where a licensed practitioner performs low-risk deliveries;

(2) "Chronic disease hospital" has the same meaning as provided in section 19a-550 of the Connecticut General Statutes;

(3) "Client" means a person eligible for goods or services under Medicaid;

(4) "Commissioner" means the Commissioner of Social Services or the commissioner's designee;

(5) "Department" means the Department of Social Services or its agent;

(6) "Early Periodic Screening, Diagnosis and Treatment special services" or "EPSDT special services" means services that are not otherwise covered under Medicaid but which are nevertheless covered as EPSDT services for Medicaid-eligible children pursuant to 42 USC 1396d(r)(5) when the service is medically necessary, the need for the service is identified in an EPSDT screen, the service is provided by a participating provider, and the service is a type of service that may be covered by a state Medicaid agency and qualify for federal reimbursement under 42 USC 1396d;

(7) "Home" means the client's place of residence, including, but not limited to, a

boarding house, community living arrangement or residential care home. "Home" does not include facilities such as hospitals, chronic disease hospitals, nursing facilities, intermediate care facilities for the mentally retarded or other facilities that are paid an all-inclusive rate directly by Medicaid for the care of the client;

(8) "Hospital" means a "short-term hospital" as defined in section 19-13-D1 of the Regulations of Connecticut State Agencies;

(9) "Intermediate care facility for the mentally retarded" or "ICF/MR" means a residential facility for individuals with intellectual disabilities licensed pursuant to section 17a-227 of the Connecticut General Statutes and certified to participate in Medicaid as an intermediate care facility for the mentally retarded pursuant to 42 CFR 442.101, as amended from time to time;

(10) "Licensed practitioner" means a physician, physician assistant, nurse practitioner, nurse midwife or such other category of practitioner licensed by the Department of Public Health pursuant to Title 20 of the Connecticut General Statutes and whose scope of practice includes the ante-partum, intra-partum and post-partum care of pregnant women and the care of newborns;

(11) "Low-risk delivery" means a delivery following a low-risk pregnancy that is anticipated to be normal, as determined by the mother's licensed practitioner acting within the licensed practitioner's scope of practice under state law;

(12) "Low-risk pregnancy" means a pregnancy that is anticipated to be normal, as determined by the mother's licensed practitioner acting within the licensed practitioner's scope of practice under state law;

(13) "Medicaid" means the program operated by the department pursuant to section 17b-260 of the Connecticut General Statutes and authorized by Title XIX of the Social Security Act;

(14) "Medical necessity" or "medically necessary" has the same meaning as provided in section 17b-259b of the Connecticut General Statutes;

(15) "Nursing facility" has the same meaning as provided in 42 USC 1396r(a) and is licensed pursuant to section 19-13-D8t of the Regulations of Connecticut State Agencies as a chronic and convalescent home or rest home with nursing supervision;

(16) "Nurse midwife" means a person licensed pursuant to section 20-86c of the Connecticut General Statutes;

(17) "Nurse practitioner" or "advance practice registered nurse" or "APRN" means a person licensed pursuant to section 20-94a of the Connecticut General Statutes;

(18) "Physician" means a person licensed pursuant to section 20-13 of the Connecticut General Statutes;

(19) "Physician assistant" means a person licensed pursuant to section 20-12b of the Connecticut General Statutes;

(20) "Prescription" means an original written order documenting medical necessity issued, signed and dated by a licensed practitioner;

(21) "Prior authorization" means approval from the department for the provision of a

service or the delivery of goods before the provider actually provides the service or delivers the goods;

(22) "Provider" means a birth center enrolled with Medicaid pursuant to a valid provider enrollment agreement with the department; and

(23) "Usual and customary charge" means the amount that the provider accepts for the service or procedure in the majority of non-Medicaid cases. If the provider varies the charges so that no one amount is accepted in the majority of cases, usual and customary shall mean the median charge. Token charges for charity patients and other exceptional charges shall be excluded when calculating the usual and customary charge.

(Effective October 2, 2012)

Sec. 17b-262-958. Provider participation

(a) To enroll in Medicaid and receive payment from the department, a provider shall comply with sections 17b-262-956 to 17b-262-965, inclusive, of the Regulations of Connecticut State Agencies and sections 17b-262-522 to 17b-262-532, inclusive, of the Regulations of Connecticut State Agencies.

(b) A birth center shall:

(1) Be accredited by the Commission for the Accreditation of Birth Centers;

(2) be licensed by the Department of Public Health as a maternity hospital in accordance with section 19-13-D14 of the Regulations of Connecticut State Agencies or be licensed by the Department of Public Health as a birth center in accordance with regulations adopted by the Department of Public Health that specifically regulate birth centers; and

(3) comply with (A) section 19a-505 of the Connecticut General Statutes and (B) section 19-13-D14 of the Regulations of Connecticut State Agencies or such other regulations adopted by the Department of Public Health that specifically regulate birth centers.

(Effective October 2, 2012)

Sec. 17b-262-959. Need for service

Service in a birth center shall be limited to maternal patients who have had a low-risk pregnancy and are likely to have a low-risk delivery, as determined by the maternal patient's licensed practitioner.

(Effective October 2, 2012)

Sec. 17b-262-960. Eligibility

Payment to a provider for birth center services is available for clients who have a need for such products and services when the items are medically necessary, subject to the conditions and limitations set forth in sections 17b-262-956 to 17b-262-965, inclusive, of the Regulations of Connecticut State Agencies.

(Effective October 2, 2012)

Sec. 17b-262-961. Services covered and limitations

(a) The department shall pay the provider a single all-inclusive fee for a normal, uncomplicated labor and delivery, which covers all services provided by the birth center, including, but not limited to:

(1) Care for, labor, delivery and recovery of the maternal patient;

(2) nursery care and other services provided to the infant patient; and

(3) other ambulatory services within the provider's scope of services established by the Department of Public Health that are offered by the provider and that are otherwise covered by Medicaid.

(b) Surgical procedures at a birth center shall be limited to those normally accomplished during an uncomplicated birth, including episiotomy and repair.

(c) No general or regional anesthesia shall be administered at a birth center. Local anesthesia may be administered at a birth center if the administration of the anesthetic is performed within the scope of practice of the licensed practitioner in attendance.

(d) No abortions shall be done at a birth center.

(Effective October 2, 2012)

Sec. 17b-262-962. Payment and payment limitations

(a) The department shall reimburse the provider when the provider has met all the requirements of sections 17b-262-956 to 17b-262-965, inclusive, of the Regulations of Connecticut State Agencies.

(b) The department's payment to the provider includes all birth center charges, including, but not limited to: charges for labor, delivery, anesthesia, laboratory, radiology, pharmacy, nursing and other clinical staff care. The department shall not pay any other charges to the provider.

(c) The department shall not pay the provider for a delivery at home or in any setting other than the birth center, except for services described in subsection (d) of this section.

(d) If the client is transferred to a hospital prior to the actual delivery, the department shall reimburse the provider for services provided in the birth center prior to such transfer at the lower of billed charges or the reduced fee specified for such services on the department's fee schedule.

(e) If the delivery occurs at the birth center, the department shall pay the provider at the lower of the fee on the department's fee schedule or the provider's usual and customary rate.

(f) Payment to the provider excludes all services provided by a licensed practitioner. Each licensed practitioner shall bill the department for services in accordance with the regulations applicable to the licensed practitioner's provider type.

(Effective October 2, 2012)

Sec. 17b-262-963. Prior authorization

(a) The department shall require prior authorization for:

(1) Any service identified on the department's fee schedule as requiring prior authorization;

(2) EPSDT special services; and

(3) any service that is not identified on the department's fee schedule.

(b) To receive reimbursement from the department, a provider shall comply with all prior authorization requirements. The department, in its sole discretion, shall determine what information is necessary to approve a prior authorization request. Prior authorization does not guarantee payment unless all other requirements are met.

(c) The provider shall submit and sign the prior authorization request, in a form and manner specified by the department, which shall include documentation of medical necessity.

(d) A prescription is required from a licensed practitioner for all services and goods provided as EPSDT special services. The provider may attach a copy of the prescription from the licensed practitioner to the completed prior authorization request in lieu of the actual signature of the licensed practitioner on the prior authorization request form. The provider shall keep the licensed practitioner's original prescription on file and available for review by the department.

(Effective October 2, 2012)

Sec. 17b-262-964. Billing procedure

Providers shall submit claims on a hard copy invoice or by electronic transmission to the department in a form and manner specified by the department, together with all information required by the department to process the claim for payment.

(Effective October 2, 2012)

Sec. 17b-262-965. Documentation

(a) Providers shall maintain a specific record for all services provided to each client, including, but not limited to: name, address, birth date, Medicaid identification number, pertinent diagnostic information, treatment notes signed by the licensed practitioner, documentation of services provided and the dates the services were provided.

(b) Providers shall maintain all required documentation in its original form for at least five years or longer in accordance with applicable federal and state statutes and regulations, subject to review by authorized department personnel. If there is a dispute concerning a service provided, documentation shall be maintained until the end of the dispute, five years or the length of time required by statute or regulation, whichever is longest.

(c) The department may disallow and recover any amounts paid to the provider for which required documentation is not maintained or not provided to the department upon request.

(d) The department may audit all relevant records and documentation and take any other appropriate quality assurance measures it deems necessary to assure compliance with regulatory and statutory requirements.

(Effective October 2, 2012)

Sec. 17b-262-966. Reserved

Agency
Department of Social Services

Subject
Connecticut Home Care Program for Elders, Standards for Access Agencies and Assisted Living Service Agencies Program Requirements

Inclusive Sections
§§ 17b-342-1—17b-342-5

CONTENTS

Sec. 17b-342-1. Connecticut home care program for elders; standards for access agencies and requirements for assisted living service agencies
Sec. 17b-342-2. Services covered under the connecticut home care program for elders
Sec. 17b-342-3. Service limitations, payment limitations, cost limits, waiting list and fee setting
Sec. 17b-342-4. Nursing facility and hospital requirements
Sec. 17b-342-5. Reporting

Connecticut Home Care Program for Elders, Standards for Access Agencies and Assisted Living Service Agencies Program Requirements

Sec. 17b-342-1. Connecticut home care program for elders; standards for access agencies and requirements for assisted living service agencies

(a) **Scope**

The purpose of sections 17b-342-1 to 17b-342-5, inclusive, of the Regulations of Connecticut State Agencies is to describe non-financial program requirements, services available and limitations under the Connecticut Home Care Program for Elders. This program provides home health services, community based services and assisted living services funded under a waiver to the Medicaid program and under a program funded with an appropriation by the General Assembly. The financial eligibility requirements for these three parts of the program differ and are specified under sections 2540.92 and 8040 to 8040.50, inclusive, of the Uniform Policy Manual of the Department of Social Services. This program includes all clients transferred from the following programs as of July 1, 1992: Promotion of Independent Living for the Elderly, Department on Aging Home Care Demonstration Project and Long Term Care Preadmission Screening and Community Based Services Program. Sections 17b-342-1 to 17b-342-5, inclusive, of the Regulations of Connecticut State Agencies also establish standards and requirements for access agencies and assisted living service agencies which operate under the Connecticut Home Care Program for Elders and the Connecticut Partnership for Long Term-Care.

(b) **Definitions**

As used in sections 17b-342-1 to 17b-342-5, inclusive, of the Regulations of Connecticut State Agencies the following definitions apply:

(1) “Access Agency” means an organization which assists individuals in receiving home and community based services by conducting assessments and developing plans of care tailored to the needs of the individuals and making arrangements with service providers. If needed by the individuals the access agency shall also coordinate services and monitor the quality of the services over an extended period, but the access agency shall not be a provider of services, other than to provide care management to department clients that are approved for program participation. An access agency shall have a governing body which assumes all financial and programmatic responsibility for the agency’s activities and shall meet the requirements pursuant to section 17b-342-1(h) of the Regulations of Connecticut State Agencies and the provisions set forth in a legal contractual provider agreement;

(2) “Applicant” means an elderly person who directly or through any representative, including but not limited to, a guardian, conservator, family member, physician, social worker or discharge planner completes a Home Care Request Form and submits it to the department or indicates to the department a desire to be considered for services under the Connecticut Home Care Program;

(3) “Assisted Living Services Agency” or “ALSA” means an agency authorized to provide and arrange for the delivery of assisted living services to clients. The participating ALSA shall be licensed with the Department of Public Health and shall enter into a contract

with a managed residential care facility that has been approved for participation and be an enrolled service provider with the Department of Social Services. The ALSA shall comply with the standards and requirements in section 19-13-D105 of the Regulations of Connecticut State Agencies;

(4) “Assisted living services” means a special combination of housing, supportive services, personalized assistance and health care designed to respond to the individual needs of clients who need help with activities of daily living and instrumental activities of daily living in managed residential care facilities approved for participation. Services are delivered in a service package model within a specific service cost package level;

(5) “Assessment” means a comprehensive written evaluation of an individual’s medical, psychosocial and economic status, degree of functional impairment and related service needs. For the purposes of the Connecticut Home Care Program, this assessment shall include a face-to-face interview and shall utilize a standard assessment tool approved by the department;

(6) “Average nursing facility cost” means a weighted average calculated by multiplying the nursing facility Medicaid rates in effect on July 1 of that calendar year for each facility by their respective number of days, adding the products and then dividing that total by the total patient days, and reducing the result by the average applied income for nursing facility patients. This figure shall be used when calculating the cost limits for fee-for-service;

(7) “Client” means a person who has met the requirements for eligibility and enrolled as an active participant in the program;

(8) “Commissioner” means the Commissioner of Social Services or his or her designee;

(9) “Community based services” includes but is not limited to care management, adult day services, assisted living services, chore services, companion services, elderly foster care, home delivered meals, homemaker services, laundry services, mental health counseling, minor home modification services, respite care, transportation and personal emergency response systems;

(10) “Connecticut Home Care Program” or “the Program” means the program operated for elders pursuant to section 17b-342 of the Connecticut General Statutes. This program was formerly known as the Long Term Care Facility Preadmission Screening and Community Based Services Program and includes all home care clients who were transferred from the former Department on Aging and the department’s Fairfield pilot program clients;

(11) “Cost of home care services” means the total amount of direct costs in state administered public funds expended to provide the home health and community based services set forth in sections 17b-342-1 to 17b-342-5, inclusive, of the Regulations of Connecticut State Agencies;

(12) “Day” means calendar day;

(13) “Department” or “DSS” means the Department of Social Services, its employees and agents;

(14) “Elder” or “elderly person” means an individual 65 years of age or older and a

resident in the State of Connecticut;

(15) "Emergency admission" means that an individual has been determined by the department to be in need of protective services and is referred to a nursing facility for admission by an appropriate state agency pursuant to the provisions of section 17b-450 to 17b-460,inclusive, of the Connecticut General Statutes. This does not include nursing home placements from the community in which the family desires to make the placement as soon as possible because of an applicant's deteriorating health condition;

(16) "Fee-for-service" means a service delivery system which a cost-and-payment methodology is used for services rendered to care-managed and self-directed clients who receive benefits under the Medicaid waiver or state- funded portions of the program, except those services rendered to clients participating in the assisted living services component of the program;

(17) "Health care professional" means a Connecticut licensed physician, Connect-icut licensed nurse, social worker or hospital discharge planning personnel;

(18) "Health screen form" means a department form used to determine whether an individual is at risk of institutionalization and if the individual meets the functional criteria for the program. This form includes information regarding the person's physical (functional and medical) and psycho-social status;

(19) "Home care request form" means a department form used to indicate if an applicant appears to be financially eligible and wishes to apply for the Connecticut Home Care Program;

(20) "Home care services" means any combination of community based services and home health services as defined in sections 17b-342-1(b)(9) and (21) of the Regulations of the State Agencies which enable elders to live in noninstitutional settings. Such services may be provided to elders living in private homes, congregate housing, assisted living demonstration project facilities, housing and urban development facilities, private facilities and homes for the aged and other community living situations as long as the services needed are not considered a regular component of the services of the community living situation;

(21) "Home health services" for the purposes of the Connecticut Home Care Program means those medical procedures included in the definition of home health services under the Medicaid program. Home health services provided under the Connecticut Home Care Program shall be defined in the same way and covered to the same extent as they are under the Medicaid program;

(22) "Hospital" means a general short term or chronic disease hospital licensed by the Department of Public Health pursuant to section 19a-490(b) of the Connecticut General Statutes;

(23) "Medicaid recipient" means an individual who has been determined eligible for Medicaid benefits;

(24) "Nursing facility" means a facility licensed by the Department of Public Health pursuant to section 19a-490(c) of the Connecticut General Statutes as a chronic and convalescent nursing home or rest home with nursing supervision and certified to participate

in the Medicaid program as a nursing facility as evidenced by a Medicaid provider agreement between the department and the facility. For purposes of this section, the term "nursing facility" does not include an Intermediate Care Facility for the Mentally Retarded (ICF/MR) or any other residential or inpatient health care facility;

(25) "Person" means an individual applicant or elder client enrolled in the Connecticut Home Care Program and a representative authorized to act on the applicant or client's behalf including guardians, conservators or other legally authorized representatives;

(26) "Plan of care" means a written individualized plan of home care services which specifies the type and frequency of all services and funding sources required to maintain the individual in the community, the names of the service providers and the cost of services, regardless of whether or not there is an actual charge for the service. The plan of care shall include any in-kind services and any services paid for by the client or the client's representative;

(27) "Re-evaluation" means a review of the functional and financial status of an applicant or client for the purpose of establishing functional and financial eligibility and determination of needs for consideration for program participation;

(28) "Related party" means an entity which is associated with another by common ownership or control. Control of or by another entity exists where an individual or organization has the power, directly or indirectly, to significantly influence or direct the actions or policies of an organization or institution. Common ownership exists when an individual or individuals possess significant ownership or equity in the provider or organization serving the provider;

(29) "Relative" means spouse, natural parent, child, sibling, adoptive child, adoptive parent, stepparent, stepchild, stepbrother, stepsister, father-in-law, mother-in-law, son-in-law, daughter-in-law, sister-in-law, grandparent and grandchild;

(30) "Risk of institutionalization" means that the individual is in danger of hospitalization or nursing facility placement due to his or her medical, functional or cognitive status but would be able to remain at home, without the creation of an unacceptable risk to the safety of the individual or others, if home care services were provided. This definition includes individuals who are currently institutionalized and who are at risk of continued institutionalization unless home care services are provided;

(31) "Self-directed care" means the ability of the client to be responsible for the self-direction, coordination and arrangement of his or her plan of care under the fee-for-service delivery option of the program;

(32) "Standard assessment tool" means a department form used to conduct an initial assessment and re-evaluation of applicants and clients for the purpose of establishing functional eligibility and determination of needs for consideration for program participation;

(33) "Status review" means a review of the functional and cognitive status of a client enrolled in the program based on a face-to-face interview in order to reevaluate the plan of care and program participation when the individual is not receiving ongoing monitoring by an access agency or services through any program component;

(34) “State administered public funds” means direct payments of state or federal funds allocated by a state agency to an individual or to an agency to pay for medical or social services required to be provided under an individual’s plan of care;

(35) “Unacceptable risk” means a situation which places an individual’s life or health in immediate jeopardy. In determining whether an unacceptable risk exists, the department shall take into account the provider’s professional standards, the client’s needs and the client’s informed viewpoint with regard to the potential risk;

(36) “Waiting list” means a record maintained by the department for the Connecticut Home Care Program that includes the names of the applicants seeking to be screened for program participation and specifies the date the contact was made. The department may maintain separate waiting lists, regional or statewide, depending on the program component and type of service.

(c) **General**

(1) The purposes of the Connecticut Home Care Program are to:

(A) Assess whether cost-effective home care services can be offered to elders who are at risk of institutionalization;

(B) determine, prior to admission to a nursing facility whether the elder does or does not need nursing facility services;

(C) authorize department payment for elders for nursing facility care or home care services if appropriate; and

(D) provide a full range of community based services, home care services and assisted living services to eligible individuals who choose to remain in the community, if such services are appropriate, available and cost effective.

(2) The program application process shall consist of:

(A) A financial eligibility determination in accordance with section 17b-10-1 of the Regulations of Connecticut State Agencies and the department’s Uniform Policy Manual sections 8040 and 2540.

(B) an initial determination as to the elder’s needs, which shall include the category of services needed, the elder’s functional eligibility and potential service options under the program. The initial determination shall be conducted by department staff based on completion or review of the health screen form.

(i) As a result of a review of the health screen form, the department shall determine:

(aa) Whether the elderly person meets the functional level for admission to the program;

(bb) whether the elderly person needs care that would otherwise be provided in a nursing facility;

(cc) which program component and category of services may be appropriate and authorized for the person in the community;

(dd) whether an initial assessment is deemed appropriate. The assessment shall be conducted only after the elder or the elder’s representative gives written consent. The assessment shall include, but not be limited to: Explaining Program participation to the elder or the elder’s representative; explaining client’s rights and responsibilities; explaining

the state's recovery policy; confirming client's functional eligibility and financial information; determining if the elder can be offered a cost-effective plan of care to enable the elder to remain in the community without creating an unacceptable risk to the elder or others;

(ee) whether the elderly person should be admitted to a nursing facility without an assessment; and

(ff) whether the elderly person requires assistance in the completion of the financial application or other assistance to establish program eligibility and participation. This does not relinquish the elderly person's responsibility to comply with all program requirements necessary to determine eligibility and program participation.

(ii) Initial determination as to the elder's needs, the category of services and functional level based on the health screen form shall be valid for sixty (60) days unless the department receives information which indicates that a person's condition has changed significantly.

(iii) The health screen form shall also be used to verify recommendations for short term placement. For purposes of this section, a short term placement means a maximum stay of ninety (90) days for rehabilitative or recuperative care which is expected to result in the person's return to the community.

(C) a referral to other sources of assistance, including authorization for admission to a nursing facility without an assessment, if appropriate.

(D) The department shall send a screening outcome letter to the applicant to provide notice of the initial functional and financial screening determination issued and to advise the applicant of their rights.

(3) Determination of Need

(A) The determination as to whether the elder is at risk of institutionalization or needs services that would otherwise require institutionalization shall be made by the department based upon an evaluation of the completed health screen and an assessment, if deemed appropriate.

(B) The basis for determining the level, type, frequency and cost of services and funding source that an elder may receive under the program shall be determined by their financial and functional eligibility and need for services.

(C) Functional eligibility means the elder must be at risk of institutionalization and needs assistance with at least one critical need. For the purposes of eligibility, critical needs are defined as "activities of daily living" which are hands-on-activities or tasks that are essential for a client's health and safety. These include, but are not limited to; bathing, dressing, transferring, toileting (bowel or bladder), feeding, meal preparation, administration of medication or ambulation.

(4) Category types

The following three category types define the funding sources which pay for the client's community based services and home health services. The category types apply to care managed cases, self directed cases and the assisted living service program component.

(A) Category Type 1:

This category applies to elders who are at risk of institutionalization but who might not immediately enter a hospital or nursing facility in the absence of the program. This category type is available to elders who meet the financial and functional eligibility criteria for the state-funded portion of the program as defined in section 17b-10-1 of the Regulations of Connecticut State Agencies and the department's Uniform Policy Manual section 8040. Some clients under Category Type 1 may be Medicaid recipients because they do not meet the functional criteria for the Medicaid waiver portion of the program.

(B) Category Type 2:

This category applies to elders who would otherwise require admission to a nursing facility on a short or long term basis. This category type is available to elders who meet the financial and functional eligibility criteria for the state-funded portion of the program as defined in the department's Uniform Policy Manual section 8040.

(C) Category Type 3:

This category applies to elders who, but for the provision of home care services, would require nursing facility care funded by Medicaid. This category type is available to elders who meet the financial and functional eligibility criteria for Medicaid under the federal waiver as defined in the department's Uniform Policy Manual section 2540.92.

(D) The program category type identifies the maximum funding level available for all program clients. The access agencies, department staff and assisted living service agencies shall specify the category type on the client's plan of care in the funding source section.

(5) The determination of services for the program's fee-for-service and assisted living services option consists of:

(A) Completion of an initial assessment by the access agency or the department;

(B) a determination if program participation is feasible;

(C) a determination of what service options under the program are appropriate;

(D) development of a plan of care for care managed cases by the access agency or the department. For clients participating in the assisted living service option, the assisted living service agency shall develop the plan of care;

(E) a determination as to the feasibility and cost-effectiveness of home care services, if deemed appropriate; and

(F) authorization for community based services and home health services in the community.

(d) **Initial Assessment and Plan of Care**

(1) A person who is determined by the department to appear to meet the financial and functional eligibility criteria of the Connecticut Home Care Program shall be referred by the department to an access agency or the department's staff for an initial assessment as defined in section 17b-342-1 (b)(5) of the Regulations of Connecticut State Agencies. The results of the initial assessment shall be used to:

(A) Determine or verify the following:

(i) Whether program participation is feasible;

(ii) whether the elderly person's financial information;

(iii) whether the elderly person's functional eligibility;
(iv) whether the assisted living services option is appropriate; if appropriate the access agency, department staff or department designee will complete an initial assessment and forward the paperwork to the department for review and processing;
(v) whether the fee–for-service option is appropriate; if appropriate, verify the elderly person's category of services for fee-for-service;
(vi) the individualized plan of care based on the cost limits for care-managed or self-directed care cases under fee-for-service; and
(vii) if the elder resides in an assisted living facility, develop an individualized plan of care based on the service package levels under the program's assisted living services option; and
(B) develop an individual plan of care. The access agencies, department, assisted living service agencies or department designee, when developing a plan of care, shall verify the elderly person's category type, category of services, level of service and financial information according to the following provisions:
(i) Determine the feasibility and cost-effectiveness of meeting the elderly person's care needs with home care services, pursuant to section 17b-342-3(b) of the Regulations of Connecticut State Agencies;
(ii) include a thorough exploration of all available services and funding resources;
(iii) establish an appropriate service delivery mix and arrangement which is non-duplicative and not overlapping (i.e. two similar services being provided at the same time);
(iv) clients shall only receive home care services through one of the following program service options: Fee-for-service (care-managed or self-directed) or assisted living services, if appropriate; and
(v) applicants or clients shall receive home care services through only one department program or state agency.
(2) Such person shall be given the opportunity to participate, to the extent possible, in the development of his or her plan of care.
(3) When carrying out its responsibilities for the initial assessment and development of the plan of care under the Connecticut Home Care Program, the department, the access agency, department staff or department designee may collaborate with other health care professionals providing services to the person to avoid the duplication of services. The access agencies, assisted living service agencies, department staff or department designee may, to the extent permitted by section 17b-342 of the Connecticut General Statutes, involve other service providers in the completion of the assessment and care plan development.
(4) Written notice of the outcome of the assessment shall be provided to the applicant and to hospital discharge planning personnel in the case of hospitalized patients. The applicant shall also be notified of appeal rights and procedures, in accordance with the department's Uniform Policy Manual sections 8040 and 1570.
(5) If the person refuses to participate in the assessment, or does not agree to accept a plan of care approved by the department, services shall not be available under the

Connecticut Home Care Program.

(6) If the department determines that a plan of care is feasible and cost-effective under the program, the elderly person may remain in the community with assistance provided under the Connecticut Home Care Program. If home care is desired, the plan of care shall be authorized by the department.

(7) For the Connecticut Home Care Program, all home care services shall be included as part of a written plan of care developed initially and updated regularly by the access agency, the assisted living service agency, department staff or department designee. The plan of care shall specify the start date of services, services to be provided, category type of services, frequency, cost, funding source and the providers of all home care services. The type and frequency of services contained in the plan of care shall be based upon the documented needs found in the assessment of the elderly person's needs and shall be reimbursed by the department only when it is determined that each service is needed in order to avoid institutional placement. For any services where the client would be at risk if the schedule of the service varied, a back-up plan shall be identified in the total plan of care. Services not included as part of the approved plan of care or not covered by sections 17b-342-1 to 17b-342-5, inclusive, of the Regulations of Connecticut State Agencies are not eligible for reimbursement from the Connecticut Home Care Program.

(8) The client's individualized plan of care must be signed by the client or the client's representative and the access agency staff, assisted living agency staff, department staff or department designee.

(9) Services that shall be covered by another payer, including but not limited to, any covered services through Medicare, private insurance or long-term care insurance, shall be included in the plan of care.

(10) In-kind services performed by family members, volunteer groups, community action agencies or any other person or entity shall be included as part of the client's plan of care.

(e) **Status Reviews**

(1) Status reviews shall be provided for clients enrolled in the program in order to re-evaluate the client's status and the plan of care. Status reviews may be conducted by the access agencies, assisted living service agencies (only when authorized by the department), department staff, department designee or agencies which provide home health services or adult day health services as described in sections 17b-342-2(b) and (h) of the Regulations of Connecticut State Agencies. The staff who conduct the status reviews shall be either registered nurses or social services workers who meet the requirements pursuant to subsections (h)(1)(A) and (B)of this section.

(2) For each client there shall be no more than one agency at any time, designated by the department, which shall be responsible for status reviews. When care management services by an access agency have been temporarily interrupted due to an institutional stay, a status review may be conducted by the access agency, department staff or department designee. When ongoing care management services have been suspended, the department shall determine in advance which agency may conduct any necessary status reviews taking into

consideration the needs and preferences of the client, if deemed feasible and allowed under the program.

(3) Status reviews shall be provided only when care management services by the access agency are not authorized, when deemed appropriate by the department and are limited to the following situations:

(A) No more than one time during a hospital stay which is less than or equal to 45 days;

(B) No more than one time during a nursing facility stay which is less than or equal to 45 days;

(C) No more than one time every twelve months for annual reassessment of a person not receiving care management from an access agency; and

(D) In other circumstances, when there is prior authorization by the department, such as when an elder is being reevaluated to consider having the care management from the access agency, department staff, or department designee reinstated after a lapse of more than two months in this service or when an elder is being reevaluated by the access agency, department staff or department's designee for reinstatement of program services following a nursing facility or hospital stay of more than 45 days.

(f) **Forms**

(1) The department shall promulgate a uniform assessment tool and all required program-related forms, including a home care request form, financial application form, a health screen form and client notices.

(2) Program information and forms shall be distributed by the department to all nursing facilities and hospitals in the State and to other providers that have contact with the elderly. Other providers may receive program information and forms upon request.

(g) **Information Submission**

Persons seeking home care services may initiate a screening for program participation by submitting a Home Care Request Form or by calling the department. Individuals or client representatives are responsible for assuring that all information necessary for determining eligibility including,but not be limited to, completing and submitting a program financial application and providing any required verifications, is submitted on their behalf to the department. Authorization for home care services shall not be granted, nor a plan of care implemented, until complete information has been provided and a financial and functional eligibility determination has been issued by the department. Failure to provide required information and non-cooperation with any of the program requirements shall be grounds for denial or discontinuance from the Connecticut Home Care Program.

(h) **Requirements of an access agency**

(1) An access agency shall ensure the selection of qualified staff.

(A) The care manager who conducts the assessments, develops care plans and provides ongoing monitoring shall be either a registered nurse licensed in the state where care management services are provided or a social services worker who is a graduate of an accredited four-year college or university. The nurse or social services worker shall have a minimum of two years of experience in health care or human services. A bachelor's degree

in nursing, health, social work, gerontology or a related field may be substituted for one year of experience.

(B) Care managers shall have the following additional qualifications:

(i) Demonstrated interviewing skills which include the professional judgment to probe as necessary uncover underlying concerns of the applicant;

(ii) demonstrated ability to establish and empathic relationships;

(iii) experience in conducting social and health assessments;

(iv) knowledge of human behavior, family/caregiver dynamics, human development and disabilities;

(v) awareness of community resources and services;

(vi) the ability to understand and apply complex service reimbursement issues; and

(vii) the ability to evaluate, negotiate and plan for the costs of care options.

(C) Care management supervisors shall meet all the qualifications of a care manager plus have demonstrated supervisory ability, and at least one year of specific experience in conducting assessments, developing care plans and monitoring home and community based services.

(2) An access agency shall ensure that care managers are appropriately trained and supervised.

(A) An access agency shall provide or arrange for orientation and initial and ongoing training for care managers and care management supervisors, including training in the use of the assessment tool, required program forms, program requirements and in all aspects of program operation.

(B) An access agency shall provide or arrange for appropriate supervision and clinical consultation for care managers. For care managers with a social service background, the access agency shall have nursing staff available for consultation during normal business hours; for care managers with a nursing background, the access agency shall have a social services staff available for consultation during normal business hours.

(3) An access agency shall have the following additional responsibilities:

(A) Establish working relationships with existing service providers and provide community education regarding the care management role;

(B) Establish a quality assurance process subject to approval by the department or the Office of Policy and Management, which includes at a minimum review of client records (without client identifiers) by professionals not employed by the agency and annual evaluation of client satisfaction;

(C) Maintain client records and administrative records to support agency activities and data collection activities;

(D) Under the Connecticut Home Care Program, subcontract with vendors to provide services needed in the plan of care;

(E) Under the Connecticut Home Care Program, submit claims through the department's claims processing agent; and

(F) Under the Connecticut Home Care Program, reimburse subcontractors when

appropriate.

(4) An access agency shall establish a written client bill of rights and responsibilities to be provided to the client or the client's representative at the time of admission to the program. At a minimum, the bill of rights shall state that the clients have the following rights:

(A) To be treated as an adult with respect and dignity;

(B) to be fully informed about all services, charges and choices available through the access agency;

(C) to participate in and have control over the plan of care to the greatest extent possible;

(D) to be treated fairly by the department regardless of client's race, color, religious creed, sex, marital status, age, national origin, ancestry, criminal record, political beliefs, sexual orientation, mental retardation, mental disability, physical disability, learning disability or source of payment;

(E) to have any problems or questions addressed and resolved in a timely manner;

(F) to have all personal, financial and medical information treated in a confidential manner and released only as necessary to authorized persons;

(G) to choose among all qualified and available service providers;

(H) to file a grievance with the access agency or the department without fear of discrimination or reprisal; and

(I) to achieve maximum self-direction and choice in lifestyle as long as this does not create an unacceptable risk.

(5) All access agency offices serving participants in the Connecticut Home Care Program shall be located within the State of Connecticut and be accessible to the public.

(6) The access agency shall have a communication system adequate to receive requests and referrals for service, including the capacity to respond to clients and health professionals in emergencies on a 24-hour basis.

(7) The access agency shall establish a grievance procedure for home care clients who are aggrieved by adverse decisions of the access agency. The procedure shall specify that a decision shall be made by the access agency within 15 calendar days after a grievance is received from a client and sooner in the case of an emergency. The procedure shall also outline steps for requesting a fair hearing by the department or other funding source in the event that the issue is not resolved within the access agency.

(8) The access agency shall have the capacity to provide or arrange necessary services for individuals who are non-English speaking, hearing impaired or who have other special needs.

(i) **Requirements of an Assisted Living Service Agency.**

(1) The ALSA shall ensure the selection of qualified staff and comply with the requirements set forth in section 19-13-D105 of the Regulations of Connecticut State Agencies.

(A) The ALSA staff shall be employed by a licensed assisted living service agency. The staff shall be responsible for annual re-evaluation, development of plans of care,

arrangement and delivery of core services, oversight of the delivery of core services and shall provide ongoing monitoring of clients.

(B) The ALSA staff that provide direct client services shall have additional qualifications as specified in section 17b-342-1(h)(1)(B)(i) to (vii) of the Regulations of Connecticut State Agencies.

(2) The ALSA shall ensure that all staff are appropriately trained and supervised.

(A) The ALSA shall provide or arrange for orientation and ongoing training for staff in all applicable department requirements, including training in the use of the assessment tool.

(B) The ALSA shall provide or arrange for appropriate supervision and clinical consultation for staff during normal business hours and after hours if needed to respond to client emergencies.

(3) The ALSA shall have additional responsibilities as specified in subsection 17b-342-1(h)(3)of the Regulations of Connecticut State Agencies.

(4) The ALSA shall provide required reports to the department, including but not limited to, reports on specific data collection. Reports shall be submitted to the department no later than the fifteenth day of every month. The reports shall include data from the preceding month.

(5) The ALSA shall establish a written bill of client rights and responsibilities, which shall be provided to each person at the time of admission to the program as specified in section 17b-342-1(h)(4)of the Regulations of Connecticut State Agencies.

(6) All ALSAs serving participants in the Connecticut Home Care Program shall be located within the State of Connecticut and be accessible to the public.

(7) The ALSA shall have a communication system adequate to receive requests and referrals for service, including the capacity to respond to clients and health professionals in emergencies on a 24 hour basis.

(8) The ALSA shall establish a grievance and appeal procedure for clients who are aggrieved by adverse decisions of the ALSA. The procedure shall specify that a decision shall be made by the ALSA within 15 calendar days after a grievance is received from a client and sooner in the case of an emergency. The procedure shall also outline steps for requesting a fair hearing by the department or other funding source in the event that the issue is not resolved within the ALSA.

(9) The ALSA shall have the capacity to provide or arrange necessary services for individuals who are non-English speaking, hearing impaired or who have other special needs.

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

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)

Sec. 17b-342-3. Service limitations, payment limitations, cost limits, waiting list and fee setting

(a) **Service Limitations**

(1) All home care services provided to individuals under the Connecticut Home Care Program shall be authorized in accordance with procedures established by the department prior to the delivery of the service;

(2) Reimbursement is not available from the department for personnel or agencies providing a home care service when such person or agency is required to be licensed, certified or otherwise regulated and does not fulfill the relevant regulatory requirements including the requirements under sections 17b-342-1 to 17b-342-5 of the Regulations of Connecticut State Agencies;

(3) When two or more providers of community based or home health services offer essentially the same service, the least costly service provider shall be used, provided that the quality of the service is similar;

(4) Providers of services, including subcontractors of the access agency and assisted living service agencies, shall maintain records to support claims made for payment, which shall be subject to audit by the department or its designee for at least seven years;

(5) Reimbursement is not available from the department for services canceled in advance either by phone or in writing;

(6) Reimbursement is not available from the department when an individual does not utilize or refuses to utilize an arranged service;

(7) Reimbursement is not available from the department for any services provided prior to the assessment or the determination of program eligibility or not documented in an approved plan of care;

(8) Reimbursement is not available from the department including, but not limited to, when an individual dies, is hospitalized, enters a nursing facility, moves temporarily or permanently out of state, requests services to be terminated or is determined ineligible;

(9) Reimbursement is not available from the department if the access agency or assisted living service agency is determined not to have followed the requirements and process established by the department for uncollectible mandatory client contribution towards their care;

(10) Reimbursement is not available for home and community based services determined not to have been performed;

(11) Reimbursement is not available for services arranged by program clients or representatives, access agencies, assisted living service agencies or service providers without prior approval by the department or department designee;

(12) Reimbursement is not available for duplication of services or payment; and

(13) Reimbursement is not available from more than one department or state agency program.

(b) **Payment Limitations**

(1) All home care service providers shall bill the usual and customary charge and the department shall pay the lowest of:

(A) The usual and customary charge;

(B) the lowest Medicaid rate;

(C) the amount in the applicable fee schedule as published by the department;

(D) the fee or rate negotiated with the access agency and the assisted living service agency; or

(E) the amount billed by the provider of the community based service to the department.

(2) The access agency shall not use department funds to purchase home care services other than assessment, status reviews and care management from itself or any related parties.

(3) The assisted living service agencies shall not use department funds to purchase home care services other than assisted living services, which include all personal care assistance services and core services, or other allowable charges incurred buy the agency.

(c) **Cost Limits on Individual Plans of Care**

(1) In order to receive home care services under the Connecticut Home Care Program,

the elderly person's plan of care shall be within the cost limits related to the person's category of service for both the fee-for-service and the assisted living service components. All state-administered costs of home care services shall be included.

The following are the cost limits which define the categories of services for fee-for-service (to be used only for care managed and self-directed clients):

(A) Category 1 Services:

Home care services may be authorized for up to 25% of the weighted average nursing facility cost for individuals who are at risk of institutional placement but who might not immediately enter a hospital or nursing facility in the absence of the program provided they also meet the financial eligibility criteria for the state-funded portion of the program.

Services for Medicaid recipients who are not functionally eligible for the Medicaid waiver portion of the program will be covered by the state-funded portion of the program.

(B) Category 2 Services:

Home care services may be authorized for up to 50% of the weighted average nursing facility cost for individuals who would otherwise require admission to a nursing facility and who meet the financial eligibility criteria for the state-funded portion of the program.

(C) Category 3 Services:

Home care services may be authorized for up to 100% of the average nursing facility cost for individuals who would otherwise require long term admission to a nursing facility and who also meet the financial eligibility criteria for Medicaid under the federal waiver. The cost of community-based services provided to individuals in category 3 shall not exceed 60% of the weighted average Medicaid rate in a nursing facility.

(2) Under the assisted living service component of the program there are four different levels of service that the assisted living service agency is to use when assigning the appropriate level of service to a client.

(A) The assisted living levels of service 1,2,3 and 4 are based on the client's nursing or personal care needs. Each level of service is reimbursed at a per diem rate established by the department. There may be different per diem rates for each of the assisted living services components depending on the negotiated rate by the assisted living service agency with the department. Refer to subsection (c)(1)(A) to (c)(1)(C), inclusive, of this section for specifics relating to the description of assisted living cost limits for categories of service.

(B) Additional cost for core services is allowed if the program client needs these supplemental services.

(C) The program client's cost for assisted living services cannot exceed the assigned service package and additional cost for core services which shall be specified on the client's plan of care and cost worksheet.

(3) Elders enrolled in the program have the ability to move from one service category to another within fee-for-service if care managed or self-directed, and from one level of service to another under the assisted living component. When the elderly person's functional or financial eligibility changes, the information shall be reviewed by department staff and a determination shall be made regarding the appropriateness of the change in service category

and funding source for the services under the program.

(4) The agency that oversees an elder's plan of care shall be responsible for applying and monitoring the Connecticut Home Care Program cost limits in accordance with the following regulations:

(A) The agency shall first determine if the state-administered public funds to be expended for home care services in accordance with the elderly person's plan of care exceed the cost limits related to the individual's category of services or service package level cost. If the costs do not exceed the limit on a monthly basis, the person may receive services under the Connecticut Home Care Program, provided the program is accepting new applicants at the level for which the person is applying.

(B) If the monthly cost of state-administered public funds for home care services required to be provided under an individual's plan of care exceeds the cost limits related to the individual's category of services (fee-for-service only under the program), the agency shall project the cost of those services for the individual over a 12-month period. If the projected annualized cost of those services falls within the cost limits, the individual may receive services under this program provided that the program is accepting new applicants at the category of service for which the individual is applying.

(C) Clients participating in the assisted living services component whose needs cannot be met within the assisted living service package levels, may be referred to the access agency to determine if their needs can be met and the necessary services are available within the cost limits of the category of services provided under the fee-for-services delivery system. Once the client is care-managed, the client may be referred to the access agency as described under this subparagraph.

(D) If the agency does not have information on the actual cost of services being provided to the elder through other state administered programs, the agency shall estimate the cost based upon payments made for similar services. Information on all services provided under the requirements of an individual's approved plan of care shall be reported to the department.

(E) The agency shall be responsible for determining that the amount of state-administered public funds expended to provide services required under the person's plan of care continues to meet the cost limits set forth in this subsection and as described in subsection (c)(1)(A) to (C), inclusive, of this section.

(F) When the rates for home care services (including care management and assisted living services, such as personal care assistance and core services), covered by the Connecticut Home Care Program are increased, the access agency, assisted living service agency or department designee shall update the plans of care to reflect those increases upon receipt of the new rates. The access agency, assisted living service agency and other providers shall be liable for charges in excess of the cost limit following that transition period unless the case is under appeal or an exception to the cost limits is granted in accordance with subparagraph (G) or (H) of this subdivision or by the department Commissioner or his or her designee.

(G) Clients who were above the cost limits prior to July 1, 1992, shall continue to receive

services to the extent that they qualify in accordance with section 17b-342(i) of the Connecticut General Statues.

(H) Any person who requires a care plan that shall place the client above the cost limits may request an exception to the cost limits from the Commissioner or his or her designee. Approvals shall be based on extreme hardship, shall be time-limited (not to exceed three months), shall in no case exceed 100% of the average nursing facility cost and shall be home health service related.

(I) Requests for exceptions to the cost limits are not allowed when a client is pending Medicaid, when the client loses his or her Medicaid eligibility because of changes to their income or assets, loses Medicare coverage or is an assisted living service participant.

(d) **Waiting List**

(1) The state funded portion of the program is subject to availability of funds.

The portion of the program funded under the federal waiver is subject to continued approval of the Medicaid waiver and to any limits on expenditures or the number of persons who can be served under the federal waiver application.

(2) In the event that the state appropriation or the upper limits under the federal waiver are insufficient to provide services to all eligible persons, the number of persons admitted to the program may be limited. When these limits are reached, the department may establish a waiting list. If a waiting list is established, the department shall serve applicants from the waiting list who meet all program requirements in order of their application except as otherwise provided in subdivision (d)(4) of this section.

(i) If there is a waiting list for either portion of the program and the applicant's name is reached, but the applicant is not eligible for benefits at the time the opening becomes available, the applicant's name may be placed in a "hold" position, unless the applicant is removed from the waiting list. The "hold" status enables the applicant to retain the position on the waiting list until such time as the applicant meets the requirements of the program. The applicant shall inform the department when the applicant meets the program requirements.

(ii) If the department learns that an applicant is deceased, or becomes enrolled in the Medicaid waiver portion of the program, the applicant shall be removed from the waiting list.

(iii) If the department learns that an applicant has entered a nursing facility or has moved out of state, or if the applicant requests removal from the waiting list, the department may remove the applicant's name from the waiting list.

(aa) The department shall notify the applicant that it intends to remove the applicant's name from the waiting list and the reason it intends to remove the applicant's name.

(bb) The applicant shall be provided with the opportunity to request that the name not be removed from the waiting list. It is the responsibility of the applicant to inform the department of the applicant's current address. If the applicant does not respond to the department, the applicant's name shall be removed from the waiting list.

(iv) If an applicant is removed from the waiting list in error, the applicant may be restored

to the waiting list in the original place.

(3) Available openings within the program shall be allocated based on the proportion of the region's elder population adjusted to take into consideration the ratio of elders who are poor, minority, impaired or living in rural areas.

(4) If funds are available under the state-funded portion of the program, the department may from time to time establish priorities which ensure that persons with the greatest medical, social and economic need receive timely assistance. The department will only establish priorities under extreme circumstances.

(e) **Rate Setting**

(1) General Provisions

(A) The department shall, in accordance with section 17b-343 of the Connecticut General Statutes, establish a fee schedule for assessment, care management and other home and community based services as they are defined in section 17b-342-1(b)(7) of the Regulations of Connecticut State Agencies. The Commissioner may annually increase any rate in the rate schedule based on an increase in the cost of services. The department shall specify the rates for these services in the Request for Proposals (RFP).

(B) All financial and clinical records of providers shall be accessible at the request of the department and are fully subject to fiscal and programmatic audit by the department or its designees.

(2) Rates for Assessment and Care Management

(A) All access agencies wishing to provide assessment and care management services, and receive reimbursement for the same under contract with the department, shall submit bids to the department in response to the RFP. These bids shall be filed with the department on a date set by the department for the initial year of the contract.

(B) The rates for assessment and care management services shall be established by the department based on the responses to the RFP. In no event may a payment exceed the usual and customary charges of the access agency. In addition, the department shall not contract for any fees determined unreasonable or in excess of the fees set by the department.

(3) Rates for Status Reviews

The department shall establish a rate for status reviews.

(4) Rates for Other Community Based Services

(A) For the Connecticut Home Care Program, rates for other home and community based services (excluding assessment and care management) shall be set by the department in accordance with section 17b-343 of the Connecticut General Statutes. The rates to be charged for other home and community based services shall be set by a contract between the access agency and the service provider even when the services are provided without care management by the access agency. In no event may a contracted rate exceed the usual and customary charge of the provider or the rate set by the department.

(B) For the Connecticut Home Care Program, under no circumstances shall an access agency or assisted living service agency select a provider whose services do not meet the standards of quality established in section 17b-342-2(h) of the Regulations of Connecticut

State Agencies.

(C) For the Connecticut Home Care Program, under no circumstances shall an assisted living service agency charge the department at a rate not approved by the department. The approved and enrolled assisted living service agency shall charge the approved rate established by the department and only for those allowable services.

(5) Rates for State-Funded Home Health Services

The rates for home health services provided to eligible persons, as defined in section 17b-342-2(h) of the Regulations of Connecticut State Agencies shall be the same as those paid under the Medicaid program. Home health services shall be paid only under fee-for-service for care managed or self-directed care program clients. For ALSA clients, these services are included in the rate.

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

Sec. 17b-342-4. Nursing facility and hospital requirements

(a) **Nursing Facility Admission Requirements**

Nursing Facilities shall comply with the following Connecticut Home Care Program requirements:

(1) Information and Forms Distributions

When a nursing facility identifies an elderly applicant for admission to the facility, the nursing facility shall inform the person about the program by providing a copy of the Home Care Request Form and program information.

(A) Medicaid Recipients and Applicants

Prior to admission to a nursing facility, recipients and individuals who have applied for Medicaid who are aged 65 years or older shall:

(i) Complete and submit to the department a Home Care Request form to confirm that they are Medicaid recipients or applicants;

(ii) be screened by the department through its health screen form to determine the need for nursing home care and the feasibility of home care pursuant to section 17b-342-1(b)(15) of the Regulations of Connecticut State Agencies; and

(iii) receive department authorization for admission and Medicaid payment for nursing facility care or home care. The effective date for Medicaid reimbursement on behalf of such person shall be no earlier than the date admission is authorized by the department.

(B) Other Requirements

(i) At the time of the admission of all other elderly persons, the nursing facility shall obtain a statement signed by the person verifying that he or she received the Connecticut Home Care Program materials and understands his or her rights and responsibilities under the Connecticut Home Care Program. The statement shall be maintained in the individual's file. If the person indicates that the program materials were not received or requests Connecticut Home Care Program materials, the facility shall provide the person with a set of materials. The nursing facility shall complete a compliance form for this purpose.

(2) Emergency Admissions for Medicaid Recipients and Applicants

(A) In the case of emergency admissions as defined in section 17b-342-1(b)(15) of the Regulations of Connecticut State Agencies, elderly persons may be admitted to a nursing facility prior to completion of the health screen form. However, the facility shall notify the department within one (1) working day of the admission. Such an emergency shall be documented in writing on the department emergency admission documentation form prior to admission by a health care professional in the facility. The health care professional's name, business address and phone number shall be noted in the patient's record. A copy of the emergency admission form that specifies compliance with these regulations shall be provided to the department and maintained in the individual's records.

(3) Exemptions

The following are elderly persons who are exempt from the Connecticut Home Care Program screening process although they may request to be screened for participation in the program:

(A) Patients transferring from one nursing facility to another and intra-facility transfers;

(B) nursing facility patients who are admitted to a hospital and discharged back to a nursing facility;

(C) individuals who are out-of-state residents at the time they are seeking admission to a nursing facility;

(D) individuals seeking short term respite care in a nursing facility as defined in section 17b-342-2(n) of the Regulations of Connecticut State Agencies; and

(E) terminally ill individuals seeking nursing facility admission. For purposes of this subsection "terminally ill" means that a physician has signed a statement in a form specified by the department for this purpose only, identifying the patient's medical diagnosis and verifying that the individual's life expectancy is six (6) months or less. A copy of the physician's statement shall be submitted to the department and also be filed in the patient's nursing facility record.

(4) Coordination with screening process for Mental Illness and Mental Retardation under OBRA 1987.

(A) The preadmission screening procedures administered under the Connecticut Home Care Program shall be coordinated with the federally mandated screening for nursing home applicants with mental illness or mental retardation. Exemptions C, D and E above do not apply to the mandatory nursing home preadmission screening for mental illness and mental retardation related to the federal Omnibus Budget Reconciliation Act of 1987 (OBRA).

(B) Except when exemptions apply or the emergency admission procedures have been followed, the department shall not reimburse a nursing facility for any days that an elderly person spends in the facility prior to completion of the preadmission screening process for the Connecticut Home Care Program and the federally mandated screening for nursing home applicants with mental illness or mental retardation.

(b) **Hospital Responsibilities**

Hospitals shall comply with the following Connecticut Home Care Program requirements:

(1) Information and Forms Distribution

(A) If it can be determined by the hospital within three (3) days of admission that an elderly person, as defined in section 17b-342-1(b)(14) of the Regulations of Connecticut State Agencies, would be expected, based upon the professional judgement of hospital personnel, to be an applicant for admission to a nursing facility without the services available through the Connecticut Home Care Program, the hospital shall distribute the Connecticut Home Care Program forms packet to such elderly person and provide information about the program. Hospital staff are encouraged to provide program information to all elders or their representatives.

(B) If the patient's condition is too unstable to make the above determination by day three, the Connecticut Home Care Program forms and information shall be provided when the determination can be made. The hospital staff shall document in the patient's record the reason for the postponement (e.g. "patient's condition too unstable to make determination"). The hospital staff shall also document the date the materials are distributed.

(2) Completion and Submission of Forms

Personnel responsible for discharge planning shall complete and submit to the department any required forms for determining nursing facility level of care eligibility.

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

Sec. 17b-342-5. Reporting

All nursing facilities, hospitals, access agencies, assisted living service agencies, lead service providers and home care service providers shall comply with any reporting, quality assurance review and audit requirements established by the department for purposes of administering, monitoring and evaluating the Connecticut Home Care Program.

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

Agency
Department of Social Services

Subject
Connecticut Statewide Respite Care Program

Inclusive Sections
§§ 17b-349e-1—17b-349e-9

CONTENTS

Sec. 17b-349e-1. Scope
Sec. 17b-349e-2. Purposes
Sec. 17b-349e-3. Definitions
Sec. 17b-349e-4. Organization and administration of program
Sec. 17b-349e-5. Application process
Sec. 17b-349e-6. Eligibility
Sec. 17b-349e-7. Sponsor agency requirements
Sec. 17b-349e-8. Provider qualifications and requirements
Sec. 17b-349e-9. Service, payment and cost limitations; fees

Connecticut Statewide Respite Care Program

Sec. 17b-349e-1. Scope

(a) Sections 17b-349e-1 to 17b-349e-9, inclusive, of the Regulations of Connecticut State Agencies, describe administration, eligibility criteria, provider qualifications, service parameters and funding guidelines for the Connecticut Statewide Respite Care Program. Sections 17b-349e-1 to 17b-349e-9, inclusive, of the Regulations of Connecticut State Agencies apply to all activities and persons participating in the Connecticut Statewide Respite Care Program, including, but not limited to, applicants, eligible individuals, caregivers, sponsor agencies and providers.

(b) Pursuant to section 17b-349e of the Connecticut General Statutes, the Connecticut Statewide Respite Care Program is limited to the provision of and payment for respite care for individuals with Alzheimer's disease or related disorders as described in sections 17b-349e-1 to 17b-349e-9, inclusive, of the Regulations of Connecticut State Agencies.

(Adopted effective March 11, 1999; Amended July 2, 2012)

Sec. 17b-349e-2. Purposes

The purpose of the Connecticut Statewide Respite Care Program is to provide, within available appropriations, the following:

(1) Respite care services for individuals with Alzheimer's disease residing in the community in order to relieve some of the stress experienced by caregivers caused by the responsibility of daily caregiving;

(2) Supportive services to relieve caregivers in order to prevent premature institutionalization of an individual with Alzheimer's disease; and

(3) New services, or expand available services, for eligible individuals with Alzheimer's disease residing in the community.

(Adopted effective March 11, 1999; Amended July 2, 2012)

Sec. 17b-349e-3. Definitions

For the purposes of sections 17b-349e-1 to 17b-349e-9, inclusive, of the Regulations of Connecticut State Agencies, the following definitions shall apply:

(1) "Adult day health services" means a program, of either a medical or social model, designed to meet the needs of cognitively or physically impaired adults through a structured, comprehensive program that provides a variety of health, social and related support services, in a protective setting, during any part of a day;

(2) "Campership" means a day or overnight accredited camp program for functionally impaired adults;

(3) "Caregiver" has the same meaning as "caretaker" as provided in section 17b-349e of the Connecticut General Statutes;

(4) "Commissioner" means the Commissioner of Social Services;

(5) "Companion service" or "sitter service" means a non-medical, basic protection and

supervision service provided to an eligible individual in the eligible individual's home on a short-term basis;

(6) "Copayment" means "copayment" as defined in section 17b-349e of the Connecticut General Statutes;

(7) "Department" means the Department of Social Services;

(8) "Division" means the department's division of aging services;

(9) "Eligible individual" means an applicant who meets the eligibility criteria as set forth in section 17b-349e-6 of the Regulations of Connecticut State Agencies;

(10) "Homemaker services" means household tasks and activities provided to an eligible individual in the eligible individual's home by a homemaker, including, but not limited to, cooking, cleaning, laundry, mending and other light household chores;

(11) "Home health aide services" means services that include personal hands-on care, household tasks and similar activities provided to an eligible individual in the eligible individual's home by a home health agency;

(12) "Income" means any payment from any source and of any kind including, but not limited to, Social Security (minus Medicare Part B premiums), Supplemental Security, Railroad Retirement income, pensions, wages, interest, dividends, net rental income, veteran's benefits or any other payments received on a one-time or recurring basis;

(13) "Individual with Alzheimer's disease" has the same meaning as provided in section 17b-349e of the Connecticut General Statutes;

(14) "Liquid assets" means any checking accounts, savings accounts, individual retirement accounts, certificates of deposits, stocks or bonds, that can be converted into cash within twenty working days;

(15) "Personal emergency response system" means a twenty-four hour electronic alarm system which enables a high risk individual to secure help in a medical, physical, emotional or environmental emergency;

(16) "Personal care assistant services" means physical assistance to enable the eligible individual to carry out activities of daily living and instrumental activities of daily living. These services are provided by a person who is employed by the eligible individual or the eligible individual's representative to assist the eligible individual in carrying out the tasks required in the service plan;

(17) "Private duty nursing" means hourly services delivered by licensed nursing personnel in the eligible individual's home;

(18) "Program" means the Connecticut Statewide Respite Care Program;

(19) "Provider" means a person, public agency, private non-profit agency or proprietary agency that is licensed, certified or otherwise approved by the commissioner to supply any service, or combination of services, described under "respite care services" as defined in this section;

(20) "Representative" means a person designated by an eligible individual or the probate court to act on the eligible individual's behalf. A representative may include a family member, an attorney, a guardian, a conservator or a person designated by the eligible

individual to act as the eligible individual's representative;

(21) "Residential health care facility" means a facility that, on a short-term basis, provides food, shelter, supervised health care and related services to four or more persons, eighteen years of age or older, who are unrelated to the owner or administrator;

(22) "Respite care services" means support services that provide short-term relief from the demands of ongoing care for an individual with Alzheimer's disease provided hourly, daily, overnight or on weekends including, but not limited to, companion or sitter services, home health aide services, homemaker services, personal care assistant services, adult day health services, short-term inpatient care in a licensed nursing facility, residential health care facility, overnight campership program, private duty nursing, transportation and the personal emergency response system;

(23) "Service plan" means a written document agreed upon by the eligible individual, the caregiver and the sponsor agency that specifies the type, frequency and duration of services to be provided. The service plan shall take into account other services available to the eligible individual and the eligible individual's caregiver;

(24) "Sponsor agency" means the organization that contracts with the department to administer the regional program, determine eligibility and arrange for services for eligible individuals; and

(25) "Relative" means spouse, natural parent, child, sibling, adoptive child, adoptive parent, stepparent, stepchild, stepbrother, stepsister, father-in-law, mother-in-law, son-in-law, daughter-in-law, sister-in-law, brother-in-law, grandparent, grandchild, aunt, uncle, niece or nephew.

(Adopted effective March 11, 1999; Amended July 10, 2000; Amended July 2, 2012)

Sec. 17b-349e-4. Organization and administration of program

(a) The division shall oversee and regularly monitor the administration of the program as follows:

(1) The division shall ensure that the first five hundred thousand dollars ($500,000) of funds appropriated is distributed in equal shares among Connecticut's five regional Area Agencies on Aging as sponsor agencies administering the program. The division may allocate appropriations exceeding five hundred thousand dollars ($500,000) to sponsor agencies based upon the demonstrated level of need for services in a particular region, and may transfer funds between regions based upon the demonstrated level of need in a particular region. A percentage of each allocation to the sponsor agencies shall be designated to cover the cost of administering the program.

(2) The division shall regularly monitor the administration of the program to ensure, verify and determine the effectiveness and quality of the program.

(b) Sponsor agencies statewide shall administer the program at a regional level as follows:

(1) Sponsor agencies shall process program applications for eligibility, establish service plans and contract for services when applicable, for eligible individuals within their

designated regions.

(2) Sponsor agencies shall monitor client satisfaction and compile and submit reports to the division as required.

(Adopted effective March 11, 1999; Amended July 10, 2000; Amended July 2, 2012)

Sec. 17b-349e-5. Application process

(a) The application process includes all activity related to a request for a determination of eligibility under the program. The process begins with the receipt of an application by a sponsor agency and continues in effect until there is an official disposition of the eligibility request from that sponsor agency.

(b) The sponsor agency servicing the city or town in which the applicant resides shall perform appropriate assessments and make a written determination of eligibility within thirty days after the receipt of an application.

(c) When the applicant is incompetent or incapable of filing an application on the applicant's own behalf, the sponsor agency shall recognize any representative as defined in section 17b-349e-3 of the Regulations of Connecticut State Agencies for the purpose of initiating such application.

(d) Each sponsor agency has the responsibility to explain to the applicant or the applicant's representative the purposes and eligibility requirements of the program and the applicant's rights and responsibilities. Each sponsor agency shall accept and process applications and maintain files that shall include applications and documents supporting each application.

(e) The applicant or the applicant's representative is responsible for completing the application forms truthfully, legibly and accurately. The applicant or the applicant's representative shall provide the sponsor agency with documentation required to support statements made on the application.

(f) Each applicant or eligible individual shall notify the sponsor agency whenever a change in his or her circumstances relating to income, assets or address occurs.

(Adopted effective March 11, 1999; Amended July 2, 2012)

Sec. 17b-349e-6. Eligibility

(a) An eligible individual shall be any person diagnosed with Alzheimer's or related diseases. An eligible individual who has been given a generic diagnosis of dementia shall have had a sufficient medical evaluation to rule out unrelated conditions such as depression, traumatic brain injury, alcoholism or drug interactions. An eligible individual shall have a physician with whom the sponsor agency may contact regarding the eligible individual. The physician shall certify that the eligible individual has completed an appropriate medical examination showing a diagnosis of irreversible and deteriorating dementia of the Alzheimer's type.

(b) An eligible individual shall be a resident of the state of Connecticut, be residing in a home in the community and be at risk of long-term institutional placement if the eligible

individual's regular caregiver cannot continue in that role.

(c) An eligible individual shall not have an annual income or liquid assets that exceed the amounts designated in section 17b-349e of the Connecticut General Statutes. On July 1, 2009, and annually thereafter, the department shall recalculate the income and asset limitations over that of the previous year to account for the annual cost of living adjustment in Social Security income, if any.

(d) An individual receiving services through the Connecticut Homecare Program for Elders shall not be eligible for services under the Connecticut Statewide Respite Care Program.

(Adopted effective March 11, 1999; Amended July 2, 2012)

Sec. 17b-349e-7. Sponsor agency requirements

(a) Each sponsor agency shall contract annually with the department to administer the regional program. Each sponsor agency shall determine the maximum number of eligible individuals to be served in its respective region based on the financial allocation made by the department. The sponsor agency shall not admit or serve more eligible individuals than can be afforded within available appropriations.

(b) Each sponsor agency shall determine the eligibility of all applicants for services under the program, additional sources of payment for such services and assess and collect all co-payments through retrospective billing.

(c) Each sponsor agency shall develop, as necessary, a service plan for each eligible individual to be served under the program, pay providers as required, provide statistical and financial reports as required by the department, and comply with sections 17b-349e-1 to 17b-349e-9, inclusive, of the Regulations of Connecticut State Agencies.

(Adopted effective March 11, 1999; Amended July 2, 2012)

Sec. 17b-349e-8. Provider qualifications and requirements

(a) Providers shall enter into contracts with sponsor agencies for the delivery of respite care services to individual clients under the program, and shall be accountable to each contracting sponsor agency as well as to individual clients or each individual's representative for the provision of those services.

(b) Providers shall have demonstrated prior experience and training in delivering services to individuals with Alzheimer's disease and agree to provide services at the rates set by the department.

(c) Providers who have received accreditation by the Joint Commission on the Accreditation of Healthcare Organizations, when available, shall receive preference in contracting for services.

(d) Providers shall meet the requirements of provider participation of the specified services as established for the Connecticut Home Care Program for Elders, pursuant to section 17b-342-2 of the Regulations of Connecticut State Agencies to the extent that such requirements do not conflict with sections 17b-349e-1 to 17b-349e-9, inclusive, of the

Regulations of Connecticut State Agencies.

(e) A provider under the Connecticut Statewide Respite Care Program shall not be a spouse or conservator of the person receiving the services. A relative of the conservator of the eligible individual receiving the services may be a provider with prior approval of the department.

(Adopted effective March 11, 1999; Amended July 10, 2000; Amended July 2, 2012)

Sec. 17b-349e-9. Service, payment and cost limitations; fees

(a) The department shall determine provider reimbursement and payment levels for the respite care services to be provided under the program. Reimbursement levels for services provided under the program shall not exceed the levels established under the Connecticut Home Care Program for Elders for similar services.

(b) An eligible individual may not receive more than three thousand five hundred dollars ($3,500) for respite care services or receive more than thirty days of out-of-home respite care services, other than adult day care, under the program in any fiscal year. An eligible individual may receive additional respite services not to exceed seven thousand five hundred dollars ($7,500) if the eligible individual has demonstrated to the sponsor agency a need for additional respite care services. A sponsor agency may consider various factors to determine if an eligible individual needs additional respite care services including, but not limited to, whether:

(1) The primary caregiver is experiencing a physical or mental impairment;

(2) the caregiver is not receiving any other respite services;

(3) the client is physically or emotionally abusive to the primary caregiver;

(4) the client is at risk for neglect or abuse; or

(5) the burden of care is significant.

(c) Service levels are subject to the limits of the funding allocations to an eligible individual's sponsor agency. In the event that it appears that all requests for services cannot be accommodated within funding allocations, then approval for services under the program may be limited. Priority for the receipt of services shall be determined by the sponsor agency on a case by case basis, giving primary consideration to the following factors:

(1) The eligible individual is not currently receiving any other respite care;

(2) the caregiver is experiencing physical or mental impairments and has primary responsibility for caring for the eligible individual;

(3) the eligible individual has been combative, non-compliant or physically or mentally abusive to the caregiver;

(4) respite care services are being requested for a specific event or commitment rather than for ongoing, periodic services; or

(5) the eligible individual lives alone.

(d) If an eligible individual's respite care service costs are covered in whole or in part by another state or federal government program or insurance contract, the government program or insurance carrier shall be the primary payer and the Connecticut Statewide

Respite Care Program shall be the secondary payer.

(e) An eligible individual shall pay a copayment of twenty per cent of the cost of all respite care services to the sponsor agency as required, unless granted a reduction or a waiver of the copayment in accordance with subsection (f) of this section. The copayment shall be applied to the cost of program services.

(f) The sponsor agency may grant a reduction or waiver of the copayment to an eligible individual based upon demonstration of financial hardship by the applicant as determined by the sponsor agency.

(Adopted effective March 11, 1999; Amended July 10, 2000; Amended July 2, 2012)

Agency
Department of Consumer Protection

Subject
Return of Drug Products to Pharmacies

Section
§ 17b-363a-1

CONTENTS

Sec. 17b-363a-1. Return of drug products to pharmacies

Return of Drug Products to Pharmacies

Sec. 17b-363a-1. Return of drug products to pharmacies

(a) Any vendor pharmacy that accepts for return drug products dispensed to long-term care facilities, pursuant to section 17b-363a of the Connecticut General Statutes, shall comply with the requirements of this section.

(b) A vendor pharmacy shall not accept for return any drug products that do not meet the criteria for return under section 17b-363a of the Connecticut General Statutes.

(c) A vendor pharmacy shall immediately physically inspect all drug products that are returned by long-term care facilities. Any drug products in original manufacturer's dispensing packages that have been opened, have had doses removed, or show any signs of tampering shall not be returned to stock. Any drug products packaged in unit dose or blister type packaging that appear to have been removed from and returned to the dispensing package, or drug products in such packaging that appears to have been tampered with or the integrity of which appears to be compromised in any way, shall not be returned to stock, except as permitted in subsection (d)(2) of this section.

(d) Except as provided in subsections (b) and (c) of this section, a vendor pharmacy may return to stock for re-dispensing drug products:

(1) packaged in original manufacturer's dispensing packages;

(2) packaged in unit dose or blister type packaging whose individual labeling and integrity remains intact even though doses may have been removed from the outer package; or

(3) originally packaged by the vendor pharmacy into multiple dose blister packaging. Except as otherwise permitted by this subdivision, such drug products shall be removed from the original dispensing package before being placed into pharmacy stock for re-dispensing. This process shall be done in a manner that insures that the lot number and expiration date for the drug product are maintained and that the individual doses of the drug product are not exposed to possible adulteration or cross-contamination. Generically equivalent drug products from more than one drug manufacturer shall not be co-mingled. Removal of the drug product from the original dispensing package prior to re-dispensing shall not be required for packaging from which no doses have been removed and for packaging that allows disassembly without handling the drug product, while maintaining product identification, lot number, and expiration date.

(e)

(1) All drug products re-dispensed on prescription from the vendor pharmacy shall be labeled with all required information, including lot number and expiration date.

(2) The expiration date assigned to the drug product for re-dispensing shall be no later than the expiration date assigned to the product when originally dispensed, or no later than the earliest expiration date originally assigned to any dose contained in the repackaged multiple dose blister card dispensed.

(3) The lot number assigned shall be the manufacturer's original lot number for products dispensed in manufacturers' original packaging, or a lot number assigned by the vendor

pharmacy for a repackaged product, from which the original lot numbers of the doses contained may be referenced.

(Adopted effective June 6, 2001)

Agency
Department of Social Services

Subject
Title III of the Older Americans Act

Inclusive Sections
§§ 17b-423-1—17b-423-19

CONTENTS

Sec. 17b-423-1.	Community services policy manual - introduction
Sec. 17b-423-2.	Community services policy manual-area agency designation
Sec. 17b-423-3.	Community services policy manual-general application and procedures and policies
Sec. 17b-423-4.	Community services policy manual-general area agency responsibilities
Sec. 17b-423-5.	Community services policy manual - Title III-C nutrition services
Sec. 17b-423-6.	Community services policy manual-title III-D/In-home services
Sec. 17b-423-7.	Disease Prevention and Health Promotion Services
Sec. 17b-423-8.	National Family Caregiver Support Program – Title III-E of the Older Americans Act
Sec. 17b-423-9—17b-423-18.	Reserved
Sec. 17b-423-19.	Community services policy manual - index

Title III of the Older Americans Act

(Transferred from §§ 17a-306-1—17a-306-19)

Sec. 17b-423-1. Community services policy manual - introduction

(a) **Definitions** - as used in this manual:

For purposes of Section 17b-423-1 through 17b-423-7, the following definitions apply:

"Area Agency on Aging (AAA)" means an Agency designated by the Department to develop and administer an area plan in a planning and service area.

"Administration on Aging (AoA)" means the agency established in the Office of the Secretary, Department of Health and Human Services charged with the responsibility for administering the provisions of the Older Americans Act, except for Title V.

"Area Plan" means the official planning document submitted by all Area Agencies on Aging to the Department for approval, which identifies measurable objectives and action steps to achieve those objectives, as well as describing all other functions of the Area Agency.

"Assistant Secretary" means the assistant secretary on Aging of the Administration on Aging.

"Comprehensive and Coordinated System" means a program of interrelated social and nutrition services designed to meet the needs of older persons in a planning and service area.

"Department" or DSS means the Department of Social Services of the State of Connecticut.

"Donated Foods or Cash" means food or cash made available by the United States Department of Agriculture (USDA).

"Eligible Individuals for Title III Programs" means persons 60 years of age and older and their spouses, and people with disabilities residing in primarily elderly housing where congregate nutrition services are located may be provided meals.

"Elderly Nutrition Project (ENP)" means an entity that is awarded a subgrant from an area agency to provide nutrition services under the area plan.

"Focal Point" means a place or mobile unit in a community or neighborhood designated by the Area Agency to encourage the maximum collocation and coordination of services for older persons.

"Greatest Economic Need" means the need resulting from an income level at or below the poverty threshold established by the Bureau of the Census.

"Greatest Social Need" means the need caused by noneconomic factors which include physical and mental disabilities, language barriers, cultural or social isolation, including that caused by racial or ethnic status which restrict an individual's ability to perform normal daily tasks or which threaten his or her capacity to live independently.

"Indian Tribal Organization" means the recognized governing body of any Indian tribe or any legally established organization of Indians which is controlled, sanctioned, or chartered by the governing body.

"Indian Tribe" means any tribe, band, nation, or other organized group of community of Indians (Native Americans) which is recognized as eligible for the special programs and services provided by the United States to Indians because of their status as Indians; or, is located on, or in proximity to a federal or state reservation or rancheria.

"Manual" means the Community Services Policy Manual.

"Multipurpose Senior Center" means a community facility for the organization and provision of a broad spectrum of services including, but not limited to, health, social, nutritional, and educational services; and the provision of facilities for recreational and group activities for older persons.

"Nonprofit" means an agency, institution or organization which is with no part of the net earnings benefiting any private share holder or individual.

"Older Americans Act (OAA)" means the Older Americans Act of 1965, as amended.

"Older Person" means a person age 60 or older.

"Planning and Service Area (PSA)" means a geographic area that is designated by the department for purposes of planning, development, delivery and administration of services under an area plan.

"Reservation" means any Federal or state recognized Indian tribe's reservation.

"Service Provider" means an entity that is awarded a subgrant or contract from an Area Agency to provide services under the area plan.

"State Plan" means the plan developed by the Department detailing the utilization of federal funds in providing services to the elderly. The plan is based on Area Agency plans, and a statewide assessment of needs and priorities.

"Target Groups" means those individuals identified as being in the greatest economic or social need of services.

"Unit of general purpose local government" means (1) a political subdivision of the state whose authority is general and not limited to only one function or combination of related functions or (2) an Indian tribal organization.

(b) **Purpose of Manual**

(1) These regulations set forth the requirements for the conduct of the Title III of the Older Americans Act of 1965, as amended. They include requirements and procedures for designation of area agencies on aging, submission and approval of area plans, service requirements and hearing procedures.

(2) The purpose of the Manual is to outline the overall program and grants administration responsibilities of the Department and it's grantee/contractor agencies. The Manual should assist and guide Connecticut's Area Agencies on Aging grantees in the operation of their programs.

(3) The Manual constitutes all current policies which have been developed by the Department, unless otherwise noted, through the time of issuance. Additional policies may be incorporated by the Department pursuant to notice thereof published in the Connecticut Law Journal.

(c) **Scope and Organization**

The general organization of the Manual of Policies and Procedures is as follows:

Section 17b-423-1: Introduction-provides an overview of the scope and organization of the Manual and a description of the Title III Program.

Section 17b-423-2: Area Agency on Aging Designation-describes the procedures for designation of planning and service areas, Area Agencies on Aging and appeal procedures.

Section 17b-423-3: Application Procedures and General Policies-sets forth the basic procedures governing the preparation of area plans and other applications under the Older Americans Act, as well as the general policies which affect grantee/contractor operations.

Section 17b-423-4: General Area Agency on Aging Responsibilities/Title III-B Operations-sets forth the policies and procedures for the use of Title III-B funds, including the conduct of Area Agency on Aging operations and grantee/contractor activities.

Section 17b-423-5: Title III-C Operations-sets forth the policies and procedures governing the administration and operation of Title III nutrition services.

Section 17b-423-6: Title III-D Operations-sets forth the policies and procedures for the use of Title III-D in-home funds.

Section 17b-423-7 Title III-F: Operations-sets forth the policies and procedures for the use of title III- F disease prevention and health promotion funds.

Section 17b-423-8 through 17b-423-18: reserved

Section 17b-423-19: Index

(d) **The Title III Program**

(1) Purpose

Title III of the Older Americans Act of 1965, as amended establishes authority for the development of programs to assist older persons, especially those with greatest economic and social needs, in the area of social services (III-B and III-D), congregate nutrition services (III-C1), home delivered nutrition services (III-C2), and disease prevention and health promotion services (III-F).

(2) Process

Title III provides formula grants to state agencies, who in turn may award funds to Area Agencies on Aging for such activities as community planning, coordination, advocacy, and for the provision of services to older persons, through sub-grantees, in the areas of supportive services and nutrition.

(Adopted effective February 26, 1992; Transferred and Amended October 7, 1997)

Sec. 17b-423-2. Community services policy manual-area agency designation

(a) **Designation of Planning and Service Areas**

(1) General

The Department is responsible for dividing the State into five planning and service areas (PSAs), in accordance with guidelines issued by the assistant secretary.

The area agency on aging shall provide assurances of compliance with the Older Americans Act as required.

(2) Application for Designation

The Department provides an opportunity to apply for designation as a planning and service area to any unit of general purpose local government, region, metropolitan area, or Indian reservation(s). The application on behalf of an Indian reservation(s) shall be made by the governing tribal organization(s).

(3) Periodic Review

The Department shall periodically examine planning and service areas and make modifications as needed.

(4) Decision

The Department documents the basis for it designation of each planning and service area.

(b) **Designation & Functions of Area Agencies on Aging (AAAs)**

(1) General Rule

The Department has designated an Area Agency on Aging in each planning and service area in which it allocates funds under Title III, and shall designate successor Area Agencies on Aging as may be necessary.

(2) Intrastate Funding Formula & Procedures

Title III funds shall be distributed to the approved Area Agencies on Aging according to the intrastate funding formula conforming to the requirements of the Older Americans Act which has been approved in the most recently accepted State Plan On Aging.

(3) Area Agency on Aging Functions

The functions of Area Agencies on Aging shall include at a minimum:

(A) Development and administration of an area plan for a coordinated and comprehensive system of services; and

(B) Serving as the advocate and focal point for older persons in the PSA.

(4) Timetable for Designation

(A) The Department has made initial designations of Area Agencies on Aging which shall remain in effect unless a redesignation is required.

(B) If an organization not currently designated as an Area Agency on Aging wishes to be considered for designation as an Area Agency on Aging, it shall submit a request to that effect to the Department at least 12 months prior to the date on which it proposes to assume the functions of an Area Agency on Aging. This provision is required to provide adequate time for preparation of an area plan and development of new interagency relationships, should the designation be granted.

(5) Types of Agencies that May Be an Area Agency on Aging

(A) The Department may designate as an Area Agency on Aging any one of the following types of agencies that has the authority and the capacity to carry out the functions of an Area Agency on Aging:

(i) An established office on aging which operates within the planning and service area;

(ii) Any office or agency of a unit of general purpose local government that is proposed by the chief elected official of the unit;

(iii) Any office of agency proposed by the chief elected officials of a combination of units of general purpose local government; or

(iv) Any other public or private non-profit agency, except any regional or local agency of the State.

(B) In designating an Area Agency on Aging, the Department shall give preference to:

(i) An established office on aging: or

(ii) An Indian tribal organization (or consortia) in any planning and service area whose jurisdiction is essentially the same as that of an Indian reservation.

(C) In designating a new Area Agency on Aging after the date of enactment of the Older Americans Act Amendments of 1984, the Department shall give the right of first refusal to a unit of general purpose local government if

(i) such unit can meet the requirements of Section 17b-423-2(b) (5) (A), and

(ii) the boundaries of such unit and the boundaries of the area are reasonably contiguous.

(6) Removal of Area Agency on Aging Designation

For adequate reason(s), as specified in Section 17b-423-4(b) (6) of this Manual, the Department may remove the designation as Area Agency on Aging from an organization serving in that capacity. In such a case, the Department shall follow the procedures described in Section 17b-423-4(b) (6).

(c) **Appeal Hearing Procedures to State Agency**

(1) Applicants/Organizations Eligible for Appeal Hearings

(A) The Department shall provide an opportunity for a hearing to:

(i) Disapprove the area plan or plan amendment submitted by the Area Agency on Aging; or

(ii) Withdraw the Area Agency on Aging's designation.

(B) Any eligible applicant for designation as a planning and service area whose application is denied;

(C) Any nutrition or supportive service provider when the Area Agency on Aging has denied funds or terminated the project.

The Department shall hear an appeal only on the issue of the process utilized by the Area Agency on Aging in denying or terminating funding to a service provider. Content issues can not be appealed to the Department.

(2) Written Request for Hearing

(A) If an agency or organization wants a hearing, it shall file a written request for a hearing with the Department within 30 days following its receipt of the notice of the adverse action.

(B) Any service provider who wishes to appeal to the Department pursuant to Section 17b-423-2(c) (1) (C) shall first follow the area appeal procedures required by its Area Agency on Aging before the Department will grant a request for State Agency hearing.

(3) Hearing Components

(A) State hearings are held to provide Area Agencies on Aging and service providers with:

(i) An opportunity to review any pertinent evidence on which the contested action was based;

(ii) An opportunity to appear in person before an impartial decision maker to refute the basis for the decision;

(iii) An opportunity to be represented by counsel or other representative;

(iv) An opportunity to present witnesses and documentary evidence;

(v) An opportunity to cross-examine witnesses; and

(vi) A written decision by an impartial decision maker which sets forth the reasons for the decision and the evidence on which the decision is based.

(B) The Department may terminate formal hearing procedures at any point if the Department and the agency or organization that requested the hearing negotiate a written agreement that resolves the issue(s) which led to the hearing.

(4) Hearings for Service Denial Due to Discrimination

(A) The Department encourages any older persons who believe that they have been unfairly denied services under any older Americans Act assistance program due to discrimination to contact the Department about such complaints. The Department shall conduct a preliminary review of such complaints, and, as appropriate, refer them to the Commission of Human Rights and Opportunities.

(B) Every grantee shall post notices within its program and service locations which indicate procedures available to older persons who want to notify the Department of their complaint. Grantees shall post notices in a conspicuous location within view of all older persons who participate.

(d) **Monitoring and Assessment**

The Department conducts ongoing monitoring and assessment of Area Agencies on Aging, and of other activities and programs under the State Plan on Aging. The Department may monitor and assess grantees of the Area Agencies on Aging as appropriate.

(Adopted effective February 26, 1992; Transferred and Amended October 7, 1997)

Sec. 17b-423-3. Community services policy manual-general application and procedures and policies

(a) **Purpose of Section**

This Section sets forth the general policies and procedures governing the application process for obtaining Title III-B and C funds and the general policies which affect program grantees.

(b) **Award of Older American Act Funds Administered by the Department**

(1) Eligible Organizations

The Department may award Older Americans Act funds to an eligible public or private nonprofit agency, organization, institution, political subdivision of the State or an official Indian tribal organization.

(2) Conditions of Awarding Title III Fund

The Department shall award Title III funds in a designated planning and service area only to an Area Agency on Aging to develop and administer an area plan on aging. No Title III funds shall be awarded directly by the Department to any other agency within a PSA when

a designated Area Agency on Aging exists, unless the Area Agency on Aging has been temporarily suspended from administering Older Americans Act programs. The designated Area Agency on Aging shall carry out, directly or through contractual or other arrangements, a program pursuant to an approved area plan within the PSA.

(c) **Responsibilities of recipients of Award Under Title III of the Older Americans Act**

The Department requires recipients of award under Title III of the Older Americans Act to carry out the policies and procedures set forth in this manual, in the Older Americans Act and in the appropriate Federal regulations. Recipients of award are responsible for familiarizing themselves with the contents of this Manual and referenced documents.

(d) **Procedures for Application for Support**

(1) General

All proposals for support through Older Americans Act or other Department administered funds shall be submitted to the Department on a format prescribed by the Department. The specific procedures applicable to each type of funding are located in the following sections of this Manual.

(A) Title III-B funds-Section 17b-423-4.

(B) Title III-C funds-Section 17b-423-5.

(C) Title III-D funds-Section 17b-423-6.

(D) Title III-F funds-section 17b-423-7

(2) Part of Area Plan Process

(e) **Department Review of Applications**

(1) General

Applications for funding shall be reviewed according to the procedures established in this manual. As necessary, additional information may be provided through General Letters, Series Memorandums or in other written formats.

(2) Notification of Award Process

The Department has established procedures to assure that all recipients of award are notified of the approval of projects in writing on a standard notification of grant award form (NOA) or other suitable award document.

(3) Award Conditions

All applications shall be approved as submitted unless the Department modifies and/or places additional conditions on the award. All approved projects shall receive a written notice of award which explains the specifics of the approved award.

(4) Operation of the Project Awarded

The recipient of the award shall operate the project in accordance with the approved application and the NOA documentation.

(f) **General Policies**

This subsection provides information on policies and procedures which uniformly impact on all Title III grantees.

(1) Applicable Laws and Regulations for Title III Older Americans Act Funds

Grantees receiving funds under the Title III Older Americans Act are subject to the following laws and regulations:

(A) All provisions of the Older Americans Act, as amended to date;

(B) Federal Regulations issued pursuant to the Older Americans Act;

(C) The policies and procedures specified in the Manual:

(D) Title 45 of the Code of Federal Regulation: Parts 74 (except subpart 80, 81, 84, and 90);

(E) Other applicable state and/or Federal regulations.

(2) Administration

The Department has been vested with the authority to carry out all functions and responsibilities prescribed for State Agencies on Aging under the Older Americans Act, Federal Regulations and Connecticut State Statutes and regulation of Connecticut State Agencies. Whenever the Department executes grants or contracts with local or Area Agencies on Aging to provide an aging service or program, it has the responsibility for assuring that such agencies or organizations are adhering to this Manual and other policies and procedures which might be developed. The Department requires all grantees to establish acceptable methods for administering Older Americans Act programs. The Department periodically monitors, assesses and evaluates the administrative systems being utilized by grantees in order to assure that they meet minimal standards of operations.

(3) Title VI of the Civil Rights Act

(A) General

All funds under the Older Americans Act shall be administered in compliance with Title VI of the Civil Rights Act of 1964, the Regulations (45 CFR Part 80) issued pursuant thereto, a Statement of Compliance Form 441 signed by each grantee and the contractors and subcontractors providing services directly to participants, and the methods of administration established by the Department in accordance with the requirements of the State Plan.

(B) Non Discrimination Policy

The Department requires that each recipient of award make no distinction because of race, color, sex, physical or mental disability, sexual orientation, marital status, age, ancestry, religion or national origin in providing to individuals any services of other benefits under projects financed in whole or in part with Older Americans Act funds.

(4) Affirmative Action

(A) Requirement as Condition of Award

The Department requires that all Older Americans Act grantees have acceptable affirmative action plans as a condition for approval of grant awards.

(B) Compliance with Title V Regulations

Any Area Agency on Aging which is a public agency shall have an affirmative action program which complies with the requirements of section 900.607 of Title V of the Code of Federal Regulations, Part 900, Subpart F, “Standards for a Merit System of Personnel Administration.”

(C) Contractor/Subcontractor Compliance Statement

Older Americans Act project grantees shall, as a minimum, obtain a statement of assurance from contractors and subcontractors that they will comply with equal employment opportunity principles. Such assurance shall commit contractors and subcontractors to providing equal opportunities in carrying out activities funded under the Older Americans Act.

(i) The statement of assurance shall be on file with the award document.

(ii) Project grantees shall monitor contractors' and subcontractors' compliance with the equal employment opportunity requirements.

(5) Confidentiality and Disclosure

(A) Confidentiality

(i) Area Agencies on Aging and service providers shall develop and maintain procedures to ensure that no information about an older person, or obtained from an older person by a service provider or an Area Agency on Aging, is disclosed by the provider or the Area Agency on Aging, in a form that identifies the person without the informed consent of the person or his or her legal representative, unless disclosure is required by court order, 45 CFR 74.24, or for program monitoring by authorized Federal, State, or local monitoring agencies.

(ii) The Department requires that lists of older persons compiled under information and referral services be used solely for the purpose of providing services, and only with the informed consent of each individual on the list.

(iii) Area Agencies on Aging shall not require any provider of legal assistance under Title III to reveal any information protected by the attorney-client privilege.

(B) Department Non-Denial of Services Policy

The Department and its grantees shall ensure that no older person is denied services because such person refuses to provide informed consent to release personal information.

(C) Maintenance of Grantee Reports and Records

Any grantee or contractor which provides information and referral services shall maintain its records and reports in a manner consistent with the standards of confidentiality of the Department, as noted in this Manual and as modified from time to time.

(D) Disclosure

(i) Subject to the confidentiality requirement in subparagraph (A) of subdivision (5) of this subsection, the Department shall make available at reasonable times and places to all interested parties the written policies under which it administers Older American Act programs and other information and documents developed or received by the Department in carrying out its responsibilities under the Act.

(ii) The Department requires Area Agencies on Aging and their contractors and subcontractors to apply the standards in 1. above to their operations.

(iii) The Department and its grantee/contractors are not required to disclose those types of information or documents that are exempt from disclosure under applicable Freedom of Information laws.

(6) Program Access Requirements

(A) Policy for Facilities Acquired with Older Americans Act and Department Funds

When Older Americans Act or other Department administered funds are used to acquire the use of a facility which involves access by older persons, the facility shall meet the provisions of Section 504 of The Rehabilitation Act of 1973 if the acquisition of the facility occurs after October 1, 1980.

(B) Policy for Facilities Acquired Prior to October 1, 1980

Facilities acquired for use before October 1, 1980 should meet the requirement in (A) where feasible.

(7) General Program Reporting Requirements

All recipients of grants from the Department shall submit such reports to the Department as are required or set forth in the Grant.

(8) Management Information System (MIS) Requirements

Area Agencies on Aging and all grantees and contractors under Title III are required to participate in the Statewide automated Management Information System (MIS), in accordance with the Department's requirements, unless a written waiver is received and approved from the Department.

When Performance-Based Contracting is used, Area Agencies on Aging shall reimburse contractors based on current MIS statistics, unless it is determined by the Department that the service cannot be accurately measured by the MIS.

(Adopted effective February 26, 1992; Transferred and Amended October 7, 1997)

Sec. 17b-423-4. Community services policy manual-general area agency responsibilities

(a) **Responsibilities of the Area Agency on Aging**

(1) Staffing

An Area Agency on Aging shall be responsible for recruiting and employing adequate numbers of staff members to develop and administer its area plan, and to carry out the functions and responsibilities prescribed by the Older Americans Act, Title III regulations and this Manual. The Area Agency on Aging shall develop and implement a staffing plan consistent with Federal and State requirements and the standards listed herein:

(A) The Area Agency on Aging shall be headed by a director qualified by education and experience to administer the areawide program, who shall be hired in conformance with the job description promulgated in the approved area plan. The director shall devote full-time solely to activities which benefit the aging population.

(B) No Area Agency on Aging shall be allowed to operate without a director for an extended period of time.

(i) In the absence of an Area Agency on Aging director, an acting director shall be designated within one week.

(ii) An Area Agency on Aging may not operate under the leadership of an acting director for more than 90 days, or it shall be subject to suspension or termination. In the case of maternity or extended medical leave, the Area Agency on Aging has the option of extending

the 90 day limit with the Department's approval.

(iii) The Area Agency on Aging shall employ:

Adequate numbers of staff (including members of minority groups), qualified by experience and training, assigned full or part-time to Title III activities; and

Persons knowledgeable-through education and/or experience-in the program area for which they will be responsible (planning, administration, coordination, program activities, etc.).

(iv) All other factors being equal, the Area Agency on Aging shall give preference to persons aged sixty or over for any full-time or part-time positions for which such persons qualify-subject to any merit system requirements.

(v) The Area Agency on Aging may contract for the performance of certain functions and responsibilities, but such contractual arrangements shall not be utilized as a substitute for adequate staffing. Prior written approval of the Department is required for such contractual arrangements.

(vi) The Area Agency on Aging may not discriminate against any qualified person with a disability as defined by the ADA who is seeking employment.

(vii) An Affirmative Action Statement shall be submitted to the Department by each Area Agency in a manner prescribed by the Department.

(2) Direct Provision of Services by an Area Agency on Aging

(A) General Rule

Area Agency on Aging shall use grants or contracts with service providers to provide all services under this part unless the Department decides that direct provision of a service by the Area Agency on Aging is necessary to assure an adequate supply of the service, or where the service is directly related to the Area Agency on Aging's administrative functions, or where such service of comparable quality can be provided more economically by the Area Agency on Aging.

(B) Services Not Funded Under Older Americans Act

The Area Agency on Aging may plan, coordinate, and provide services funded under other programs, if it does not use funds under this part for those services, and if it continues to meet all its Area Agency on Aging responsibilities.

(C) Notification of Intent to Deliver Services

At the time when an Area Agency on Aging submits its area plan, it shall include waiver proposal(s) detailing any intent to utilize Title III B monies to directly deliver services. The proposal(s) shall include a description of the service to be provided directly by the Area Agency on Aging, an estimated budget, and an explanation as to how this service will impact Title III B services in general.

For fiscal years, when the Area Agency on Aging is not required to submit an area plan and the Area Agency on Aging intends to utilize Title III B service monies to directly deliver services for any reason, public notice and the opportunity for public comment shall be given prior to submission of the Area Agency on Aging's annual budget to the Department. Acceptable forms of public notice include a public hearing, a public service announcement,

a newsletter, an article or public notice announcement in the Area Agency on Aging's newsletter, or any other method of mass public distribution approved by the Department. The notice is to include, at a minimum, a description of the service to be delivered, an estimated budget, and an explanation as to how this service will impact Title III B service in general.

(3) Written Procedures

An Area Agency on Aging shall have written procedures for complying with all of its functions as prescribed in the regulations and this Manual. Such written procedures shall either be incorporated in its area plan, or in an Area Agency on Aging Manual on file at the Area Agency on Aging. The manual shall be available to the Department on request.

(4) Corporate Eldercare

(A) Scope and Definition

(i) Area Agencies on Aging may enter into contracts with corporations to provide corporate eldercare services, as hereinafter defined.

Such contracts shall require payment by the corporation to the Area Agency on Aging for the provision of such eldercare services, and may be entered into only in strict conformance with the requirements and limitations herein set forth.

These regulations shall be attached to all eldercare contracts as a condition thereof.

(ii) "Corporate Eldercare Services" means services funded by a private sector corporation, to benefit its employees who have caregiver responsibilities for elderly relatives. Such services most often consist of information and referral, but may extend to other services or programs as determined by the corporation.

(iii) Types of corporate eldercare services which Area Agencies on Aging may provide include activities such as, but not limited to, consulting, development and publication of written materials, development and production of videotapes, and presentation of or participation in workshops, seminars and conferences.

(B) Criteria

(i) Before engaging in any corporate eldercare service, the Area Agency on Aging shall first obtain the approval of the Area Agency on Aging board of directors.

(ii) Contracts with corporations for eldercare services shall be submitted to the Department for review at least two (2) weeks prior to their effective date. The Area Agency on Aging shall, upon request of the Department, submit such additional information as may be necessary to adequately assess the proposed service.

(iii) Simultaneous with its submission of any proposed corporate eldercare services contract to the Department for review, the Area Agency on Aging shall also provide the Department with written assurances as to the following considerations:

(I) The proposed activity is compatible with the statutory mission of the Area Agency on Aging as prescribed in the Older Americans Act and related state law;

(II) The proposed activity precludes any inference or requirement of exclusivity, i.e., the area agency must be free to negotiate other similar contracts;

(III) The proposed activity, when undertaken, shall not diminish the ability of the Area

Agency on Aging to carry out its principal mission, not to target its efforts to older persons with the greatest economic or social needs, with particular attention to low income minority persons;

(IV) All personal, identifying information obtained regarding program participants shall remain confidential to the extent allowed under federal and state law;

(V) The proposed activity shall not directly or indirectly, involve the use of any governmental funds for any purposes, including administration and overhead.

(C) Fiscal controls

(i) Each Area Agency on Aging providing corporate eldercare services shall establish separate accounts for all funds devoted to eldercare activities, to which the Department shall have access for the purpose of reviewing the activity.

(ii) The percentage of staff time allocated to corporate eldercare services shall be identified.

(iii) Funds received by any Area Agency on Aging in connection with corporate eldercare services shall be accounted for by the Area Agency on Aging in accordance with generally accepted accounting and auditing practices and all other applicable requirements of federal and state law, and relevant provisions of the Area Agency on Aging's contract with the Department.

(D) Public interest & department oversight

(i) The Area Agency on Aging shall describe its approach to, plan for and involvement in corporate eldercare services in the area plan or amendments; and

(ii) The Department shall monitor each Area Agency on Aging's involvement in corporate eldercare services as contemplated by these regulations through annual on-site assessment, review of eldercare contracts, continued monitoring of area agency targets, and area plan review.

(b) **The Area Plan Process**

(1) General Provisions

(A) Purpose of the Area Plan

An area plan is the document submitted by an Area Agency on Aging to the Department which outlines the work plan of the Area Agency on Aging for the plan period. The Area Plan also functions as the application for Title III funding from the Department.

(B) Duration and Format of the Area Plan

(i) Area plan periods shall be determined by the Department in accordance with Title III regulations.

(ii) The Department shall periodically set forth the format, criteria for approval, and instructions for the development and submission of the area plan. The instructions and format shall be in conformity with the Title III regulations, this Manual and other AoA and Department directives which may be developed periodically.

(iii) The Area Agency on Aging shall submit an area plan, amendments, and annual budgets to the Department in accordance with the uniform area plan format, information provided by the Department, and other instructions contained in the Manual.

(2) Content of Area Plan

(A) General

The area plan shall contain provisions required by the Act and this Manual and commitments that the Area Agency on Aging shall administer activities funded under Title III in accordance with all Federal and State requirements. The area plan also shall contain a detailed statement of the manner in which the Area Agency on Aging is developing a comprehensive and coordinated system throughout the planning and service area for all services authorized under Title III. An Area Agency on Aging may use its Title III funds only for activities in its approved plan. Any deviation from activities or resource allocation in the approved plan requires prior written approval from the Department.

(B) Area Agency on Aging Function Requirements

An area plan shall provide that the Area Agency on Aging functional requirements, as specified in appropriate sections of this Manual, are met for:

(i) Monitoring, evaluation and commenting on policies and programs affecting older persons;

(ii) Arrangements with children's or adult day care organizations;

(iii) Assessment of need for services in the planning and service area, and evaluation of effectiveness of services being provided;

(iv) Entering into subgrants or contracts for the provision of services under the area plan;

(v) Technical assistance and evaluation of all service providers;

(vi) Considering the views of older persons;

(vii) Outreach efforts;

(viii) Designation of community focal points;

(ix) Coordination with other federal programs serving older persons;

(x) Conducting efforts to facilitate the coordination of community-based, long-term care services designed to retain individuals in their home;

(xi) Identifying entities involved in the prevention, identification and treatment of the abuse, neglect and exploitation of older individuals and determining the extent of unmet needs for appropriate services in this area;

(xii) Working to ensure community awareness of and involvement in addressing the needs of residents of long-term care facilities;

(xiii) Establishing a grievance procedure for individuals denied services;

(xiv) Cooperating with non-profit providers of housing for the elderly;

(xv) coordinating transportation services.

(C) Provision of Comprehensive and Coordinated Service Delivery System

An area plan shall provide for the development of a comprehensive and coordinated service delivery system for all supportive and nutrition services needed by older persons in the planning and service area. The Area Agency on Aging may accomplish this purpose by entering into new cooperative arrangements with other service planners and providers to:

(i) Facilitate access to and utilization of all existing services; and

(ii) Develop supportive and nutrition services effectively and efficiently to meet the

needs of older persons.

(D) Service Delivery Requirements

An area plan shall provide that the service delivery requirements, as specified in appropriate sections of this Manual, are met for:

(i) Giving preference to older persons with greatest economic or social need, with particular attention to low-income minority individuals;

(ii) Restricting direct provision of services;

(iii) Service providers concerning licensure, training, outreach, coordination, giving preference to those with greatest economic or social need, contribution, maintenance of non-Federal support for services, and advisory role for older persons;

(iv) Multipurpose senior center activities;

(v) Nutrition services;

(vi) Legal assistance;

(vii) Information and referral services;

(viii) Transportation services.

In providing such services, special attention should be given to utilizing quality staff, meeting basic standards and use of voluntary relationships.

(E) Priority Service Requirements

(i) An area plan shall provide an adequate proportion of its supportive services allotment, excluding amounts used for administration, for the following categories of services, with at least some funds spent in each category:

Services associated with access to other services. These services are transportation, outreach, and information and referral;

In-home services. These services include homemaker and home-health aid, visiting and telephone reassurance, chore maintenance, and supportive services to families of elderly victims of Alzheimers's disease and related disorders with neurological and organic brain dysfunction;

Legal Assistance.

(ii) An area plan, as submitted or as amended, shall specify in detail the amount of funds expended for each of the above listed categories during the fiscal year most recently concluded.

(iii) The Department may waive the requirement for expending an adequate proportion of an Area Agency's Part B allotment for access, in-home, or legal service, if the area agency demonstrates to the department that the services being provided in the PSA for any specific category of service are sufficient to meet the need of such service.

(F) Informational Requirements

An area plan shall specify:

(i) Program goals and objectives, to implement the service delivery requirements of the Older Americans Act and goals, objectives, and measures established by the Department;

(ii) A resource allocation plan indicating the proposed use of all funds to be used in programs for older persons directly administered by the Area Agency on Aging;

(iii) An identification of designated community focal points;

(iv) Methods the Area Agency on Aging uses to set service priorities under the plan; and

(v) Proposed methods for giving preference in the provision of services under the plan to those with greatest economic or social need, with particular attention to low-income minority individuals. These methods:

Shall include, but are not limited to, consideration of older persons with greatest economic or social need in the designation of community focal points;

Shall include targeting of low income clients at a prescribed rate as determined by the Department of all clients served for each service category, and targeting of minority clients at a reasonable level, as determined by the Department, not to be less than the level of the prior planning year; at a minimum, minority targets should reflect the proportion of minority elderly persons to the total elderly population in the towns served by the specific program;

May not include use of a means test. A means test is the use of an older person's income or resources to deny or limit that person's receipt of services under the Act.

(3) Amendments to an Area Plan

An Area Agency on Aging shall amend its area plan if:

(A) A new or amended State or Federal statute or regulation requires a new provision, or conflicts with any existing plan provisions;

(B) A U.S. Supreme Court decision changes the interpretation of a statute or regulation;

(C) The Area Agency on Aging proposes to change the designation of the single organizational unit or component unit;

(D) The Area Agency on Aging proposes to add, substantially modify, or delete any area plan objective(s); or:

(E) The Department requires further annual amendments.

(4) Review of an Area Plan and Amendments

(A) Public Hearing

An Area Agency on Aging shall:

(i) Include participation of the Advisory Council in the development and implementation of the area plan. The Advisory Council shall review the area plan before the public hearing(s), and again after the public hearing(s), but before submission to the Department;

(ii) Hold at least one public hearing on its area plan;

(iii) Hold a public hearing on any proposed amendment to the area plan if instructed by the Department to do so;

(iv) Submit its area plan and any amendment for review and comment to the area Advisory Council and Board of Directors, prior to submission to the Department.

(B) Public Hearing Standards

The Area Agency on Aging shall apply the following standards in the conduct of its public hearing(s);

(i) Public notice shall be given at least two weeks before the public hearing(s);

(ii) The public hearing(s) shall be scheduled to allow sufficient time for review of the area plan by the Advisory Council and Board of Directors prior to the date of the public

hearing(s);

(iii) Notice of the public hearing(s) shall be publicized through widely circulated newspapers or other forms of public media;

(iv) Notice of the public hearing(s) shall be published in a language other than English, when deemed appropriate by the Area Agency on Aging and/or the Department;

(v) Notice of the public hearing shall include the availability of a sign language interpreter and Hispanic interpreter upon request;

(vi) Notice of the public hearing(s) shall be provided to appropriate service providers, nutrition providers, organizations of older persons, and other public and private agencies in the planning and service area;

(vii) The public hearing(s) shall be scheduled at a convenient time(s) and location(s) to ensure:

maximum attendance by interested parties, including representatives of the Advisory Council, other local advisory councils to nutrition and other service providers, and older persons; and accessibility to the handicapped;

(viii) A complete copy of the area plan shall be available for review by the general public at the office of the Area Agency on Aging prior to, and after, the public hearing(s);

(ix) Summaries of major components of the area plan including a program description, objective, action plans, and resource allocation plans, shall be available prior to and during the public hearing(s);

(x) The formula or other methods used to distribute aging funds among service providers shall be available at the public hearing(s);

(xi) Procedures for review and analysis of comments received at the public hearing(s) shall be established and described in writing;

(xii) Summaries of the comments made at the public hearing(s) shall be available at the office of the Area Agency on Aging after the public hearing(s); and

(xiii) All records of the public hearing(s) shall be on file at the Area Agency on Aging as a part of the area plan.

(C) Other Methods For Public Participation

The Area Agency on Aging may utilize additional mechanisms to obtain the view of older persons in developing and administering its area plan.

(5) Area Plan Submission, Review and Approval

(A) General

An area plan shall be submitted to the Department in accordance with the schedules and procedures established by the Department.

(B) Schedule of Area Plan and/or Annual Update Reviews

The following schedule outlines the process for review and approval of area plans or annual updates:

(i) The Department shall notify all Area Agencies on Aging at least 90 days before the area plan is due at the Department office. This notice shall include the transmittal of the required area plan format, the Department criteria for area plan approval, and instructions

for developing the area plan.

(ii) Area plans, whether for initial or continuation funding, are due at the Department office 75 days prior to the beginning date of the planned funding period.

(iii) Department staff requests for revisions in area plans, shall be made 45 days before the beginning date of the planned funding period.

(iv) Final area plan revisions shall be submitted by Area Agency on Aging to the Department at least 30 days prior to the beginning date of the planned funding period.

(v) An approval letter shall be issued by The Department prior to the start of the funding period. The letter shall include any contingencies to be placed on the award.

(C) Department Actions on Area Plans

The Department shall provide notification in writing to the Area Agency on Aging of the final actions taken in either approving, approving with conditions, or disapproving its area plan.

(i) Approval

The Department shall provide the Area Agency on Aging with a formal notice of approval of the area plan and the amount of approved funds on an appropriate award document.

(ii) Approval with Conditions

The Department may approve an area plan with conditions when necessary.

The conditions shall be stated in writing on the award letter to the Area Agency on Aging.

All conditions placed on an approved area plan shall be consistent with the authority delegated to the Department.

When an area plan is approved with conditions, it shall be the responsibility of the grantee to meet these conditions within the specified time frame. As the conditions are met by the grantee, the Department shall officially notify the grantee that all conditions have been met.

(iii) Disapproval

Any area plan which is not in conformity with the Older Americans Act, the Federal regulations or the Department's policies shall be disapproved.

When the Department proposes to disapprove an area plan, it shall notify the Area Agency on Aging in writing of its intention and set forth the reasons for the proposed disapproval. The Department shall:

Issue a letter of intent to disapprove the area plan to the Area Agency on Aging indicating the reasons for the proposed disapproval within sixty day of receipt of the area plan; and

Inform the area Agency on Aging of the opportunity for a hearing on the area plan under the provisions of Section 17b-423-2-(c) of this Manual and shall carry out those procedures.

(iv) Final Disapproval

If, after providing the Area Agency on Aging with a proper opportunity for a hearing, the Department still finds the area plan unacceptable, the Department shall disapprove the plan, using the following procedures:

The Department shall withhold further payments to the Area Agency on Aging.

If the Department terminates funds under the above provision, it shall notify the assistant secretary in writing of its action; provide a plan for the continuity of services in the affected

planning and service area; and designate a new Area Agency on Aging in the planning and service area in a timely manner.

(6) Withdrawal of Area Agency on Aging Designation

(A) Conditions for Withdrawing Area Agency on Aging Designation

The Department may withdraw the Area Agency on Aging designation whenever the Department, after reasonable notice and opportunity for a hearing, finds that:

(i) The Area Agency on Aging does not meet the requirements under the Older Americans Act and Federal Regulations;

(ii) The plan or plan amendment is not approved; or

(iii) There is substantial failure in the provisions or administration of an approved area plan to comply with any provision of the federal regulations or this manual.

(B) Department Procedures to Withdraw Area Agency on Aging Designation

If the Department withdraws an Area Agency on Aging's designation under subparagraph A of this subdivision, it shall:

(i) Notify the Area Agency on Aging immediately;

(ii) Notify the assistant secretary in writing of its action at the time the Area Agency on Aging is notified;

(iii) Provide for the continuity of services in the affected planning and service area; and

(iv) Designate a new Area Agency on Aging in the planning and service area in a timely manner.

(7) Redesignation of an Area Agency on Aging

An agency that has had its designation as an Area Agency on Aging withdrawn in accordance with the policies in this Manual shall not be considered for redesignation until such time as it can demonstrate to the satisfaction of the Department that changes have occurred to remove the causes that led to the withdrawal of designation. The criteria for designation as an Area Agency on Aging set forth in Section 17b-423-2(b) of this Manual shall apply in all instances of redesignation.

(8) Prior Approval of Contracts

(A) The Department shall require prior written approval of a contract proposed for funding under an area plan when the contract will be executed with a profit-making organization and when the Area Agency on Aging is contracting for an administrative function. This includes, but is not limited to contracts for training, audit, personal services, and any Performance-Based Contracts which fall under this criteria. Such approval shall be obtained on an annual basis, except in the case of multiyear contracts.

(B) Record of the Department's approval of such contracts shall be maintained on file by the Area Agency on Aging or grantee.

(c) **Area Agency on Aging Functions and Responsibilities Under an Area Plan**

(1) Advocacy Responsibilities of the Area Agency on Aging

An Area Agency on Aging shall:

(A) Monitor, evaluate, and where appropriate, comment on all policies, programs, hearings, levies and community actions which affect older persons;

(B) Conduct public hearings on the needs of older persons;

(C) Represent the interests of older persons to local level and executive branch offices public and private agencies or organizations;

(D) Carry out activities in support of the State administered long-term Ombudsman program;

(E) Coordinate planning with other agencies and organizations to promote new or expanded benefits and opportunities for older persons; and

(F) Comment on other services provided for the elderly through the intergovernment review process.

No requirement in this section shall be deemed to supersede statutory or other regulatory restrictions regarding lobbying or political advocacy with Federal funds.

(2) Area Agency on Aging General Planning and Management Responsibilities An Area Agency on Aging shall:

(A) Develop and administer an area plan for a comprehensive and coordinated service delivery system in its planning and service area in compliance with all applicable laws and regulations, including all requirements of this Manual;

(B) Assess the kinds and levels of services needed by older persons in the planning and service area, and assess the effectiveness of the use of various resources in meeting these needs;

(C) Except as provided in Section 17b-423-4(b) (2) of this Manual, enter into grants or contracts to provide all services under the plan, utilizing a request for proposal (RFP) process which assures equal opportunity for all potential applicants for funding to apply, including publication of notice in the area's public media and the use of a wide mailing list which includes, but is not limited to, current grantees or contractors;

(D) Provide technical assistance, monitoring, and periodic evaluation of the performance of all service providers under the plan, utilizing a schedule that provides for conducting both fiscal and programmatic field monitoring of each grantee at least once biennially.

(E) Coordinate the administration of its plan with other Federal, State and local resources, in order to develop a comprehensive and coordinated service system;

(F) Establish an Advisory Council consisting of more than 50% older individuals and of minority individuals at least in proportion to the representation of minority elderly in the PSA.

(G) Give preference in the delivery of services under the plan to older persons with the greatest economic or social need; with particular attention to low income minority individuals.

(H) Assure that older persons in the planning and service area have reasonably convenient access to information and referral services;

(I) Provide adequate and effective opportunities for older persons to express their views to the Area Agency on Aging on policy development and program implementation under the plan;

(J) Have outreach efforts to identify older persons, including older Indians, and inform

them of the availability of services under the area plan, and conduct an annual evaluation of the effectiveness of such outreach. These outreach efforts should have special emphasis on the rural elderly, and on those with greatest economic and social needs, especially low-income minority individuals, and older individuals with severe disabilities. With respect to nutrition services, the Area Agency on Aging shall have outreach efforts that ensure that the maximum number of eligible persons have an opportunity to receive services;

(K) If possible, have arrangements with organizations providing day care services for children or adults, and respite for families, so that older persons can volunteer to help provide such services;

(L) Develop and publish the methods that the Area Agency on Aging uses to establish priorities for services, particularly the consideration given to the Title III priority services;

(M) Establish procedures governing outreach, training, and coordination activities of service providers;

(N) Attempt to involve the private bar in legal assistance activities, including groups within the private bar that furnish legal services on a pro bono and reduced fee basis;

(O) Designate community focal points, where feasible.

(3) Designation of Community Focal Points for Service Delivery

In order to facilitate ready access to services provided under the area plan, an Area Agency on Aging shall designate, if feasible, a focal point for comprehensive service delivery in each community.

(4) Area Agency on Aging Board of Directors

(A) Functions of the Board

Each Area Agency on Aging shall establish a Board of Directors. The Board shall be responsible for:

(i) Achieving the stated objectives and purpose of the organization;

(ii) Making policies and plans;

(iii) Supervising the executive director;

(iv) Appointing committees.

(B) Composition of the Board

Board members and officers of private agencies or other community agencies or governmental body may serve on the board of directors, but may not vote, participate in discussions, or in any way influence matters related to the financial or contractual affairs of their agency or body. Area Agency on Aging board members shall sign an annual declaratory statement which discloses all other boards and commissions on which they currently serve, and declare their intent to avoid participation in, discussion of, or in any other way influencing, the vote on any issue affecting one of those boards or commissions.

Those ineligible for Board membership are:

(i) Paid staff of any Title III funded agency

(C) Frequency of meetings

The Area Agency Board of Directors shall hold at least ten (10) monthly meetings annually.

(D) Support

The Area Agency on Aging shall provide staff and assistance to the Board of Directors.

(E) Bylaws

The Area Agency on Aging shall develop and make public bylaws which specify the role and function of the Board of Directors, number of members, procedures for selection of member, terms of membership, and frequency of meetings.

(5) Area Agency on Aging Advisory Council

(A) Functions of the Council

Each Area Agency on Aging shall establish an advisory council in accordance with the requirements of this section. The council shall advise the agency on:

(i) Developing and administering the area plan;

(ii) Conducting public hearings;

(iii) The interests of older persons; and

(iv) Its review of and comments on all community policies, programs and actions which affect older persons.

(B) Composition of the Council

The advisory council shall be made up of:

(i) More than 50 percent older persons, including:

Older persons with greatest economic or social need; and Participants of Older Americans Act programs;

(ii) Minority individuals in proportion to their representation among older persons in the PSA.

(iii) Representatives of older persons;

(iv) Local elected officials, or their representatives;

(v) The general public.

(C) Frequency of Meetings

The Area Agency on Aging Advisory Council shall meet at least quarterly.

(D) Support

The Area Agency on Aging shall provide staff and assistance to the Advisory Council.

(E) ByLaws

The Area Agency on Aging shall develop and make public bylaws which specify the role and function of the Advisory Council, number of members, procedures for selection of members, terms of membership, and frequency of meetings.

(6) Preference for Older Persons with Greatest Economic or Social Need

All service providers under the Older Americans Act shall follow priorities set by the Area Agency on Aging for serving older persons with greatest economic or social need, with particular attention to low-income minority individuals. Service providers may use methods such as selecting certain locations for providing services and specializing in the types of services most needed by these groups to meet this requirement. Service providers may not use a means test.

(7) Contributions for Services Under the Area Plan

(A) Opportunity to Contribute

Each service provider shall:

(i) Provide each older person with a free and voluntary opportunity to contribute to the cost of the service he/she receives;

(ii) Protect the privacy of each older person with respect to his or her contribution;

(iii) Establish appropriate procedures to safeguard and account for all contributions; and

(iv) Use all contributions to expand the services of the provider under Title III. Nutrition service providers shall use all contributions to increase the number of meals served by the project involved, to facilitate access to such meals, and to provide other supportive services directly related to nutrition services.

(B) Failure to Contribute

A service provider that receives funds under the Act may not deny any older person a service because the older person will not or cannot contribute to the cost of the service.

(C) Contributions as Program Income

Contributions made by older persons who are recipients of services are considered program income.

(8) Maintenance of Non-Federal Support for Services

(A) All service providers shall assure their Area Agency on Aging that Federal funds shall not be used to replace funds from non-federal sources.

(B) Service providers shall agree to continue to initiate efforts to obtain support from private sources and other public organizations for services funded.

(9) Opportunity for Input by Consumers

Each service provider under the area plan shall have procedures for obtaining the views of participants about the services they receive.

(Adopted February 26, 1992; Amended June 2, 1992; Transferred and Amended October 7, 1997)

Sec. 17b-423-5. Community services policy manual - Title III-C nutrition services

(a) **Purpose**

An Area Agency on Aging shall award nutrition service funds received under Title III of the Older Americans Act to provide meals, nutrition screening and nutrition education, to older persons. In addition, these funds may be used to provide outreach, nutrition assessment, nutrition counseling, and other related services to older persons. In making these awards, the Area Agency on Aging shall assure that based on an assessment of need by the Area Agency on Aging and nutrition service providers, congregate meals, home delivered meals, nutrition screening and nutrition education are all provided in the PSA. The Area Agency on Aging shall develop a formula providing for equitable distribution of nutrition funds throughout the PSA.

(b) **Selection of Nutrition providers**

(1) General Rule

An Area Agency on Aging may make awards for congregate meals, home delivered meals, nutrition education, nutrition screening, nutrition assessment and counseling, and

related nutritional services to a provider or providers that furnish any or all types of services. Such a provider shall meet the requirements of this section.

(2) Process for Selecting Nutrition providers

(A) Area Agency on Aging Award Process

An Area Agency on Aging shall award nutrition funds through a competitive grant or contract process.

Whenever there is no evidence of improved quality of services or cost effectiveness on the part of another bidder, an existing provider of services who receives funds under Title III of the Older Americans Act of 1965 as amended shall be given preference.

An Area Agency on Aging shall award Title III, Part C funds to organizations which are able to provide nutritional services efficiently and reasonably.

(B) Assurances of Maintenance of Effort and Non-Supplanting of Funds

The Area Agency on Aging shall have furnished assurances to maintain efforts to solicit voluntary support and not to use funds received under this part to supplant funds from non-Federal sources.

(c) **Bid Procedures For Contracts With Caterers**

(1) Procedure for Solicitation of Bids

The procedure for solicitation of bids shall be as follows:

(A) Bids shall be solicited on an annual basis, unless caterer is operating on a multi-year contract. In the case of a multi-year contract, additional bids should be solicited for maximum increases for the year(s) after the first year.

(B) The Area Agency on Aging shall assure that nutrition projects coordinate their bids or develop a combined bid to seek most favorable price and quality.

(2) Bid Specifications

(A) Bid Specifications shall include the requirement that the caterer either (i) obtains a Performance Bond in an amount and in form satisfactory to the Elderly Nutrition Project (ENP), the Area Agency on Aging and the Department or (ii) enters into an agreement for damages. The following is an example of a contractual default clause:

Default/Damages

"In the event of breach or default by bidder in performance of the contract, ENP may act immediately to provide replacement services and if so shall notify bidder. In the event replacement services are provided, bidder shall be liable to ENP for damages in an amount measured by the difference between the cost of services under the bidder's contract and the higher cost, if any, of providing similar requirement replacement services."

One of the following methods, as appropriate, should be utilized to define the period for which damages would be sought by ENP:

(i) If the contract contains a provision authorizing the caterer to give notice of its intention to terminate the contract, then the above damage clause shall contain the following additional sentence: "Damages shall be collected for the period from the time of default by caterer for the ensuing days" (The blank being the length of notice).

(ii) If the contract contains no such notice provision, or if the remaining term of the

contract is less than any such notice term, then the damages shall be for the remainder of the contract term.

Bid specifications and Contracts may, at the option of ENP, contain the following paragraphs:

"The parties further agree that ENP may withhold any funds due to the bidder in the hands of ENP at the time of default or breach, which funds may be used by ENP to offset damages. The parties further agree that ENP may retain not to exceed $ (as determined by ENP otherwise due to bidder for services hereunder, for this purpose.

"The parties further agree that, in the event that ENP is unable to provide replacement services, damages shall be as determined by a court of law, or as otherwise agreed to by the parties, and that the amount retained by ENP as herein above set forth, may be retained by ENP until that time."

(B) Bid specifications shall include but are not limited to menu policies, delivery time, and food temperature maintenance requirements.

(C) The bid specification may request a working plan from the caterer on how they would set up their program to include anticipated staffing, employee requirement, and sanitation policies, use of standardized recipes, transport equipment and other relevant factors.

(D) If the contract contains a provision authorizing the caterer to give notice of their intention to terminate the contract, the notice term shall not be less than sixty (60) days.

(3) Options Available to Soliciting Party

After bids have been opened and reviewed, three options are open to the soliciting party:

(A) A bid can be accepted. After the bids have been received, the parties cannot negotiate price or specifications, or in any way alter the bids. The bids shall be accepted as they are submitted.

Any otherwise conforming bid may be amended by the bidder or soliciting party to correct computational errors which do not affect the cost or quality of services; such amendment shall be prior to acceptance.

(B) Any of the bids can be rejected with justification. Bids can be rejected if they are too high, if they do not meet specifications, or if they are incomplete.

(C) All bids can be rejected. If all bids received are unacceptable for any of the reasons cited above, the project can resolicit bids.

(4) Review of Approved Bids by the Department

AAA approved bid packages shall be submitted to the Department for review.

Proposed contracts with profit-making organizations shall require final approval from the Department. All bid packages shall include:

(A) A copy of the letter of solicitation for bids.

(B) A copy of advertisements of bids showing names of newspapers and dates published.

(C) A list of names and addresses of caterers the project contacted directly.

(D) A copy of the total bid packet sent to caterers, including the sample menu and bid specifications.

(E) A list of organizations who declined to bid and their reason if known.

(F) A copy of each detailed bid quotation.

(G) A description of the bid opening - date, location, persons in attendance, and organizations they represent.

(H) A description of criteria used for evaluation of bids and bidders and the rank given to each criterion.

(I) A description of involvement of the Project Council and grantee agency's governing body in evaluation of bids and selection decision.

(J) The name and address of selected bidder.

Note: If the lowest bid had not been chosen, specific, strong justification for choosing a higher bid shall be provided.

(K) A completed copy of the "Caterer's Assurance for USDA Cash Reimbursement". The level of USDA Cash Reimbursement is left blank until reimbursement level is known.

(L) A copy of the contract to be signed with caterer.

(d) **Operating Requirement for nutrition service providers**

(1) Staffing

(A) Adequate Number to Operate Program

Nutrition service providers shall employ adequate numbers of qualified staff to assure satisfactory conduct of the service in keeping with the provisions of this Manual.

(B) Employment Preference give to 60+

Preference should be given to employing persons age 60 and over.

(C) Consideration given to Employing Minorities

Consideration should be given to employing minority individuals at least in proportion to the numbers of minority older persons represented among the service area's populations.

(D) Nutritionist Staff Requirement

Each service provider that receives Title III-C funds shall be established and administered with advice of a nutritionist. In addition the nutritionist shall be responsible for menu development, nutrition screening and education, monitoring of food preparation and in-service training of food service personnel and volunteers. The nutritionist shall meet the following minimum qualifications:

Shall have two years of recent relevant full time work experience preferably in geriatric nutrition food service management or community nutrition, in addition to one of the following criteria:

(i) Registered Dietitian, or

(ii) State certified dietitian/nutritionist, or

(iii) Bachelor's Degree from an accredited four year institution with a major in foods and nutrition, institutional food management, community nutrition dietetics or related field.

One year of the work experience requirement may be waived with possession of Registered Dietitian status, and/or Master's degree from an accredited institution in nutrition, dietetics, institutional food management, public health, business administration or relate field.

(E) Nutrition Assistant

A Nutrition Assistant, under the supervision of the Nutritionist on staff or Nutrition Consultant on contract, may also provide nutrition education and conduct eligibility and nutritional screening interviews. The Nutrition Assistant shall meet the following minimum qualifications:

(i) Diet Technician, Registered; or,

(ii) Associate degree or equivalent from an accredited program with a major in foods and nutrition, community nutrition, dietetics or related field.

(2) Congregate Meals

(A) Requirement that the Area Agency on Aging approve all New, Reopened, or Relocated Meal Sites Prior to Opening.

The Area Agency on Aging shall approve all new, reopened or relocated sites prior to opening. This applies to temporary as well as permanent locations. The following shall be considered when granting approval:

(i) In the case of closing the site: the reason and procedures used to notify the participants and public;

(ii) In site relocation: the reasons and procedures to assure continued participation at the new location;

(iii) In a new or reopened site: location and assurances that it meets local and state fire, safety, sanitation and building requirements.

(B) Congregate Nutrition Provider Requirements

Each congregate nutrition service provider shall:

(i) Provide at least one hot or other appropriate meal in a congregate setting at least once a day, five or more days per week;

(ii) Locate congregate nutrition services as close as possible to, and where feasible and appropriate, within walking distance of the majority of eligible older persons, especially those in the greatest social and economic need;

(iii) When necessary (in case of illness, injury, etc.) make home delivered meals available to congregate mealsite participants;

(iv) Serve a minimum of 98% of all meals to eligible participants and their spouses;

(v) Develop procedures for responding to emergency situations for all congregate sites and provide ongoing training on emergency procedures to all site managers and other site staff;

(vi) Where feasible, seek out and be involved in local group purchasing efforts.

(vii) Make nutrition education available to mealsite participants at a minimum of once each quarter. Each Area Agency on Aging shall submit nutrition education plans for approval to, the Department or Area Agency on Aging nutritionist one month prior to the start of each program year.

Nutrition education sessions shall be conducted by the nutritionist, other health professionals with adequate background and training in nutrition, or nutrition assistant.

Nutrition education subjects shall be based on the needs of the participants. Nutrition information and visual educational materials shall be available to the participants on a

continuing basis.

(C) Congregate Nutrition Site Requirements

Each congregate nutrition site shall:

(i) Have a designated site manager who is responsible for activities at the site.

Where Title III-C funds are utilized, they can pay for a maximum of 5 hours per mealtime if an average of 25 or more participants are served; and, for a maximum of 3 hours per mealtime if fewer than an average of 25 participants are served. If home delivered meals are prepared at a site serving fewer than 25 participants, Title III-C funds can pay for a maximum of 5 hours if a waiver is received from the Area Agency on Aging.

(ii) Where possible, local support should be sought for mealsite operations.

(iii) Serve an average of at least 25 participants per mealtime unless a waiver is received from the Area Agency on Aging. If fewer than 25 participants are served, consideration shall be given to providing meals in single serving units;

(iv) Be located in a facility which meets the accessibility requirements of the Americans With Disabilities Act of 1990 or, if not accessible, be located in an ENP catchment area. (An ENP catchment area is an area within the Project Service area containing at least one accessible site. Transportation shall be available to and from the site designated as accessible from all points in the catchment area);

(v) Be located in a facility where all eligible individuals will feel comfortable visiting. Site selection shall take into consideration the type and location of the facility so as not to offend the cultural and ethnic preference of the eligible individuals in the service area;

(vi) Meet all Local and State fire, health, safety and building codes;

(vii) Be open for at least three hours per mealtime unless a waiver is received from the Area Agency on Aging;

(viii) Be neat, clean and have adequate lighting, ventilation, and temperature control.

(ix) Establish written food handling procedures and provide site staff and volunteers with ongoing training and monitoring;

(x) Serve meals at a pre-established time each day.

(xi) Serve all hot food within 2 hours from the time food preparations ends unless a waiver is received from the Area Agency on Aging. Maintain hot foods at a temperature above 140°F. and cold foods at below 45°F (41°F after October 1, 1997) from the time preparation ends until the food is served to a participant. Reheat to 165°F hot foods received at 130°F to 140°F. Refuse or discard hot foods received at less than 130°F and potentially hazardous cold foods received at more than 50°F, and have available shelf stable or other suitable substitute foods as replacement.

(xii) Be equipped with the proper utensils to ensure portion control;

(xiii) Have an established procedure for closing the mealsite in inclement weather, and for informing the participants about the closing.

(3) Home Delivered Meals

Each home delivered meals provider shall:

(A) Assess the needs of, and complete the elderly nutrition assessment form (W689) for

intakes on all eligible home delivered meals applicants annually or more often as necessary. (See 17b-423-5(g) (2) for definition of eligibility.) Individuals whose names have been on a waiting list for longer than six months shall be re-screened.

(B) Establish target groups for receipt of home delivered meals;

(C) Provide a nutritious home delivered meal at least once a day, 5 days a week.

Meals may be hot, cold, frozen, dried, or canned foods with a satisfactory storage life;

(D) With the consent of the older person, or his/her representative, bring to the attention of appropriate officials for follow up conditions or circumstances which place the older person or the household in imminent danger;

(E) Make arrangements for the availability of meals to older persons in weather related emergencies;

(F) Assist participants in taking advantage of benefits under other programs;

(G) Deliver meals to participants' homes within 2 hours after completion of preparation, unless a waiver is received from the Area Agency on Aging. The temperature shall be maintained above 140°F for hot foods, below 45°F (41°F after October 1, 1997) for cold foods and at 10°F for frozen meals from the time food preparation ends until the food is delivered to the participant's home.

(H) Offer nutrition education to home bound clients or their caretakers at least twice per year. One session should be a discussion with client or caretaker, unless refused by client or caretaker or deemed unproductive by the provider on a case by case basis.

(I) Appropriately instruct clients or their caretakers on the following safe practices for handling delivered food, as they may apply:

(i) To eat hot food within 1 hour of delivery.

(ii) To eat cold foods immediately or place them in the refrigerator.

(iii) To eat fast chilled meals within 3 days of delivery and to store them at 41°F or less.

(iv) To eat frozen meals within 1 month of delivery and to store them at 10°F or less.

(v) To have an accurate thermometer in their refrigerator if they store fast chilled meals, and one in their freezer if they store frozen meals.

(e) **Food Procurement, Food and Nutrition requirements for Nutrition Service Providers**

(1) Food Procurement

(A) USDA Food Assistance

(i) The Department has an agreement with the USDA State Distributing Agency to assure the availability of food, cash, or a combination of food and cash to nutrition service providers.

(ii) Those nutrition service providers receiving cash instead of food from USDA shall spend the USDA cash only for U.S. agricultural commodities and other food.

(iii) In the case of the caterer using commodity foods: The caterer shall allow to the elderly nutrition project a credit equal to the value of the USDA Commodities that are furnished to the caterer for use in the program.

(iv) In the use of USDA Commodities, sufficient precautions should be taken to transport

and store commodities to preserve their quality and prevent theft.

(B) Food Stamp Program

Nutrition service providers shall assist participants in taking advantage of benefits available to them under the food stamp program.

(2) Food Requirements

(A) For Purchasing, Preparing and Delivering Meals

In purchasing food, and in preparing and delivering meals, the nutrition service providers shall follow appropriate procedures to preserve nutritional value and food safety.

(B) Provision of Special Menus

Nutrition service providers shall provide special menus, where feasible and appropriate, to meet the particular dietary needs arising from the health requirements, religious requirements, or ethnic backgrounds of eligible individuals. In determining feasibility and appropriateness, a provider shall use at least the following criteria:

(i) Whether there are sufficient numbers of persons who need the special menus to make their provision practical; and

(ii) Whether the food and skills necessary to prepare the special menus are available in the planning and service area;

(C) Availability of Appropriate Food Containers and Utensils

Nutrition service providers shall use, upon request, appropriate food containers and utensils for blind and handicapped participants.

(3) Food Quality and Safety

(A) Standards of Quality, Sanitation and Safety

(i) All personnel and facilities involved in producing or dispensing foods or beverages for the elderly, including caterers, shall comply with State of Connecticut Public Health Regulations 19-13-B42 and B48, as amended.

(ii) Meals shall be delivered to a congregate site or home delivered meal recipient within two hours after completion of preparation unless a waiver is received from the Area Agency on Aging. The temperature shall be maintained above 140°F for hot foods, below 45°F (41°F after October 1, 1997) for cold foods and at 10°F or below for frozen meals from the time preparation ends until the food is delivered (whether to the participant's home or to the congregate site). The Area Agency on Aging may grant a waiver for the 2 hours and extend the delivery time if proper equipment is used and if the ENP will agree to conduct regularly scheduled monitoring to assure that proper food temperatures and food quality are maintained throughout the delivery process (from the time food preparation ends until the food is delivered, whether to the congregate site or to the participant's home). The total time of rethermalization, delivery and holding of potentially hazardous hot food, shall not exceed 4 hours. In issuing the waiver, consideration shall be given to progress made toward reducing the total time to two hours or less.

(III) Meal sites storing quick-chilled food shall protect it from contamination (and oxygen where practical) and store it at 35°F or less. The total time between initial cooking and eating of quick-chilled food shall be no longer than 5 days unless extended by written

authorization from the Department.
(B) Requirement to Use Only Commercially Processed Foods
No food prepared, frozen or canned in the home may be used in meals provided by projects financed through Title III. Only commercially processed canned and frozen food may be used.
(C) Items Prohibited from Purchase with Title III, Part C.
Nutrition service providers may not purchase vitamins and/or mineral supplements, nor alcoholic beverages, with funds under Title III, Part C.
(D) ENP Reporting Procedures Regarding Food Borne Illness
The ENP shall report immediately the occurrence, or suspicion of, any incidence of food borne illness to the proper public health authorities, to the Area Agency on Aging, and to the Department.
(E) Cooling Rate and Storage Requirements for Kitchens
Potentially hazardous food shall be served within 4 hours of cooking or meet cooling rate and length of storage requirements specified in writing by the department and use a batch coding system specifying an "eat by" date.
(F) Record of Recent Health Inspection
A recent (within 180 days) health inspection report having a score of 90 or above with no unresolved 4 point items shall be kept on file.
(4) Nutrition Standards
(A) Nutritional Value of Menus
The nutritional value of menus shall be confirmed either by
(i) nutritional analysis,
(ii) conformance to a department approved meal pattern,
(iii) selection from a list of department approved menus with accompanying recipes, or
(iv) an individually prescribed menu.
If the value of menus is confirmed by nutritional analysis, each regular meal shall provide all essential food components in amounts specified in writing by the department. If two meals are served per day, food components may be averaged over two meals; if three meals are served, over three meals. Fat and fat soluble vitamins may be averaged over one week.
More rigorous dietary standards may be used at the discretion of the nutritionist to improve nutrition, flavor, appearance, texture or smell.
(B) Fruit Requirement
Fruit (including fruit juices) shall be served at least three times every six meals with fresh fruit served at least once subject to seasonal quality.
(5) Menu and Recipe Requirements
(A) Menus
Menus shall specify amount of each item to be prepared and served, and shall reference all recipes used in the preparation of mixed dishes.
(B) Recipes
Tested quality recipes, adjusted to yield the numbers of servings needed, shall be used.

Each recipe should specify cooking, cooling and storage procedures as well as exact ingredient amounts and preparation instructions, to assure the production of a uniform, high quality and safe food or dish.

(C) Certification Required

Menus shall be certified in writing by the nutritionist as providing at least one-third of the current recommended dietary allowances (RDA's) of The National Academy of Sciences for energy, protein, vitamins and essential minerals, and as conforming to the*Dietary Guidelines for Americans.* Menus shall be submitted to the Department or Area Agency on Aging nutritionist at least two weeks prior to use for review of nutritional adequacy.

(D) Certification of Individually Prescribed and Therapeutic Menus

Individually prescribed menus, including menus for each type of therapeutic diet, shall be certified by a registered dietitian of the American Dietetic Association.

(E) Record Keeping

Recipes and certified menus shall be kept on file at the nutrition provider's office for a minimum of two years following the year during which they were in use.

(6) Funding restricted for foods not conforming to menu

No funds authorized under this section shall be used to pay for foods served that fail to conform to the menu, without approval by the nutritionist.

(7) Leftover Food

Only the following may be taken from the meal site and at the discretion of the manager: fruit, baked goods and other foods in individually sealed units that have been protected from contamination and held at 45°F (41°F beginning October 1, 1997) or less. All other food shall be offered as a second serving or discarded. Potentially hazardous food offered as a second serving shall be protected from contamination and held at 140°F or more if hot, and at 45°F (41°F beginning October 1, 1997) or less if cold.

(f) **Coordination with other providers/educators in the PSA**

Title III nutrition services may be coordinated with other preventive medicine, health maintenance and in-home service providers; with the University of Connecticut Cooperative Extension and other nutrition and physical fitness educators; and, with providers of elderly services in the PSA. Coordination may involve joint planning and resource sharing.

(g) **Eligibility**

(1) Congregate Nutrition Services

(A) Program Participants

Persons eligible to participate in this program include: a participating person age 60 or older, and the spouse of the person regardless of age; and handicapped or disabled individuals who have not attained 60 years of age, but who reside in housing facilities occupied primarily by the elderly at which congregate nutrition services are provided.

(B) Volunteers/Individuals with Disabilities

Each Area Agency on Aging shall establish procedures that will allow nutrition projects the option to offer a meal, on the same basis as meals are provided to elderly participants, to individuals providing volunteer services during meal hours, and to individuals with

disabilities who reside at home with and accompany older eligible individuals.

(2) Home Delivered Meals

Persons eligible to participate in this program include: a person age 60 or older who is homebound because of illness, or incapacitating disability, or who is otherwise isolated; and the spouse of the older person, regardless of age, if, according to the criteria established by the Area Agency on Aging, receipt of the meal is in the best interest of the older person; and a non-elderly disabled person who is a member of the household of an elderly home-delivered meals recipient.

(3) Assessment of Need

The Area Agency on Aging shall assess the level of need for congregate and home delivered meals within the planning and service area.

(h) **Contributions for Nutrition Services**

(1) Mandated Uses of Contributions

Nutrition services contributions shall be used to increase the number of meals served by a project, to facilitate access to such meals, and to provide other supportive services directly relate to nutrition services.

(2) Area Agency on Aging Policy on Contributions

Each Area Agency on Aging shall develop clear written policies for use by its service providers regarding contributions for services received through the program. These policies shall include:

(A) A statement stressing that no older person shall be denied service for failure or refusal to contribute to the cost of the meal.

(B) Meal fee policies for non-participants.

(C) A procedure which ensures the confidentiality of individuals' contributions.

This may include highly specific steps such as placement of a contribution box or collection of envelopes. The procedure determined by the Area Agency on Aging should avoid giving participants the impression that there is a fee for nutrition services.

(D) Procedures to safeguard and account for all contributions; which should include the counting of donations by at least two people, and the regular deposit of contributions.

(3) Cost of meals for Non-Participants

The cost of meals to non-participants shall, at a minimum, include the following costs: raw food, labor, transportation of food, utilities, cost of disposables.

(Adopted February 26, 1992; Amended June 2, 1992; Transferred and Amended October 7, 1997)

Sec. 17b-423-6. Community services policy manual-title III-D/In-home services

(a) **Purpose**

An Area Agency on Aging shall award funds received under Title III-D of the older Americans Act to provide in-home services to frail older individuals, including in-home supportive services for older individuals who are victims of Alzheimer's disease and related disorders with neurological and organic brain dysfunction, and to families of such victims.

(b) **Coordination**

In carrying out the provisions of Title III-D, the Area Agency on Aging shall coordinate with other community agencies and voluntary organizations providing counseling and training for family caregivers and support services personnel in management of care, functional and needs assessment services, assistance with locating, arranging for, and coordinating services, case management, and counseling prior to admission to nursing home to prevent premature institutionalization.

(c) **Eligibility Criteria**

An Area Agency on Aging shall award Title III-D funds to provide in-home services to clients who meet at least two of the four following eligibility criteria, or to the families of such clients:

(1) Are age 75 or older.

(2) Are in greatest economic need.

(3) Have non-economic factors contributing to their frail condition. This is defined as having one or more functional limitations in their activities of daily living (ADLs), or being diagnosed as having an Alzheimer's related dementia.

(4) Have non-economic and nonhealth factors contributing to the need of such services.

(d) **Maintenance of Effort**

Title III-D funds shall be in addition to, and may not be used to supplant any funds that are or would otherwise be expended under Federal, State, or local law by a State or unit of general purpose local government.

(Adopted February 26, 1992; Amended June 2, 1992; Transferred and Amended October 7, 1997)

Sec. 17b-423-7. Disease Prevention and Health Promotion Services

(a) **Purpose**

An Area Agency on Aging shall award funds received under Title IIIF of the Older Americans Act to provide disease prevention and health promotion services, and information at multipurpose senior centers, at congregate meal sites, through home delivered meals programs, or at other appropriate sites.

(b) **Distribution**

The state agency shall give priority, in carrying out the provisions of Title IIIF to areas of the state which are (1) medically underserved; and (2) in which there are a large number of older individuals who have the greatest economic need for such services.

(c) **Definition**

In carrying out the provisions of Title IIIF, the term "disease prevention and health promotion services" means -

(1) Health risk assessments;

(2) Routine health screening, which may include hypertension, glaucoma, cholesterol, cancer, vision, hearing, diabetes, and nutrition screening;

(3) Nutritional counseling and educational services for individuals and their primary caregivers;

(4) Health promotion programs, including programs relating to chronic disabling

conditions (including osteoporosis and cardiovascular disease) prevention and reduction of effects, alcohol and substance abuse reduction, smoking cessation, weight loss and control, and stress management;

(5) Programs regarding physical fitness, group exercise, and music, art, and dance-movement therapy, including programs for multigenerational participation that are provided by an institution of higher education; a local educational agency, as defined in section 1471 of the elementary and secondary education act of 1965 (20 U.S.C. 2891); or a community-based organization;

(6) Home injury control services, including screening of high-risk home environments and provision of educational programs on injury prevention (including fall and fracture prevention) in the home environment;

(7) Screening for the prevention of depression, coordination of community mental health services, provision of education activities, and referral to psychiatric and psychological services;

(8) Educational programs on the availability, benefits, and appropriate use of preventive health services covered under Title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.);

(9) Medication Management screening and education to prevent incorrect medication and adverse drug reactions;

(10) Information concerning diagnosis, prevention, treatment, and rehabilitation of age-related diseases and chronic disabling conditions, including osteoporosis, cardiovascular diseases, and alzheimer's disease and related disorders with neurological and organic brain dysfunction;

(11) Gerontological counseling; and

(12) Counseling regarding social services and follow up health services based on any of the services described above.

(Adopted February 26, 1992; Amended June 2, 1992; Transferred and Amended October 7, 1997)

Sec. 17b-423-8. National Family Caregiver Support Program – Title III-E of the Older Americans Act

(a) **Purpose**

The Department of Social Services shall operate a family caregiver support program pursuant to Title III-E of the Older American Act, 42 USC 3030s, as amended from time to time. The program shall be known as the "National Family Caregiver Support Program." The department shall award funds received under Title III-E of the Older Americans Act to an Area Agency on Aging to provide multifaceted systems of support services for family caregivers and for grandparents or older individuals who are relative caregivers. These services include information and assistance to caregivers, respite care to enable caregivers to be temporarily relieved of caregiver responsibilities and supplemental services to complement the care provided by caregivers. In addition, these funds may be used to provide individual caregiver counseling and training, as well as for the organization and operation

of support groups.

(b) **Definitions**

As used in this section:

(1) "Care recipient" means a child or an older individual who is receiving direct care services from a caregiver or a service provider;

(2) "Caregiver" means a "family caregiver" or a "grandparent or older individual who is a relative caregiver" as defined in subdivisions (b)(4) and (5) of this section. The caregiver is the recipient of the support services funded by the National Family Caregiver Support Act;

(3) "Child" means an individual who is not more than 18 years of age or who is an individual with a disability;

(4) "Family caregiver" means an adult family member, or another individual, who is an informal provider of in-home and community care to an older individual;

(5) "Grandparent or older individual who is a relative caregiver" means a grandparent or stepgrandparent of a child, or a relative of a child by blood, marriage or adoption who is 55 years of age or older and (A) lives with the child; (B) is the primary caregiver of the child because the biological or adoptive parents are unable or unwilling to serve as the primary caregiver of the child; and (C) has a legal relationship to the child, such as legal custody or guardianship, or is raising the child informally;

(6) "Program" means a caregiver support program funded by Title III-E, the National Family Caregiver Support Act, 42 USC § 3030s;

(7) "Personal care assistant services" means physical assistance provided to the care recipient, under the self-directed care option, that assist the care recipient to carry out activities of daily living and instrumental activities of daily living;

(8) "Self-directed care" means an optional approach to providing services under the National Family Caregiver Support program under which the respite services, provided by a personal care assistant, are planned, budgeted and purchased under the direction and control of the caregiver, the care recipient or the care recipient's representative; and

(9) "Title III-E" means the National Family Caregiver Support Program established pursuant to the National Family Caregiver Support Act, 42 USC 3030s.

(c) **Coordination**

An Area Agency on Aging shall coordinate its activities with the activities of other community agencies and volunteer organizations that provide the types of services required by the program to carry out the provisions of Title III-E.

(d) **Maintenance of Effort**

Title III-E funds shall be used in addition to, and may not be used to supplant, any funds that are or would otherwise be expended under federal, state or local law by a state or unit of general purpose local government for program services

(e) **Funding Parameters**

(1) The federal share of the cost of carrying out a program pursuant to this section shall not exceed seventy-five per cent of the total cost of the program. The nonfederal share of

the cost shall be provided from state and local sources.

(2) An Area Agency on Aging shall not use more than ten per cent of the total of federal and nonfederal shares awarded to them to provide program services to grandparents and older individuals who are relative caregivers.

(3) An Area Agency on Aging shall not use more than twenty per cent of the total federal and nonfederal share awarded to them to provide supplemental services to caregivers.

(4) An Area Agency on Aging shall not provide a direct subsidy to any caregiver through the program.

(f) **Eligibility**

For a caregiver to be eligible for caregiver support services under Title III-E, the following requirements shall be met:

(1) The caregiver shall be a "family caregiver" or a "grandparent or an older individual who is a relative caregiver" as defined in subsections (b)(4) and (5) of this section;

(2) the care recipient shall be a Connecticut resident who is residing in the community; and

(3) the care recipient shall be:

(A) A "child" as defined in subsection (b)(3) of this section; or

(B) an older individual who:

(i) Is unable to perform at least two activities of daily living without substantial human assistance, or three such activities if the care recipient is severely disabled; including verbal reminding, physical cueing, or supervision; or

(ii) due to a cognitive or other mental impairment, requires substantial supervision because the older individual behaves in a manner that poses a serious health or safety hazard to themselves or another individual.

(g) **Limitations on Services**

(1) Only one caregiver per care recipient may receive respite services in any fiscal year.

(2) Only one caregiver per care recipient may receive supplemental services in any fiscal year.

(3) A caregiver shall not receive respite service benefits for any care recipient in excess of $3,500 in any fiscal year. A caregiver shall not receive supplemental service benefits for any care recipient in excess of $7,500 in any fiscal year.

(h) **Priority**

Service levels are subject to the limits of funding allocations to an Area Agency on Aging. If an Area Agency on Aging determines that all requests for services cannot be accommodated within the funds allocated, then priority shall be given to:

(1) Caregivers who are older individuals with the greatest social need, and older individuals with the greatest economic need, with particular attention to low-income older individuals;

(2) grandparents or older individuals providing care to care recipients with severe disabilities, including children with severe disabilities as defined in 42 USC § 3002(48); or

(3) caregivers who provide care for care recipients with Alzheimer's disease and related

disorders with neurological and organic brain dysfunction.

(i) **Selection of Service Providers**

(1) General Rule

An Area Agency on Aging shall make awards for information and assistance to caregivers, individual caregiver counseling and training, organization and operation of support groups, respite care to enable caregivers to be temporarily relieved of caregiver responsibilities and supplemental services to complement the care provided by caregivers to a provider or providers that furnish any or all types of services. All service providers, except personal care assistants hired by the caregiver, the care recipient or the care recipient's representative under the self-directed care option, shall meet the requirements of subdivision (3) of this subsection.

(2) Process for Selecting Service Providers

(A) An Area Agency on Aging shall award funds either through a competitive grant process or contract process, as appropriate; or

(B) the caregiver, care recipient or the representative of a care recipient may opt to receive respite services through the self-directed care option, as defined in subsection (b) of this section. Under self-directed care, respite service providers are selected by the caregiver, the care recipient or the care recipient's representative.

(3) Service Provider qualifications

(A) A provider of services shall be accountable to each the contracting Area Agency on Aging, the caregiver, the care recipient or the care recipient's representative, as appropriate.

(B) A provider of respite services and supplemental services, as applicable, shall meet the requirements of provider participation of the specified services as established for the Connecticut Homecare Program for Elders, pursuant to section 17b-342-2 of the Regulations of Connecticut State Agencies, to the extent that such requirements do not conflict with this section.

(C) A provider of respite services funded by the National Family Caregiver Support program shall not be the spouse of the care recipient nor the conservator of the care recipient. The relative of the conservator of the care recipient may only be a provider of respite care services with prior approval from the department.

(D) A provider of respite care services shall agree to the rates of reimbursement established by the department for the Connecticut Home Care Program for Elders for the same or similar services. If the caregiver, the care recipient or the care recipient's representative chooses the self-directed care option, the rate paid to the personal care assistant shall be negotiated between the caregiver, the care recipient or the care recipient's representative and the personal care assistant.

(j) **Voluntary Contributions**

(1) A caregiver or a care recipient may, but shall not be required to, contribute to the cost of any service.

(2) An Area Agency on Aging:

(A) shall establish a non-coercive solicitation process to facilitate voluntary contributions

for program services;
(B) may request that a caregiver or a care recipient share in the cost of respite or supplemental services by voluntarily contributing to the cost of those services;
(C) shall not request that a caregiver or a care recipient share in the cost of services if the income of the care recipient is at or below the federal poverty level; and
(D) shall use funds received from voluntary contributions to apply to respite and supplemental program costs for services as appropriate.

(Adopted effective November 17, 2003; Amended June 5, 2012)

Sec. 17b-423-9—17b-423-18. Reserved

Sec. 17b-423-19. Community services policy manual - index
Sec. 17b-423-1. Introduction
(a) Definitions
(b) Purpose of Manual
(c) Scope and Organization
Section 17b-423-1: Introduction
Section 17b-423-2: Area Agency Designation
Section 17b-423-3: Application Procedures and General Policies
Section 17b-423-4: General Area Agency Responsibilities/Title III-B Operations
Section 17b-423-5: Title III-C Operations
Section 17b-423-6: Title III-D Operations
Section 17b-423-7: Title III-F Operations
Section 17b-423-19: Index
(d) The Title III Program
Sec. 17b-423-2. Area agency designation
(a) Designation of Planning and Service Areas
(1) General
(2) Application for Designation
(3) Periodic Review
(4) Decision
(b) Designation and Functions of Area Agencies on Aging
(1) General Rule
(2) Intrastate Funding Formula & Procedures
(3) Area Agency on Aging Functions
(4) Timetable for Designation
(5) Types of Agencies that May be an Area Agency on Aging
(6) Removal of Area Agency on Aging Designation
(c) Appeal Hearing Procedures to State Agency
(1) Applicants/Organizations Eligible for Appeal Hearings
(2) Written Request for Hearing
(3) Hearing Components

(4) Hearings for Service Denial Due to Discrimination
(d) Monitoring and Assessment
Sec. 17b-423-3. General application procedures and policies
(a) Purpose of Section
(b) Award of Older Americans Act Funds Administered by the Department
(1) Eligible Organizations
(2) Conditions of Awarding Title III Funds
(c) Responsibilities of Recipients of Award Under Title III of the Older Americans Act
(d) Procedures for Application for Support
(1) General
(2) Part of Area Plan Process
(e) Department Review of Applications
(1) General
(2) Notification of Award Process
(3) Award Conditions
(4) Operation of the Project Awarded
(f) General Policies
(1) Application Laws and Regulations for Title III Older Americans Act
(2) Administration
(3) Title VI of the Civil Rights Act
(A) General
(B) Non-Discrimination Policy
(4) Affirmative Action
(A) Requirement as Condition of Award
(B) Compliance with Title V Regulations
(C) Contractor/Subcontractor Compliance Statement
(5) Confidentiality and Disclosure
(A) Confidentiality
(B) Department Non Denial of Services Policy
(C) Maintenance of Grantees Reports and Records
(D) Disclosure
(6) Program Access Requirement
(A) Policy for Facilities Acquired with Older Americans Act and Department Funds
(B) Policy for Facilities Acquired Prior to October 1, 1980
(7) General Program Reporting Requirements
(8) Management Information System (MIS) Requirements
Sec. 17b-423-4. General area agency responsibilities
(a) Responsibilities of the Area Agency on Aging
(1) Staffing
(2) Direct provision of Services by an Area Agency on Aging
(A) General Rule

(B) Services Not Funded Under Older Americans Act
(C) Notification of Intent to Deliver Services
(3) Written Procedures
(4) Corporate Eldercare
(A) Scope and Organization
(B) Criteria
(C) Fiscal Controls
(D) Public Interest & Department Oversight
(b) The Area Plan Process
(1) General Provisions
(A) Purpose of Area Plan
(B) Duration and Format of the Area Plan
(2) Content of Area Plan
(A) General
(B) Area Agency on Aging Function Requirements
(C) Provision of Comprehensive and Coordinated Service Delivery System
(D) Service Delivery Requirements
(E) Priority Service Requirements
(F) Informational Requirements
(3) Amendments to an Area Plan
(4) Review of Area Plan and Amendments
(A) Public Hearings
(B) Public Hearing Standards
(C) Other Methods For Public Participation
(5) Area Plan Submission, Review and Approval
(A) General
(B) Schedule of Area Plan and/or Annual Update Reviews
(C) Department Actions on Area Plans
(6) Withdrawal of Area Agency on Aging Designation
(A) Conditions for Withdrawing Area Agency on Aging Designation
(B) Departmental Procedures to Withdraw Area Agency on Aging Designation
(7) Redesignation of an Area Agency on Aging
(8) Prior Approval of Contracts
(c) Area Agency on Aging Functions and Responsibilities Under an Area Plan
(1) Advocacy Responsibilities of the Area Agency on Aging
(2) Area Agency on Aging General Planning and Management Responsibilities
(3) Designation of Community Focal Points for Service Delivery
(4) Area Agency on Aging Board of Directors
(A) Functions of the Board
(B) Composition of the Board
(C) Frequency of Meetings

(D) Support
(E) Bylaws
(5) Area Agency on Aging Advisory Council
(A) Functions of the Council
(B) Composition of the Council
(C) Frequency of Meetings
(D) Support
(E) Bylaws
(6) Preference for Older Persons with Greatest Economic or Social Need
(7) Contribution for Services Under the Area Plan
(A) Opportunity to Contribute
(B) Failure to Contribute
(C) Contributions as Program Income
(8) Maintenance of non-Federal Support for Services
(9) Opportunity for Input by Consumers.

Sec. 17b-423-5. Community services policy manual title III-C/nutrition services

(a) Purpose
(b) Selection of Nutrition Providers
(1) General Rule
(2) Process for Selecting Nutrition Providers
(A) Area Agency on Aging Award Process
(B) Assurances of Maintenance of Effort and Non-Supplanting of Funds
(c) Bid Procedures for Contracts with Caterersit
(1) Procedures for Solicitation of Bids
(2) Bid Specifications
(3) Options Available to Soliciting Party
(4) Review of Approved Bids by the Department
(d) Operating Requirements for Nutrition Service Providers
(1) Staffing
(A) Adequate Number to Operate Program
(B) Employment Preference Given to 60+
(C) Consideration Given to Employing Minorities
(D) Nutritionist Staff Requirement
(E) Nutrition Assistant
(2) Congregate Meals
(A) Requirement that the Area Agency on Aging Staff Approve All New, Reopened or Relocated Meal Sites Prior to Opening
(B) Congregate Nutrition Provider Requirements
(C) Congregate Nutrition Site Requirements
(3) Home Delivered Meals
(e) Food Procurement/Food and Nutrition Requirements for Nutrition Service Providers

(1) Food Procurement
(A) USDA Food Assistance
(B) Food Stamp Program
(2) Food Requirements
(A) For Purchasing, Preparing and Delivering Meals
(B) Provision of Special Menus
(C) Availability of Appropriate Food Containers and Utensils
(3) Food Quality and Safety
(A) Standards of Quality, Sanitation and Safety
(B) Requirement to Use Only Commercially Processed Foods
(C) Items Prohibited From Purchase With Title III-C Funds
(4) Nutrition Standards
(A) Nutritional Values of Menus
(B) Fruit Requirement
(5) Menu and Recipe Requirements
(A) Menus
(B) Recipes
(C) Certification Required
(D) Certification of Individually Prescribed and Therapeutic Menus
(E) Record keeping
(6) Funding Restricted for Foods Not Conforming to Menu
(7) Leftover Food
(f) Coordination With Other Providers/Educators in the PSA
(g) Eligibility
(1) Congregate Nutrition Services
(A) Program Participants
(B) Volunteers/Individuals With Disabilities
(2) Home Delivered Meals
(3) Assessment of Need
(h) Contributions for Nutrition Services
(1) Mandated Uses of Contributions
(2) Area Agency on Aging Policy on Contributions
(3) Cost of Meals for Non-Participants
Sec. 17b-423-6. Title III-D/In-home services
(a) Purpose
(b) Coordination
(c) Eligibility Criteria
(d) Maintenance of Effort
Sec. 17b-423-7. Title III-F/disease prevention and health promotion services
(a) Purpose
(b) Distribution

(c) Definition

Secs. 17b-423-8—17b-423-18. Reserved

Sec. 17b-423-19. Index

(Adopted February 26, 1992; Amended June 2, 1992; Transferred and Amended October 7, 1997)

Agency
Department of Social Services

Subject
Protective Services for the Elderly

Inclusive Sections
§§ 17b-461-1—17b-461-9

CONTENTS

Sec. 17b-461-1. Definitions
Sec. 17b-461-2. Reporting suspected cases of abuse, neglect, exploitation or abandonment of elderly persons
Sec. 17b-461-3. Reporting requirements
Sec. 17b-461-4. Evaluation of report
Sec. 17b-461-5. Findings, referrals, registry and confidentiality
Sec. 17b-461-6. Procedures on referrals
Sec. 17b-461-7. Access to records, authority of the department and assistance by public or private agencies
Sec. 17b-461-8. Court procedures
Sec. 17b-461-9. Payment for protective services; procedures when elderly person unable to pay

Protective Services for the Elderly

Sec. 17b-461-1. Definitions

For purposes of sections 17b-461-1 through 17b-461-9

(a) "Abandonment" means the desertion or wilful forsaking of an elderly person by a caretaker, or the foregoing of duties, the withdrawal or neglect of duties and obligations owed an elderly person by a caretaker or other person.

(b) "Abuse" includes, but is not limited to, the wilful infliction of physical pain, injury or mental anguish, or the wilful deprivation by a caretaker of services which are necessary to maintain physical and mental health.

(c) "Capacity to consent" means the ability to understand, make and communicate responsible decisions concerning one's own person.

(d) "Caretaker" means"caretaker" as defined in Section 17b-450 of the Connecticut General Statutes.

(e) "Commissioner" means the Commissioner of Social Services.

(f) "Department" means the Department of Social Services.

(g) "Elderly person" means any resident of Connecticut who is sixty years of age or older.

(h) "Exploitation" means advantage taken of an elderly person by another person or caretaker whether for monetary, personal, or other benefit, gain or profit.

(i) "Neglect" means "neglect" as defined in section 17b-450 of the Connecticut General Statutes.

(j) "Protective Services" means the provision, by the state or other governmental or private organizations or individuals, of services necessary to prevent abuse, neglect, exploitation or abandonment.

(k) "Report" means a complaint received by the Commissioner or his designee which presents reasonable cause to believe that an elderly person is being or has been abused, neglected exploited or abandoned.

(*l*) "Reasonable cause" means sufficiently substantiated allegations of an elderly person's physical, mental, emotional or financial condition, and of the action or inaction of any other person(s) with regard thereto establishing a basis for suspicion or belief that the elderly person is being or has been abused, neglected, exploited or abandoned.

(m) The term "services which are necessary to maintain physical and mental health" includes, but is not limited to, the provision of medical care for physical and mental health needs, the relocation of any elderly person to a facility or institution able to offer such care, assistance in personal hygiene, food, clothing, adequately heated and ventilated shelter, protection from health and safety hazards, protection from maltreatment the result of which includes, but is not limited to, malnutrition, deprivation of necessities or physical punishment, and transportation necessary to secure any of the above stated needs, except that this term shall not include taking such person into custody without consent except as

provided in Sections 17b-450 to 17b-461, inclusive, of the Connecticut General Statutes.

(Effective October 2, 1991; Transferred and Amended June 10, 1998)

Sec. 17b-461-2. Reporting suspected cases of abuse, neglect, exploitation or abandonment of elderly persons

(a) Persons required by law to report instances of abuse, neglect, exploitation or abandonment of an elderly person shall report such information within five calendar days to the Commissioner or to the Commissioner's designee.

(1) Persons required to make such reports are any physician or surgeon licensed under the provisions of Chapter 370 or 371 of the Connecticut General Statutes, any resident physician or intern in any hospital in this state, whether or not so licensed, any registered nurse, any nursing home administrator, nurse's aide or orderly in a nursing home facility, any person paid for caring for a patient in a nursing home facility, any staff person employed by a nursing home facility, any patient's advocate and any licensed practical nurse, medical examiner, dentist, osteopath, optometrist, chiropractor, podiatrist, social worker, clergyperson, police officer, pharmacist or physical therapist, who has reasonable cause to suspect or believe that any elderly person has been abused, neglected, exploited or abandoned or is in a condition which is the result of such abuse, neglect, exploitation or abandonment, or who is in need of protective services, shall within five calendar days report such information or cause a report to be made in any reasonable manner to the Commissioner or to the person or persons designated by him to receive such reports. Any person required to report under the provisions of this section who fails to make such report shall be fined not more than five hundred dollars.

(2) This report shall include the name and address of the elderly persons, description of the abuse, neglect, exploitation or abandonment being reported, as well as any other information which the person making the report believes may be helpful in the investigation of the case or the protection of the victim.

(b) Any other person who has reasonable cause to believe that an elderly person is being, or has been, abused, neglected, exploited or abandoned or is in need of protective services, may report the matter to the Commissioner or the Commissioner's designee.

(c) Treatment of an elderly person by a Christian Science practitioner, rather than by a licensed physician or medical practitioner, shall not of itself constitute grounds for the implementation of protective services.

(Effective October 2, 1991; Transferred and Amended June 10, 1998)

Sec. 17b-461-3. Reporting requirements

(a) Reports of suspected abuse, neglect, exploitation or abandonment shall be received:

(1) At the regional offices of the department during the usual and customary business hours of the Department or

(2) During nonbusiness hours, at such telephone numbers as the department may

designate and appropriately publicize.

(Effective October 2, 1991; Transferred and Amended June 10, 1998)

Sec. 17b-461-4. Evaluation of report

(a) Each report received shall be promptly and thoroughly evaluated, as follows:

(1) The department, or such other appropriate person(s) or agency as may be requested and available to assist in the evaluation, shall visit the elderly person, unless the elderly person or his caretaker denies access for such a visit;

(2) The department, or such other person(s) or agency as may be requested and available to assist in the evaluation, shall consult with such others as may have additional knowledge of the particular circumstances or needed expertise in regard thereto.

(b) Any person(s) requested and available to assist the department in evaluating a report must promptly transmit any findings to the department.

(c) Based on information gathered through personal visit(s) and/or consultations, or otherwise determined in the course of the evaluation, the department shall make written findings as to the report of abuse, neglect, exploitation or abandonment including verification of the elderly person's age.

(Effective October 2, 1991; Transferred and Amended June 10, 1998)

Sec. 17b-461-5. Findings, referrals, registry and confidentiality

(a) If upon completion of the evaluation of a report the department determines that protective services are needed and, if the elderly person consents, the department shall arrange for protective services.

(b) If upon completion of the evaluation of a report the department determines that protective services are needed but the elderly person fails to consent thereto, and the department has reason to believe that such person is incapable of managing his personal or financial affairs, the department shall determine the appropriateness of establishing a conservatorship for such person.

(c) If the department determines that no protective services are needed, the department may:

(1) Take such steps, including contacting any other agencies, organizations or individuals as may be appropriate, to assure the resolution of the reported situation; and/or

(2) Close the case.

(d) The department shall maintain a statewide registry of reports received and case narrations which shall include actions recommended and taken in the form of a case plan.

(e) The client's file, the original report and the evaluation report shall not be deemed public records or be subject to the provisions of Section 1-19 of the Connecticut General Statutes. The name of the person making the original report or the name of any person mentioned in such report shall not be disclosed unless: the person making the original report specifically requests such disclosure; or unless a judicial proceeding results therefrom; or unless disclosure of the name of the elderly person about whom the report was made is

required to fully evaluate a report.

(Effective October 2, 1991; Transferred and Amended June 10, 1998)

Sec. 17b-461-6. Procedures on referrals

(a) Upon receipt of a report, the Department shall initiate activities for the provision of appropriate services.

(b) If the elderly person refuses services offered by the Department the case shall be closed unless the department has reason to believe that such elderly person is incapable of managing his personal or financial affairs. In such case, the department shall provide protective services to the extent possible and may apply to probate court for the appointment of a conservator of person or estate, as appropriate.

(Effective October 2, 1991; Transferred and Amended June 10, 1998)

Sec. 17b-461-7. Access to records, authority of the department and assistance by public or private agencies

(a) Any person, department, agency or commission authorized to carry out the duties enumerated in Chapter 319dd inclusive of the Connecticut General Statutes shall have access to all relevant records, except that records which are confidential to an elderly person shall only be divulged with the written consent of the elderly person or his/her representative. The authority of the Department under Section 17b-454 of the Connecticut General Statutes, shall include, but not be limited to, the right to initiate or otherwise take those actions necessary to assure the health, safety and welfare of any elderly person, subject to any specific requirement for individual consent.

(b) In performing the duties set forth in Chapter 319dd of the Connecticut General Statutes, the department may request the assistance of the staffs and resources of all appropriate state departments, agencies and commissions and local health directors, and may utilize any other public or private agencies, groups or individuals who are appropriate and who may be available.

(Effective October 2, 1991; Transferred and Amended June 10, 1998)

Sec. 17b-461-8. Court procedures

(a) If it appears to the social worker responsible for providing necessary protective services to a consenting elderly person that the caretaker of such person, as defined in Section 17b-461-1 of the Regulations of Connecticut State Agencies, is interfering with or threatens to interfere with the provision of protective services to the extent that the delivery of such services will become impaired, that information shall be reported to the Commissioner or his designee. If the facts of the case indicate that court action is required, a petition may be filed with the probate court in the district in which the elderly person resides for an order enjoining the caretaker as provided by Section 17b-453(b) of the Connecticut General Statutes. The Commissioner shall be represented by the Attorney General in any such proceedings. If it appears to the Attorney General that the application

for a restraining order hereunder is of such serious nature that it may result in appeal or other legal problems, then upon the advice of the Attorney General, the commissioner may, as an alternative, file such application in the superior court of proper jurisdiction. At any hearing held on such application, those persons from the Department who have knowledge of the facts involved shall appear as witnesses. Other witnesses may be subpoenaed by the Attorney General as necessary.

(b) In the event that a restraining order is obtained under subsection (a) of this section and the caretaker of the elderly person refuses to allow the delivery of services as provided in Section 17b-453(b) of the Connecticut General Statutes, then the Commissioner shall apply to the superior court which has jurisdiction as set forth in the Connecticut General Statutes and the Connecticut Practice Book for a contempt of court order against such caretaker.

(c) If the Commissioner finds that an elderly person is being abused, neglected, exploited or abandoned and lacks capacity to consent to reasonable and necessary protective services, he may petition the probate court for appointment of a conservator of the elderly person pursuant to the provisions of Chapter 802h of the Connecticut General Statutes in order to obtain such consent. Such petition shall be brought in the probate court for the district in which such elderly person resides or has his or her domicile. At any hearing scheduled by the probate court on said petition, the commissioner or his designee shall be represented by the Office of the Attorney General.

(d) In any proceeding in probate court pursuant to provisions of the Connecticut General Statutes the probate court shall appoint an attorney to represent the elderly person if he or she is without other legal representation.

(e) If the probate court concludes that a conservator is required and appoints the commissioner to be conservator of the person, then the necessary protective services shall be delivered. Whenever the Commissioner is designated herein to act as conservator, he may delegate the performance of such duties in accordance with the Connecticut General Statutes.

(f) If the court appoints an individual, agency or organization other than the commissioner to be conservator of such elderly person then the commissioner or his designee shall make suitable arrangement with such conservator for the delivery of services. In the event the conservator refuses to allow the delivery of such services, the commissioner or his designee may petition the court of probate which appointed such conservator for his removal for cause shown.

(g) In the event that it appears to any person involved in the delivery of protective services that an elderly person is being abused, neglected, exploited or abandoned and lacks capacity to consent to reasonable and necessary protective services, and that to have an application for the appointment of a conservator of his person processed in the ordinary manner would result in a delay which would cause imminent danger to the health and welfare of such elderly person, then the commissioner shall apply for the appointment of a temporary conservator under the provisions of Section 45a-654 of the Connecticut General

Statutes. The provisions of Section 17b-461-8(c) above with respect to the representation of the commissioner by the Office of the Attorney General shall apply.

(h) In the event that the commissioner or his designee concludes that there is no need for continuation of a conservatorship of an elderly person then the commissioner or his designee shall apply to the probate court which appointed such conservator for the termination of the conservatorship. The commissioner or his designee shall provide such investigative, medical reports and other evidence as may be requested by the court of probate for use in determining whether or not to grant such application. In the event the court of probate denies such application, but the commissioner determines that further involvement of the Department is either unnecessary or unwarranted, then the commissioner or his designee may resign as conservator of the elderly person. If the court of probate concludes that it is in the best interest of such elderly person, then it shall appoint some other suitable person to be conservator of his or her person under the provision of section 45a-660 of the Connecticut General Statutes.

(Effective October 2, 1991; Transferred and Amended June 10, 1998)

Sec. 17b-461-9. Payment for protective services; procedures when elderly person unable to pay

(a) Protective services shall be provided for any elderly person prior to an evaluation of his or her ability to pay, if needed. The Department shall conduct an investigation to determine the client's ability to pay for such services as soon as possible.

(b) It shall be determined that an elderly person has the ability to pay for services if: (1) his or her income exceeds 200% of the federal poverty income guidelines as published from time to time in the Federal Register and/or; (2) his or her assets exceed those established for the state funded portion of the Connecticut Home Care Program for Elders.

(c) The commissioner or his designee may petition the probate court for reimbursement of provided services, from a client's income and/or estate, when a client has the ability to pay but refuses to do so.

(d) The commissioner or his designee shall follow the procedures and policies established under the department's uniform policy manual section 7500 when it becomes necessary to recover payment for protective services made for a financially ineligible client. This shall include referral to the regional resource staff and collection by the Bureau of Collections.

(Effective October 2, 1991; Transferred and Amended June 10, 1998)

Agency
Department of Social Services

Subject
Management of Continuing Care Facilities

Inclusive Sections
§§ 17b-533-1—17b-533-11

CONTENTS

Sec. 17b-533-1. Definitions
Sec. 17b-533-2. Registration; filing and acknowledgment
Sec. 17b-533-3. Disclosure statements: form and content
Sec. 17b-533-4. Escrow accounts
Sec. 17b-533-5. Reserve fund escrow
Sec. 17b-533-6. Annual filings
Sec. 17b-533-7. Disclosure statements: revisions
Sec. 17b-533-8. Investigations
Sec. 17b-533-9. Receivership: rehabilitation, and liquidation
Sec. 17b-533-10. Miscellaneous
Sec. 17b-533-11. Advisory committee

Management of Continuing Care Facilities

Sec. 17b-533-1. Definitions

As used in Section 17b-533-1 to Section 17b-533-11, inclusive:

(a) **Continuing-care contract** means:

(1) An agreement pursuant to which a provider undertakes to furnish to a person not related by consanguinity or affinity to the provider, shelter and medical or nursing services or other health-related benefits for the life of a person or for a period in excess of one year, and which requires a present or future transfer of assets, or an entrance fee in addition to or instead of periodic charges, and the amount of the assets required to be transferred or the entrance fee is equal to or in excess of twenty thousand dollars.

(2) Notwithstanding the amount of assets or entrance fee, all contracts through which continuing-care is offered at a facility offering any "continuing-care contract" as hereinabove defined, shall be included in that definition.

(3) Contracts involving usual and customary leaseholds, and for conveyances of ownership interests, including condominiums, which are freely transferable and which constitute security for the purchaser's payment, shall not be deemed to constitute continuing-care contracts.

(b) **Act** means P.A. 86-252, an Act concerning management of continuing-care facilities (C.G.S. Sec. 17a-360 et seq.)

(c) **Commissioner** means the commissioner on aging.

(d) **Committee** means the advisory committee established by the C.G.S. 17b-535.

(e) **Continuing care retirement community** means the actual or proposed site or sites at which services or care are to be provided in accordance with a continuing care contract.

(f) **Disclosure statement** means the documents required to be filed with the department by either by the Act, or these regulations, or provided to a prospective purchaser or resident.

(g) **Escrow Agent** means a financial institution authorized to conduct business in this State, which has a fiduciary relationship with a provider, for the purpose of meeting the requirements of the Act and of these regulations.

(h) **Legal representative** means an attorney, guardian, conservator, or any other person including a family member, designated by a resident or potential future resident as his or her representative.

(i) **Medical or nursing services or other health-related benefits** means services or benefits to which a resident becomes contractually entitled as a result of a transfer of assets, payment of the entrance fee or of the periodic charges, or purchased for a fee in addition to a transfer of assets, an entrance fee, or periodic charges. These services or benefits include the following when a facility or service is licensed pursuant to C.G.S. Sec. 19a-490, et seq.:

Hospital care;

Home health care by a Home Health Care Agency, or Homemaker-Home Health Aide Agency; and

Care in a Nursing Home, or priority access to a nursing home.

(j) **Offer** means an offer through either personal, telephone or mail contact or other

communication directed to or received by a person at a location within this state as an inducement, solicitation, or attempt to encourage a person to enter into a continuing-care contract and shall include any paid advertisement published or broadcast within this state, except for advertisements in periodicals where more than two-thirds of the circulation is outside this state.

The term "offer" shall not include marketing or feasibility studies, or any communication with an individual at the request of, or initiated by, that individual in regard to a continuing-care contract not intended to be performed within this state.

In regard to proposed facilities, the term "offer" shall not include options, or rights of first refusal involving consideration of one thousand dollars or less, provided that any such funds are (1) Either maintained in a passbook or equivalent account in the name of the prospective resident, or in an escrow account established with a financial institution solely for the purpose of holding such funds, (2) returnable to the individual upon demand, together with accrued interest thereon, by transfer of the passbook or otherwise, and the prospective resident is made fully aware of the foregoing provisions, by means which shall include contrasting, prominent type, setting forth the essence of these provisions in every option document.

(k) **Reasonable charge** means either the amount specified in a continuing-care contract or disclosure statement or, in the absence of being specified, a fee based upon actual costs in time, expense, overhead, etc. of selling or re-selling a continuing-care contract in regard to a specific dwelling unit at a facility.

(Effective January 31, 1996)

Sec. 17b-533-2. Registration; filing and acknowledgment

(a)

(1) The commissioner, or the designee of the commissioner, shall acknowledge in writing the filing of a disclosure statement within ten business days of the date such statement is received if the disclosure statement, on its face, either meets the requirements of the Act, and these regulations, or contains only technical discrepancies. Such acknowledgment shall specify the fee which is due under Section 17b-533-10 (c) (2) of these regulations.

(2) If the commissioner determines that the disclosure statement, on its face, does not meet the requirements of the Act or these regulations, and will not be accepted for filing, written notification of that determination, stating the reasons therefor, will be given to the provider within ten business days of the date such statement is received. Such notification will not be accompanied by a return of the documents tendered.

(3) If neither an acknowledgment of filing nor notification of non-acceptance for filing is made within ten business days a provider may, until notification to the contrary, utilize the disclosure statement for the purposes of the Act.

(b) Upon notification that the disclosure statement has been accepted for filing, and that the required fee has been received pursuant to Section 17b-533-10 (c) of these regulations, the provider may use the disclosure statement for the purposes of the Act.

(c)

(1) Upon notification that the disclosure statement submitted is not accepted for filing, the provider may not, until resolution of the discrepancies by acceptable amendment, appeal, litigation, agreement, or otherwise, use the disclosure statement for the purposes of the Act and, until such resolution, shall refrain from offering or entering into a continuing-care contract in this state, or with any resident of this state, or regarding any facility in this state, based upon the rejected disclosure statement.

(2) Use of a rejected disclosure statement for the purposes of the Act shall be grounds for an immediate request to the Attorney General by the commissioner for the initiation of appropriate legal action, including action to enjoin use of such a rejected disclosure statement.

(d)

(1) Notwithstanding an acknowledgement of acceptance for filing, the commissioner may at any time thereafter review or investigate the information contained in any disclosure statements accepted for filing to determine accuracy and completeness thereof.

(2)

(A) In the event that a subsequent review or investigation determines that any disclosure statement does not in fact meet the requirements of the Act and of these regulations, the commissioner shall forthwith notify the provider thereof, and the reasons therefor, but no penalties shall be assessed or sought for use of the defective disclosure statement for the period between an initial favorable acknowledgement and subsequent review and notice of discrepancies.

(B) In the event of such a subsequent determination, the commissioner may, in the case of technical or minor discrepancies, authorize continued use of the defective disclosure statement until the discrepancies can be conveniently corrected either by way of amendment or in a subsequent disclosure statement.

(C)

(i) In the event discrepancies in the disclosure statement arise by reason of an untrue statement of material fact or failure to state a material fact then, on notification by the commissioner, the provider shall take such action as may be satisfactory to the commissioner to correct the disclosure statement and to notify prospective residents of changes therein.

(ii) In the event that a provider shall fail to take such action, or if it appears to the commissioner that the discrepancies were intentional, then the commissioner shall request the Attorney General to initiate appropriate legal action, including action to enjoin any use of the disclosure statement.

(Effective January 31, 1996)

Sec. 17b-533-3. Disclosure statements: form and content

(a) There shall be one disclosure statement for each facility.

(1) No representation shall be made on the cover page or elsewhere in any disclosure statement as to the validity of the disclosure statement, a period of time during which the

disclosure statement remains valid or effective, or which in any manner indicates, infers, or represents that the disclosure statement is effective or valid.

(2) The disclosure statement must include a cover page, table of contents, and the information required by the Act and these regulations.

(3) In addition to such other items as a provider may wish to list therein, the Table of Contents must include the following headings, in prominent type, to identify where in the disclosure statement, or the continuing-care contract, the information required by the Act is located: (Numerical reference is to the subsections of C.G.S. Section 17b-522 (a).):

NAME AND ADDRESS OF PROVIDER	(1)
OFFICERS, DIRECTORS, AND TRUSTEES	(2)
BUSINESS EXPERIENCE	(3)
JUDICIAL PROCEEDINGS	(4)
AFFILIATION	(5)
DESCRIPTION OF PROPERTY	(6)
BENEFITS INCLUDED	(7)
INTEREST ON DEPOSITS	(8)
TERMINATION OF CONTRACT	(9)
RIGHTS OF A SURVIVING SPOUSE	(10)
MARRIAGE OF A RESIDENT	(11)
DISPOSITION OF PERSONAL PROPERTY	(12)
TAX CONSEQUENCES	(13)
RESERVE FUNDING - ESCROWS	(14)
FINANCIAL STATEMENTS	(15)
SOURCE OF FUNDS (if facility is not in operation)	(16)
PRO FORMA INCOME STATEMENTS	(17)
ENTRANCE FEES/PERIODIC CHARGES	(18)
PRE-PAID OBLIGATIONS, ACTUARIAL VALUE	(19)
DEPARTMENT ON AGING - FILINGS	(20)
CONTINUING-CARE CONTRACT	(21) (c)

(4) A disclosure statement may utilize a table of contents other than as set forth in subsection (3) if, when submitted for filing, the disclosure statement is accompanied by an index which cross-references the requirements of subsection (3) above with the table of contents in the disclosure statement.

(5) The disclosure statement may include the required information in any order, at the discretion of the provider, provided that the Table of Contents or separate index clearly sets forth the location of the required information.

(6) The disclosure statement shall be assembled into one document, except if a provider shall determine that financial and actuarial data can be more conveniently or logically combined into one separate document, then two documents may be submitted as the disclosure statement.

(b) A disclosure statement submitted to the department for filing may be accompanied by an actuarial certificate, signed by a member in good standing of the American Academy of Actuaries, stating that financial and actuarial projections have been made upon an actuarially sound basis in accordance with accepted actuarial principles. In that event, the initial requirements for filing in regard to actuarial soundness shall be deemed to have been met.

(c)

(1) Actions initiated by the Attorney General against a provider in regard to non-compliance with the Act or these regulations shall, if not concluded, be affirmatively disclosed in disclosure statements filed subsequent to the initiation of such action by inclusion of a statement, under the heading JUDICIAL PROCEEDINGS, to the effect that such an action or actions have been instituted and are continuing. In such event, the provider shall initiate the filing of a revised disclosure statement not later than one (1) year from the date on which any such action is initiated.

(2) The requirements set forth in subsection (c) (1), above, may be waived by the commissioner upon application in writing by a provider, if the commissioner determines that the action or actions instituted arose by reason of the existence of a good faith dispute as to the scope or applicability of the Act or the regulations.

(3) If there are no proceedings to be reported under the heading JUDICIAL PROCEEDINGS, the disclosure statement shall contain an affirmative statement to that effect. Both the heading and this statement shall be omitted from the disclosure statement if the only disclosure required had been in regard to actions brought by the Attorney General, and the disclosure of such action had been waived pursuant to subsection (c) (2), above.

(d) If the manner in which periodic charges or other recurring fees may be adjusted is not set forth with specificity in the contract, by formula or otherwise, but rather indicates a general basis therefor, such as, "increases in taxes, and maintenance costs of the facility," then the disclosure statement shall include a statement to the effect that periodic charges (or other recurring fees) may be made at the discretion of the provider. Such a statement shall be included under the heading "Entrance Fees/Periodic Charges."

(e) A disclosure statement for a continuing care retirement community at which any incident of ownership is or may be transferred in whole or in part shall meet the foregoing requirements, and in addition, the proposed documents which would transfer any incident of ownership shall be included under item "(21)."

(Effective January 31, 1996)

Sec. 17b-533-4. Escrow accounts

(a) No escrow agreement entered into pursuant to this section shall be deemed to meet

the requirements of the Act or these regulations if it provides either for withdrawals contrary to the terms of the Act, or for changes in terms of the escrow agreement in regard thereto without prior notification to the commissioner of the proposed changes.

(b) Every escrow agreement shall contain, either in the original agreement, or in an amendment thereto, the requirement of prior notification to the commissioner as set forth in subsection (a), above.

(c) In the event the commissioner determines that an escrow agreement filed with the department does not meet the requirement of the Act and this section of the regulations, the commissioner may take such action as is consistent with the Act and these regulations.

(d) A provider may submit any existing or proposed escrow agreement to the department for an informal review. Notwithstanding either favorable or adverse comments thereon, such informal review or comments shall in no way be construed to be the position of the department, which can only be determined after such instrument is formally reviewed.

(Effective January 31, 1996)

Sec. 17b-533-5. Reserve fund escrow

(a) Upon written application by a provider, the commissioner may authorize a facility to maintain a reserve fund escrow or escrows in an amount less than required pursuant to the computation set forth in C.G.S. Sec. 17b-525, if the commissioner finds that the contractual liabilities of the provider and the best interests of the residents may be adequately protected by a reserve fund escrow or escrows in a lesser amount.

(b) The written application by the provider shall contain sufficiently detailed supporting information, including that relating to contracts, deposit agreements, and other material necessary to fully disclose to the commissioner the scope and status of such matters, and the basis for the application.

(c) Matters that will be considered by the commissioner in regard to the application include, but are not limited to, the following:

(1) Whether any separate fund which the provider wishes to have considered is maintained with an escrow agent pursuant to a written agreement;

(2) Whether the portion which would be withdrawn monthly from the reduced Section 17b-525 escrow without approval of the commissioner is substantially in accordance with the following formula:

Portion Authorized to be Withdrawn monthly = $A/S \times 1/12$

Where A = The reduced escrow amount; and

Where S = The statutory escrow amount.

(3) Whether the combined total amount proposed to be withdrawn from all such reserve or operating funds without the prior approval of the commissioner, does not exceed 1/12 of the combined amount of such funds.

(Effective January 31, 1996)

Sec. 17b-533-6. Annual filings

(a) A provider operating any facility located in this state shall file with the department the following financial and actuarial information pertaining to residents under continuing-care contracts for each facility located in this state and operated by the provider or by a manager under contract to the provider:

(1) The facility's current rate schedule;

(2) Residential turnover rates for the most recently completed fiscal year, and anticipated for the next five years;

(3) The projected average age of the residents for the next five years;

(4) Health-care utilization rates, including admission rates and days per one hundred residents by level of care for the most recently completed fiscal year, and anticipated for the next five years;

(5) Occupancy rates for the most recently completed fiscal year, and anticipated for the next five years;

(6) The number of Health care admissions pursuant to continuing-care contracts for the most recently completed fiscal year, and anticipated for the next five years;

(7) The days of care per year for the most recently completed fiscal year, and anticipated for the next five years;

(8) The number of permanent transfers to a facility that provides medical or nursing services or other health-related benefits for the most recently completed fiscal year;

(9) A statement of source and application of funds for the five-year period beginning the year of initial filing pursuant to C.G.S. section 17b-528 or subsequent filing pursuant to C.G.S. section 17b-528;

(10) Financial statements including certified current balance sheets and certified income statements, changes in financial position, and pro forma statements for the next five years as provided in C.G.S. section 17b-522, and either such information as is necessary to assess the actuarial soundness thereof or an actuarial certificate as provided below in subsection (i) (2) of this section;

(11) The basis for amortization assumptions for the provider's capital cost;

(b) The financial and actuarial information shall be filed annually, within one hundred fifty days following the end of the fiscal year of the provider. At the discretion of the provider, the first such statement may be filed simultaneously with the initial revised disclosure statement as set forth in section 17b-533-7 hereof.

(c)

(1) If a provider is required to submit an annual financial and actuarial filing, a valid filing shall be supplemental to, and a prerequisite for, the continued effectiveness of a provider's latest disclosure statement on file with the department.

(2) In the event that an annual filing is not submitted as required, the provider's latest disclosure statement on file with the Department shall cease to be effective for the purposes of the Act, and such disclosure statement shall remain ineffective until the provider receives acknowledgement of the filing of the financial and actuarial information required by this

section.

(d) The commissioner shall acknowledge in writing the filing of the financial and actuarial information within ten business days of the date it is received, if the information either meets the requirements of the Act or contains only technical discrepancies.

(e) The commissioner shall set forth the initial determination of the department in conjunction with such acknowledgement, in the same manner as provided in section 17b-533-2 of these regulations regarding disclosure statements.

(f) If the commissioner determines that the information filed does not on its face meet the requirements of the Act or these regulations, and will not be accepted for filing, the provider shall be notified in writing within ten business days of receipt of the financial and actuarial information of such determination and the reasons therefor. Such notification will not be accompanied by return of the documents.

(g) If neither an acknowledgement of filing nor notification of non-acceptance for filing is made within ten business days, a provider may, until notification to the contrary, deem that the financial and actuarial information has been accepted for filing.

(h) Upon a determination that the financial and actuarial information will not be accepted for filing, the commissioner may notify the Office of the Attorney General of the deficiency and request that appropriate legal action be initiated to compel compliance with the Act, recover an appropriate fine therefor, or for such other relief as may be deemed appropriate; provided, that no such request shall be made for non-material technical discrepancies with respect to the Act or these regulations.

(i)

(1) Required financial and actuarial information shall be filed in one document which shall consist of a cover page, a table of contents, and the information in such order as may be convenient for the provider; provided, that the table of contents adequately identifies by number, words, or both, the material included in the filing for ready comparison with the information required by the Act and these regulations.

(2) Any filing under this section which is accompanied by an actuarial certificate signed by a member in good standing of the American Academy of Actuaries stating that the financial and actuarial projections have been made on an actuarially sound basis in accordance with accepted actuarial principles shall be deemed to have met the initial requirements for filing in regard to actuarial soundness.

(j) Notwithstanding acknowledgement of acceptance for filing, the commissioner may at any time thereafter review and investigate the financial and actuarial information filed pursuant to this section to determine the accuracy and completeness thereof.

(Effective January 31, 1996)

Sec. 17b-533-7. Disclosure statements: revisions

(a) Within one hundred fifty days following the end of the first fiscal year of a provider in which a registration is filed, and if that registration has not been withdrawn, a provider shall file a revised disclosure statement.

(b) Subsequent to the mandatory submission of the first revision of its disclosure statement, a provider need only initiate the filing of such revised disclosure statements as it deems necessary to prevent a disclosure statement from containing a material misstatement of fact or from omitting a material fact required to be stated therein. Filings of optional disclosure statements shall be accompanied by a written statement from the provider setting forth why it deemed such a revision to be necessary.

(c) Acknowledgement of filing or rejection of revised disclosure statements, shall be in the same manner as set forth in Section 17b-533-2 of these regulations.

(d) The form and content of revised disclosure statements shall be the same as set forth in Section 17b-533-3 of these regulations.

(e) Notwithstanding an acknowledgement of acceptance for filing, the commissioner may at any time thereafter review and investigate the information contained in revised disclosure statements accepted for filing to determine accuracy and completeness thereof.

(f) In the event that a subsequent review determines that a revised disclosure statement does not in fact meet the requirements of the Act and of these regulations then the commissioner may take such actions as are set forth in Section 17b-533-2 (d) (2).

(Effective January 31, 1996)

Sec. 17b-533-8. Investigations

(a) Investigations, inquiries, and investigatory hearings as are deemed necessary by the commissioner to develop information for the use of the department may be conducted for the following purposes:

(1) To determine whether any person has violated any provision of the Act or of these regulations, relating to registration, disclosure, or escrow provisions relating to continuing-care contracts;

(2) To aid in the enforcement of the Act, including the regulations promulgated pursuant thereto; and

(3) To aid in the prescribing of regulations by the commissioner.

(b)

(1) Notice of investigatory hearings shall be given in such manner and to such persons as appropriate in order to afford adequate, timely knowledge of the proceeding to any person specifically affected thereby; provided, that in hearings pertaining to providers or continuing-care contracts in general, no general notifications to all providers need be made.

(2) Notice of investigatory hearing shall provide for a hearing date not less than ten calendar days from the date of mailing the notice. The hearing date may be changed by the commissioner, for good cause shown, upon the request of any person.

(3) The commissioner, or any presiding officer authorized by the commissioner to conduct any inquiry, investigation or hearing shall have power to administer oaths and take testimony under oath relative to the matter of inquiry or investigation. At any investigatory hearing ordered by the commissioner, the commissioner or such presiding officer having authority by law to issue such process may subpoena witnesses and require the production

of records, papers and documents pertinent to such inquiry. If any person disobeys such process or having appeared in obedience thereto, refuses to answer any pertinent question put to him by the commissioner or by the presiding officer or to produce any records and papers pursuant thereto, the commissioner or the presiding officer as the commissioner's agent may apply to the superior court for Hartford county or for the county wherein the person resides or wherein the business has been conducted, or to any judge or said court if the same is not in session, setting forth such disobedience to process or refusal to answer, and said court or such judge shall cite such person to appear before said court or such judge to answer such question or to produce such records and papers.

(4) Any person subpoenaed to attend a hearing may be accompanied by an attorney and may, not less than five days prior to such hearing, request that a transcript of the hearing be made by an official stenographer or court reporter.

(5) It shall be the sole responsibility of any person desiring a copy of a hearing transcript to obtain a copy from the reporter or stenographer.

(c) If, as the result of an investigation, inquiry, or investigatory hearing conducted for the purposes set forth in the Act and these regulations, the commissioner determines that any provider has violated any provision of the Act, the commissioner may, without further action, request the attorney general to seek a temporary or permanent injunction and such other relief as may be appropriate to enjoin such provider from continuing such violation or violations.

(Effective January 31, 1996)

Sec. 17b-533-9. Receivership: rehabilitation, and liquidation

(a) The commissioner shall give not less than five calendar days written notice to a provider or a facility of an intention to request the Attorney General to apply for an order appointing a receiver to rehabilitate or liquidate a facility.

(b) Such notice shall be sent by certified mail, return receipt requested, or delivered personally to the business or other office of the provider at the facility, or elsewhere within the state, in which event an affidavit of service shall be executed.

(c) Such notice shall include a summary of the basis for the action, and the date on which the commissioner will request the Office of the Attorney General to initiate action, together with the following statement:

YOU MAY REQUEST A HEARING

ON THIS MATTER NOT LATER THAN

(one day prior to the date on which

the commissioner is to take action.)

SUCH A REQUEST MUST BE IN WRITING.

FAILURE TO REQUEST SUCH A HEARING WILL

RESULT IN LEGAL ACTION FOR THE APPOINTMENT

OF A RECEIVER TO REHABILITATE OR LIQUIDATE YOUR FACILITY.

(d)

(1) A request for a hearing must be in writing, and shall be delivered to the commissioner.

(2) The provider or the facility may propose a date for the hearing which shall not be more than ten days from the date of the request, and may also request that a verbatim transcript be made of the proceeding, and that all testimony be taken under oath.

(3) Such request for a hearing shall specify the names of attorneys who will represent the facility.

(4) The commissioner shall, not more than 3 business days after receiving the request, notify the facility of the time and date of the hearing, which shall not be less than five business days from the date of the request.

(5) The commissioner shall, not more than 5 business days from the close of the hearing, make a determination which shall be communicated to the facility, and if appropriate simultaneously request the Attorney General to initiate action.

(6) Notwithstanding the foregoing limitations on the commissioner in regard to requesting action to have a receiver appointed, the commissioner may request the Office of the Attorney General to initiate such other action as the Attorney General may deem appropriate in the circumstance.

(Effective January 31, 1996)

Sec. 17b-533-10. Miscellaneous

(a) **Continuing-care:**

A determination by the department that an arrangement in regard to existing or prospective shelter, and medical or nursing services or other health-related benefits constitutes a continuing care contract and the site or sites at which provision of services and benefits is made constitutes a continuing care retirement community, will be made after consideration of the following guidelines:

(1) The resident’s right to occupy shelter does not solely constitute either an ownership interest, or a usual and customary leasehold;

(2) There are specific commitments for present or future medical or nursing services or other health-related benefits;

(3) A present or future transfer of assets is required, a specific part of which may be applicable to the obligation to provide medical or nursing services or other health-related benefits, and part of which may be applicable to the obligation to provide shelter;

(4) There are periodic charges or a part thereof which may be applicable to the obligation to provide medical or nursing services or other health related benefits;

(5) There are limited rights to transfer shelter to another person whether or not to or through the provider, or no such rights of transfer at all;

(6) There may be, in the event of the departure or death of a resident subsequent to the occupation of the shelter, limitations on return to a resident or his estate of any advance payments or transfers of funds made by him.

(7) The provision of qualifying medical or nursing services or other health related benefits is a condition of occupancy of any residential unit.

(b) **Filing of documents:**

(1) Three copies of disclosure statements, financial and actuarial data, and any other documents or information required to be filed, shall be submitted by certified mail, return receipt requested, or delivered by hand to the Department on Aging, 175 Main Street, Hartford, CT 06106, Attn: Office of the Commissioner.

(2) All documents shall, upon receipt by the Department, be date stamped on the cover page and on one inside page.

(3) (A) A date-stamped receipt shall be given for any documents hand delivered, but such a receipt shall not constitute "acknowledgement" within the meaning of the Act.

(B) Any receipt shall also specify the name of the provider, and shall identify the documents delivered.

(c) **Annual fees:**

(1) Each provider having an accepted disclosure statement or an accepted revised disclosure statement on file with the department shall pay an annual fee equal to twenty four dollars ($24.00) multiplied by the number of residential units at the facility to which the disclosure statement applies. Said fee shall be paid not later than five business days after the first day of January in each year, and shall be accompanied by a signed letter from the provider specifying the number of residential units at the facility. Acknowledgment, in writing, of receipt of the required fee shall be promptly issued by the department. If the fee is not paid as herein set forth, the disclosure statement for the facility shall cease to be effective for the purposes of the act until the provider has received the department's written acknowledgment of payment of the fee.

(2) Initial disclosure statements: An initial disclosure statement submitted for filing shall not be accompanied by any fee. Acknowledgment by the commissioner of acceptance for filing in accordance with Section 17b-533-2 (a) (1) of these regulations shall specify the amount of the fee which is due, based on the formula set forth in (1) above. Notwithstanding acknowledgment of acceptance for filing, the disclosure statement shall not be effective for purposes of the act until notification to the provider from the department that the required fee has been received.

(d) **Fiscal year:**

(1) When an initial disclosure statement is filed, the provider shall state the fiscal year of the provider either in the transmission letter, or on the cover page of the disclosure statement.

(2) In the event a provider changes its fiscal year it shall notify the commissioner thereof. The commissioner may, on such terms and conditions in regard to required filings as the commissioner deems appropriate, require interim filings or bridge reports.

(e) **Informal reviews:**

(1) A provider may, at any time, seek the informal advice or views of the department in regard to any matter pertaining to the provisions of the Act or these regulations, but in no

event shall any views given or advice rendered informally by the department be deemed binding on actions or determinations of the department which may subsequently be undertaken or rendered in a formal determination.

(2) Actions taken by a provider in good faith reliance or informal advice shall not be subject to any penalty, or action by the commissioner other than as may be necessary to provide for full disclosure.

(Effective January 31, 1996)

Sec. 17b-533-11. Advisory committee

(a) The name of the committee established by the Act shall be

THE CONTINUING-CARE ADVISORY COMMITTEE.

(b) The committee shall have the following purposes:

(1) To assist the commissioner in the various reviews and the registration functions to be performed under the Act and these regulations;

(2) To report to commissioner on developments in the field of continuing-care;

(3) To report to the commissioner any special problems in the field of continuing care;

(4) To recommend changes in relevant statutes, and these regulations; and

(5) To advise on any other matters referred to the committee by the commissioner.

(c) The committee shall be composed of not more than twelve (12) members.

(1) In the event a vacancy occurs on the committee by virtue of death, resignation, inability to serve, or termination by the commissioner, any such vacancy shall be filled by the commissioner for the balance of the unexpired term.

(2) Members of the committee may be re-appointed to additional terms, without limitation.

(d) The advisory committee shall be comprised of professionals such as accountants, actuaries, insurance representatives, representatives of the continuing-care industry, and may include residents of continuing-care facilities and others knowledgeable in the field of continuing-care and familiar with the provisions of the Act. Members of the committee shall be appointed in accordance with the provisions of C.G.S. Section 4-9a.

(1) The commissioner may seek recommendations for membership on the committee from any individual, business entity, association or group, in order to meet the requirements for membership established by the Act.

(e) Meetings of the committee shall be held at such times and places as may be established by the commissioner, with the advice of the chairman.

(1) The committee shall meet at least four (4) times in each calendar year, with at least one meeting in each quarter, if possible.

(2) The commissioner may as deemed necessary, or upon a request in writing from a majority of members, call additional meetings.

(3) Meetings shall be attended by the commissioner, or the designee of the commissioner.

(4)

(A) The agenda for regularly scheduled meetings must be approved by the commissioner,

and such agendas shall be submitted to the commissioner by the chairman for approval.

(B) The agenda for any special or additional meetings shall be prepared by the commissioner.

(C) Meetings of the committee shall be conducted in accordance with all applicable provisions of the Freedom of Information Act.

(f) Staff support for the committee shall be provided by the department, by such individuals as may be designated by the commissioner to perform such functions.

(g) The committee shall remain in existence until terminated by act of the General Assembly.

(Effective January 31, 1996)

Agency
Department of Social Services
Subject
Personal Care Assistance Program
Inclusive Sections
§§ 17b-605-1a—17b-605-18a

CONTENTS

Sec. 17b-605-1a—17b-605-9a.	Reserved
Sec. 17b-605-10a.	Definitions (Repealed)
Sec. 17b-605-11a.	Eligibility for personal care assistance (Repealed)
Sec. 17b-605-12a.	Elements of the application filing (Repealed)
Sec. 17b-605-13a.	Application review and determination of eligibility (Repealed)
Sec. 17b-605-14a.	Waiting list and payments (Repealed)
Sec. 17b-605-15a.	Recordkeeping and verification of service (Repealed)
Sec. 17b-605-16a.	Overpayment recovery procedure (Repealed)
Sec. 17b-605-17a.	Repealed
Sec. 17b-605-18a.	Fair hearings (Repealed)

Personal Care Assistance Program

Sec. 17b-605-1a—17b-605-9a. Reserved

Sec. 17b-605-10a. Definitions (Repealed)

Repealed June 11, 2014.

(Effective July 3, 1996; Repealed June 11, 2014)

Notes: For 2014 repeal, see Sec. 54 of Public Act 14-187. (June 11, 2014)

Sec. 17b-605-11a. Eligibility for personal care assistance (Repealed)

Repealed June 11, 2014.

(Effective July 3, 1996; Repealed June 11, 2014)

Notes: For 2014 repeal, see Sec. 54 of Public Act 14-187. (June 11, 2014)

Sec. 17b-605-12a. Elements of the application filing (Repealed)

Repealed June 11, 2014.

(Effective January 31, 1996; Repealed June 11, 2014)

Notes: For 2014 repeal, see Sec. 54 of Public Act 14-187. (June 11, 2014)

Sec. 17b-605-13a. Application review and determination of eligibility (Repealed)

Repealed June 11, 2014.

(Effective July 3, 1996; Repealed June 11, 2014)

Notes: For 2014 repeal, see Sec. 54 of Public Act 14-187. (June 11, 2014)

Sec. 17b-605-14a. Waiting list and payments (Repealed)

Repealed June 11, 2014.

(Effective January 31, 1996; Repealed June 11, 2014)

Notes: For 2014 repeal, see Sec. 54 of Public Act 14-187. (June 11, 2014)

Sec. 17b-605-15a. Recordkeeping and verification of service (Repealed)

Repealed June 11, 2014.

(Effective July 3, 1996; Repealed June 11, 2014)

Notes: For 2014 repeal, see Sec. 54 of Public Act 14-187. (June 11, 2014)

Sec. 17b-605-16a. Overpayment recovery procedure (Repealed)

Repealed June 11, 2014.

(Effective January 31, 1996; Repealed June 11, 2014)

Notes: For 2014 repeal, see Sec. 54 of Public Act 14-187. (June 11, 2014)

Sec. 17b-605-17a. Repealed

Repealed July 3, 1996.

Sec. 17b-605-18a. Fair hearings (Repealed)

Repealed June 11, 2014.

(Effective January 31, 1996; Repealed June 11, 2014)

Notes: For 2014 repeal, see Sec. 54 of Public Act 14-187. (June 11, 2014)

Agency
Department of Social Services

Subject
Family Support Grant Program

Inclusive Sections
§§ 17b-616-1—17b-616-26

CONTENTS

Sec. 17b-616-1—17b-616-14.	Reserved
Sec. 17b-616-15.	Definitions
Sec. 17b-616-16.	Eligibility criteria
Sec. 17b-616-17.	Grandfathered cases
Sec. 17b-616-18.	Waiting list and termination of funding in the event of inadequate appropriation
Sec. 17b-616-19.	Application filing
Sec. 17b-616-20.	Elements of the application
Sec. 17b-616-21.	Application review, notification and funding
Sec. 17b-616-22.	Family support payments
Sec. 17b-616-23.	Department review
Sec. 17b-616-24.	Recordkeeping and verification of service
Sec. 17b-616-25.	Overpayment recovery procedure
Sec. 17b-616-26.	Fair hearings

Family Support Grant Program

Sec. 17b-616-1—17b-616-14. Reserved

Sec. 17b-616-15. Definitions

For purposes of Sections 17b-616-15 through 17b-616-26:

(a) "Child with a disability" means any child under the age of 18 who has a developmental disability but does not include any child with mental retardation.

(b) "Commissioner" means the Commissioner of the Department of Human Resources.

(c) "Department" means the Department of Human Resources.

(d) "Developmental disability" means a severe, chronic disability of a person 5 years of age or older which:

(1) Is attributable to a mental or physical impairment or combination of mental and physical impairments;

(2) Is manifested before the person attains age twenty-two;

(3) Is likely to continue indefinitely;

(4) Results in substantial functional limitations in three or more of the following areas of major life activity;

(A) self-care;

(B) receptive and expressive language;

(C) learning;

(D) mobility;

(E) self-direction;

(F) capacity for independent living;

(G) economic self-sufficiency; and

(5) Reflects the person's need for a combination and sequence of special, interdisciplinary, or generic care, treatment, or other services which are of lifelong or extended duration and are individually planned and coordinated; except that such term, when applied to infants and young children means individuals from birth to age 5, inclusive, who have substantial developmental delay or specific congenital or acquired conditions with a high probability of resulting in developmental disabilities if services are not provided.

(e) "Disability-related expenses" means those costs incurred on behalf of the child with a disability directly associated with his or her disability and may include, but are not limited to, the following expenses not covered or reimbursable by insurance or other funding sources: disability-related medical supplies, equipment, prescriptions, medical and dental care, and related transportation costs, and other disability-related costs as determined by the Commissioner.

(f) "Extraordinary financial impact" is defined as substantial ongoing monthly expenses which meet or exceed the level of the grant, which are not reimbursable and which are related to the unique needs and/or care of a child with a disability.

(g) "Family applicant" means any parent or other family member who resides in the same residence as the child with a disability and who has primary responsibility for

providing continuous care to the child with a disability.
(h) "Family Support" means the monthly grant provided to a recipient.
(i) "Grant Reduction Recoupment" is a method of recoupment in which the Department reduces the recipient's monthly grant totalling the amount of the overpayment.
(j) "Gross Income" means all income, from whatever source derived, including, but not limited to:
(1) Earned income such as compensation paid by an employer to an employee for personal services and includes wages, salaries, tips, commissions, bonuses, and earnings from self-employment or contractual agreements;
(2) Unearned income such as pensions, annuities, dividends, interest, rental income, estate or trust income, royalties, social security or supplemental security income, unemployment compensation, workers' compensation, alimony, child support, and cash assistance from federal, state or municipal assistance programs.
(k) "Income" means the gross income of the family applicant, any legally liable relative in the household of the child with a disability, and the income of the child with a disability, less the disability-related expenses listed in subsection (e) of this section.
(*l*) "Installment Recoupment" is a method of recoupment in which the recipient makes monthly installment payments to the Department totalling the amount of the overpayment.
(m) "Lump-sum Recoupment" is a method of recoupment in which the recipient makes payment to the Department of the entire amount of the overpayment in one payment.
(n) "Overpayment" is the amount of financial assistance paid on behalf of a recipient in excess of the amount to which he or she is properly entitled. The overpayment may be caused by:
(1) The Department's incorrect action or failure to act within the appropriate time limits;
(2) The recipient's failure to report excess income;
(3) The recipient's failure to verify expenditures of the Family Support Grant;
(4) The recipient's failure to notify the Department that a child who was initially found eligible for the program has been diagnosed as having mental retardation or;
(5) The recipient's failure to notify the Department of any change in circumstances affecting eligibility.
(o) "Recipient" means a person who has been determined eligible and is receiving a Family Support Grant.
(p) "Recoupment" is a process by which the Department recovers an overpayment from the recipient.

(Effective November 30, 1995)

Sec. 17b-616-16. Eligibility criteria

In order to be eligible for a Family Support Grant under this program the requirements of both subsection (a) for the family applicant and of subsection (b) for the child with a disability must be met.
(a) In order to be eligible, the family applicant must meet the following criteria:

(1) Be a parent or adult family member;
(2) Be a resident of Connecticut;
(3) Reside in the same household as the child with a disability;
(4) Have primary responsibility for providing continuous care to the child with a developmental disability other than mental retardation;
(5) Have income not greater than 140% of the previous year's median family income for Connecticut as determined annually by the U.S. Department of Housing and Urban Development (HUD) pursuant to Section 3 (b) (2) of the U.S. Housing Act of 1937 as amended; and
(6) Comply with the requirements of sections 17b-616-19 to 17b-616-25, inclusive.
(b) In order to be eligible, the child with a disability must meet the following criteria:
(1) Be a resident of Connecticut;
(2) Be under the age of 18;
(3) Have a developmental disability as defined in Section 17b-616-15 (d) of this regulation; the developmental disability must be other than mental retardation as defined in Conn. Gen. Stat. Section 1-1g and this developmental disability must result in extraordinary financial impact for the family applicant, as defined in Section 17b-616-15 (f).

(Effective November 30, 1995)

Sec. 17b-616-17. Grandfathered cases

(a) Participants in the Department's Pilot Phase of the Family Support Program during the calendar years 1990, 1991 and 1992 shall be grandfathered onto this program.
(b) Such cases shall be added effective January 1, 1993 when funding from the Developmental Disabilities Council ends.

(Effective November 30, 1995)

Sec. 17b-616-18. Waiting list and termination of funding in the event of inadequate appropriation

(a) The Family Support Grant Program is not an entitlement program. Funding shall be provided within available appropriations. The Department has established a waiting list as follows:
(1) The initial waiting list consists of a randomly ordered list of all persons who submitted their names to the Department as of June 30, 1992, and were not selected for the program.
(2) Thereafter, additional names will be submitted by the district offices in writing, or by any other person either orally or in writing, to the Bureau of Field Operations and will be added to the waiting list as received.
(b) In the event that the Commissioner determines that there is not sufficient funding to provide grants throughout the fiscal year on behalf of families who are receiving assistance under the program, the Commissioner may elect to:

(1) Remove families in order of greatest income from the program so that the program may operate through the remainder of the year or;

(2) Maintain all families on the program as long as funding is available and terminate the program for the current fiscal year when funding is exhausted.

(c) Families denied assistance due to the lack of sufficient funding pursuant to this subsection shall not be entitled to a Fair Hearing pursuant to Section 17b-616-26.

(Effective November 30, 1995)

Sec. 17b-616-19. Application filing

(a) Application forms shall be available at the Department's district offices and shall be mailed to the next family applicant on the waiting list as funds become available.

(b) Upon request of the family applicant, a Department worker shall assist with the application and arrange for a social study at the same time. If no assistance has been requested, a Department worker shall, upon receipt of the completed application form, contact the family applicant and arrange for a home visit in order to prepare a social study.

(c) A properly completed and signed application form and other documents as may be necessary to determine eligibility shall be submitted to enable the Department to conduct a thorough review of the family applicant's eligibility for family support under this program.

(Effective November 30, 1995)

Sec. 17b-616-20. Elements of the application

(a) The Family Support Program application shall include, but is not limited to, the following information:

(1) Nature of the child's disabling condition;

(2) A statement of the diagnosis and medical needs signed by the child's health care professional; including verification that the child does not have mental retardation;

(3) Verification of Income: wage stubs for the last six (6) weeks, and a complete copy of the I.R.S. Federal Income Tax Return for the previous calendar year; and

(4) Expected use of the family grant including information as to the ongoing extraordinary financial expenses.

(b) The Department shall conduct a social study in order to evaluate the home and family situation and to determine eligibility. The elements of the social study shall include but not be limited to: family members and relationships, description of the child with a disability, financial information and a description of the home environment.

(Effective November 30, 1995)

Sec. 17b-616-21. Application review, notification and funding

(a) Within forty five (45) days of the receipt of a completed application as described in Section 17b-616-20 (a) and other supplementary material, the Department shall determine the eligibility of the family applicant and notification of acceptance or non-acceptance into the program shall be mailed to the family applicant.

(b) It shall be the responsibility of the recipient to notify the district office within fifteen (15) days of any change in circumstances affecting eligibility. Failure to do so may be cause for discontinuance from the program.

(c) Funding shall be provided within available appropriations at the rate of $250 per month.

(Effective November 30, 1995)

Sec. 17b-616-22. Family support payments

(a) Family Support payments shall be used to pay for disability-related expenses incurred on behalf of the child with a disability.

(b) The Department shall require a written participant agreement between the Department and the family applicant accepted into the program. The terms of the participant agreement shall include:

(1) The recipient must reside in the same household and have primary responsibility for the continuous care of a child, who has a developmental disability other than mental retardation. The child must be under the age of eighteen (18).

(2) The recipient must agree to provide information about the expenditures made with the Family Support Grant to the Department.

(3) The recipient must notify the Department within fifteen (15) days of any change in income or any other circumstances which affect eligibility.

(4) The Department will redetermine eligibility at least semi-annually.

(5) Upon full execution of the participant agreement the Department shall provide the family applicant with a monthly check for the agreed upon amount of family support.

(Effective November 30, 1995)

Sec. 17b-616-23. Department review

(a) All conditions of eligibility shall be subject to review semi-annually. Semiannual review shall include verification of expenditures of the Family Support Grant received for the previous six months. Failure to provide such verification may be cause for discontinuance from the program. Prior to discontinuance of the Family Support Grant a recipient shall be given thirty (30) days written notice.

(b) If the Department's worker finds, at the time of review or at any other time that a child who was initially found eligible for the program is thereafter diagnosed as having mental retardation, that child shall be discontinued from the program upon thirty (30) days written notice to the recipient. A referral will be made to the Department of Mental Retardation which administers a similar program for families with children who have mental retardation.

(Effective November 30, 1995)

Sec. 17b-616-24. Recordkeeping and verification of service

The recipient shall maintain records verifying that the Family Support Grant payments

from the Department have been expended for the care of the child with a disability.

(Effective November 30, 1995)

Sec. 17b-616-25. Overpayment recovery procedure

(a) Program recipients and former recipients are obligated to reimburse the Department for any overpayment received.

(b) The Commissioner may waive recoupment of an overpayment if in his/her judgment the imposition of recoupment measures would result in unnecessary hardship for the recipient's family.

(c) Prior to the Department initiating any recoupment process, the recipient shall be notified of the amount of the overpayment, the reason the overpayment occurred, the time period covered by the overpayment, the proposed method for recovering the overpayment and the process for appealing the recoupment action in accordance with Section 17b-616-26.

(d) **Method of Recoupment:**

(1) The Department shall attempt to recover overpayments from recipients and former recipients by the lump-sum recoupment method.

(2) If the recipient or former recipient who owes the overpayment is unable to make a lump sum repayment, the Department will attempt to recover the money through the installment recoupment method. Recipients may agree to the grant reduction recoupment method in lieu of installment recoupment.

(3) In cases where the recipient who owes the overpayment fails or refuses to make a lump sum payment, sign an installment agreement, or comply with the provisions of an installment agreement, the Department may utilize the grant reduction recoupment method by reducing each subsequent payment made to the recipient by up to 25% of the total amount owed until such overpayment is recovered.

(4) When there is failure to agree to an appropriate repayment plan, the Commissioner shall take whatever action he/she deems appropriate to recover such overpayment including referral to the office of the Attorney General.

(Effective November 30, 1995)

Sec. 17b-616-26. Fair hearings

An aggrieved person shall be given an opportunity for a fair hearing in accordance with the Connecticut General Statutes Sections 17-603 and 17-604, as same may be amended. The Department of Human Resources fair hearing procedures are governed by applicable provisions of the Uniform Administrative Procedures Act and the agency's separate fair hearing regulations.

(Effective November 30, 1995)

Agency
Department of Social Services

Subject
Bureau of Rehabilitation Services

Inclusive Sections
§§ 17b-653-1—17b-653-24

CONTENTS

Sec. 17b-653-1. Description
Sec. 17b-653-2. Definitions
Sec. 17b-653-3. Administration
Sec. 17b-653-4. Standards and prohibited practices
Sec. 17b-653-5. Order of selection
Sec. 17b-653-6. Confidentiality
Sec. 17b-653-7. Applicants for services
Sec. 17b-653-8. Eligibility/ineligibility
Sec. 17b-653-9. Employment plan
Sec. 17b-653-10. Counseling and guidance services
Sec. 17b-653-11. Comparable services and benefits
Sec. 17b-653-12. Physical and mental restoration services
Sec. 17b-653-13. Rehabilitation technology services
Sec. 17b-653-14. Vocational and other training services
Sec. 17b-653-15. Training in institution of higher education or vocational training facilities
Sec. 17b-653-16. Maintenance services
Sec. 17b-653-17. Alterations to client housing or small business property
Sec. 17b-653-18. Transportation and related expenses
Sec. 17b-653-19. Purchase of tools and equipment
Sec. 17b-653-20. Self-employment services
Sec. 17b-653-21. Homemaker services
Sec. 17b-653-22. Informal review
Sec. 17b-653-23. Administrative hearing and mediation
Sec. 17b-653-24. Case closure

Bureau of Rehabilitation Services

Sec. 17b-653-1. Description

Sections 17b-653-2 to 17b-653-24, inclusive, of the Regulations of Connecticut State Agencies shall apply to the state Department of Social Services, Bureau of Rehabilitation Services in its implementation of vocational rehabilitation services as described in Section 17b-650 through 17b-665 of the Connecticut General Statutes, the Rehabilitation Act of 1973, as amended, and implementing regulations.

(Adopted effective June 6, 2000)

Sec. 17b-653-2. Definitions

(a) The definitions provided by Section 17b-650 of the Connecticut General Statutes shall govern the interpretation and application of this section and sections 17b-653-3 to 17b-653-24, inclusive, of the Regulations of Connecticut State Agencies.

(b) In addition thereto, the following definitions shall apply:

(1) “Act” means the Rehabilitation Act of 1973, as amended (29 USC 701 et seq.);

(2) “Applicant” means a person who has applied for vocational rehabilitation services from the Bureau of Rehabilitation Services;

(3) “Architectural alteration services” means services provided to adapt or modify a client’s home or small business. These services may include architectural consultation, design, construction and inspection to determine whether the services meet the necessary building and accessibility codes and client needs;

(4) “Assistive technology device” means any item, piece of equipment, or product system, whether acquired commercially off the shelf, modified, or customized, that is used to increase, maintain, or improve the functional capabilities of an individual with a disability;

(5) “Assistive technology service” means any service that directly assists an individual with a disability in the selection, acquisition, or use of an assistive technology device, including:

(A) the evaluation of the needs of an individual with a disability, including a functional evaluation of the individual in his or her customary environment;

(B) purchasing, leasing, or otherwise providing for the acquisition by an individual with a disability of an assistive technology device;

(C) selecting, designing, fitting, customizing, adapting, applying, maintaining, repairing, or replacing assistive technology devices;

(D) coordinating and using other therapies, interventions, or services with assistive technology devices, such as those associated with existing education and rehabilitation plans and programs;

(E) training or technical assistance for an individual with a disability or, if appropriate, the family members, guardians, advocates, or authorized representatives of the individual; and

(F) training or technical assistance for professionals (including individuals providing

education and rehabilitation services) employers, or others who provide services to, employ, or are otherwise substantially involved in the major life functions of individuals with disabilities, to the extent that training or technical assistance is necessary to the achievement of an employment outcome by an individual with a disability;

(6) "Bureau" means the Bureau of Rehabilitation Services;

(7) "Client" means a person who has been determined to be eligible for vocational rehabilitation services from the bureau;

(8) "Client Assistance Program" (CAP) is a unit within the Office of Protection and Advocacy of the State of Connecticut. The purpose of the Client Assistance Program is to provide information and advice to applicants and clients of all available benefits under the act.

(9) "Commensurate" means, with respect to the comparison of various programs or services, those programs or services which will enable the applicant or client to, as applicable:

(A) complete the assessment for determining eligibility and priority for services;

(B) complete the assessment for determining rehabilitation needs; or

(C) achieve an employment outcome.

(10) "Community rehabilitation program" means a program that provides directly or facilitates the provision of vocational rehabilitation services to individuals with disabilities, and that provides, singly or in combination, for an individual with a disability to enable the individual to maximize opportunities for employment, including career advancement:

(A) medical, psychiatric, psychological, social, and vocational services that are provided under one management;

(B) testing, fitting, or training in the use of prosthetic and orthotic devices;

(C) recreational therapy;

(D) physical and occupational therapy;

(E) speech, language, and hearing therapy;

(F) psychiatric, psychological, and social services, including positive behavior management;

(G) assessment for determining eligibility and vocational rehabilitation needs;

(H) rehabilitation technology;

(I) job development, placement, and retention services;

(J) evaluation or control of specific disabilities;

(K) orientation and mobility services for individuals who are blind;

(L) extended employment;

(M) psychosocial rehabilitation services;

(N) supported employment services and extended services;

(O) services to family members when necessary to the vocational rehabilitation of the individual;

(P) personal assistance services;

(Q) services similar to the services described in paragraphs (A) through (P) of this

subdivision. For the purposes of this definition, the word program means an agency, organization, or institution, or unit of an agency, organization, or institution, that provides directly or facilitates the provision of vocational rehabilitation services as one of its major functions.

(11) “Comparable services and benefits” means services and benefits that are:

(A) provided or paid for, in whole or in part, by other federal, state, or local public agencies, by health insurance, or by employee benefits;

(B) available to the individual at the time needed to achieve the employment outcome in the individual’s employment plan, in accordance with section 17b-653-11; and

(C) commensurate to the services that the individual would otherwise receive from the bureau;

(12) “Competitive employment” means work,

(A) in the competitive labor market that is performed on a full-time or part-time basis in an integrated setting; and

(B) for which an individual is compensated at or above the minimum wage, but not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by individuals who are not disabled.

(13) “Counselor” means the bureau employee who is responsible for obtaining, analyzing, and evaluating pertinent applicant and client information, determining eligibility for rehabilitation services, developing and implementing rehabilitation plans with applicants or clients, providing counseling, guidance, and placement services, and recommending closure where appropriate;

(14) “Department” means the state Department of Social Services;

(15) “Director” means the director of the Bureau of Rehabilitation Services;

(16) “Eligible” or “Eligibility” when used in relation to an applicant’s qualification for rehabilitation services means a certification that:

(A) the applicant is an individual with a disability, as defined in subsection (b)(22) of this section; and

(B) the individual requires vocational rehabilitation services to prepare for, enter, engage in or retain gainful employment;

(17) “Employment outcome” means, with respect to an individual, entering or retaining full-time or, if appropriate, part-time competitive employment in the integrated labor market, supported employment, self-employment, telecommuting, or business ownership;

(18) “Employment plan”, also known as the individualized plan for employment, means a plan which is designed to achieve an employment outcome and approved by the bureau;

(19) “Experimental procedure” means a medical, rehabilitation, educational or related service, device or methodology which is unproven or is not generally accepted as effective within the professional discipline best able to evaluate the procedure;

(20) “Family member” means any relative by blood or marriage of an applicant or client with a disability and other individuals living in the same household with whom the applicant or client with a disability has a close interpersonal relationship;

(21) "Impartial hearing officer" means an individual who

(A) is not an employee of a public agency (other than an administrative law judge, hearing examiner, or employee of an institution of higher education). An individual is not an employee of a public agency solely because the individual is paid by that agency to serve as a hearing officer;

(B) has not been involved previously in the vocational rehabilitation of the applicant or client;

(C) has knowledge of the delivery of vocational rehabilitation services, the federal and state rules governing the provision of such services and has received training with respect to the performance of official duties;

(D) has no personal or financial interest that would be in conflict with the individual's objectivity; and

(E) is not a member of the state rehabilitation advisory council for the bureau;

(22) "Individual with a disability" means an individual who,

(A) has a physical or mental impairment which for such individual constitutes or results in a substantial impediment to employment; and

(B) can benefit in terms of an employment outcome from the provision of vocational rehabilitation services;

(23) "Individual with a most significant disability" means an individual with a significant disability who:

(A) has serious limitations in a total of three or more functional areas (such as mobility, communication, self-care, interpersonal skills, work tolerance or work skills) in terms of an employment outcome; or

(B) will require significant ongoing disability-related services on the job in order to maintain employment following case closure with the bureau;

(24) "Individual with a significant disability" means an individual with a disability who has a severe physical or mental impairment which seriously limits one or more functional capacities (such as mobility, communication, self-care, self-direction, interpersonal skills, work tolerance, or work skills) in terms of an employment outcome, whose vocational rehabilitation can be expected to require multiple vocational rehabilitation services over an extended period of time, and who has one or more physical or mental disabilities resulting from amputation, arthritis, autism, blindness, burn injury, cancer, cerebral palsy, cystic fibrosis, deafness, head injury, heart disease, hemiplegia, hemophilia, respiratory or pulmonary dysfunction, mental retardation, mental illness, multiple sclerosis, muscular dystrophy, musculoskeletal disorders, neurological disorders (including stroke and epilepsy), paraplegia, quadriplegia, and other spinal cord conditions, sickle cell anemia, specific learning disability, end-stage renal disease, or another disability or combination of disabilities determined on the basis of an assessment for determining eligibility and vocational rehabilitation needs to cause comparable substantial functional limitation;

(25) "Individualized written rehabilitation program" means an employment plan;

(26) "Informal review" means an informal procedure through which the bureau affords

an opportunity to a client or applicant for vocational rehabilitation services, or if appropriate, his or her parent, guardian or other representative, to express and seek remedy for dissatisfaction with any determinations made by the bureau concerning the provision or denial of such services. An informal review does not constitute a "contested case" within the meaning of section 4-166(2) of the Connecticut General Statutes;

(27) "Informed choice" means that the individual:

(A) has meaningful options from which to choose;

(B) understands his or her abilities, capabilities and interests related to the employment outcome; and

(C) participates in a planning process with bureau staff which considers such issues as:

(i) relevant factors regarding choices made in the rehabilitation process. This includes, but is not limited to, service provider effectiveness and consumer satisfaction, relative cost of service options and labor market trends; and

(ii) applicable laws, regulations, state plan provisions and policy which establish parameters within which choices shall be made;

(28) "Institution of higher education" means a university, college, junior college, community college, vocational school, technical school or other post secondary institution legally authorized to provide a program of education beyond secondary education;

(29) "Integrated setting"

(A) with respect to the provision of services, means a setting typically found in the community in which applicants or eligible individuals interact with non-disabled individuals other than non-disabled individuals who are providing services to those applicants or eligible individuals.

(B) with respect to an employment outcome, a setting typically found in the community in which applicants or eligible individuals interact with non-disabled individuals, other than non-disabled individuals who are providing services to those applicants or eligible individuals, to the same extent that non-disabled individuals in comparable positions interact with other persons;

(30) "Maintenance" means monetary support provided to an applicant or eligible individual for those expenses, such as food, shelter, and clothing, that are in excess of the normal expenses of the individual and that are necessitated by the individual's participation in a program of vocational rehabilitation services;

(31) "Ongoing support services" means services

(A) provided to individuals with the most significant disabilities;

(B) provided, at a minimum, twice monthly:

(i) to make an assessment, regarding the employment situation, at the worksite of each such individual in supported employment, or, under special circumstances, especially at the request of the client, off site; and

(ii) based on the assessment, to provide for the coordination or provision of specific intensive services, at or away from the worksite, that are needed to maintain employment stability; and

(C) consisting of:

(i) a particularized assessment supplementary to the assessment for determining rehabilitation needs described in section 17b-653-8(e);

(ii) the provision of skilled job trainers who accompany the individual for intensive job skill training at the worksite;

(iii) job development, job retention, and placement services;

(iv) social skills training;

(v) regular observation or supervision of the individual;

(vi) followup services such as regular contact with the employers, the individuals, the individuals' representatives, and other appropriate individuals, in order to reinforce and stabilize the job placement;

(vii) facilitation of natural supports at the worksite;

(viii) any other vocational rehabilitation service, as defined in section 17b-653-2(b)(44);

(ix) a service similar to another service described in this subparagraph;

(32) "Party" means an applicant, a client or a representative of the bureau who is seeking remedy under an informal review or administrative hearing;

(33) "Personal assistance services" means a range of services designed to assist an individual with a disability to perform daily living activities on or off the job that the individual would typically perform without assistance if the individual did not have a disability. The services shall be designed to increase the individual's control in life and ability to perform everyday activities on or off the job. The services shall be necessary to the achievement of an employment outcome and may be provided only while the individual is receiving other vocational rehabilitation services. The services may include training in managing, supervising and directing personal assistance services;

(34) "Post-employment services" means one or more of the services identified in subsection (b)(44) of this section that are provided subsequent to the achievement of an employment outcome and that are necessary for an individual to maintain, regain, or advance in employment, consistent with the individual's strengths, resources, priorities, concerns, abilities, capabilities, and interests;

(35) "Rehabilitation engineering" means the systematic application of engineering sciences to design, develop, adapt, test, evaluate, apply, and distribute technological solutions to problems confronted by individuals with disabilities in functional areas, such as mobility, communications, hearing, vision, and cognition, and in activities associated with employment, independent living, education, and integration into the community;

(36) "Rehabilitation technology" means the systematic application of technologies, engineering methodologies, or scientific principles to meet the needs of, and address the barriers confronted by, individuals with disabilities in areas that include education, rehabilitation, employment, transportation, independent living, and recreation. The term includes "rehabilitation engineering" as defined in subsection (b)(35) of this section, "assistive technology devices" as defined in subsection (b)(4) of this section, and "assistive technology services" as defined in subsection (b)(5) of this section;

(37) "Reviewer" means a person designated by the director to conduct informal reviews and render decisions;

(38) "Reviewing official" means the commissioner of the Department of Social Services, as the designated official authorized to review the decision rendered by an impartial hearing officer, pursuant to section 17b-653-23;

(39) "State agency" means the state Department of Social Services;

(40) "State plan" means the plan for vocational rehabilitation services submitted by the bureau on behalf of the State of Connecticut to the Rehabilitation Services Administration of the United States Department of Education pursuant to 34 CFR Sec. 361.2;

(41) "Substantial impediment to employment" means that a physical or mental impairment (in light of attendant medical, psychological, vocational, educational, and other related factors) hinders an individual from entering into, engaging in, retaining or preparing for employment consistent with the individual's capacities and abilities;

(42) "Supported Employment" means:

(A) competitive work in an integrated work setting or employment in integrated work settings in which individuals are working toward competitive work with ongoing support services for individuals with the most significant disabilities,

(i) for whom competitive employment has not traditionally occurred or has been interrupted or intermittent as a result of a significant disability; and

(ii.) who, because of the nature and severity of their disabilities, need intensive supported employment services from the bureau and extended services after transition in order to perform this work; or

(B) transitional employment for individuals with the most significant disabilities due to mental illness;

(43) "Supported employment services" means ongoing support services and other appropriate services needed to support and maintain an individual with a most significant disability in supported employment that:

(A) are provided singly or in combination and are organized and made available in such a way as to assist an eligible individual to achieve competitive employment;

(B) are based on a determination of the needs of an eligible individual, as specified in an employment plan; and

(C) are provided by the bureau for a period of time not to extend beyond 18 months, unless under special circumstances the eligible individual and rehabilitation counselor or other appropriate bureau staff jointly agree to extend the time in order to achieve the rehabilitation objectives identified in the employment plan;

(44) "Vocational rehabilitation services" means any services described in an employment plan necessary to an individual with a disability in preparing for, securing, retaining, or regaining an employment outcome consistent with the strengths, resources, priorities, concerns, abilities, capabilities, interests, and informed choice of the individual, including:

(A) assessment for determining eligibility and priority for services in accordance with section 17b-653-8(a);

(B) assessment for determining vocational rehabilitation needs in accordance with section 17b-653-8(e);

(C) vocational rehabilitation counseling and guidance, including information and support services to assist an individual in exercising informed choice in the development of an employment plan;

(D) referral and other services necessary to help applicants and eligible individuals secure needed services from other agencies and to advise those individuals about the client assistance program;

(E) physical and mental restoration services in accordance with section 17b-653-12;

(F) vocational and other training services in accordance with sections 17b-653-14 and 17b-653-15;

(G) maintenance, in accordance with section 17b-653-16 and the definition of that term in section 17b-653-2(b)(30);

(H) transportation, in accordance with section 17b-653-18;

(I) vocational rehabilitation services to the family of an individual with a disability necessary to assist the individual to achieve an employment outcome;

(J) interpreter services for individuals who are deaf or hard of hearing and tactile interpreting services for individuals who are deaf-blind;

(K) reader services, rehabilitation teaching services, and orientation and mobility services for individuals who are blind;

(L) job search and placement assistance and job retention services;

(M) supported employment services in accordance with the definition of that term in section 17b-653-2(b)(43);

(N) on-the-job or other related personal assistance services, in accordance with the definition of that term in section 17b-653-2(b)(33), provided while an individual is receiving other vocational rehabilitation services;

(O) post-employment services in accordance with the definition of that term in section 17b-653-2(b)(34);

(P) occupational licenses, tools, equipment, initial stocks, and supplies;

(Q) rehabilitation technology in accordance with section 17b-653-13 and the definition of that term in section 17b-653-2(b)(36), including vehicular modification, telecommunications, sensory and other technological aids and devices;

(R) transition services for students with disabilities that facilitate the achievement of the employment outcome identified in the employment plan;

(S) self-employment services, in accordance with section 17b-653-20;

(T) homemaker services, in accordance with section 17b-653-21;

(U) other goods and services determined necessary for the individual with a disability to achieve an employment outcome; and

(45) "Vocational training" means instruction designed to prepare a client to perform a particular skill or occupation.

(Adopted effective June 6, 2000)

Sec. 17b-653-3. Administration

(a) **Designated State Unit.** The designated state unit to administer this plan shall be the Bureau of Rehabilitation Services of the state Department of Social Services.

(b) **Staffing.** The designated State unit shall have a full-time director and a staff, all or almost all of whom are employed full time on the rehabilitation work of the designated state unit.

(Adopted effective June 6, 2000)

Sec. 17b-653-4. Standards and prohibited practices

The following practices and standards shall apply to every phase of the administration of the vocational rehabilitation program including the determination and certification of eligibility or ineligibility for vocational rehabilitation services:

(a) **Creed, Race, Age, Color, Ancestry, National Origin, Gender or Physical or Mental Disability**

The bureau shall not discriminate against an applicant or client on the grounds of creed, race, age, color, ancestry, national origin, gender or physical or mental disability.

(b) **Native Americans**

The bureau shall apply the same eligibility requirements to Native Americans as is applied to the rest of the client population.

(c) **Standards of Reasonableness**

Sections 17b-653-1 to 17b-653-24, inclusive, of the Regulations of Connecticut State Agencies will be governed by a standard of reasonableness and all interpretations shall be based on what is reasonably necessary and cost efficient when considering both the applicant or client and the entire client population. In such cases where an applicant or client chooses goods or services which are beyond those necessary to render the individual employable or which are at a higher cost to the bureau than necessary in providing a commensurate service, the bureau shall not be responsible for the additional cost.

(d) **Payment for Experimental Procedures**

The bureau shall not be responsible for the provision of procedures which are determined by the bureau to be experimental. In cases where the bureau has made such a determination, the applicant or client shall have the burden of proving by clear and convincing evidence that the procedure is not experimental.

(e) **Preference for In-State Services**

Preference shall be given to services provided within the state of Connecticut. Exceptions may be made when either:

(1) there are no commensurate services offered within the state of Connecticut, or

(2) out-of-state services can be provided at a lower total cost to the bureau. In such cases where a commensurate service is available to the client within the state of Connecticut at a lower cost than an out-of-state option, a client may choose to pay the additional cost of the out-of-state option.

(f) **Authorization for Services**

A written authorization shall be made before the provision of goods or services. Verbal authorization may be made before or at the time of the provision of goods or services with the approval of the director or his/her designee. The bureau shall not be responsible for retroactive authorization of goods or services unless it is determined by clear evidence that preauthorization of services was not made due to bureau error.

(Adopted effective June 6, 2000)

Sec. 17b-653-5. Order of selection

(a) The intent of this section is to establish a contingency plan to be utilized in the event that services cannot be provided to all eligible persons who apply.

(b) An order of selection shall be invoked in the event that the funding needed by eligible persons exceeds the funding available to the bureau.

(c) The following shall be followed:

(1) A priority selection forecast shall be completed at the discretion of the director based on the cost of current services provided, the budgeted appropriations, grants for the current year, and the projected client population and cost of services. The priority selection forecast shall, if applicable, state a date prospectively in which the priority selection shall be invoked. The forecast may be revoked at the discretion of the director when money from all sources shall meet the cost of current and projected services.

(2) Clients who are determined eligible for services shall be assigned a priority level, in descending order of priority, as follows:

(A) all individuals with the most significant disabilities;

(B) all individuals with significant disabilities;

(C) all individuals with non-significant disabilities;

(3) All individuals shall be placed in the highest priority level for which they are eligible.

(4) Every individual within a particular priority level shall be served before individuals in the next highest priority level are served.

(5) In the event that all individuals within the same priority level cannot be served, individuals in that priority category shall be served chronologically based on the date of eligibility determination.

(6) At least 30 days prior to invoking priority selection, all individuals shall be notified in writing of their priority level and their right to appeal.

(Adopted effective June 6, 2000)

Sec. 17b-653-6. Confidentiality

(a) All client and applicant information shall be kept confidential to the extent allowed by law. All clients or their representatives shall be informed that applicant and client information shall be kept confidential to the extent allowed by law.

(b) When information held by the bureau is requested and is not exempted by law from the requirement for written consent in order to be released, the authorization to so release shall be obtained from the client or applicant, or their legal guardian, prior to release of the

information.

(c) Medical, psychological or other information which the bureau believes may be harmful to the client or applicant shall not be released directly to the client or applicant but shall be provided through his or her designated representative.

(d) Notwithstanding any provision of the regulations of Connecticut state agencies, including the Department of Social Services' uniform policy manual, information regarding a change of circumstances reported by a client to the bureau shall not constitute the reporting of such a change to the department for recipients of any department assistance or services, except those administered directly by the bureau.

(Adopted effective June 6, 2000)

Sec. 17b-653-7. Applicants for services

(a) An individual is considered to have applied for services at such time as she or he:

(1) has completed and signed an agency application form or has otherwise requested services;

(2) has provided information necessary to initiate an assessment to determine eligibility and priority for services; and

(3) is available to complete the assessment process.

(b) if application is completed by or on behalf of an individual who has not attained the age of eighteen (18), the individual's parent or guardian shall also sign the application form.

(Adopted effective June 6, 2000)

Sec. 17b-653-8. Eligibility/ineligibility

Upon application to the bureau, an applicant shall be evaluated by the bureau and, pursuant to the criteria and procedures established by sections 17b-653-1 to 17b-653-24, inclusive, of the Regulations of Connecticut State Agencies, shall be certified as either eligible or ineligible for vocational rehabilitation services.

(a) **Assessment for Determining Eligibility and Priority for Services**

(1) For the purpose of determining whether an applicant is eligible for vocational rehabilitation services and assigning the individual's priority under an order of selection, the bureau shall provide an assessment for eligibility and priority for services which shall include a review of existing data and a preliminary review of any additional data needed to make such determinations.

(2) The determination of the applicant's eligibility shall be based only on the following criteria:

(A) a determination that the applicant is an individual with a disability, as defined in section 17b-653-2(b)(22); and

(B) a determination that the applicant requires vocational rehabilitation services to prepare for, secure, retain or regain employment.

(3) It shall be presumed that an individual can benefit in terms of an employment outcome with respect to section 17b-653-2(b)(22)(B), unless the bureau determines that

there is clear and convincing evidence that the individual is incapable of benefiting from vocational rehabilitation services in terms of an employment outcome due to the severity of the individual's disability. In making such a determination, the bureau shall explore the individual's abilities, capabilities and capacities to perform in work situations through the use of trial work experiences, except under limited circumstances when an individual cannot take advantage of such experiences.

(4) If the individual has a disability under Title II or Title XVI of the Social Security Act, the bureau will presume that,

(A) the applicant is eligible for vocational rehabilitation services (provided that the individual intends to achieve an employment outcome consistent with the unique strengths, resources, priorities, concerns, abilities, capabilities, interests and informed choice of the individual), unless the bureau determines by clear and convincing evidence that the applicant is incapable of benefiting in terms of an employment outcome from vocational rehabilitation services due to the severity of the disability, and

(B) the individual has a significant disability, in accordance with the definition of that term in section 17b-653-2(b)(24).

(5) The bureau shall make the determination whether the individual is eligible within a reasonable period of time, not to exceed 60 days after the individual has submitted an application, unless:

(A) exceptional and unforeseen circumstances beyond the control of the bureau preclude making an eligibility determination within 60 days and the bureau and individual agree to a specific extension of time, or

(B) the bureau is exploring an individual's abilities, capabilities and capacity to perform in work situations under subsection (a)(3) of this section.

(b) **Eligibility Determination**

(1) At the completion of the assessment for determining eligibility and priority for services, a determination will be made as to whether the applicant has satisfied the criteria for eligibility.

(2) No service other than diagnostic services and services to determine eligibility and priority for services may be provided by the bureau prior to completion of the certificate of eligibility.

(3) Certificate of Eligibility. In the event that all eligibility criteria are satisfied, the applicant will be accepted for vocational rehabilitation service and, simultaneously with this, a dated certificate stating the applicant has met the eligibility requirements shall be completed and signed by the appropriate representative of the bureau.

(c) **Certification of Ineligibility**

(1) When a determination is made that an applicant for vocational rehabilitation services is ineligible for services, a dated certificate shall be completed and signed by the appropriate representative of the bureau stating:

(A) that the applicant is ineligible for service; and

(B) the reasons for the determination of ineligibility.

(2) The bureau may make such an ineligibility determination only after providing an opportunity for full consultation with the individual or, as appropriate, with the individual's representative.

(3) The bureau shall notify the applicant in writing, supplemented as necessary by other appropriate means of communication consistent with the informed choice of the individual, of the determination. Such notice shall include the reason for that determination, his or her rights and means by which he or she may express and seek remedy for any dissatisfaction, including procedures for informal review and administrative hearing, the services offered by the Client Assistance Program (CAP) and how to contact that program.

(4) When appropriate the applicant shall be referred to other agencies or facilities.

(d) **Review of Ineligibility**

When an applicant for vocational rehabilitation services has been determined to be ineligible because of a finding that he or she is incapable of achieving an employment outcome, the determination will be reviewed by the bureau within twelve (12) months and annually thereafter if requested by the individual except that such review need not be conducted:

(1) when the applicant is no longer present in the state;

(2) when the applicant has refused it;

(3) when the applicant's whereabouts are unknown; or

(4) when the applicant's medical condition is rapidly progressive or terminal.

(e) **Assessment for Determining Rehabilitation Needs**

(1) The bureau shall provide an assessment for determining vocational rehabilitation needs for clients who are certified as eligible for vocational rehabilitation services and for whom the bureau is able to provide services under an order of selection, if applicable;

(2) The purpose of an assessment for determining vocational rehabilitation needs is to determine,

(A) the employment outcome and the objectives, nature and scope of vocational rehabilitation services to be included in the employment plan, designed to achieve the employment outcome; and

(B) the individual's unique strengths, resources, priorities, concerns, abilities, capabilities, career interests, and informed choice.

(3) To the extent possible, the assessment for determining vocational rehabilitation needs shall consist of existing data and data used for the assessment for determining eligibility and priority for services.

(4) The assessment for determining vocational rehabilitation needs may include to the degree needed, an appraisal of the client's personality, interests, interpersonal skills, intelligence and related functional abilities, educational achievements, work experience, vocational aptitudes, personal and social adjustment, emotional adjustment, employment opportunities and other pertinent data helpful in determining for each client, as appropriate, his or her capabilities to perform adequately in the work environment through an appraisal of the client's pattern of work behavior, abilities to acquire occupational skills and capacity

for suitable job performance including the utilization of work in real job situations.

(f) **Closure without Eligibility Determination**

The bureau may close a case without any determination of eligibility when the bureau determines that an applicant or client has declined to participate in, or is unavailable to complete an assessment for determining eligibility and priority for services, and the bureau has made a reasonable number of attempts to contact the applicant or, if appropriate, the applicant's representative to encourage the applicant's participation.

(Adopted effective June 6, 2000)

Sec. 17b-653-9. Employment plan

The following standards and procedures shall apply in the development, amendment and use of the employment plan.

(a) **Timing and Initiation of the Employment Plan**

The employment plan shall be initiated after certification of eligibility for individuals for whom the bureau is able to provide services under an order of selection, if applicable.

(b) **Plan Development and Approval**

(1) The employment plan may be developed by the client or in conjunction with the appropriate representative of the bureau and the client with a disability and, as appropriate, his or her parent, guardian or other representative.

(2) The plan shall be jointly reviewed by the client and counselor, or other appropriate bureau representative.

(3) The plan shall be approved by the client, counselor and, as deemed necessary by the bureau, other representative of the bureau. Reasons for which the bureau may deny approval of an employment plan, in whole or in part, may include but shall not be limited to a determination by the bureau that:

(A) The employment outcome chosen by the client is inconsistent with the individual's unique strengths, resources, priorities, concerns, abilities, capabilities, interests or informed choice;

(B) The nature, scope or duration of one or more of the services contained within the plan are not necessary to achieve the employment outcome or otherwise not appropriate to the vocational rehabilitation needs of the client; or

(C) The plan is otherwise inconsistent with federal or state statute, regulations or the state plan.

(c) **Provision for Copy of Employment Plan to the Client**The client or, as appropriate, his or her parent, guardian or other representative shall be provided with a copy of the employment plan and any amendments thereto and shall be advised by the bureau of the procedures and requirements affecting the development and review of the employment plan.

(d) The client shall cooperate in applying for or otherwise securing comparable benefits and services, benefits available as a legal right under state or federal law or other resources that may be necessary in order to achieve the employment outcome. Except as provided in subsection 17b-653-23(g) of sections 17b-653-1 to 17b-653-24, inclusive, of the Regulations

of Connecticut State Agencies, the bureau may deny or terminate services in such cases where a client fails to cooperate in the securing of such benefits and services. Services may be included under an employment plan only after consideration of comparable benefits and services, in accordance with section 17b-653-11.

(e) **Review**

The employment plan shall be reviewed as often as necessary but at least every twelve months. Each client or, as appropriate, his or her parent, guardian or other representative shall be given an opportunity to review the plan and, if necessary, jointly redevelop and agree to its terms.

(f) **Ineligibility Determination for Persons Receiving Services under an Employment Plan**

(1) If services are to be terminated under an employment plan because of a determination that the client is no longer eligible for services, the bureau shall:

(A) complete a certificate of ineligibility and inform the client, in accordance with section 17b-653-8(c); and

(B) review the decision, in accordance with section 17b-653-8(d).

(2) A determination that the individual is no longer eligible due to a finding that the client cannot benefit from vocational rehabilitation services shall be based on the bureau determining that there is clear and convincing evidence that the individual is incapable of benefiting in terms of an employment outcome from such services.

(g) **Content of the Employment Plan**The employment plan shall:

(1) include a statement of the specific employment outcome based on an assessment for determining vocational rehabilitation needs;

(2) include a statement of the specific vocational rehabilitation services that are needed to achieve the employment outcome, and the projected date for the initiation of services and the projected time lines for the achievement of the individual's employment outcome;

(3) include the entity that will provide services and the methods used to procure services;

(4) include a description of criteria to evaluate progress toward achievement of the employment outcome;

(5) include the terms and conditions of the employment plan, including, as appropriate, information describing:

(A) the responsibilities of the bureau;

(B) the responsibilities of the eligible individual, including:

(i) the responsibilities the eligible individual will assume in relation to the employment outcome of the individual;

(ii) if applicable, the participation of the eligible individual in paying for the costs of the plan; and

(iii) the responsibility of the eligible individual with regard to applying for and securing comparable benefits;

(C) the responsibilities of other entities;

(6) for individuals with the most significant disabilities for whom the employment

outcome is supported employment, include the nature and source of extended services needed after completion of services provided by the bureau; and

(7) be reviewed annually.

(h) Except as provided in section 17b-653-23(g), an employment plan can be modified or discontinued in whole or in part under any of the following conditions:

(1) by mutual agreement by the parties;

(2) a determination by the bureau that:

(A) the client is no longer eligible;

(B) the client has failed to comply with the terms of the employment plan;

(C) the employment outcome is no longer deemed appropriate;

(D) the duration, nature or scope of services contained within the plan is no longer appropriate; or

(E) services have been obtained through misrepresentation, fraud, collusion or criminal conduct on the part of the client or the client's representative; or

(3) budgetary shortfall or other circumstances beyond the control of the bureau which necessitate a discontinuation or modification of the plan.

(i) Clients shall have the responsibility of being actively involved in treatment or other interventions which the bureau determines necessary in order for the individual to achieve an employment outcome. In such cases where the client fails to comply with such treatment or intervention, the bureau may decline to approve or, except as provided in subsection 17b-653-23(g), may discontinue services contained within an employment plan.

(Adopted effective June 6, 2000)

Sec. 17b-653-10. Counseling and guidance services

(a) Counseling and guidance services will be provided by the bureau to each applicant or client throughout the vocational rehabilitation process, to the extent appropriate, for the purpose of:

(1) developing an appropriate employment plan towards the employment outcome;

(2) reviewing the applicant's or client's progress towards the vocational goal, amending the employment plan if necessary; and

(3) developing the applicant's or client's ability to seek and maintain employment.

(b) counseling and guidance services may also include, as appropriate, counseling to resolve a specific problem that is interfering with the applicant's or client's progress towards the vocational goal and referral to other agencies as appropriate.

(Adopted effective June 6, 2000)

Sec. 17b-653-11. Comparable services and benefits

(a) **Definitions.** The terms used in this section shall, unless the context otherwise requires, have the following meanings.

(1) "Eligible", when used in relation to an applicant's or client's qualification for comparable services and benefits, means legal entitlement or the applicant's or client's

ability to meet the criteria for obtaining services from other programs.

(2) "Program" means an organized, ongoing form of service or assistance, whether public or private, free or requiring a deductible, coinsurance feature, token payment, or personal claim.

(b) **Services Subject to Consideration of Comparable Services and Benefits** All vocational rehabilitation services, except as noted in subsections (c) and (d) of this section, shall be subject to consideration of comparable services and benefits.

(c) Services excepted from consideration of comparable benefits and services include:

(1) an assessment for determining eligibility and vocational rehabilitation needs by qualified personnel;

(2) counseling, guidance and referral services.

(d) The bureau may elect to utilize comparable services and benefits for the following services, when the bureau determines that these resources are known to be readily available at the time the service is needed to accomplish the employment outcome:

(1) placement in suitable employment; and

(2) rehabilitation technology services.

(e) **Criteria for the Use of Comparable Services and Benefits**

The bureau shall determine whether comparable services and benefits are available under any other program, unless such a determination would interrupt or delay:

(1) the progress of the individual toward achieving the employment outcome identified in the employment plan;

(2) an immediate job placement; or

(3) the provision of such service without which would place the individual at extreme medical risk.

(f) **Application to Provision of Physical and Mental Restoration Services and Maintenance Services.**

Full consideration shall be given to any comparable service or benefit available under any other program to an applicant or client to meet, in whole or in part, the cost of physical and mental restoration services and maintenance services provided to such an applicant or client.

(g) **Application to the Provision of Training Services**

The bureau shall require that applicants or clients make maximum effort to secure grant assistance, in whole or in part, to pay for training and training services in institutions of higher education. Applicants or clients approved to attend institutions of higher education shall be required to apply for federal and/or state grants where available.

(h) If comparable services or benefits exist under any other program, but are not available to the individual at the time needed to achieve the employment outcome in the individual's employment plan, the bureau shall provide vocational rehabilitation services until those comparable services and benefits become available.

(Adopted effective June 6, 2000)

Sec. 17b-653-12. Physical and mental restoration services

(a) The treatment of disability is not the primary focus of the bureau of rehabilitation services program. Physical and mental restoration services are provided only insofar as the bureau determines they will benefit the client in removing or adjusting to barriers to an employment outcome. Disabling conditions that do not or are not expected to adversely affect the attainment of the employment outcome are not to be remediated through the provision of physical or mental services by the bureau.

(b) Restoration services provided by the bureau shall, within a reasonable period of time, be expected to correct or modify substantially an impairment which constitutes a substantial impediment to employment. In estimating "a reasonable period of time", the following factors shall be considered: (1) the nature of the disability; (2) prognosis with respect to life expectancy; (3) employment potential, and; (4) other contributing factors such as age, work and premorbid personality. In general, restoration services provided by the bureau should not exceed six months in duration.

(c) Periodic evaluations of progress shall be made, at least every 90 days, and further decision made at those times.

(d) The bureau may seek consultation from a bureau medical consultant or other appropriate expert, particularly when any unusual, non-traditional, long-term or very costly procedure is being discussed, recommended or seriously considered for a client.

(e) Physical and mental restoration services may include, but are not limited to, the following:

(1) corrective surgery or therapeutic treatment of a mental or physical impairment;

(2) diagnosis for mental or emotional disorders by a physician skilled in the diagnosis of such disorders or by a licensed psychologist;

(3) treatment of mental or emotional disorders by a physician skilled in the treatment of such disorders, a psychologist, or social worker who is licensed in the state of Connecticut;

(4) dentistry;

(5) nursing services;

(6) necessary hospitalization (either inpatient or outpatient care) in connection with surgery or treatment and clinic services;

(7) drugs and supplies;

(8) prosthetic, orthotic or other assistive devices essential to obtaining or retaining employment;

(9) eyeglasses and visual services, including visual training and the examination and services necessary for the prescription and provision of eyeglasses, contact lenses, microscopic lenses, telescopic lenses and other special visual aids as prescribed by a physician skilled in diseases of the eye or by an optometrist, as appropriate;

(10) podiatry;

(11) physical therapy;

(12) occupational therapy;

(13) speech or hearing therapy;

(14) mental health services;

(15) treatment of either acute or chronic medical complications and emergencies which are associated with or arise out of the provision of physical and mental restoration services, or are inherent in the condition under treatment;

(16) special services for the treatment of individuals with end-stage renal disease, including transplantation, dialysis, artificial kidneys, and supplies;

(17) other medical or medically related rehabilitation services.

(f) Physical or mental restoration services may be provided to the extent that financial support is not available from a source (such as health insurance of the individual or through comparable services and benefits) other than the bureau.

(Adopted effective June 6, 2000)

Sec. 17b-653-13. Rehabilitation technology services

(a) Rehabilitation technology services are provided only insofar as they will benefit the client in removing, adjusting, or adapting to functional limitations that are barriers to required assessments in accordance with subsections (a), (b) or (e) of section 17b-653-8 or the achievement of an employment outcome, in accordance with section 17b-653-9(g). Functional limitations that are not expected to adversely affect the attainment of the vocational objective are not to be addressed through the provision of rehabilitation technology services by the Bureau of Rehabilitation Services.

(b) **Scope of Services -** Rehabilitation technology services may include one or more of the following:

(1) rehabilitation engineering services

(2) assistive technology services

(3) assistive technology devices

(c) **Modification/Adaptation of a Motor Vehicle -** Subject to the conditions listed herein, motor vehicle modification may be authorized when vehicle modifications are necessary in order for the client to enter, maintain or regain competitive employment.

(1) Vehicle modifications should be considered only after every other transportation option has been explored and only after it has been determined that vehicle modification is the most cost efficient approach for the client and the bureau.

(2) Vehicle modifications are only provided to those clients who have been determined eligible for vocational rehabilitation services and are entering, maintaining or regaining competitive employment.

(3) The bureau shall not participate financially to equip a vehicle with anything that was available to the client as a factory/dealer option at the time the vehicle was ordered and was recommended to the client by the bureau.

(4) The bureau may arrange for a thorough mechanical inspection of any vehicle before determining whether or not it is feasible for the vehicle to be modified, remodified or adapted.

(5) The financial participation and expenditure of the bureau shall be as follows:

(A) first time up to 100%

(B) remodification of same vehicle or another vehicle may be provided under the following conditions, provided the client has maintained appropriate insurance on the original adaptive equipment:

(i) within three (3) years and 54,000 miles following the most recent modification funded by the bureau, the client shall be expected to bear the complete cost. The bureau shall bear none of the cost.

(ii) more than three (3) years and at least 54,000 miles following the most recent modification- the bureau may provide up to 50% of the transfer or remodification. The client shall bear the cost of the balance.

(iii) more than five (5) years and at least 90,000 miles following the most recent modification funded by the bureau, the bureau may provide up to the entire cost.

(6) The bureau's participation in modifying or adapting a vehicle will be limited to the least expensive type of vehicle modification that will accomplish the goal of enabling the client to enter, maintain or regain employment, based on evaluations performed by the bureau's central office consultant and the Department of Motor Vehicle's handicapped drivers consultant or other entity deemed qualified by the bureau.

(7) The client shall cooperate in undergoing evaluation and testing as necessary to determine the client's ability to drive and needs for special equipment and vehicle modification. The bureau may deny the provision of vehicle modification services where a client fails to cooperate in such evaluations.

(8) Vehicle modification shall be provided only in conjunction with and to support the attainment of a specific vocational goal.

(9) Basic vehicle repairs and routine maintenance including special adaptive equipment shall be the sole responsibility of the client.

(10) Insurance on the vehicle, including any insurance on the vehicular adaptive equipment, shall be the sole responsibility of the client.

(11) If the client or the client's family have entered into negotiations or contracts for services with particular vendors, it shall not be binding upon the bureau to provide services through said vendor(s). Any work that has been initiated or equipment that has been installed or ordered prior to approval under an employment plan will not be retroactively authorized by the bureau.

(Adopted effective June 6, 2000)

Sec. 17b-653-14. Vocational and other training services

The bureau may provide vocational and other training services, when necessary to achieve an employment outcome, as part of an employment plan approved by the bureau.

(a) **Scope of Services -** Vocational and other training services may include one or more of the following types of training:

(1) personal and vocational adjustment training;

(2) training in the use of artificial limbs, hearing aids or other appliances;

(3) remedial training;
(4) literacy training;
(5) vocational training;
(6) academic training;
(7) speech and hearing training which is not medically directed;
(8) lip reading;
(9) mobility training;
(10) rehabilitation teaching;
(11) transitional employment;
(12) on-the-job training;
(13) any other kind of organized training needed to meet the rehabilitation needs of the client being served.

(b) **Provider of Training.** Training may be provided at schools, colleges or universities, through community rehabilitation programs, by tutor or correspondence, apprenticeship or in an on-the-job training situation or by bureau staff or some other organized training program.

(c) **Length of Training.** The length of time required by a client to complete training is to be determined by the time necessary in each case to acquire sufficient knowledge and skill to meet the demands of the employment outcome. Training time should be designed, however, to ensure the minimum time required to accomplish a reasonable individual training program.

(d) Training material and supplies include necessary books and such training supplies as are necessary in order for the individual to participate in training services.

(e) Training is provided to prepare the client to achieve to an employment outcome.

(f) Trainees and students are expected to maintain grade averages or such reasonable progress as to enable them to complete the course successfully and attain the employment outcome.

(g) Vocational training will be provided only in accordance with an appropriately completed employment plan. The employment plan shall be designed to ensure the lowest cost to the bureau in providing a reasonable training service.

(h) Progress in training shall be evaluated on no less than a semester or term basis for educational institutions that operate on that basis and no less than a monthly basis for all other training programs and continued authorization of training shall be based on achievement of significant progress by the applicant or client in relation to the planned employment outcome.

(Adopted effective June 6, 2000)

Sec. 17b-653-15. Training in institution of higher education or vocational training facilities

(a) Financial participation by the bureau in providing training in institutions of higher education or vocational training facilities shall be made to assure that the cost to the bureau

will not exceed the cost of a program at a public Connecticut state supported college, university, community technical college or similar program which the bureau determines to be commensurate, unless an alternative program is necessary because of the individual's disability.

(b) Financial participation by the bureau in providing training in institutions of higher education or vocational training facilities shall be made only in accordance with an appropriately completed employment plan and shall be limited to support of training that is needed to achieve the employment outcome.

(c) No training in institutions of higher education shall be paid for by the bureau unless maximum efforts have been made to secure comparable benefits or other assistance in whole or in part from other sources to pay for such training. These benefits shall include family contribution, basic grant entitlement under student financial aid programs, private or institution-based scholarships, tuition waiver, work-study and earnings. The amount of bureau support, together with institutional aid, shall not exceed the cost of the education. A client will be encouraged but not required to apply for student loans.

(1) In pursuing a determination of available comparable benefits and assistance from other sources, the applicant or client shall make application to the training institution's financial aid office (FAO) and shall cooperate in the provision of all information required by the financial aid office in its calculation of the applicant's or client's eligibility for financial assistance.

The bureau shall presume the correctness of the computation made by the FAO at the post-secondary training institution which the client is attending regarding the amount of parental and family contribution which can be expected to be applied toward the cost of the client's post-secondary training. However, where evidence is presented that the computation made by the FAO is clearly erroneous, and when time or other circumstances make it impossible or impractical for the client to have the computation by the FAO corrected, the bureau will not allow these factors to adversely affect the amount of assistance to the client.

The bureau will assume primary responsibility for disability-related expenses, such as personal care, personal assistants, or specialized tutoring, as appropriate to the successful completion of program, provided such services are not covered under Title II or III of the Americans with Disabilities Act of 1990. In no case shall the bureau assume the role or responsibility as employer of the personal assistant, tutor or other individual assisting the client.

(2) The applicant or client shall give written authorization to the bureau and the financial aid office to exchange information relevant to the determination of eligibility for financial assistance.

(3) Application by the applicant or client to the financial aid office will be made in sufficient time to permit a decision to be rendered by the financial aid office prior to the starting date of training (and in no case less than sixty (60) days prior to the starting date of training).

(4) The bureau may deny support of training services in cases where a client fails to

apply for financial aid in a timely manner or otherwise cooperate with the financial aid office or bureau in order to make a determination of the client's financial needs.

(d) The bureau shall not be required to provide post-secondary education services beyond the baccalaureate level unless,

(1) the client requires graduate training to enter employment within the profession which is identified and agreed upon in the employment plan and is consistent with the client's strengths, resources, priorities, concerns, abilities, capabilities, interests and informed choice; and

(2) the severity of the client's disability limits his/her ability to function in an appropriate initial career position while simultaneously completing additional training at the graduate level required to advance in the profession.

(Adopted effective June 6, 2000)

Sec. 17b-653-16. Maintenance services

(a) Maintenance may be provided under the following conditions:

(1) Maintenance payments shall be limited to the increased cost directly attributable to the applicant's or client's participation in the vocational rehabilitation program.

(2) Maintenance after employment has started may be continued or paid to an eligible client up to the date of receipt of his or her first pay or, in the case of self-employment, up to thirty (30) days.

(b) Payments for maintenance services are limited to expenses that are needed in order to participate in other vocational rehabilitation services to the applicant or client and shall not be made if said other rehabilitation services have been discontinued or never started.

(c) Amount of maintenance required by the applicant or client shall be determined by the bureau in consultation with the client and shall be based on:

(1) the published rates for room and board for applicants or clients living away from home when such service is made available by the provider;

(2) the average cost to the applicant or client to be calculated on the experience of actual cost gathered over a two-week base period by the client and the bureau; or

(3) the individual circumstances of the applicant or client to meet his/her unique needs.

(Adopted effective June 6, 2000)

Sec. 17b-653-17. Alterations to client housing or small business property

Subject to the conditions listed below, architectural alteration services may be provided to enable a client to accomplish safe egress from and ingress to the home or the workplace, or to enable a client to function vocationally within the home or workplace.

(a) The bureau's participation in alterations shall be limited to those determined by the bureau to meet the functional needs of the client at the least cost. Ramps, grab bars, lifts, or bathroom modifications are examples of such services.

(b) Alterations to work sites or business properties shall only be considered when they are not covered under the Americans with Disabilities Act of 1990, 29 U.S.C. § 12101 et

seq.

(c) **Exempted Services**

(1) Except as provided in subsection (c)(2) of this section, the bureau shall not be responsible for financial participation in extensive or elaborate reconstruction, structural modifications, the addition of a room or rooms, or any other alteration that adds appreciable value to the property.

(2) The director or his/her designee may approve bureau participation in a structural addition or reconstruction in such cases where the bureau determines that, with respect to removing the architectural barriers which need to be eliminated in order for the individual to achieve an employment outcome:

(A) there is no other alternative; or

(B) such addition or reconstruction is the least costly alternative for the bureau.

(3) In any case where the bureau makes an exception under subsection (c)(2) of this section, the bureau's participation shall be limited to the minimum cost necessary to eliminate such architectural barriers.

(d) Architectural alterations will only be provided to the extent necessary for the successful completion of the client's employment plan. The case record will contain the following:

(1) Limitation of activities and functioning, due to the client's disability, shall be explained specifically and in detail and should be supported by reports from appropriate sources recognized by the bureau;

(2) The client's vocational impediment or barrier to employment that will be eliminated or reduced by the provision of the architectural modification service shall be thoroughly explained and supported; and

(3) The architectural barriers of the present site shall be clearly and carefully delineated in the case record together with an explanation as to how they impede the successful attainment of the client's employment outcome. It shall be explained how these barriers will be eliminated or reduced through the planned alteration services.

(e) The bureau will not be required to participate in alterations that are anticipated to meet the client's needs for a period of less than two years after the completion of the alterations, due to factors either related to the living situation or the client's disability. Alterations to a site may be made only after the client has provided written agreement that the client's planned occupancy is a minimum of two years beyond completion of alteration services.

(f) The client shall provide a signed agreement by the owner of the site to be modified, giving consent and authorization for the bureau to provide or participate in the provision of the necessary modifications to the property occupied by the client. Without such written consent, the bureau cannot provide or participate in the provision of such services.

(g) If the client or his/her family is building a home where the client is to reside, necessary alterations will be the responsibility of the client or his/her family. The bureau will not participate in the financing of such construction.

(h) If the client or the client's family have entered negotiations with a vendor for alteration work to be done or for equipment or materials to be supplied, any resulting agreements shall not be binding upon the bureau.

(i) The bureau shall not assume and is not responsible for the full restoration of structures or grounds that are disturbed in the process of alterations. Such areas will be functionally restored to the minimum level allowable by applicable codes. The bureau shall not be responsible for the matching of finishes, trims, and accessories when special sizing, tooling, and construction methods and materials would be required to do so.

(j) The bureau's financial participation in alterations for a client will be limited to a one-time basis, with the exception of cases where there are changes in the client's disability, employment or other circumstances beyond the control of the client which warrant additional modifications in accordance with this section of the regulations.

(k) Once the alterations are completed, the client is thereafter responsible for upkeep, maintenance, insurance and repairs. The bureau shall not pay for such expenses nor be responsible for the cost of removing ramps and restoration of property back to its original state after the accessibility-related construction is no longer needed.

(*l*) As determined necessary by the bureau, when it anticipates that alteration services may be part of a client's employment plan and may require financial participation by the bureau, the bureau will secure consultation by a licensed architect or other qualified technical consultant approved by the bureau.

(m) The bureau requires that a local building permit be issued for each project, which shall be provided to the bureau upon demand. Any zoning variance or other requirements necessary to secure such permit are the sole responsibility of the property owner.

(n) If a bureau representative discovers a structural defect or building code violation on the property that has direct bearing on the proposed modifications, the bureau will not proceed until corrective action or repair has occurred. Any cost of repair will be the sole responsibility of the property owner. Documentation of sufficient corrective action shall be submitted to the bureau before proposed modifications can resume.

(o) The bureau may deny assistance with any architectural modifications that it determines to be unsafe, unstable, in violation of applicable building codes or where, due to the nature of the site to be modified, the costs will be unreasonable.

(Adopted effective June 6, 2000)

Sec. 17b-653-18. Transportation and related expenses

The following standards and procedures shall apply in the provision of transportation services and related expenses to clients and applicants:

(a) Transportation service may be provided only:

(1) in connection with the provision of another vocational rehabilitation service and needed by the individual to achieve an employment outcome, or

(2) to enable the client or applicant to participate in the informal review or administrative hearing procedures.

(b) Transportation service may include:

(1) fares or travel costs associated with the use of public or private conveyances including parking fees and tolls;

(2) subsistence during travel;

(3) relocation and moving expenses necessary for achieving an employment outcome identified in the employment plan; or

(4) other expenses related to travel.

(c) Rates of payment shall be determined by the bureau in consultation with the client or applicant and shall be based, at the discretion of the director, upon the following as applicable:

(1) published rates for public transportation;

(2) maintenance costs related to travel, up to the amount allowed to management personnel of the bureau; or

(3) mileage costs, up to the rate established by the state for mileage reimbursement of management employees of the bureau using personally owned automobiles.

(d) Selection of mode of transportation shall be made on the basis of the circumstances and special needs of the client or applicant and at the least cost.

(e) **Personal assistants.** The use of a personal assistant or escort by a client or applicant in transit shall be limited to individuals with significant disabilities and payment for such service will be based on the state minimum wage. Payment to a family member acting as a personal assistant shall be limited to costs of travel and subsistence during travel established by sections 17b-653-1 to 17b-653-24, inclusive, of the Regulations of Connecticut State Agencies. In no case shall the bureau assume the role or responsibility as employer of the assistant.

(f) Transportation in support of placement service may be provided to a client who has been placed in employment until the client has received his or her first pay.

(g) Transportation service may be provided to a client who has been closed as rehabilitated to enable the client to benefit from a post-employment service as needed and if provided for in an employment plan.

(h) The bureau shall not provide financial assistance in the purchase of a vehicle.

(Adopted effective June 6, 2000)

Sec. 17b-653-19. Purchase of tools and equipment

Subject to the conditions listed below, tools and equipment may be provided to enable a client achieve the employment outcome identified in the employment plan.

(a) Tools and equipment provided for a client shall become the property of the client.

(b) The client will be responsible for maintenance, repair and insurance of all tools and equipment so provided.

(c) Tools and equipment shall be provided only in conjunction with and to support the attainment of a specific employment outcome.

(Adopted effective June 6, 2000)

Sec. 17b-653-20. Self-employment services

(a) The bureau may provide services to individuals for the development of self-employment or a small business enterprise under the following conditions:

(1) A business plan shall be developed by the client and approved by a Connecticut Small Business Development Center as an economically viable proposal. In lieu of the Small Business Development Center, an alternative small business resource that is acceptable to both the bureau and the client may be used. The bureau may provide self-employment services without such approval where the director or his/her designee determine that, in his/her opinion, there is clear and convincing evidence that the business is likely to be successful within a reasonable period of time. In such cases, the client shall bear the burden of proving the likelihood of the success of the business.

(2) Before providing any services under an employment plan to achieve an employment outcome of self-employment, the bureau shall approve both the employment outcome and the business plan. The bureau may disapprove a business plan where it determines that the employment outcome is not feasible, as a result of:

(A) the earning potential of the business; or

(B) inconsistency with the client's strengths, resources, priorities, concerns, abilities, capabilities, or informed choice.

(3) The limits of the bureau's contribution toward the establishment of a small business, excluding training costs and excluding any needed costs for vehicle or work site modifications necessitated by the individual's disability, shall be as follows:

(A) ten thousand dollars, in cases where the net income that the business is projected to generate after two or more years in operation following the anticipated completion of services is at or above the amount recognized by the Social Security Administration as substantial gainful activity;

(B) five thousand dollars, in cases where the net income the business is projected to generate after two or more years in operation following the anticipated completion of services is less than substantial gainful activity level, as determined by the Social Security Administration.

(4) Clients will be required to make a contribution toward the self-employment venture, in cash, materials, or in-kind labor, in an amount valued at no less than ten percent of the bureau's contribution as defined in subsection (a)(3) of this section. Except as provided in subsection (c) of this section, the bureau may deny the provision of self-employment services in cases where the client will not fulfill their responsibility under this subdivision.

(b) Self-employment services may include start-up services and goods such as business consultants, bookkeeping, advertising, initial stocks, insurance, permits, fees, equipment, supplies, rent, utilities, transportation, telephone, and postage.

(c) If a bureau representative determines that there are circumstances in an individual case that warrant an exception to the provisions in subsection (a)(4) or the cost limits established in subsections (a)(3)(A) or (a)(3)(B) of this section, a full explanation and justification shall be presented to the director or his/her designee for consideration. The

director may grant an exception in such cases as he/she determines that:
(1) client hardship requires such exception; and
(2) without such exception, there are no viable alternatives that would allow the client to achieve the employment outcome.

(Adopted effective June 6, 2000)

Sec. 17b-653-21. Homemaker services
(a) The bureau may provide services that will enable a client to achieve an employment outcome of homemaker within the client's home, only in such situations where the client:
(1) is required to care for his/her dependant children who are under the age of eighteen or who have a severely disabling condition; or
(2) is required to perform homemaker duties in order for another member of the household to enter full-time competitive employment.
(b) Services provided by the bureau to clients with an employment outcome of homemaker will be limited to those which eliminate the barriers to performing the functions which,
(1) are essential functions of the role of homemaker; and
(2) cannot reasonably be expected to be performed by other members of the client's household.
(c) In cases where the bureau makes a determination that the requirements under subsection (a) or (b) of this section are not met, the client shall have the burden of proving by a preponderance of the evidence that the requirements under (a) and (b) are met.

(Adopted effective June 6, 2000)

Sec. 17b-653-22. Informal review
(a) An informal review is a procedure through which the bureau affords an opportunity to a client or applicant for vocational rehabilitation service or the individual's representative, as appropriate, to express and seek remedy if the individual is aggrieved by a decision made by the bureau. An informal review is not a "contested case" within the meaning of section 4-166(2) of the Connecticut General Statutes.
(b) The request for an informal review shall be in writing, or other mode of communication appropriate to the applicant or client's disability needs, and contain a clear and concise statement of the issue for which remedy is sought. Such request shall be addressed to the respective bureau district director and received by the bureau not more than 30 days after the date of notification by the bureau of the decision for which the client seeks redress.
(c) Reviewer: An informal review shall be conducted by a member or members of the bureau's staff to be designated by the director.
(d) **Opportunity for an Informal Review.**
(1) The bureau shall afford the opportunity to request an informal review to every client or applicant.

(2) Clients or applicants may be granted an informal review in any of the following situations:

(A) the denial of an applicant or, the denial of the right to apply or reapply for services provided by the bureau;

(B) any bureau action concerning the development, implementation, denial, suspension, reduction or termination of services under an employment plan; or

(C) unresolved disputes pertaining to the scope of services provided to the client or the applicant by the bureau.

(3) If the applicant or client is represented by legal counsel, lay advocate, relative or other spokesperson, any fees incurred by such representation are the responsibility of the client or applicant.

(e) **Scheduling and Location of Informal Review:** An informal review shall be:

(1) Scheduled within a timely manner upon receipt of the written request for review.

(2) Held during bureau working hours, or at a time mutually agreed upon by the parties and approved by the reviewer, and

(3) Conducted at a bureau office or at an accessible location mutually agreed upon by the parties and approved by the reviewer.

(f) **Use of Client's or Applicant's Case Record.** When requested in writing by the involved client or applicant or his or her designated representative, the bureau shall make available all information in the case record accessible to the client or applicant or release it to him or her or a designated representative in a timely manner. Medical, psychological or other information which the bureau determines may be harmful to the client or applicant shall not be released directly to the client or applicant but shall be provided through his or her designated representative.

(g) **Default.** Failure to appear at a scheduled review shall be deemed a waiver of a right to a review. Upon such failure, the reviewer at his or her option may issue an order disposing of the matter or may, if requested by the defaulted party within ten (10) days of default, reschedule the review for good cause shown.

(h) **Adjustment of Matters Related to an Informal Review.** The fact that a request for an informal review has been filed does not prohibit the parties from making an adjustment by agreement in the matters at issue prior to an informal review. If, as a result of an adjustment, the client or applicant is satisfied and wishes to withdraw all or part of his or her petition for informal review, the client or applicant or his or her authorized representative shall transmit to the reviewer his or her signed written withdrawal. However, neither the bureau representative(s) nor the reviewer may delay or cancel an informal review because of a possible adjustment that is under consideration unless the bureau and the applicant or client agree to a delay or cancellation.

(i) **Rights of the Client or Applicant.** The client or applicant shall have the opportunity to present relevant facts by oral or written statement on his or her behalf.

(j) **Duties and Authority of the Reviewer.**

(1) The reviewer shall have the duty to conduct a fair review to assure equitable treatment

to all parties, to define the issues, to receive and consider all relevant evidence, to exclude irrelevant or redundant evidence and to reach a fair and impartial decision based upon the issues and evidence presented and in accordance with the law and good professional practices in vocational rehabilitation.

(2) The reviewer shall have the authority to schedule or reschedule the review, request a statement of the issues, define the issues and regulate the proceedings including the introduction of evidence and to render a decision.

(k) **Basis of Decision.** The reviewer's decision shall be based upon the applicable law and evidence presented at the review unless the evidence is in the nature of additional reports requested by the reviewer at the review.

(*l*) **Decision.**

(1) The reviewer shall accept a settlement of the issues as agreed to by the parties or may decide in favor of the client or applicant or in favor of the bureau. In lieu of a decision in favor of either party, the reviewer may recommend that the bureau and the applicant or client be involved in mediation, if agreed to by both parties. If the parties do not agree to mediation, the reviewer shall issue a decision in favor of one of the parties.

(2) The reviewer may accept a withdrawal of the claim or default any party who fails to appear.

(m) **Form of Decision.** The decision shall be a statement of the issues involved in the review, a finding of fact and a statement of the conclusions including the basis for the conclusions.

(n) **Notice of Decision.** The reviewer shall mail a copy of the decision to appropriate bureau staff, the client or applicant and, as applicable, the authorized representative.

(Adopted effective June 6, 2000)

Sec. 17b-653-23. Administrative hearing and mediation

(a) Clients or applicants who have been aggrieved by a decision made by the bureau have a right to an administrative appeal. For purposes of this subsection, an applicant or client for whom the bureau has denied mediation, in accordance with subsection (e) of this section, shall not be considered as aggrieved by a decision made by the bureau. Clients or applicants who have been aggrieved by a decision made by the bureau have a right to an administrative hearing in any of the following situations:

(1) the denial of an applicant or the denial of the right to apply or reapply for services provided by the bureau;

(2) any bureau action concerning the development, implementation, denial, suspension, reduction or termination of services under an employment plan; or

(3) unresolved disputes pertaining to the scope of services provided to the client or the applicant by the bureau.

(b) Administrative hearings shall be conducted in accordance with the Administrative Procedures Act, Connecticut General Statutes sections 4-176e to 4-181. Unless otherwise specified in sections 17b-653-1 to 17b-653-24, inclusive, of the Regulations of Connecticut

State Agencies, the applicant or client has the burden of proving by a preponderance of the evidence that the bureau's decision does not comply with state or federal law or is clearly erroneous.

(c) Applicants and clients shall be informed of the right to an administrative hearing and mediation, including the name and address to which the request for an administrative hearing is to be forwarded:

(1) at the time the individual applies for vocational rehabilitation services;

(2) at the time the employment plan for the individual is developed; and

(3) upon reduction, suspension, or cessation of vocational rehabilitation services for the individual.

(d) **Request for an Administrative Hearing.** The client or applicant may request an administrative hearing, including mediation, in accordance with the following criteria:

(1) The request for an administrative hearing, which may include a request for mediation, shall be in writing or other mode of communication appropriate to the applicant or client's disability needs.

(2) The request shall contain a clear and concise statement of the issue for which remedy is sought.

(3) The request shall be received by the bureau director within 30 days of the latter of, as applicable:

(i) the date of notification of the bureau decision for which the client seeks redress;

(ii) mailing of the informal review decision, in accordance with section 17b-653-22; or

(iii) completion of mediation, in accordance with subsection (e) of this section.

(e) **Mediation**

(1) Applicants or clients who request an administrative hearing in accordance with this section may request that mediation be held prior to an administrative hearing. The bureau shall consider all such requests, and shall grant the applicant or client's request, provided both the bureau and the applicant or client agree to mediation.

(2) The bureau may deny a request for mediation where it determines that mediation is not likely to resolve the issue for which remedy is sought. In such cases, the applicant or client may request to pursue an administrative hearing.

(3) The mediation shall be conducted by an individual deemed qualified by the bureau who is trained or otherwise skilled in conducting mediation and is knowledgeable of the vocational rehabilitation program.

(4) An agreement by the bureau and the applicant or client shall be set forth in writing.

(5) The mediation shall be considered completed at such time as the signing of an agreement by the parties or formal termination of the mediation, whichever is later. In the absence of a signed agreement or formal termination, mediation shall be considered completed on the date of the last mediation session concerning the issue for which remedy is sought.

(6) Discussions that occur during the mediation process shall be confidential and shall not be used as evidence in any subsequent hearing or civil proceeding.

(7) The bureau shall choose a mediator from a list of qualified individuals maintained by the bureau.

(8) The bureau may, at its discretion, offer mediation as an option to applicants or clients other than those who have requested an administrative hearing. With the exception of subsections (e)(5), (e)(6) and (e)(9) of this section, none of the requirements in this section shall apply in such cases where the bureau is not required to offer mediation.

(9) The bureau shall not be bound by terms in a mediation agreement where the issues for which the applicant or client requested mediation are subsequently appealed in an administrative hearing or civil proceeding.

(f) **Disclosure of Agency Case Record.** The client or applicant may request access and disclosure of the case record in accordance with applicable laws.

(g) **Service Provision During Pending Administrative Hearing.**

(1) Unless the applicant or client so requests, or, in an appropriate case, the individual's representative, so requests, pending a decision by a mediator, hearing officer, or reviewing official under this section, the bureau shall not institute a suspension, reduction, or termination of services being provided for the individual, including evaluation and assessment services and plan development, unless such services have been obtained through misrepresentation, fraud, collusion, or criminal conduct on the part of the individual or the individual's representative.

(2) For purposes of this subsection, "services being provided" means:

(A) as applies to evaluation and assessment services, services needed to complete the assessment for determining eligibility and priority for services which had begun as of the time of the director's receipt of the request for a review under this section;

(B) as applies to plan development, assessment for determining rehabilitation needs which had begun at the time of the request for a review is received by the director;

(C) as applies to services under an employment plan, the specific services identified in the plan which had begun prior to the request for a review is received by the director. It includes the scope, time frames and providers specified in the employment plan.

(h) **Scheduling.**

(1) An administrative hearing and mediation, if requested, shall be held within a timely manner of the receipt of the request by the director;

(2) Administrative hearings and mediation shall be conducted during bureau working hours or at a time mutually agreed upon by the parties and approved by the impartial hearing officer or mediator and at an accessible location mutually agreed upon by the parties and approved by the hearing officer or mediator.

(i) **Evidence in Administrative Hearing.** Evidence in administrative hearing cases shall be in compliance with Section 4-178 of the Connecticut General Statutes. The client or applicant shall be afforded the opportunity to present additional evidence, information, and witnesses to the impartial hearing officer.

(j) **Representation.** Any applicant or client who requests an administrative hearing or mediation shall have the right to representation by counsel or other appropriate advocate of

their choice. The fee for said counsel or advocate is the sole responsibility of the applicant or client.

(k) **Impartial Hearing Officer.** The impartial hearing officer shall conduct the administrative hearing and prepare a decision.

The impartial hearing officer shall render a written decision based on the provisions of the approved state plan, the federal Rehabilitation Act, federal regulation, and the state statutes, regulations and policy governing this program. The decision shall contain a full written report of the findings and the grounds for the decision and shall be provided to the client or applicant or, if appropriate, the individual's parent, guardian, or other representative, and to the director not more than thirty (30) calendar days of the completion of the hearing.

(*l*) **Review of Decision:**

(1) The department may establish procedures for review of the impartial hearing officer's decision by the Commissioner of Social Services. If such a procedure is established, the following shall apply:

(A) Not later than 20 days after the decision by the impartial hearing officer is rendered, either party may request that the reviewing official review the decision.

(B) Factors which the reviewing official may consider in determining whether an impartial hearing officer's decision should be reviewed include, but are not limited to:

(i) whether the initial decision is arbitrary, capricious, an abuse of discretion or otherwise unreasonable;

(ii) whether the initial decision is supported by substantial evidence, consistent with facts and applicable federal and state policy and law;

(iii) in reaching the initial decision, whether the impartial hearing officer has given appropriate and adequate interpretation to such factors as federal statutes and law; the state plan as it applies to the specific issues in question; the state procedures manual as it applies to the specific issues in question; key portions of conflicting testimony; state agency options in the delivery of services; federal or bureau policy as it relates to the issues in question.

(m) **Kinds of Decisions.** In rendering the decision the impartial hearing officer may, and in making the final decision the reviewing official may, take one of several courses of action which include, but are not limited to, the following:

(1) find in favor of the client or applicant;

(2) uphold the action or inaction of the bureau;

(3) accept a written withdrawal of the appeal which is signed by the client or applicant, or her or his authorized representative;

(4) accept a settlement of the issues agreed to by the parties; or

(5) default any party who fails to appear. Upon such failure, the impartial hearing officer at his or her option may issue an order disposing of the matter or may, if requested by the defaulted party within ten (10) days of default, reschedule the hearing for good cause shown.

(n) **Notice of Final Decision.**

(1) The decision of the impartial hearing officer shall be a final decision, unless a review

is completed pursuant to subsection (*l*) of this section, in which case the decision of the commissioner shall become the final decision.

(2) The director shall mail a copy of the final decision to appropriate bureau staff, the client or applicant and her or his authorized representative.

(o) **Extensions of Time.** Except for the time limitations established in subsection (*l*)(1)(A) of this section, the director may grant reasonable time extensions for good cause shown at the request of a party or at the request of both parties.

(p) **Appeal.** Section 4-183 of the Connecticut General Statutes shall apply to appeals of the final decision in an administrative hearing.

(Adopted effective June 6, 2000)

Sec. 17b-653-24. Case closure

(a) Reasons for which the bureau may close an applicant or client's case shall include, but not be limited to, a determination by the bureau that:

(1) the applicant or client is not eligible for services;

(2) the applicant or client has been rehabilitated;

(3) the applicant or client is not available to receive services, due to his/her having moved or inability to otherwise be located or contacted, refusal of services, failure to cooperate in participation in services, institutionalization, or death;

(4) transportation is not available or feasible to obtain or maintain employment; or

(5) extended support services are not available to an individual who requires supported employment services.

(b) The following standards and procedures are the requirements when determining that a client has been rehabilitated and his or her case record is closed as rehabilitated:

(1) The employment outcome is consistent with the individual's strengths, resources, priorities, concerns, abilities, capabilities, interests, and informed choice;

(2) The employment outcome is in the most integrated setting possible, consistent with the individual's informed choice;

(3) Rehabilitation services provided in accordance with an employment plan have contributed to the achievement of the employment outcome;

(4) It has been determined that the client has maintained the employment outcome for at least 90 days; and

(5) At the end of the 90-day period, the client and appropriate bureau staff consider the employment outcome to be satisfactory and agree that the individual is performing well on the job.

(c) **Post Employment Services**

After a client has been determined to be rehabilitated, post employment services may be provided to assist a client to maintain or regain employment.

(Adopted effective June 6, 2000)

Agency
Department of Social Services

Subject
Employment Opportunities

Inclusive Sections
§§ 17b-666-1—17b-666-6

CONTENTS

Sec. 17b-666-1. Description
Sec. 17b-666-2. Definitions
Sec. 17b-666-3. Administration
Sec. 17b-666-4. Eligibility
Sec. 17b-666-5. Services provided
Sec. 17b-666-6. Administrative review

Employment Opportunities

Sec. 17b-666-1. Description

Sections 17b-666-2 to 17b-666-6, inclusive, of the Regulations of Connecticut State Agencies shall apply to the state Department of Social Services in its implementation of the employment opportunities program, as described in Section 17b-666 of the Connecticut General Statutes.

(Adopted effective November 17, 2003)

Sec. 17b-666-2. Definitions

The following definitions shall govern the interpretation and application of this section and sections 17b-666-3 to 17b-666-6, inclusive, of the Regulations of Connecticut State Agencies:

(1) "Bureau" means the Bureau of Rehabilitation Services of the Department of Social Services;

(2) "Client" means an individual who has been determined eligible for services under the employment opportunities program;

(3) "Coaching and other related services" means services provided by a skilled job trainer that are based on an assessment, which provide for the coordination or provision of specific services that are necessary to maintain employment stability. These services are provided at the worksite, or under special circumstances, especially at the request of the client and agreed to by the bureau, may be provided offsite. The term consists of:

(A) job skill training;

(B) regular observation or supervision of the individual; and

(C) facilitation of natural supports.

(4) "Competitive employment" means work,

(A) in the competitive labor market that is performed on a full-time or part-time basis in an integrated setting; and

(B) for which an individual is compensated at or above the minimum wage, but not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by individuals who are not disabled.

(5) "Department" means the Department of Social Services;

(6) "Director" means the director of the Bureau of Rehabilitation Services;

(7) "Integrated site" means a setting typically found in the community in which the client would interact with non-disabled individuals, other than non-disabled individuals who are providing services to the client, to the same extent that non-disabled individuals in comparable positions interact with other persons;

(8) "Individual with the most significant disabilities" means an individual who, due to a physical or mental impairment,

(A) has serious employment limitations in a total of three of more functional areas including, but not limited to, mobility, communication, self-care, interpersonal skills, work tolerance or work skills, or

(B) will require significant ongoing disability-related services on the job in order to maintain employment;

(Adopted effective November 17, 2003)

Sec. 17b-666-3. Administration

The employment opportunities program shall be administered by the Bureau of Rehabilitation Services.

(Adopted effective November 17, 2003)

Sec. 17b-666-4. Eligibility

(a) A determination of eligibility for the employment opportunities program shall be based on a determination by the bureau that the individual:

(1) is an individual with the most significant disabilities;

(2) requires ongoing coaching and other related services in order to maintain supported employment; and

(3) is ineligible for coaching and other related services from the Department of Mental Retardation, Department of Mental Health and Addiction Services or other entity providing the coaching and other related services available through the employment opportunities program. This means that:

(A) The individual has made application, as applicable, to the Department of Mental Retardation, Department of Mental Health and Addiction Services or other entity providing services covered by the employment opportunities program and has been determined by that department or entity to not meet the respective agency's eligibility criteria, including eligibility to be placed on the respective agency's waiting list; or

(B) The bureau has determined that it is unlikely that the individual would meet the eligibility criteria for coaching and other related services through the Department of Mental Retardation, Department of Mental Health and Addiction Services or other entity providing services covered by the employment opportunities program.

(b) Clients served by this program shall have the responsibility of being actively involved in treatment or other interventions which the bureau determines necessary in order for the individual to maintain employment and minimize the amount of services needed under this program. In such cases where the individual fails to comply with such treatment or intervention, the bureau may decline to approve or may discontinue services.

(Adopted effective November 17, 2003)

Sec. 17b-666-5. Services provided

(a) Services provided under the employment opportunities program are limited to coaching and other related services that are necessary in order for the eligible individual to maintain employment:

(1) that is in an integrated site; and

(2) for which the average weekly compensation to the eligible individual is, at a

minimum, the dollar equivalent of fifteen hours of work at the minimum wage for the State of Connecticut.

(b) Notwithstanding subdivisions (a)(1) and (a)(2) of this section, the bureau may continue providing coaching and other related services which were being provided to an individual as of the effective date of this section in an employment site which does not meet the requirements established in subdivisions (a)(1) and (a)(2) of this section. Clients for whom this subsection applies who become unemployed shall be eligible to reenter the employment opportunities program under the provisions of this subsection within one year of termination from that employment.

(c) The level of services provided by the employment opportunities program shall not exceed that which the client is expected to need once intensive support services have been completed.

(d) Services will be rendered to an individual by a provider approved by the bureau which meets the needs and is consistent, to the extent practicable, with the informed choice of the client. In such cases where the client or his or her representative chooses services which will be at a higher cost than the bureau determines is reasonably necessary in order for the individual to maintain employment, the bureau will not be responsible for the additional cost.

(Adopted effective November 17, 2003)

Sec. 17b-666-6. Administrative review

Individuals aggrieved by a decision concerning their eligibility for, or services rendered to them by, the employment opportunities program may request an administrative review, which shall be conducted by the director of the Bureau of Rehabilitation Services or his or her designee. Such request shall be in writing and received by the director not later than 30 days after the date of notification by the bureau of the decision for which the individual seeks redress. The review shall be scheduled in a timely manner upon receipt of the request. The reviewer shall issue a written decision of his or her findings and mail a copy of the decision to the appropriate bureau staff and the individual. An administrative review is not a "contested case" within the meaning of section 4-166(2) of the Connecticut General Statutes.

(Adopted effective November 17, 2003)

Agency
Department of Social Services

Subject
Child Care Assistance Program

Inclusive Sections
§§ 17b-749-01—17b-749-23

CONTENTS

Sec. 17b-749-01. Definitions as used in section 17b-749-01 to 17b-749-23 of the Regulations of Connecticut State Agencies, inclusive
Sec. 17b-749-02. Rights and responsibilities
Sec. 17b-749-03. Individuals included in the family
Sec. 17b-749-04. Non-financial eligibility requirements
Sec. 17b-749-05. Financial eligibility requirements
Sec. 17b-749-06. Verification
Sec. 17b-749-07. Notice requirements
Sec. 17b-749-08. Prioritization for child care funding
Sec. 17b-749-09. Application process
Sec. 17b-749-10. Wait list
Sec. 17b-749-11. Eligible children
Sec. 17b-749-12. Eligibility requirements for child care providers
Sec. 17b-749-13. Payment calculations
Sec. 17b-749-14. Certificates of payment
Sec. 17b-749-15. Payment process
Sec. 17b-749-16. Supplemental payments
Sec. 17b-749-17. Payment adjustments
Sec. 17b-749-18. Continued eligibility
Sec. 17b-749-19. Changes in eligibility or benefits
Sec. 17b-749-20. Benefit errors
Sec. 17b-749-21. Administrative hearings
Sec. 17b-749-22. Administrative disqualification hearings
Sec. 17b-749-23. Implementation

Child Care Assistance Program

Sec. 17b-749-01. Definitions as used in section 17b-749-01 to 17b-749-23 of the Regulations of Connecticut State Agencies, inclusive

(1) "Actual charge" means the fee charged by the provider for all children attending the same program as determined in subsection (a) of section 17b-749-13 of the Regulations of Connecticut State Agencies;

(2) "Accredited provider" means a child care provider whose program has earned national accreditation or who has completed approved course or degree work pursuant to subsection (d) of section17b-749-13 of the Regulations of Connecticut State Agencies;

(3) "Applicant" means the person with whom the child resides who is the child's parent as defined in subsection (32) of this section who submits the request for assistance to the Child Care Assistance Program;

(4) "Application" means the form prescribed by the department used to apply for child care assistance;

(5) "Assistance unit" means the group of individuals who live together whose circumstances are taken into consideration when determining eligibility or benefits for the Temporary Family Assistance (TFA) program pursuant to section 8500 of the Uniform Policy Manual;

(6) "Attending high school" means enrollment in and regularly attending classes at a state day program accredited by the State Department of Education or the New England Association of Schools and Colleges, a general equivalency diploma program, or an adult education, technical high school or vocational secondary school program which shall lead to a high school level diploma or certificate;

(7) "Cash assistance" means financial assistance provided by the department to families with dependent children under the Temporary Family Assistance program (TFA), including families assigned to the control group or who receive Diversion Program assistance pursuant to section 8500 of the Uniform Policy Manual;

(8) "Certificate of payment" means the document issued by the CCAP administrator authorizing payment of CCAP assistance for a specific child to a specified child care provider;

(9) "Child care" means the care and supervision of an eligible child for not more than twelve hours in a twenty-four hour day, excluding therapy, medical treatment and public or private school or academic programs;

(10) "Child care assistance" means a subsidy for child care expenses authorized under the Child Care Assistance Program;

(11) "Child Care Assistance Program (CCAP)" means the program that provides child care assistance in accordance with sections 17b-749-01 to 17b-749-23 of the Regulations of Connecticut State Agencies, inclusive;

(12) "Child care agreement" means the form prescribed by the department used to collect and document information concerning provider eligibility and the agreement between the parent and the provider for the provision of child care services;

(13) "CCAP administrator" means the unit designated by the department or an organization acting under contract with the department and acting under its direction that is responsible for the day-to-day administration of the CCAP program;

(14) "Child with special needs" means a child under the age of nineteen who meets the requirements of subsection (b) of section 17b-749-11 of the Regulations of Connecticut State Agencies;

(15) "Commissioner" means the commissioner of the Department of Social Services or his designee;

(16) "Countable income" means gross income less allowable deductions and excluded income;

(17) "Department" means the Department of Social Services;

(18) "Earned income" means compensation for personal services, including but not limited to wages, salaries, commissions, bonuses and earnings from self-employment or contractual agreements;

(19) "Eligible child" means a child residing with the applicant who is under the age of thirteen or under the age of nineteen with special needs, who needs child care during the hours the parent is participating in employment or an approved employment services activity;

(20) "Eligible provider" means a licensed child care provider or child care provider who is exempt from licensing that meets the requirements specified in section 17b-749-12 of the Regulations of Connecticut State Agencies;

(21) "Employment services activity" means education, training, job search or other activity pursued by a parent receiving cash assistance which is designed to eliminate barriers to employment or increase earnings and which has been approved by the Department of Social Services, the state Department of Labor or the designee of either agency in accordance with the requirements of the TANF State Plan submitted by the Department pursuant to section 402 (a) of Public Law 104-193;

(22) "Family" means the group of individuals who live together in the same household whose circumstances are taken into consideration when determining eligibility for the CCAP program pursuant to section 17b-749-03 of the Regulations of Connecticut State Agencies;

(23) "Foster child" means a child placed in a foster home by the Connecticut Department of Children and Families for whom the parent receives foster care payments;

(24) "Good cause" means circumstances or events outside the control of the family, including but not limited to severe weather, illness or the death of an immediate family member, that reasonably prevent or delay the parent from complying with a CCAP program requirement or other good cause circumstances specified in sections 17b-749-02 to 17b-749-23 of the Regulations of Connecticut State Agencies, inclusive;

(25) "Household" means all of the individuals who live together at the same address, including individuals not included in the CCAP family unit for eligibility purposes;

(26) "Income" means the gross countable earned and unearned income;

(27) "In loco parentis" means a person with whom the child lives who is responsible for

the day-to-day care and custody of the child when the child's parent by blood, marriage, adoption or court order is not performing such duties;
(28) "Issued" means the date a notice, payment or other correspondence is mailed, sent electronically or delivered in person by the department or the CCAP administrator;
(29) "Licensed provider" means a day care center, group or family day care home licensed by the Department of Public Health to provide child day care services pursuant to section 19a-77 of the Connecticut General Statutes;
(30) "Minor parent" means the child's natural parent by blood who is under the age of eighteen;
(31) "Missing Information" means verification, forms, documentation or other information used in determining eligibility for the program, a provider, payment eligibility or the amount of assistance that is absent;
(32) "Parent" means a person with whom the child resides who is either the child's parent by blood, marriage, adoption or a spouse or former spouse of such individuals, a legal guardian, a caretaker relative under the cash assistance program or other person standing in loco parentis;
(33) "Provider" means the person, facility or program chosen by the parent(s) to provide child care;
(34) "Relative" means a person of any of the degrees of kinship as specified in subdivision (b)(5) of section 19a-77 of the Connecticut General Statutes;
(35) "Residing with" means living with on a regular basis, including taking meals together and sleeping in the same home;
(36) "Self-employed" means working for pay either full or part-time where the individual is not considered an employee of another entity for purposes of reporting social security tax or unemployment compensation;
(37) "School-based child care program" means a child care program operated by a public or private school pursuant to the requirements of subdivision (b)(1) and (b)(2) of section 19a-77 of the Connecticut General Statutes;
(38) "State median income" means the state median income standards which are promulgated by the United States Department of Health and Human Services;
(39) "Teenage parent" means a parent under the age of twenty;
(40) "Temporary Family Assistance" means the program that provides assistance to needy families with children pursuant to section 17b-112 of the Connecticut General Statutes;
(41) "Unlicensed child care provider" means any provider operating legally in Connecticut that is exempt from licensing as a child day care services provider pursuant to subsection (b) of section 19a-77 of the Connecticut General Statutes;
(42) "Unearned income" means pensions, annuities, dividends, interest, rental income, lottery winnings, royalties, Social Security, supplemental security income, unemployment compensation, workers' compensation, alimony, child support, foster care payments, income from means tested programs, gifts and other cash income that is not compensation for

employment or self-employment;

(43) "Verification" means documentation or other evidence sufficient to enable the department or CCAP administrator to determine the veracity of information pertinent to establishing eligibility for the program, a provider, payments or the amount of assistance;

(44) "Victim of domestic violence" means a person who has been battered or subjected to extreme cruelty by physical acts that resulted in or were threatened to result in physical injury; sexual abuse; sexual activity involving a child in the home; being forced to participate in nonconsensual sexual acts or activities; mental abuse; or neglect or deprivation of medical care; and

(45) "Working" means employment in one or more jobs as an employee of another individual, a partnership, corporation or self-employment, for which compensation is paid in the form of earned income.

(Adopted effective July 10, 2001)

Sec. 17b-749-02. Rights and responsibilities

(a) **Rights of Parents and Providers**

(1) Parents shall have the right to apply for assistance or withdraw an application, to request discontinuance or reapply for CCAP at any time.

(2) Parents shall have the right to choose a child care provider who meets the requirements of section 17b-749-12 of the Regulations of Connecticut State Agencies.

(3) Parents and providers shall have the right to be treated fairly without regard to race, color, religion, sex or sexual orientation, marital status, national origin, ancestry, age, political beliefs, or disability.

(4) Parents and providers who speak Spanish shall have the right to request and receive forms and notices in Spanish. They shall have the right to have the CCAP Administrator provide an interpreter when contacting the CCAP program. Other non-English speaking individuals or persons with limited-English proficiency shall have the right to request an interpreter provided by the CCAP administrator.

(5) Individuals with vision or hearing impairments shall have the right to request auxiliary aids or other accommodations.

(6) Parents and providers who are not satisfied with actions taken by the case worker shall have the right to speak to a supervisor, a grievance mediator or other individual not directly involved with the parent's case.

(7) Parents shall have the right to an administrative hearing or an administrative disqualification hearing as set forth in sections 17b-749-21 and 17b-749-22 of the Regulations of Connecticut State Agencies.

(8) Parents shall have the right to appeal to the U.S. Department of Health and Human Services Office of Civil Rights if they feel that the Department or the CCAP administrator has violated their civil rights.

(9) Parents receiving TFA cash assistance shall be informed of the availability of exemptions from mandatory participation in employment services activities if appropriate

child care is not available, affordable or cannot be accessed.

(10) Parents who state that they or their children have been victims of domestic violence or who state that they are at risk of further domestic violence shall be informed of the available community services that assist victims of domestic violence and how to voluntarily and confidentially access these services.

(b) **Responsibilities of Parents and Providers**

(1) Parents and providers shall be responsible for supplying all requested forms, information and verification needed to determine eligibility and calculate the amount of benefits within fifteen days of the date the information was initially requested or by the date specified by the department.

(2) Parents shall permit the department to verify information independently whenever necessary to determine eligibility or calculate the amount of benefits.

(3) Parents shall report changes in household circumstances and child care arrangements within ten days of the date of the change, including but not limited to the following circumstances:

(A) residency;

(B) address;

(C) household composition;

(D) citizenship or non-citizen status;

(E) countable income of a family member;

(F) employment status, including a change in employers, income, work schedule or work hours;

(G) any change in the child care arrangements, including changes in providers or the location where care is given, a change in the relationship of the provider to the child, cost, or the need for child care;

(H) employment service activities, including changes in schedule or the hours of participation; and

(I) high school attendance.

(4) Parents shall not be required to report changes in a child’s age provided the child’s date of birth has been accurately reported.

(5) Parents shall report changes in household circumstances or child care arrangements in writing, by phone or in person directly to the CCAP administrator within ten days of the date of the change. Changes that are not reported timely may result in ineligibility, the loss of benefits or in an overpayment pursuant to the requirements of sections 17b-749-02 through 17b-749-23, inclusive.

(6) To be eligible for CCAP, parents and providers shall cooperate in taking any actions necessary to establish eligibility or payment level. Parents and providers shall cooperate with the department’s fraud investigation and quality control divisions by completing any required forms, responding to scheduled interview appointments and by making requested records or information available. Parents and providers who do not cooperate may be determined to be ineligible for CCAP until they cooperate.

(7) Providers shall submit invoices to the CCAP administrator that accurately report information about attendance and the cost of care.

(8) Providers shall report changes in the child care arrangements, including but not limited to changes in the hours of care, actual charges, changes in programs due to a change in the age group of the child, the location where care is given and any changes in licensing or accreditation status pursuant to subdivision (b)(5) of section 17b-749-12 of the Regulations of Connecticut State Agencies.

(c) **Responsibilities of the CCAP Administrator**

(1) The CCAP administrator shall assure that the rights of parents and providers are upheld in accordance with the requirements of this section.

(2) The CCAP administrator shall give parents the opportunity to file an application at any time.

(3) The CCAP administrator shall take timely action within the time frames established in sections 17b-749-1 through 17b-749-23 of the Regulations of Connecticut State Agencies, inclusive, to process applications, redeterminations and changes in household circumstances and child care arrangements and to determine the impact on eligibility or benefits.

(4) The CCAP administrator shall give parents and providers written notice of actions they are required to take to establish program or payment eligibility.

(5) The CCAP administrator shall provide parents and providers with written notice of any decisions that affect eligibility or benefits.

(6) The CCAP administrator shall provide parents or their legal representatives with reasonable access to case record information, including computer information that is part of the parents case record, subject to the limitations established in subsection (d) of this section. Parents shall submit a written statement granting their legal representative access to case record information. The information shall be made available within a reasonable period of time following submission of the written request at a location mutually agreed to by both parties, unless the information can only be accessed at a specific location. If an administrative hearing has been scheduled, the information shall be made available prior to the hearing.

(7) The CCAP administrator shall inform parents of their rights and of any benefits that may be available to them under the CCAP program.

(d) **Safeguarding Information**

(1) Information about the family shall not be disclosed by the department except when disclosure is authorized by law, including but not limited to the following reasons:

(A) when directly connected with the administration of CCAP or other programs administered by the department or the administration of other state or federally assisted programs that are needs based;

(B) for purposes related to performing quality assurance audits or fraud investigations; or

(C) when necessary to determine the suitability of child care arrangements.

(2) By making application, parents and families shall grant the CCAP administrator

permission to share information with the child care provider to the extent necessary to determine eligibility, the level of benefits or to notify the provider of information concerning eligibility or payments. Personal family information not relevant to such determinations shall not be disclosed and not be shared with the provider. Providers for whom a current child care agreement form is on file with the CCAP administrator may contact the administrator to determine the status of an application.

(3) Information about the provider shall be shared with the parent if the information is considered public information, or as needed to determine payment eligibility or to inform the parent of the reason the provider does not meet the eligibility requirements. By enrolling in the CCAP program, providers shall grant the CCAP administrator permission to share information concerning compliance with the program health and safety standards with the parent, including the results of criminal and child abuse or neglect background checks.

(4) Application information shall be disclosed to a landlord, employer or other third party only to the extent necessary to obtain specified information or verification from such parties.

(5) Information may be disclosed to any authorized representative of the Commissioner of the Department of Administrative Services (DAS), the Commissioner of the Department of Public Safety (DPS), the Office of the Chief State's Attorney, local police departments, the Office of Attorney General, or the Judicial Department, Support Enforcement Division for the purpose of collection of overpayments, investigating fraud, collection of child support or the location of absent parents or for any other purpose for which disclosure of such information is permitted by law.

(6) Information shall be disclosed to any authorized representative of the Commissioner of Mental Health and Addiction Services when necessary for the implementation and operation of the basic needs supplement program or for the management of and payment for behavioral health services for applicants and recipients of general assistance.

(7) Information shall be released to any authorized representative of the Commissioner of the Department of Labor or to his official designee when required for the administration of the Unemployment Compensation or employment services programs or activities.

(8) Information shall be released to any authorized representative of the Commissioner of Children and Families concerning a child's health, safety or welfare if the same is determined to be in imminent danger as determined by the Department of Children and Families or the Department of Social Services. Notwithstanding a request for information, the department shall notify the commissioner of Children and Families or his official designee if there is reason to believe that any child under the age of eighteen is being subjected to physical or mental abuse or neglect while in the care of a parent or child care provider.

(9) The current address of an applicant or recipient of benefits shall be disclosed to federal, state, or local law enforcement officers under the following conditions:

(A) if such officer provides the department with a name of such applicant or recipient of benefits; and

(B) if the family member is fleeing to avoid prosecution, or custody or confinement after conviction; and

(C) the law enforcement officer provides the family member's name and indicates that the conditions listed above in (A) and (B) exist and verifies that the location or apprehension of the recipient is within his or her official duties.

(Adopted effective July 10, 2001)

Sec. 17b-749-03. Individuals included in the family

(a) CCAP program and payment eligibility shall be determined based on the circumstances of the individuals who reside together in the same household. Parents who state that they are not living together, but maintain separate residences in the same building or adjacent apartments shall be considered to be residing together if they routinely sleep in the same home, take meals together and continue to function as a family unit. Evidence of separation of financial responsibilities and the pursuit or payment of child support from the non-custodial parent shall be considered when making this determination.

(b) A person who is temporarily absent from the household shall be considered to be a family member if the person intends to return to the home, does not establish a permanent residence elsewhere and the absence is not expected to continue for more than ninety consecutive days. A minor dependent shall be considered to be a family member if the parent retains custody or primary responsibility for the child during the absence. A minor dependent who is temporarily absent while attending school outside the home shall be considered to be a family member if the parent maintains living quarters for the child and the child is expected to return to the home following completion of the school activity. Other temporary absences of a household member shall not affect the determination of the composition of the family, as long as the person is absent for not more than ninety consecutive days.

(c) If the child's parents are separated and have joint custody of the child, the child shall be considered living with the parent with whom the child resides at least fifty percent of the time. If the child lives with each parent for an equal amount of time, the parents shall be required to reach an agreement concerning which parent shall apply for CCAP as a condition of eligibility. If the parents cannot reach an agreement, the child shall be considered to be living with the parent who applied for CCAP first. Only one parent shall be eligible to receive assistance for the child in any month unless the child goes to live with the other parent during the month on a permanent basis.

(d) The following individuals shall be included in the family, unless otherwise specified in this section:

(1) parents of the children for whom assistance is requested as defined in subsection (32) of section 17b-749-01 of the Regulations of Connecticut State Agencies;

(2) the parent's spouse and their minor dependents; and

(3) any individuals who receive cash assistance together as part of the same TFA assistance unit.

(e) If the household contains a minor parent, the legal guardian or parents of the minor

parent through blood, marriage or adoption and their current or former spouses shall be included in the family together with their minor dependents.

(f) If a minor parent lives with someone acting in loco parentis who is not his or her legal guardian or parent through blood, marriage or adoption or the current or former spouse of such individuals, the family shall include the individual acting in loco parentis, his or her current or former spouse and their minor dependents under the following conditions:

(1) if the person acting in loco parentis receives TFA cash assistance as part of the same assistance unit as the minor parent; or

(2) if the person acting in loco parentis requests child care assistance to support his or her own work, school or employment services activity or that of his or her spouse.

(g) If a minor parent lives with someone acting in loco parentis who is not his or her legal guardian or parent through blood, marriage or adoption or the current or former spouse of such individuals, the family shall include only the minor parent, the minor parent's children and the other parent of the minor parent's children under the following conditions:

(1) if assistance is requested only for the children of the minor parent(s); and

(2) assistance is requested only to support the work, school, or employment services activity of the minor parent(s).

(h) A separate family unit shall be established for children receiving foster care payments from the Connecticut Department of Children and Families. The foster parent and other household members shall not be included in the same family unit with the foster child or children for purposes of determining income eligibility or benefits. The CCAP administrator shall establish a separate family unit if the foster parent requests assistance for another child in the household who is not a foster child.

(i) A child who is adopted from Connecticut Department of Children and Families shall continue to be treated as his or her own family unit for twelve months following the date of the adoption. After twelve months following the date of adoption, the adoptive parent and other household members shall be included in the family unit.

(Adopted effective July 10, 2001)

Sec. 17b-749-04. Non-financial eligibility requirements

(a) **Residency**

(1) To be eligible for assistance, the family members shall be residing in Connecticut. The department shall not apply a durational requirement when making a determination of residency or require the family to live in a permanent dwelling or to have a fixed mailing address.

(2) Family members shall be considered residing in Connecticut under the following conditions:

(A) if they intend to remain in the state permanently or for the foreseeable future; or

(B) if they entered the state with a job commitment or for the purpose of seeking employment.

(4) Temporary absence from the state does not constitute a change in residency if the

family member intends to return to Connecticut within thirty days and the individual maintains his or her residence in Connecticut. The commissioner may extend the thirty-day limit for up to ninety days if the family member is absent due to a temporary military duty assignment. A child who is temporarily absent from the home while attending school out of the state shall be considered a resident if the parent maintains living quarters for the child and the child intends to return home following completion of the school activities.

(5) Family members who apply for or receive cash assistance, Food Stamps, Medical Assistance or other public benefits from another state shall be not considered residents of Connecticut.

(b) **Social Security Numbers**

(1) Disclosure of the Social Security number of a family member shall be mandatory only for children whose CCAP subsidy is or will be claimed by the Department as an expense under the TANF program or other federal programs that require recipients to disclose a Social Security Number. This requirement shall not apply to children who are not citizens of the United States who are not eligible to obtain a Social Security number (SSN) from the Social Security Administration. Disclosure of the Social Security numbers of other family members shall be voluntary. If the SSN is not disclosed, the CCAP administrator may obtain and use the SSN of a family member for whom disclosure is voluntary to the extent the number is available from other programs or agencies with whom the Department shares such information.

(2) Assistance shall not be delayed pending verification of an SSN unless there is a discrepancy between a number given and other available information that causes the CCAP administrator to question the identity of the individual. The parent shall have thirty days from the date assistance is granted to verify that an application has been submitted to the Social Security Administration for a child who does not have an SSN for whom such number is mandatory.

(3) Parents shall disclose the SSN of any member who did not have a valid number by the first redetermination following the onset of initial eligibility.

(4) Child care providers shall disclose their SSN or a Connecticut Tax ID as a condition of eligibility for the provider.

(5) An individual who has more than one SSN shall disclose all of the numbers.

(6) Disclosure may be from a number which has been committed to memory, a written document, such as a wage stub, Social Security award or denial letter, income tax return, or Social Security card.

(7) If disclosure is mandatory, the individual child shall be ineligible if the parent fails to disclose or apply for an SSN for the child. Ineligibility shall continue until such time that the parent applies for or discloses the SSN.

(c) **Securing Child Support**

(1) If a child for whom assistance is requested is deprived of financial support from the child's natural or adoptive parent, the custodial parent or person acting in loco parentis shall agree to apply for services and cooperate with the Bureau of Child Support Enforcement

(BCSE) in obtaining support from the non-custodial parent, unless support is actively being pursued through private legal means or an exemption from cooperation is granted pursuant to section 17b-179(a)-4 of the Regulations of Connecticut State Agencies.

(2) The custodial parent shall not be required to apply for support services for children for whom assistance is not being requested or children who are emancipated pursuant to sections 46b-150b and 46b-150e of the Connecticut General Statutes. The department shall waive the fee charged to non-assistance recipients pursuant to 17b-179(i)-1 of the Regulations of Connecticut State Agencies.

(3) Parents who apply for or receive cash or medical assistance from the department for a child for whom child care assistance is requested shall not be required to apply for support for the child as long as the parent complies with the requirements of the other program. The family, however, shall become ineligible for child care assistance until proof of cooperation is provided if a sanction is imposed for noncompliance with the support requirements of the other program.

(4) The application for support shall be made pursuant to section 17b-179 (h) of the Connecticut General Statutes. Parents shall verify that an application was filed not later than the first redetermination conducted after the initial date of eligibility for the child. The CCAP administrator shall provide written information about the procedure for applying for support to the parent.

(5) The parent shall cooperate with the department as provided in section 17b-179(a)-4 of the Regulations of Connecticut State Agencies. The parent shall supply accurate and complete information about the non-custodial parent(s). When paternity has not been established for a child, the parent shall supply accurate and complete information about the putative father and take part in any legal proceedings as requested by the department unless an exemption is granted under section 17b-179(a)-4. Parents shall not be required to take additional action if an exemption is granted or if the department decides not to pursue support for reasons other than non-cooperation.

(6) The entire family shall be determined ineligible if the parent does not comply with the requirements of this section and shall remain ineligible until such time that the parent complies.

(d) **Citizenship**

(1) To be eligible for CCAP, the child for whom assistance is requested shall meet the citizenship requirements established under section 431 of Public Law 104-193, the Personal Responsibility and Work Opportunity Reconciliation Act, as amended. The citizenship status of the child's parents or other family members shall not be taken into consideration when determining eligibility for CCAP.

(2) To be eligible for assistance, the child shall be a United States citizen, a national of the United States pursuant to 8 U.S.C. section 1101, or an eligible non-citizen who is a lawfully residing immigrant.

(3) Citizens shall include the following individuals:

(A) individuals born in the United States or a US territory;

(B) a naturalized citizen;

(C) individuals under the age of 19 whose parents are citizens; and

(D) individuals who meet specific Immigration and Naturalization Service conditions for citizenship including a foreign born individual with at least one parent who is a citizen and the foreign born spouse of a U.S. citizen.

(4) Eligible non-citizens shall include, but not be limited to the following individuals as determined by the Immigration and Naturalization Service:

(A) a non-citizen lawfully admitted for permanent residence under the Immigration and Nationality Act;

(B) a non-citizen granted asylum under section 208 of the Immigration and Nationality Act;

(C) a refugee admitted to the United States under section 207 of the Immigration and Nationality Act;

(D) a non-citizen paroled into the United States under section 212 (d)(5) of the Immigration and Nationality Act for a period of at least one year;

(E) a non-citizen whose deportation is being withheld under section 243 (h) of the Immigration and Nationality Act as in effect prior to April 1, 1997, or whose removal is being withheld under section 241 (b)(3) of the Act;

(F) a non-citizen who is a Cuban or Haitian entrant as defined in section 501 (e) of the Refugee Education Assistance Act of 1980; or

(G) a non-citizen whose child has been battered or subjected to extreme cruelty in the United States and otherwise satisfies the requirements of 8 U.S.C. 1641 (c).

(5) Parents shall be required to disclose the citizenship status of the child, provide requested verification of the child's immigration status and to report any changes in the child's status within 10 days of the date of the change as a condition of eligibility. Where federal law prohibits copying naturalization papers, the CCAP administrator shall make arrangements to schedule a meeting with the parent to review the naturalization documents. The meeting shall be conducted in the local regional office of the department or other mutually agreed upon location.

(6) If assistance is denied because a child does not meet the citizenship requirements, the CCAP administrator shall provide written notice to the parent explaining the reason for the denial and how to contact the Immigration and Naturalization Service to seek correction if the parent believes the information regarding the child's citizenship status to be erroneous. If the parent requests an administrative hearing to appeal the determination to deny assistance, the CCAP administrator shall contact the Immigration and Naturalization Service for assistance if the parent challenges the determination of the child's citizenship status. The CCAP administrator shall not be required to contact the Immigration and Naturalization Service if the parent does not contest the child's status, but disputes whether the status makes the child ineligible.

(e) **Need for Care**

(1) The parent shall have at least one eligible child residing in the home who needs child

care assistance. Families with no eligible children shall be ineligible for CCAP. The approved hours of care shall be determined in accordance with the requirements of subsection (b) of section 17b-749-13 of the Regulations of Connecticut State Agencies.

(2) To be eligible for assistance, child care shall be needed to allow parents to participate in the following approved activities:

(A) employment for which the individual receives wages as opposed to goods or services for compensation;

(B) a self-employment activity as defined in subsection (f) of this section;

(C) for individuals receiving cash assistance, an employment services activity approved by the Department of Social Services, the Department of Labor or the designee of either agency in accordance with the State Plan requirements for the TFA cash assistance program; or

(D) for teenage parents under the age of twenty whom do not receive cash assistance, attending high school as defined in subsection (6) of section 17b-749-01 of Regulations of Connecticut State Agencies.

(3) Parents who were participating in an employment services activity at the time their TFA cash assistance benefits were discontinued shall be eligible for child care services to support completion of the activity for up to twelve months after TFA assistance is discontinued, provided that the parent is employed and all other eligibility requirements are satisfied. Eligibility based on the employment services activity shall end if the parent stops participating in the activity or if the activity ends.

(4) Parents shall maintain continuous involvement in an approved work or employment services activity. Assistance shall be available only during the hours the parent or family member is participating in an activity listed in subdivision (2) of this subsection.

(5) A child shall not be eligible for assistance if the applicant's spouse or the child's other parent is living in the home and is available and capable of providing care. The spouse or other parent shall be considered unavailable if the individual is participating in an activity defined in subdivision (2) of this subsection during hours that exclude the possibility of providing care. The spouse or other parent shall be considered incapable of providing care if the individual has a significant physical or mental condition, disability or impairment that would prevent him or her from caring for the child for a period which is expected to last for at least one calendar month.

(6) The parent shall demonstrate that his or her spouse or the other parent is not available to provide care by certifying that the spouse or other parent does not reside in the household or by verifying participation in an activity listed in subdivision (2) of this subsection.

(7) Parents working at home shall be considered unavailable to provide care only if the nature of the employment or self-employment activity prevents the parent from providing adequate care or supervision, or if the parent routinely operates equipment or machinery that would be hazardous if the child was in the same room or area with the parent.

(8) The applicant shall be required to verify that the spouse or the other parent is incapable of providing care by submitting verification from a treating physician or state

certified mental health professional. The verification shall provide details of the nature and degree of the person's disability or impairment, the reason the condition prevents the individual from providing care and the expected duration of the disability or impairment. The CCAP administrator may refer, but shall not require the individual to apply for disability benefits with the Social Security Administration if the condition is expected to last for more than twelve months. The evidence shall clearly establish that the spouse or other parent is not capable of providing safe and competent care. The CCAP administrator may request additional verification if the information submitted is not conclusive. In determining that an individual is not capable of providing safe and competent care, the department shall consider the age of the child, special needs, the degree of supervision required, medical information and all other available evidence.

(f) **Specific Requirements for Self-Employed Family Members**

(1) Child care assistance shall be approved to support a self-employment activity only if the activity is carried on to create a livelihood and in good faith to make a profit as evidenced by business and financial records and tax returns. The parent shall be required to provide documentation of continuous activities that are not passive or casual, or more appropriately associated with a hobby or volunteer work. Family members who own multiple or multi-family properties shall not be considered self-employed unless the individual actively manages the properties and can demonstrate work hours that justify the need for care.

(2) Parents working at home as child care providers shall be considered available to provide care for their own children during their work hours, except under the following conditions:

(A) if the parent is a licensed family day care home provider; and

(B) if caring of his or her own children would cause the parent to exceed the licensed capacity established by the Department of Public Health.

(3) The self-employment business activity shall be producing some taxable income at the time assistance is requested as reported as net profit on Schedule C of IRS form 1040. After six months, the taxable earnings for each family member involved in the activity shall equal or exceed the state minimum wage times the number of hours the family member purports to be working on the activity on a continual basis. Child care needs related to the activity shall be disapproved if income from the activity does not meet the income standards. Any subsequent requests for assistance made by the family related to self-employment shall be approved only if the gross taxable income produced equals or exceeds the state minimum wage times the number of hours each family member spends working on the activity.

(4) The parent shall be responsible for submitting tax returns, estimated tax filings and business records documenting the income, business deductions and hours of participation where appropriate. Upon request, families with reported income that does not appear sufficient to meet basic daily living expenses shall provide verification of how the expenses are being met, including checking account, savings or loan records or an alternate means of financial support. The gross income from the self-employment business activity shall be

used to determine eligibility and the amount of assistance if the information submitted by the parent is not sufficient to adequately determine the net profit.

(g) **Availability of Other Child Care Resources**

(1) Payments shall not be made for the hours the child attends school, home schooling or other academic programs, or for the hours the child attends an after-school program or other state, federal or privately funded program for which the parent does not incur a fee.

(2) If the family receives a direct subsidy or funds for child care expenses from a source other than CCAP, including support payments from a non-custodial parent earmarked specifically for child care, this funding shall be applied first as payment toward the approved cost of care as determined in subsection 17b-749-13 of the Regulations of Connecticut State Agencies. Scholarships, Pell grants and other awards provided directly to students shall be exempt and shall not be applied toward the approved cost of care.

(Adopted effective July 10, 2001)

Sec. 17b-749-05. Financial eligibility requirements

(a) **Gross Income Eligibility**

(1) Gross countable family income for applicants and recipients shall be less than fifty percent of the state median income level for the appropriate family size as established by the Department of Health and Human Services. The commissioner shall have discretion to increase the income limit to up to seventy-five percent of the state median income level for all CCAP recipients or for both applicants and recipients. The commissioner may also, upon the request of the commissioner of Children and Families, waive the gross income limit for families who need child care assistance for a child who was adopted from the Department of Children and Families after October 1, 1999 and whose countable income does not exceed the maximum level established for participation pursuant to 42 CFR section 98.20 of the federal Child Care and Development Fund Regulations. Adoptive families for whom the income limit is waived shall be responsible for paying the maximum fee required pursuant to subsection (f) of section 17b-749-13 of the Regulations of Connecticut State Agencies.

(2) A family whose income equals or exceeds the established income limit shall be ineligible for CCAP, unless the income exceeds the limit for not more than one calendar month due to an extra pay period or other temporary increase.

(3) Income shall be counted in the month it is received by the family member, except to the extent the income is averaged in accordance with requirements of subsection (d) of this section.

(4) The department shall adjust the state median income standards annually. For new applicants, the adjusted standards shall take effect beginning on or after July 1 of each year. For families receiving child care assistance on June 30, the adjusted standards shall take effect not later than the first redetermination completed after July 1 of each year.

(b) **Countable Income**

(1) In determining the gross income, the following types of income shall be counted except as specified in subdivision (2) of this section:

(A) unearned income of all adult and child family members; and
(B) gross earnings of all parents and adult family members.
(2) The following types of income shall be excluded from the gross income determination:
(A) TFA cash assistance benefits;
(B) child support payments;
(C) income paid by the Census Bureau to low-income temporary census workers;
(D) the value of Food Stamp benefits;
(E) the earnings of a family member who is under the age of eighteen who is not the parent of a child for whom assistance is requested;
(F) earned income credit payment, including advanced payments;
(G) cash contributions from non-profit charitable agencies or organizations;
(H) interest and dividends totaling less than six hundred dollars per calendar year;
(I) lump sum payments from unearned income sources totaling less than six hundred dollars per calendar year;
(J) income tax refunds;
(K) special need payments issued by the department on behalf of a cash assistance recipient that are paid to a vendor;
(L) income from the sponsor of a non-citizen;
(M) grants, loans and scholarships paid to students;
(N) cash gifts received on an irregular basis, the aggregate of which does not exceed twelve hundred dollars per calendar year;
(O) the value of goods and services given as in-kind income rather than cash payments;
(P) reimbursements for expenditures that do not represent a benefit or gain to the recipient;
(Q) disaster assistance paid under the Disaster Relief Act of 1974, as amended, including the Individual and Family Grant (IFG) program, and comparable disaster assistance provided by states, local governments and private organizations, and any interest earned on funds from this source;
(R) payments made by the Department of Labor to meet the cost of pursuing employment;
(S) state or federal government rental subsidies;
(T) security deposits returned by a landlord to the family;
(U) payments made under means-tested energy assistance programs and utility subsidies; and
(V) payments received under Title II of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970.
(c) **Income Deductions**
(1) Self-employed individuals shall be entitled to standard deductions for business expenses permitted under the Internal Revenue Code. Deductions shall be allowed only after submission of appropriate documentation using applicable Internal Revenue Service

forms and schedules.

(2) Payments made for child support shall be deducted from the gross income of the individual who makes the support payment. A representative average shall be used if the amount of the support payments fluctuates.

(d) **Income Calculations**

(1) Gross income shall be calculated based on the best estimate of the income the family is expected to receive. Income received monthly or over a more frequent period shall be annualized based on the amount received in the four week period immediately prior to the date of the income calculation. If the income fluctuates in an unpredictable manner, the income shall be averaged over a longer more representative period. If income is received regularly according to a schedule, the income shall be annualized based on such schedule.

(2) School or other employees who are under contract shall have income annualized over the contract period. Income received less frequently than monthly shall be averaged over the period which it is intended to cover.

(3) If the income is expected to change or when a family member is beginning new employment or changing work schedules, gross income shall be calculated based on the best estimate of the income the family is expected to receive over the next six months. The CCAP administrator shall use all available documentation to make the determination.

(4) Self-employed family members shall have income calculated based on the prior years income tax return or current business records, whichever is most representative of the current projected earnings. Standard business deductions shall be allowed in accordance with the requirements of subdivision (1) of subsection (c) of this section.

(Adopted effective July 10, 2001)

Sec. 17b-749-06. Verification

(a) **Responsibilities for Providing Verification**

(1) The parent shall have primary responsibility for supplying, on a timely basis, information sufficient to determine eligibility and the level of benefits. The CCAP administrator shall allow parents to submit any evidence they believe will support a factor that needs to be verified.

(2) The CCAP administrator shall assist in obtaining verification of application information on behalf of the family under the following conditions:

(A) when the CCAP administrator has the capacity to obtain the information internally by accessing the department’s computer records or through other direct access; or

(B) when the parent has been unable to obtain the needed verification after making a bona fide effort and the assistance unit has requested help; and

(C) when the CCAP administrator has the capability to obtain the verification needed without undue administrative hardship.

(3) Providers shall be responsible for providing verification requested from them by the CCAP administrator.

(4) The CCAP administrator shall consider all evidence submitted or received from other

sources.

(b) **Standard of Proof**

A statement or condition shall be considered verified when the available evidence indicates that it is more likely to be true than not.

(c) **Verification Requirements**

(1) The CCAP administrator shall require verification of information when required by federal or state law, when necessary to confirm any circumstances pertaining to eligibility for the family, a child care provider or the amount of benefits. The CCAP administrator shall not require parents or providers to verify circumstances not relevant to the case.

(2) Applicants assigned to the waiting list pursuant to section 17b-749-10 of the Regulations of Connecticut State Agencies shall be required to provide verification of information upon request of the CCAP administrator.

(3) Self-employed individuals shall be required to provide copies of federal and state income tax returns and business records upon request. If the reported income does not appear sufficient to meet family needs, the CCAP administrator may require the parent to verify current living expenses and document any alternate means of financial support, such as a loan or credit card expense.

(4) The CCAP administrator may conduct an investigation if the gross or net income reported from rental property or a self-employment enterprise is not consistent with the income produced by other similar rental properties or businesses.

(5) The CCAP administrator shall not require parents or providers to verify a negative or nonexistent condition or circumstance, unless evidence exists to suggest that the information provided is erroneous.

(6) The CCAP administrator shall issue a written notice whenever verification of information is requested. The notice shall specify the information that is needed, the date the information is due, that assistance may be available if the parent is unable to obtain the requested information and a statement that eligibility or benefits may be affected if the information is not submitted timely by the due date.

(d) **Effect of Not Providing Verification**

(1) If establishing eligibility for the program depends directly upon a factor or circumstance for which verification is required, not providing the requested information shall result in ineligibility for the entire family.

(2) If establishing eligibility for an individual child depends directly upon a factor or circumstance for which verification is required, not providing verification shall result in ineligibility only for the child. The entire family shall be ineligible if there are no other eligible children in the home.

(3) If the eligibility of the provider depends directly upon a factor or circumstance for which verification is required, not providing verification shall result in ineligibility for the provider.

(4) If only the approved hours of care or benefit calculation is affected, not providing verification shall result in the disallowance or non-consideration of the unverified factor or

circumstance.

(e) **Good Cause**

(1) The department shall not deny assistance, discontinue or reduce a family's benefits if the parent can establish good cause for not providing requested verification. A parent shall be considered to have good cause for not providing verification under the following circumstances:

(A) if the parent has had difficulty obtaining information requested from a third party source other than a family member or the parent's child care provider and the parent has made all reasonable attempts to obtain the verification and is complying with the CCAP administrator's request; or

(B) if the CCAP administrator has taken responsibility for assisting the parent in obtaining the verification; or

(C) if extenuating circumstances, including but not limited to a death in the immediate family, severe illness or other mitigating circumstances prevented the parent from timely submitting the verification.

(2) To be eligible for good cause, the parent shall contact the CCAP administrator and request a good cause exemption within ten days of the date the notice of denial or adverse action is issued in accordance with section 17b-749-07 of the Regulations of Connecticut State Agencies.

(f) **Methods of Verification**

(1) Parents shall be required to submit written documentation as the primary method or source of verification, except where self-declarations are requested on the application or other program forms.

(2) In the absence of written documentation or where the verification submitted is questionable, the CCAP administrator shall have the option of verifying information by contacting other disinterested third party sources or persons who are not members of the household or the child care provider.

(3) Whenever possible, the CCAP administrator shall use information obtained through on-line computer interfaces or other automated resources to verify eligibility factors or circumstances to the extent the information is reliable, current and is readily available.

(4) Parents shall submit written documentation from reliable independent sources whenever such documentation is available. Parents may submit affidavits or self-declarations as verification. Such documentation shall be evaluated together with all other available evidence to determine if a circumstance has been verified. The CCAP administrator shall obtain a notarized statement on a form prescribed by the department prior to replacing a lost, stolen or destroyed check and may require parents and providers to submit affidavits in other situations where documentation is insufficient or not available.

(Adopted effective July 10, 2001)

Sec. 17b-749-07. Notice requirements

(a) **Requirements of the CCAP Administrator**

(1) Parents shall be notified of their rights and responsibilities as specified in section 17b-749-2 of the Regulations of Connecticut State Agencies, including but not limited to the need to report changes in household circumstances to the CCAP administrator within ten days of the date of the change. Providers shall be notified of their responsibility to report changes in accordance with requirements of subdivision (b)(5) of section 17b-749-12 of the Regulations of Connecticut State Agencies.

(2) Parents shall be notified of the receipt of an initial or reopened application, of any actions they are required to complete and the effect of any reported or requested changes on eligibility or the level of benefits.

(3) When a Social Security number is requested, parents shall be notified if the disclosure of the number is not mandatory.

(4) Parents and their current providers for whom a completed child care agreement form has been submitted shall be notified of the following circumstances:

(A) action to grant or deny assistance;

(B) assignment to the wait list;

(C) the scheduling of a redetermination and the results of the redetermination;

(D) changes affecting program eligibility, provider eligibility or eligibility of an individual child;

(E) a change in the payee; and

(F) increases or decreases in benefit or payment amounts.

(5) Parents shall be notified when their case is assigned to a specific worker and when their case is reassigned to a different worker.

(6) Parents assigned to the wait list shall be notified of changes in their priority status, if they are removed from the wait list and of any actions necessary to maintain eligibility for the wait list.

(7) All notices of actions taken by the CCAP administrator or actions required by the parent or provider shall be given in writing. Written notice shall include documents and forms delivered by mail, in person, by facsimile machine or through formalized electronic communication processes established with the parent or provider. Each notice shall contain sufficient information to allow the parent or provider to clearly understand the reason for the action and the relevant state statute or regulation upon which the action is based.

(8) Parents shall be notified of their rights to an administrative hearing whenever an action is taken that affects eligibility, benefits, provider eligibility or eligibility for the wait list. Parents shall be notified of their right to an administrative disqualification hearing pursuant to section 17b-749-22 of the Regulations of Connecticut State Agencies.

(9) Parents and providers shall be notified of their right to speak to a CCAP supervisor or someone not directly involved with the case if they are not satisfied with the actions taken by the case worker.

(b) **Date of Notification**

The date of notification shall be the date a notice is issued by the CCAP administrator.

(c) **Adverse Action Notice Requirements**

(1) Parents and their approved provider(s) shall be notified when a change in circumstances results in the discontinuance, termination or reduction in benefits.

(2) Adverse action notices shall contain a reference to the relevant statute or regulation upon which such action was based.

(3) Notice shall be given at least ten days prior to the effective date of the intended action, except as specified in subdivision (4) of this subsection.

(4) Notice shall be given no later than the effective date of the action under the following circumstances:

(A) when the a child who is receiving child care assistance is deceased;

(B) when a parent who is the only adult member of the family is deceased;

(C) when the Department receives a written request to discontinue benefits from the parent;

(D) when changes are made following completion of a redetermination;

(E) when mail is returned with no forwarding address and the CCAP administrator is not able to determine the whereabouts of the family from other department records;

(F) when the parent or a child for whom assistance was requested is granted public benefits in another state;

(G) when a child who receives assistance is removed from the home by the Department of Children and Families or is placed in foster care;

(H) when assistance is granted for a specific period of time and written notice was given at the time of the grant explaining that eligibility or benefits will terminate at the end of the specified period;

(I) when an application for benefits is denied;

(J) when the parent or provider informs the CCAP administrator that the child is no longer receiving care or has changed providers;

(K) when a provider becomes ineligible for payment incentives for accreditation or professional development pursuant to subsection (d) of section 17b-749-13 of the Regulations of Connecticut State Agencies;

(L) when the Department of Public Health notifies the CCAP administrator that the provider's licensed has been revoked; and

(M) when the CCAP administrator has obtained reliable evidence that the child care provider does not meet the health and safety requirements of the CCAP program specified in subsection 17b-749-12 (c) to subsection 17b-749-12 (f) of the Regulations of Connecticut State Agencies, inclusive.

(Adopted effective July 10, 2001)

Sec. 17b-749-08. Prioritization for child care funding

(a) Each family shall be assigned to an applicable priority group. Within available funding, the department shall accept applications and authorize payments based on the following order of priorities:

(1) parents receiving TFA cash assistance who are employed or participating in an

approved employment services activity and working parents who are completing an approved employment services activity that started before the family's TFA cash assistance was discontinued pursuant to subdivision (e)(3) of section 17b-749-04 of the Regulations of Connecticut State Agencies;

(2) working parents whose cash assistance benefits were discontinued within six calendar months prior to the date of application for CCAP;

(3) parents under the age of twenty not receiving cash assistance who attend high school;

(4) working parents with gross countable family income below fifty percent of the state median income;

(5) working parents with gross countable family income between fifty and seventy-five percent of the state median income who request assistance for a child who was adopted from the Department of Children and Families; and

(6) all other working parents with gross countable family income between fifty and seventy-five percent of the state median income.

(b) A family's priority status shall not be affected if the parent is removed from cash assistance due to the application of a TFA program sanction.

(c) The commissioner may establish additional priority groups from time to time based on exceptional public need that results from unforeseen circumstances. When establishing additional priority groups, the commissioner shall designate a target expenditure level for each additional priority group created if such level is not otherwise specified by legislative action. Additional priority groups may be added or deleted based on available funding.

(d) The CCAP administrator shall maintain a list of any additional priority groups established. The list shall include the expenditure level specifically allocated to each additional priority group. A copy of the listing of additional priority groups shall be made available to the public upon written request.

(Adopted effective July 10, 2001)

Sec. 17b-749-09. Application process

(a) **Filing an Application**

(1) The parent shall apply for assistance by submitting an application to the CCAP administrator using a form prescribed by the department. The parent may use a copy of the application form, provided the information submitted on the form is original and not copied. If the form submitted is obsolete or inadequate, the CCAP administrator may require the parent to complete a new application. The date of application shall be the date the initial application was filed.

(2) If the family contains a minor parent, the minor or the minor's parent may submit the application. The parent of the minor parent shall be considered the applicant and shall be required to sign the application form before assistance is granted, unless the minor parent is emancipated by marriage or court decree.

(3) The application form shall be submitted to the address specified by the department for the submission of applications. Applications received by the department at an address

other than the one specified for the submission of CCAP applications shall be forwarded to the CCAP administrator within one business day of the date the application was received.

(4) Parents may apply or reapply for the program at any time. The parent shall be required to complete a new application form with each application, except under the following circumstances:

(A) when an application is reopened in accordance with the requirements of subsection (e) of this section, the CCAP administrator shall not require the parent to submit a new application form if the original application form submitted by the parent is not more than sixty days old; or

(B) if the original application was denied because the parent did not comply with a request for missing information or verification, the CCAP administrator shall waive the requirement for submitting a new application form if the parent submits some or all of the missing information within sixty days of the previous application date.

(5) Telephone contacts or other requests for assistance not utilizing the prescribed application form shall be considered inquiries and do not constitute an application.

(6) At a minimum, the application form filed shall include the full name and address of the parent, the date and the parent's signature. Applicants shall not be required to submit a child care agreement form or other documentation with the application.

(7) Application forms may be requested from the CCAP administrator by phone or in writing. Application forms requested by phone shall be mailed to the parent by the next business day following the date of the request. Application forms shall also be made available in local offices of the department at sites designated for the coordination of employment services activities for cash assistance recipients. Upon request, the CCAP administrator shall make application forms available in reasonable quantities to licensed child care providers, legal assistance organizations or other entities that regularly assist low and moderate income families.

(8) Parents may be required to complete a telephone interview as part of the application process. Interviews may be scheduled by contacting the parent by phone, except that written notice shall be issued before an application is denied because the parent did not comply with attempts to complete the interview. Interviews shall be scheduled within thirty days of the date of application at a time mutually agreed to by the parent and the CCAP administrator.

(b) **Date of Application**

(1) The date of application shall be the date the signed and dated application form is received by the CCAP administrator at the address specified by the department for filing child care applications. If the application form is sent to the department, but to an incorrect address, the date of application shall be the earlier of the date the application is received by the CCAP administrator or the next business day following the date the application form was received by the department.

(2) If the requirement to file a new application form is waived in accordance with the requirements of subdivision (a)(4)(B) of this subsection, the date of application shall be the

date upon which the CCAP administrator receives documentation sufficient to reopen the applicant's case using a previously submitted application form.

(3) For applications reopened in accordance with the requirements of subsection (e) of this section, the application date shall be the date the original application form was filed.

(c) **Application Processing**

(1) Applications shall be processed and eligibility determined within thirty days of the date that the CCAP administrator receives the application form, unless otherwise specified in this subsection. The first day of the processing period shall begin on the day following the date the application form was received. The parent shall be notified of the eligibility decision in accordance with the requirements of section 17b-749-07 of the Regulations of Connecticut State Agencies. The provider shall also be notified if a completed child care agreement form was submitted with the application.

(2) Eligibility shall be determined when sufficient information exists to determine if the family is eligible or ineligible. If the application is incomplete, the CCAP administrator shall issue a notice to the parent requesting the information that is missing. The parent shall be given a minimum of fifteen days from the date the notice is issued to return the information to the CCAP administrator. The first day of the fifteen-day period begins on the day the notice was issued.

(3) If the parent has not selected a provider by the time eligibility is determined, the CCAP administrator shall determine if the family is eligible for the program without regard to eligibility for payments. The parent shall be notified of the decision and informed that eligibility will be terminated if a provider is not selected and the information needed to enroll the provider is not submitted within thirty days. The CCAP administrator shall determine if a child is eligible for payment within ten days of the date the provider information is submitted. The family shall become ineligible if the information needed to determine payment eligibility for at least one child is not submitted within thirty days of the date assistance was granted.

(4) Incomplete applications shall be denied only if the parent has been given at least fifteen days to comply with an initial request for missing information.

(5) Parents shall be given additional time to respond to a request for missing information if good cause exists for not providing the information in accordance with the requirements of subsection (e) of section 17b-749-06 of the Regulations of Connecticut State Agencies. Applications that remain incomplete after the fifteen day notice period has expired shall be processed without regard to the missing information if good cause does not exist. If eligibility has not been established, the application shall be denied and the parent notified.

(6) The processing period shall be extended beyond thirty days under the following conditions as long as the parent continues to cooperate with the application process:

(A) if good cause exists for not providing verification in accordance with the requirements of subsection (e) of section 17b-749-06 of the Regulations of Connecticut State Agencies, and the delay causes the application to remain pending for more than thirty days;

(B) if the parent or provider was not given at least fifteen days to respond to an initial request for information;

(C) if the parent responds timely to a request for missing information and the information submitted is either incomplete or requires additional verification before the application can be processed; or

(D) if the CCAP administrator has assumed responsibility for obtaining missing information and has not been able to obtain the information.

(7) The application shall continue to be processed if a good cause extension is granted or while the CCAP administrator is waiting to obtain additional verification. The extension shall continue for as long as necessary provided that the parent continues to cooperate and responds to written requests for verification in a timely manner. Additional verification or reverification of circumstances that have already been verified may be required if the application remains pending more than thirty days. The delay in processing the application shall be considered the responsibility of the parent as long as the CCAP administrator has taken prompt action to request the missing information in time to process the application within thirty days.

(d) **Application Dispositions**

(1) If the family is eligible and funding is available for the parent's priority group, the application shall be approved. A notice of eligibility for the program shall be issued to the parent if the information needed to enroll the provider and determine payment eligibility has not been submitted. The notice shall identify any action the parent is required to take to determine payment eligibility and the specified time frames.

(2) If at least one child has been determined eligible for payment, a certificate of payment eligibility shall be issued to the parent and the approved provider. The parent shall also be notified of any actions that need to be completed to secure payment eligibility for other children in the home and the date for completing such actions.

(3) If a family is eligible but funding is not available for the parent's priority group, the family shall be assigned to the wait list if the wait list is open pursuant to section 17b-749-10 of the Regulations of Connecticut State Agencies. If the wait list is closed, the application shall be denied.

(4) If the application is denied, a copy of the notice shall be sent to any provider for whom a completed child care agreement form was submitted with the application.

(e) **Reopening Denied Applications**

(1) A denied application shall be reopened retroactive to the original date of application under the following conditions:

(A) if the application was denied because the parent did not comply with a request for missing information; and

(B) the parent is able to establish good cause for not submitting missing information within ten days of the date the application was denied in accordance with the requirements of subsection (e) of section 17b-749-06 of the Regulations of Connecticut State Agencies; or

(C) if some or all of the missing information is submitted to the CCAP administrator within ten days of the date the application was denied; or

(D) if the application was denied in error.

(2) Applications that are reopened shall be given priority over other pending applications. The CCAP administrator shall have thirty days from the date the application is reopened to complete the eligibility determination.

(f) **Applications Assigned to the Wait List**

(1) The CCAP administrator shall maintain a wait list if sufficient funding is not available to keep the program open for all priority groups. If a family meets the eligibility requirements for the program but funding is not available for the parent's priority group, the family shall be assigned to the wait list unless the wait list is closed pursuant to section 17b-749-10 of the Regulations of Connecticut State Agencies. Parents and their providers shall be notified if the family is placed on the wait list.

(2) If the commissioner chooses to close the wait list to some or all priority groups, applicants who fall into priority groups to whom the wait list is closed shall be denied. Action to close the wait list shall not be subject to an administrative hearing.

(g) **Eligibility Period**

(1) For families approved without assignment to the wait list, including families whose applications are reopened pursuant to subsection (e) of this section, eligibility shall be granted eligibility retroactive for up to fifteen days prior to the date of application if the family is otherwise eligible and using child care services as of that date.

(2) Families selected from the wait list shall be granted retroactive for up to fifteen days prior to the date on which the parent submits required documentation in response to a notice of selection from the wait list or on the date specified by the CCAP program administrator, whichever is later.

(3) If the parent did not timely submit information or verification needed to determine eligibility for a particular child without good cause, eligibility for the child shall begin on the date the parent provides some or all of the requested information or verification.

(4) Eligibility shall be approved for up to a maximum of six months from the month of application. The CCAP administrator shall schedule a redetermination within six months in accordance with the requirements of subsection (b) of section 17b-749-18 of the Regulations of Connecticut State Agencies.

(Adopted effective July 10, 2001)

Sec. 17b-749-10. Wait list

(a) **Assignment to the Wait List**

(1) Families shall be assigned to a wait list based on their priority group and the date of application. Families qualifying for more than one priority group shall be assigned to the priority group with the highest likelihood of selection for CCAP participation.

(2) Families assigned to the wait list shall be required to notify the CCAP administrator of changes in address and to submit updated documentation of eligibility upon request by

the CCAP administrator. The parent shall have a minimum of fifteen days to supply the requested documentation. Where updated information indicates a change in family circumstances, the CCAP administrator may reassign eligible families to the appropriate priority group or remove ineligible families from the wait list. The parent shall be notified of any changes made to their priority group status or eligibility for the wait list.

(3) Parents shall inform the CCAP administrator in writing of any changes in address.

(b) **Selection from the Wait List**

(1) As funding becomes available, the CCAP administrator shall select families from the wait list beginning in order of the highest priority group. The family's application shall be processed in accordance with the requirements of section 17b-749-09 of the Regulations of Connecticut State Agencies. If the program is not opened to all families within a particular priority group or groups, the CCAP administrator shall select families based on the date of the original application upon which assignment to the wait list was based. Selection from the next lower category may begin only after all families in the higher priority categories have been given an opportunity to participate.

(2) Families shall be notified of their selection from the wait list, of any required actions and the specified time frames for completing the actions. The CCAP administrator shall have the option to specify the effective date of initial eligibility based on funding or other administrative considerations. If a date is specified, the family shall also be notified of the effective date.

(3) The parent shall have a minimum of fifteen days to respond in writing to the notice of selection from the wait list. The family shall be denied if the parent does not respond timely.

(4) Families selected from the wait list may be required to submit a new application and updated verification of family circumstances. Applications of families selected from the wait list shall be processed in a manner identical to applications not assigned to the wait list.

(c) **Removal from the Wait List**

(1) Families shall be removed from the wait list under the following circumstances:

(A) when the family is selected from the wait list;

(B) if the parent requests removal;

(C) if the parent does not update information when requested or reply timely to the notice of selection from the wait list;

(D) if any mail sent to the parent is returned due to an unreported change in address;

(E) when a change in family circumstances renders the family ineligible; or

(F) if a change in CCAP regulations renders the family ineligible.

(2) At the discretion of the commissioner, families may be removed from the wait list if CCAP is expected to remain closed to the family's priority group for at least twelve months.

(3) Families removed from the wait list shall be issued a denial notice if they are not selected for participation in CCAP.

(d) **Closing the Wait List**

(1) The commissioner shall have discretion to close the wait list for some or all priority groups. The decision to close the wait list shall be based on available funding, the number of families already assigned to the wait list and the likelihood of selecting newly added families from the list within twelve months.

(2) If the wait list is closed, families for whom funding is not available shall have their application denied.

(3) The commissioner shall have the option of reopening the wait list to some or all of the priority groups if additional funding becomes available or if a sufficient number of families are selected from the list to warrant reopening the list.

(Adopted effective July 10, 2001)

Sec. 17b-749-11. Eligible children

(a) The child shall be less than thirteen years old or less than nineteen years of age, if the child has special needs. A child shall remain eligible through the last day of the month in which the child reaches the appropriate age limit, provided the child was eligible on the first day of that month. A child whose thirteenth or nineteenth birthday falls in the same month for which assistance is initially requested is not eligible for CCAP.

(b) A child shall be considered to have special needs if the child's independence, self-sufficiency and safety is dependent on others and the child requires extra supervision, care, or assistance in the child care setting due to the following physical, mental, behavioral or emotional conditions, including but not limited to:

(1) a physical handicap or health impairment that causes chronic or acute health problems, such as a heart condition, orthopedic impairment, tuberculosis, asthma, epilepsy, cerebral palsy, leukemia or congenital abnormality that has been diagnosed by a physician;

(2) mental retardation or autism spectrum disorder as diagnosed by a physician, pediatrician or psychologist;

(3) a behavioral or emotional disturbance, maladjustment or developmental delay that causes the child to exhibit marked and inappropriate behaviors or characteristics over extended periods that has been diagnosed by a psychologist, psychiatrist or other clinically trained and state-certified mental health professional acting within his or her scope of practice;

(4) a speech, language, vision or hearing impairment that has been diagnosed by a physician or state certified health care professional acting within his or her scope of practice; or

(5) multiple handicaps that cause problems or interfere with the child's ability to function in the child care setting without extra care or supervision.

(c) Parents shall be required to notify the CCAP administrator and the provider if a child has special needs. A determination that a child has special needs shall not guarantee eligibility for additional or increased payments. The child's payment rate and eligibility for a special needs supplement shall be subject to the requirements of subsection (c) of section 17b-749-13 and subsection (b) of section 17b-749-16 of the Regulations of Connecticut

State Agencies, respectively.

(d) The child shall meet the citizenship requirements established in subsection of section 17b-749-04 of the Regulations of Connecticut State Agencies.

(e) The child shall have age-appropriate immunizations in accordance with the childhood immunization schedule established by the Department of Public Health pursuant to section 19a-7 of the Connecticut General Statutes. Parents and providers shall certify that the child has had age-appropriate immunizations and has had age-appropriate comprehensive health screening examinations required by the Early and Periodic Screening and Diagnostic Treatment Program established under 42 U.S.C. § 1396d(r) or according to the schedule recommended by the American Academy of Pediatrics. Parents shall provide documentation of age-appropriate immunizations and other health information to the provider and the CCAP administrator upon request, including the name and address of the child's physician, primary health care provider and health insurance company.

(f) If a child who receives care has not been immunized, the parent shall have sixty days from the date assistance is granted to verify that the child has begun the immunization process. The child's benefits shall be terminated if the parent does not provide the required verification within sixty days. The child shall remain ineligible until such time that the parent verifies that the child has been or is in the process of being immunized. If there are no other eligible children in the home, the family shall become ineligible.

(g) The CCAP administrator shall waive the immunization requirement if the parent is able to demonstrate that the child's medical condition or the parent's sincere religious beliefs preclude the child from being immunized.

(Adopted effective July 10, 2001)

Sec. 17b-749-12. Eligibility requirements for child care providers

(a) **Eligible Settings**

(1) To be eligible for payments, care shall be given in one of the following settings located and operating legally within Connecticut:

(A) the child's home;

(B) a family day-care home licensed by the Department of Public Health;

(C) a day-care center licensed by the Department of Public Health;

(D) a group day-care home licensed by the Department of Public Health;

(E) the home of a relative as defined in subsection (34) of section 17b-749-01 of the Regulations of Connecticut State Agencies;

(F) the home of a non-relative provider, if care is provided for less than three hours per day;

(G) a public or private school-based child care program as defined in subsection (37) of section 17b-749-01 of the Regulations of Connecticut State Agencies;

(H) a recreational program operated by a library, boys' and girls' club, church-related organization, scouting, camping or community youth program or other similar entity that is legally exempt from separate licensing by the Department of Public Health pursuant to

section 19a-77 of the Connecticut General Statutes, and that provides stable and regular care; or

(I) a drop-in supplemental child care program where parents are present on-site, for which the parent is charged a fee for child care services.

(2) The commissioner shall have discretion to approve payments for child care services given by a licensed provider located and operating legally in an adjoining state on an exception basis. Approval shall be based on the circumstances of the individual family, including, but not limited to the availability of licensed child care services in the area where the family lives, the need to utilize out-of-state services due to the location of the child's school or the parent's work, education or employment services activity and any special needs of the child. The provider shall be licensed and in good standing with the state agency responsible for regulating child care services in the adjoining state. In addition, the provider shall be subject to all other relevant requirements specified in section 17b-749-01 to17b-749-23 of the Regulations of Connecticut State Agencies, inclusive, and shall cooperate with the department in providing or obtaining any verification needed to establish the eligibility of the child care arrangement. The determination by the commissioner shall be considered final and is not subject to an administrative hearing.

(3) When determining if a provider is eligible, the department shall give full force and effect to any decision rendered by another agency concerning a license or application for a license to provide child care.

(4) The following individuals shall not be eligible to receive payments from CCAP for providing child care because of their relationship to the child:

(A) a person who is a mandatory inclusion in the family unit for CCAP eligibility purposes pursuant to section 17b-749-03 of the Regulations of Connecticut State Agencies;

(B) the natural or adoptive parent or legal guardian of the child, or the current or former spouse of such individual;

(C) if the child's parent is a minor who is not emancipated, the natural or adoptive parent or legal guardian of the minor parent, or the current or former spouse of such individual if living in the same household as the minor parent;

(D) the child's sibling through blood, marriage or adoption if living in the same household as the child regardless of the sibling's age;

(E) an adult, regardless of relationship, living in the same household with the child who provides care between the hours of eleven o'clock p.m. and seven o'clock a.m., unless the child is less than three years of age or has special needs; and

(F) an individual who has been designated as the caretaker relative of the child under the cash assistance program and the individual's spouse.

(5) A child care provider who has been convicted of vendor fraud pursuant to section 17b-99 of the Connecticut General Statutes shall not be eligible to receive payments from the CCAP program for providing child care services.

(b) **Provisions Applicable to all Providers**

(1) The department shall not be considered a licensing authority or the employer of the

provider. The agreement to provide care is an arrangement between the parent and the provider and shall not be considered a legal contract between the department or the CCAP administrator and the provider. Parents shall be responsible for selecting a provider who can provide safe, appropriate and suitable care for their child. The Department or the CCAP administrator shall only determine whether the provider has submitted evidence of compliance with the requirements of section 17b-749-12 of the Regulations of Connecticut State Agencies and is therefore eligible to participate in the CCAP program. Neither the Department nor the CCAP administrator shall undertake any duty of care that can be reasonably relied upon by any person that a provider is suitable or appropriate to provide child care.

(2) Neither the department nor the CCAP administrator shall be considered the employer of the provider. The Department or the CCAP administrator, by making benefit payments on behalf of an eligible family to a provider that has been selected by the family, does not undertake any of the responsibilities of an employer, including, but not limited to, tax withholding, unemployment compensation or worker's compensation. The Department's responsibility shall be limited to making child care assistance payments to providers who are eligible to receive payment for child care services provided on behalf of eligible families, in accordance with the terms, conditions and limitations of sections 17b-749-01 to 17b-749-23 of the Regulations of Connecticut State Agencies, inclusive.

(3) Providers shall allow parents unlimited access to their children and to the location where child care is provided.

(4) Providers shall certify that they will report any instances of suspected child abuse or neglect to the appropriate protective service agency in a manner required by section 17a-101a of the Connecticut General Statutes.

(5) In order to maintain eligibility for payments, providers shall provide the following information to the CCAP administrator upon request:

(A) the name, address, photo identification, Social Security number and telephone number of the provider and all adults who work for or reside at the location where care is provided;

(B) the name and address of the child's doctor or primary care provider and health insurance company;

(C) whether the child is immunized and has had appropriate health screens; and

(D) the number of children cared for by the provider.

(6) Providers shall notify the CCAP administrator of any changes in the child care arrangements, including but not limited to changes in the hours of care, actual charges, changes in programs due to the age group of the child, the location where care is given and changes in licensing or accreditation status. Changes shall be reported in writing or by phone by the time the first invoice is submitted following the date of the change. This requirement shall not relieve the parent of the responsibility to report these changes to the CCAP administrator within ten days of the date of the change.

(7) Providers shall report actual charges and attendance accurately in the format required

by the CCAP administrator. Providers shall maintain records of such figures on-site for at least one year and make such records accessible to the department for inspection upon request.

(8) Providers shall not charge or report charges for CCAP participants at a rate that is higher than the rate charged to a comparable family not participating in the CCAP program. The charges reported to CCAP shall be the actual amount charged to the parent for services, unless the child attends a state-supported day care center or school readiness program funded under section 8-210(b) or sections 10-16p(8)(c) or 10-16p(8)(d) of the Connecticut General Statutes respectively. For children attending such state-supported programs, the charges reported to CCAP for use in determining the benefit calculation and payment shall be the lesser of the provider's full charge for the program or the approved cost of care as determined in subsection (a) of section 17b-749-13 of the Regulations of Connecticut State Agencies.

(9) Providers shall not increase charges to CCAP parents to offset a reduction in payments due to an overpayment that was caused by the provider that is being recouped by the department.

(c) **Requirements for Providers Subject to Licensing by the Department of Public Health**

(1) Child care providers that are required to be licensed by the Department of Public Health in accordance with section 19a-77 of the Connecticut General Statutes shall be licensed and in good standing before any payments to the provider are approved.

(2) Providers shall report changes in licensing status to the CCAP administrator by phone or in writing by the time the first invoice is submitted following the date the Department of Public Health informs the provider of the change. Changes in accreditation status shall be reported within ten days of the date of the change.

(3) Payments shall not be made for child care services provided during periods the provider did not possess or maintain the required license, except when the provider has timely taken steps to renew a license but the Department of Public Health has not completed the renewal process. Providers shall not be entitled to advance notice if payments are terminated because the provider is not licensed.

(4) The CCAP administrator shall withhold any payments that have not already been issued for periods during which the provider was determined to be operating illegally without a license. Any payments issued for services provided during periods the provider was operating without a required license shall be considered overpayments caused by the provider.

(5) The CCAP administrator shall report providers who appear to be over capacity to the Department of Public Health for investigation of regulatory violations.

(d) **Requirements for Unlicensed Child Care Providers**

(1) Unlicensed child care providers shall be eighteen years of age or older. Parents receiving benefits for care given by a provider who is less than eighteen years old shall have up to ninety days from the effective date of this regulation to locate a new provider.

Payments shall continue during the ninety-day period provided the family is otherwise eligible.

(2) The provider shall disclose his or her full name, residence address, date of birth and social security number or any other information necessary to verify identity. Upon request, the provider shall provide identification that includes the provider's photograph, date of birth and signature.

(3) The provider shall not be working another job during the hours that the child is in care or engage in an activity that distracts his or her attention from providing child care services.

(4) No child care subsidy shall be paid to an unlicensed child care provider if such provider has been convicted of any crime involving sexual assault of a minor or serious physical injury to a minor or any crime committed in any other state or jurisdiction the essential elements of which are substantially the same as such crimes pursuant to section 17b-750 of the Connecticut General Statutes. The commissioner shall have discretion to refuse payments to any provider if the person has been convicted in this state or any other state of any crimes specified in section 17b-749k of the Connecticut General Statutes or has a criminal record or was the subject of a substantiated report of child abuse or neglect in this state or in any other state that the commissioner reasonably believes renders the person unsuitable to provide child care.

(5) The commissioner shall have discretion to refuse payments under the following conditions:

(A) if the provider has an outstanding arrest warrant for any offense that is classified as a felony;

(B) if the provider has a child abuse or neglect allegation pending;

(C) if the provider is physically or mentally incapable of providing safe or competent care to the child; or

(D) whenever the commissioner has obtained information from a reliable source that a provider has not been providing or is not capable of providing safe or competent care, including but not limited to a record of an outstanding arrest for child abuse or neglect, risk of injury or impairing the morals of a minor, the illegal use, sale or possession of controlled substances, a crime against persons or other similar offenses.

(6) The parent and provider shall both certify that the provider is capable of providing safe and competent care as a condition of payment eligibility, including the ability to feed, bathe and toilet the child as appropriate, the ability to respond to potential emergencies and the ability to provide adequate care and supervision. The department may deny payment if sufficient evidence exists to support a conclusion that the child's needs may not be satisfied or that the child's health and safety may be at risk in the child care setting. In making this determination, the department shall consider information obtained from police records, medical records and information obtained from other agencies, physicians, health care workers, social workers health officials or other sources. The hours of care, the child's age and special needs shall be taken into consideration when assessing the ability of the provider

to properly care for and supervise the child.

(7) The provider shall certify in writing that he or she has not been convicted of any crime or subject to any of the conditions listed in subdivisions (4) and (5) of this subsection.

(8) The provider and parent shall certify by signing the child care agreement form that the child care location meets the following requirements:

(A) there is an operating fire extinguisher available at the child care location;

(B) there is an operating smoke alarm installed at the child care location;

(C) there is an operating hard wired telephone at the child care location or a cellular phone owned and operated by the provider with emergency telephone numbers posted; and

(D) the child care location complies with all applicable local and state fire, zoning and building codes.

(9) The child care arrangements shall not be approved if care is provided in a location that does not meet the requirements of subdivision (8) of this subsection.

(10) An unlicensed child care arrangement shall not be approved if care is provided by an in-home child care provider or a relative who provides child care services to more than six children during substantially the same hours. Up to three children under the age of two may receive child care services together at a time, as long as they are the only children in the provider's care. No more than two infants may receive care at any one time if the provider cares for any other preschool or school age children during the same hours.

(e) **Criminal and Child Abuse Background Checks for Unlicensed Providers**

(1) The department shall check the state's child abuse registry at application and periodically according to a schedule established by the department to determine if the provider has a substantiated history of child abuse or neglect.

(2) The department shall check the state and national criminal history of any unlicensed provider that is suspected of having a conviction for sexual assault of a minor or other related crime in accordance with the requirements of section 17b-750 of the General statutes.

(3) The department shall conduct criminal background checks for unlicensed providers pursuant to the requirements of sections 17b-749k and 17b-750 of the Connecticut General Statutes.

(4) Providers shall be informed of the requirements to conduct criminal and child abuse background checks and shall supply the department with fingerprints and any other information required to conduct the background check when requested by the CCAP administrator. Providers shall be given a minimum of thirty days to return the requested information to the department.

(5) The department may charge the provider for any fees charged by the State Police or the FBI for conducting the criminal background check. The department may deduct the fee from payments made to the provider or require the submission of payment with the fingerprints. A provider who does not submit fingerprints, fees or other information when requested shall be ineligible for payments until such time the provider complies with the request.

(6) Assistance shall not be delayed pending the completion of a criminal or child abuse

background check unless evidence exists to warrant a delay, except as specified in subdivision (f) of this section.

(f) **Termination of Payments**

(1) No child care subsidy shall be paid to any licensed or unlicensed child care provider if there is evidence that a child's needs are not being met, or that the child is not receiving or is not likely to receive safe and competent care from the provider. Parents and providers shall be notified of the denial or termination of payments to the provider. Disclosure of information obtained from the child abuse registry shall be in accordance with the requirements of subsection (d) of section 17b-749-02 of the Regulations of Connecticut State Agencies.

(2) Providers who disagree with the results of the background check shall be referred to the Departments of Children and Families or Public Safety if they wish to dispute the findings of those agencies. If the findings are reversed, payments may be authorized as of the date verification of the decision by the Department of Children and Families or Public Safety is submitted to the department.

(3) Providers may ask the department to reconsider the decision to deny or discontinue payments if they feel the decision was made in error. The decision by the department shall be considered final and shall not be subject to an administrative hearing request by the provider. Parents may appeal the decision to deny or discontinue payments pursuant to the requirements of section 17b-749-21 of the Regulations of Connecticut State Agencies.

(4) The request for reconsideration shall be made in writing by the provider and contain the details the department is being asked to consider. The department shall reach a decision within ten days of the date of the written request for reconsideration or the date that all necessary documentation has been submitted or obtained. The parent and provider shall be provided with a written response concerning the request for reconsideration..

(g) **Enrollment of the Provider**

(1) To be eligible for payment, the child care provider shall enroll in the CCAP program as the child's provider. To enroll, the provider shall complete the following actions:

(A) submit a completed child care agreement using a form prescribed by the department that provides details of the child care arrangements, including but not limited to information about the provider's licensing and accreditation status, the relationship of the provider to the child, the location where care is given, the days and hours of care and the actual charges for the care provided;

(B) certify that the child care provider and the facility meet the licensing and health and safety standards outlined in this section;

(C) provide any additional documentation required by the CCAP administrator, including but not limited to verification of identity;

(D) agree to report changes in the child care arrangements or licensing and accreditation status by the date the first invoice is submitted following the date of the change, whichever is earlier; and

(E) submit a completed W-9 form or other documentation of tax identification number

as specified by the department.

(2) The parent shall be required to co-sign the child care agreement form. The parent's signature confirms the child care arrangements and serves as a release to allow the department to share information with the provider or as necessary for the administration of the CCAP program in accordance with the requirements of subsection (d) of section 17b-749-02 of the Regulations of Connecticut State Agencies.

(Adopted effective July 10, 2001)

Sec. 17b-749-13. Payment calculations

(a) **Calculating the Approved Cost of Care**

(1) The CCAP administrator shall calculate the approved monthly cost of care for each eligible child based on the activity schedule, the need for care, the applicable payment rate and eligibility for increased payments due to an ongoing special needs supplement. The approved cost of care shall represent the maximum ongoing CCAP payment, excluding adjustments for supplements, accreditation and professional development incentives or underpayment corrections. The approved cost shall not exceed the amount charged by the provider, except to the extent that weekly charges are converted to an average monthly amount as specified in subdivision (2) of this subsection.

(2) In calculating the approved cost, the weekly payment rate and the provider's actual weekly charges shall be converted to average monthly amounts by multiplying by a factor of four and three tenths weeks per month. The results may be rounded to the nearest whole dollar amount.

(3) The approved monthly cost of care shall be the lesser of the following amounts:

(A) the maximum payment rate based on the authorized hours of care, the type of child care setting, the age of the child, the location where care is given or the location of the family's residence in cases were payment is approved for an out-of-state provider pursuant to subdivision (a)(2) of section 17b-749-12 of the Regulations of Connecticut State Agencies, plus

(B) fifteen percent of the amount determined in subparagraph (A) for a child with special needs who is eligible for an increase in the standard payment rate pursuant to the requirements of subdivision (b)(3) of section 17b-749-16 of the Regulations of Connecticut State Agencies; or

(C) the provider's actual monthly charges.

(4) The actual charge shall be the amount charged to the parent for services, unless the child attends a state-funded day care center or a school readiness program that charges families according to a sliding income scale pursuant to subdivision (b)(7) of section 17b-749-12 of the Regulations of Connecticut State Agencies. For children attending such programs, the actual charge shall be considered to be the lesser of the following amounts:

(A) provider's full charge for the program; or

(B) the maximum CCAP payment rate based on the authorized hours of care, the type of child care setting, the age of the child and the location where care is given; plus

(C) fifteen percent of the amount determined in subparagraph (B) for a child with special needs who is eligible for an increase in the standard payment rate pursuant to the requirements of subdivision (b)(3) of section 17b-749-16 of the Regulations of Connecticut State Agencies.

(5) Actual charges shall not exceed the amount charged by the provider for children attending the same program who do not receive assistance from CCAP.

(b) **Authorized Hours of Care**

(1) The CCAP administrator shall calculate the number of hours of care that are needed for each eligible child. The number of hours of care authorized shall be based on all of the following factors and shall be limited to not more than twelve hours in a twenty-four hour period:

(A) hours of the work or employment services activity;

(B) the availability of a parent who is living with the child to provide care;

(C) the hours the child is in school;

(D) travel time to and from the approved activity; and

(E) the hours of care specified on the child care agreement form.

(2) Care shall not be authorized during the hours the child is in school, an academic or home schooling program, when a parent living in the home is available and capable of providing care or outside the activity schedule, including travel and lunch time.

(3) The time needed to commute to and from the activity shall be taken into consideration when determining the actual number of hours of care that is needed. Travel time shall be limited to a maximum of one hour per day, unless the parent verifies that additional time is needed.

(4) Households where both parents participate in approved activities at different times shall be required to arrange their home schedules, including sleep time, in a manner that maximizes each parent's availability to provide care. If after making reasonable efforts to adjust their schedules child care is needed, care shall be authorized for the part of the day the parents are not able to supervise the child.

(5) A maximum of four hours per day may be approved to allow a parent who works third shift or an equivalent schedule to sleep if the child does not attend school or if the other parent is not available to provide care.

(6) Care shall not be authorized between the hours of eleven p.m. and seven a.m. if the child care provider is a person who resides in the same home as the child, unless the child is less than three years of age or has special needs.

(7) Weekly schedules shall be converted to monthly figures by multiplying by a factor of four and three tenths weeks per month. The result may be rounded to the nearest half-hour.

(8) If the hours of the activity fluctuate in an unpredictable manner, the CCAP administrator shall calculate the authorized hours by using a representative average of number of hours the individual is expected to participate in the activity over the period of the certificate.

(9) For parents beginning a new employment services activity, employment or changing schedules, the number of hours authorized shall be based on documentation provided by the parent, the employer or entity responsible for coordinating the employment services activity.

(10) The number of hours authorized shall not exceed the number of hours specified on the child care agreement form.

(11) The number of hours of care authorized shall be used as the basis for determining the level of care needed and the applicable payment rate. The maximum number of hours approved for any one child shall not exceed sixty-five hours per week or two hundred eighty hours per calendar month, except to the extent the child is eligible for a supplemental payment for an alternate child care provider pursuant to section 17b-749-16 of the Regulations of Connecticut State Agencies.

(c) **Payment Rates**

(1) The commissioner shall establish payment rates pursuant to the requirements of this subsection. The payment rates shall be updated periodically in accordance with state and federal requirements after consideration of local market conditions, or for unlicensed providers, changes in the minimum wage. The rates shall be established with the intention of providing participating parents with reasonable access to child care services available to the general public in a variety of settings. The payment rates shall be made available to the general public upon request.

(2) The payment rates for all providers shall be based on four levels of care. Each level shall cover a range of hours. The number of hours authorized in subsection (b) of this section shall be converted to an average monthly amount and used to determine the maximum allowable payment rate for each certificate of payment. The lower and upper limits of the four levels of care shall be as follows:

(A) for care in excess of full-time care, fifty one to sixty-five hours per week;

(B) for full-time care, thirty-five to fifty hours per week;

(C) for half-time care, sixteen to thirty-four hours per week; and

(D) for quarter-time care, one hour to fifteen hours per week.

(3) The commissioner shall have discretion to modify the payment rate structure to establish daily rates or other payment levels as necessary to approximate the manner in which child care providers charge for care in the open market, including supplemental payments for extended nontraditional hours.

(4) Payment rates for school-based child care programs and providers licensed by the Department of Public Health shall depend on the age of the child in care. Children shall be classified into the following age groups:

(A) infants/toddlers under the age of three;

(B) preschool children ages three through five; and

(C) school age children age six and older.

(5) The child's age group shall be established as of the date the certificate of payment is issued and shall remain the same until the family's next redetermination or until the

certificate is cancelled and a new certificate of payment is issued for the child.

(6) Separate rates shall be established for the following types of child care providers:

(A) licensed child day care centers;

(B) licensed group day care homes;

(C) licensed family day care homes; and

(D) relatives, in-home care providers and other types of unlicensed providers.

(7) Payment rates for licensed providers shall be established for geographic regions as defined by the commissioner based on a review of local market conditions. The regional payment rate for a particular child shall be determined by the location at which child care is provided.

(8) With the exception of school-based child care programs, payment rates for unlicensed providers shall be based on the state minimum wage. The weekly payment rate for the full-time care of one child shall be equal to one third of the state minimum wage times forty hours. Payment rates for school-based child programs shall be determined in the same manner as rates for child day care centers, group and family day care homes licensed by the Department of Public Health.

(9) Providers who have attained national accreditation or completed professional development course work shall be entitled to bonus payments pursuant to subsection (d) of this section.

(10) The commissioner may take other market factors into consideration when establishing payment rates, including discounts given by providers who care for more than one child from the same family. The commissioner may establish payment limits or differentials for children who are cared for in their own homes pursuant to 45 CFR 98.30 based on the additional cost of providing care in a licensed setting, including insurance, facility and business expenses, staffing, professional certifications and early childhood education programming.

(11) The payment rate shall be increased by fifteen percent for a child with special needs who meets the requirements established in subsection (b) of section 17b-749-16 of the Regulations of Connecticut State Agencies.

(12) Payment rates may be modified at any time. Changes in rates shall be made effective on the date specified by the commissioner. A minimum of thirty days advance notice shall be given to parents and providers with active certificates of payment if the payment rates are decreased.

(d) **Payment Incentives for Accreditation and Professional Development**

(1) Licensed child care providers whose programs meet the standards promulgated by state or national accrediting agencies recognized by the commissioner shall be entitled to a payment incentive as long as they maintain their accreditation. The payment incentive shall be equal to five percent of the amount calculated in subdivision (b)(1) of section 17b-749-15 of the Regulations of Connecticut State Agencies prior to any deductions for fees, overpayments or any mandated withholding. Accrediting agencies recognized by the commissioner shall include but not be limited to:

(A) the National Academy of Early Childhood Programs, a division of the National Association for the Education of Young Children;

(B) the National School Age Child Care Alliance;

(C) the National Association of Family Child Care; and

(D) the Council on Accreditation of Services for Families and Children, Inc.

(2) The commissioner may establish additional payment incentives for licensed and unlicensed providers eligible for CCAP based on completion of course work toward achieving a Child Development Associate credential, a degree program or other professional development courses or credentials or other quality standards. Incentives may be paid as a lump sum bonus, a flat amount added to the monthly payment or as an increase in the payment rate.

(3) Providers shall apply for payment incentives in a manner specified by the CCAP administrator and shall provide satisfactory documentation. Incentives for eligible providers shall become effective in the month following the month in which the application and all required documentation are submitted to the CCAP administrator. Providers may be required to submit updated documentation confirming their current accreditation or professional development status. Providers shall notify the CCAP administrator if their accreditation is revoked or expires, or if the conditions that qualified the provider for the incentive pursuant to subdivision (2) of this subsection change. Incentives shall continue to be paid until the end of the month in which such status changes.

(e) **Maximum Payments**

(1) Payments for a child who is cared for by a single provider shall not exceed the established payment rate for fifty-one to sixty-five hours of care per week, excluding incentive payments for accreditation and professional development authorized under subsection (d) of this section and supplemental payments authorized under subsection (b) of section 17b-749-16 of the Regulations of Connecticut State Agencies.

(2) If a child receives care from two or more providers, the payment rate shall be calculated independently for each provider. The payment rate for each certificate of payment shall be based on the hours of care authorized for the provider, except that the total hours authorized for all providers shall not exceed sixty-five hours per week or two hundred eighty hours per month. To determine the level of care, the CCAP administrator shall first calculate the weekly number of authorized hours of care for the provider with whom the child spends the majority of time or the provider for whom an existing certificate is already in effect. The authorized hours for this provider shall be subtracted from the sixty-five to determine the maximum number of hours available for the other or new provider. If the hours are approximately equal, the CCAP administrator may consult with the parent to determine how the hours will be allocated. The CCAP administrator shall not be required to cancel a certificate that is already in effect.

(f) **Parent Fee and Financial Responsibilities**

(1) The parent shall be responsible for all costs not reimbursed by CCAP on behalf of the parent. In addition, families with earnings or self-employment income shall be

responsible for paying a portion of the authorized cost of care based on a monthly sliding fee scale.

(2) To determine the monthly fee, the family's gross countable annual income shall be compared to the state median income standard (SMI) for the family size as promulgated annually by the Department of Health and Human Services. The fee shall be equal to the following percentage of the family's gross countable income:

(A) for families with income below twenty percent of the SMI, two percent;

(B) for families with income of twenty percent to less than thirty percent of the SMI, four percent;

(C) for families with income of thirty percent to less than forty percent of the SMI, six percent;

(D) for families with income of forty percent to less than fifty percent of the SMI, eight percent; and

(E) for families with income of fifty percent of SMI to less than seventy-five percent of SMI, ten percent.

(3) The fee may be rounded to the nearest whole dollar amount and applied against the approved cost of care as determined in subsection (a) of this section.

(4) The fee shall be allocated to the youngest child first or in a manner that will avoid the need to allocate a portion of the fee across multiple certificates. If the fee exceeds the approved cost for a child, the remaining amount shall be allocated to the next oldest child until the full parent share has been allocated. If payment is terminated, the CCAP administrator shall apply the unallocated fee to the remaining active children or to the new certificate issued for the same child after giving appropriate notice to the parent and provider.

(5) The family shall be ineligible if the monthly fee exceeds the approved cost for all of the eligible children.

(6) The monthly fee shall be determined at the time of application and when a redetermination is conducted. The fee shall remain the same until the next redetermination, unless an ongoing decrease in income occurs that is expected to last for at least two or more months. The fee shall not be increased between redeterminations if the family's income increases, except to correct an error in the prior calculation. Families shall be subject to the gross income limit and shall report increases in income exceeding fifty dollars per month even if the change does not immediately affect the fee.

(7) Decreases in the monthly fee shall be implemented in the month following the month in which the change is reported if the change is verified timely. If the change is not verified timely, the decrease shall take effect in the month following the month in which the change is verified, unless good cause exist for not providing timely verification pursuant to subsection (e) of section 17b-749-06 of the Regulations of Connecticut State Agencies.

(8) Parents shall be responsible for paying the fee to the provider. The family's eligibility shall not be affected if the fee is not paid to the provider.

(g) **Compliance with Applicable Labor and Tax Laws for In-Home Care**

Parents shall be responsible for compliance with applicable laws governing in-home

domestic services. The CCAP administrator may withhold the parent's share of any mandated unemployment compensation, Social Security or Medicare taxes from payments issued to an in-home provider to the extent that benefits are paid to the in-home provider instead of the parent.

(Adopted effective July 10, 2001)

Sec. 17b-749-14. Certificates of payment

(a) **Authorizing Payments**

(1) The CCAP administrator shall determine payment eligibility at the time assistance is granted if the information needed to enroll the provider was submitted with the application. If the information needed to determine payment eligibility was not submitted with the application, payment eligibility shall be determined within ten days of the date the completed child care agreement form and other information needed to determine payment eligibility is received.

(2) The CCAP administrator shall issue a certificate of payment to the parent and the provider if payment is approved. The certificate of payment is evidence of payment eligibility. Certificates of payment shall be issued for a particular child, provider and location of care, number of hours of care and for a specified period. Child care services provided outside the scope of the certificate shall not be eligible for payment by CCAP. A certificate of payment shall not be considered a grant or contract between the department and the child care provider.

(3) Certificates of payment shall include the names of the parent, the child and the provider, the number of authorized hours of care, the certificate authorization period, the maximum approved cost, the monthly fee where applicable, the approved payment amount and the payment authorization period.

(4) Certificates of payment shall be issued even when the authorized payment is zero due to the application of the monthly fee, provided another child is eligible to receive a payment.

(b) **Payment Authorization Period**

(1) Payment shall be limited to child care services provided between the start and end dates of the certificate of payment. The payment authorization period shall not exceed six months for any individual certificate.

(2) Payments may be authorized for up to ten days prior to the start of an activity if the parent is required to pay for services before the activity starts to secure a child care slot with a licensed provider. Payment shall be authorized prior to the start of the activity only if the slot would otherwise be filled because of a lack of vacancies in the program. Payments shall not be authorized in advance of the activity if care is given by an unlicensed provider.

(3) For families newly approved for participation in the CCAP program, the payment start date shall be the later of the following dates:

(A) the date the family becomes eligible for the program pursuant to subsection (g) of section 17b-749-09 of the Regulations of Connecticut State Agencies;

(B) the date child care services begin; or

(C) fifteen days prior to the date the completed child care agreement is submitted to the CCAP administrator if the application was granted without an approved provider for the child.

(4) For active families, the payment start date shall be the applicable date specified in section 17b-749-19 of the Regulations of Connecticut State Agencies.

(c) **Payment End Date**

(1) Eligibility for payment shall terminate automatically as of the date printed on the certificate of payment. Additional notice shall not be required.

(2) A certificate of payment shall be cancelled prior to the date indicated on the certificate under the following circumstances:

(A) if the family or child becomes ineligible for CCAP;

(B) if the child care provider becomes ineligible for CCAP; or

(C) if changes in household circumstances, the activity schedule or provider arrangements require recalculation of the benefit.

(3) Notice shall be given pursuant to the requirements of subsection (c) of section 17b-749-07 of the Regulations of Connecticut State Agencies.

(4) Payment eligibility shall end on the earlier of the following dates:

(A) the date specified on the certificate of payment;

(B) the last day services are provided;

(C) six calendar months from the start of the payment authorization period, but not later than the last day of the month family is scheduled for redetermination;

(D) the day the ten day advance notice of adverse action expires; or

(E) the date the notice of adverse action is issued if advance notice is not required.

(Adopted effective July 10, 2001)

Sec. 17b-749-15. Payment process

(a) **Monthly Invoices**

(1) Payments shall be post-paid on a monthly basis. Payments shall be considered assistance to the parent, not assistance to the provider.

(2) The CCAP administrator shall issue a monthly invoice to the provider by the first day following the end of the service month or at the time the certificate of payment is issued to the provider for a retroactive period of payment eligibility.

(3) Providers shall return the completed invoice. By submitting the invoice, the provider shall attest to the services performed and the actual amount charged to the parent. The parent may also be required to sign the invoice as confirmation of the amount and cost of services performed. Invoices shall be submitted after the end of the service month. The provider shall have one hundred twenty days from the end of the service month or from the date the CCAP administrator issued the invoice to return the invoice to the department, whichever is later. Invoices submitted more than one hundred twenty days after the end of the service month shall not be paid unless the invoice is submitted late due to a CCAP administrative

error or delay.

(4) The completed invoice shall reflect the provider's actual charges and shall be signed and dated by the provider. Weekly charges shall be converted to an average monthly amount by multiplying by a factor of four and three tenths. Providers shall also report attendance or other information as required by the CCAP administrator. The parent may be required to co-sign the invoice for all or specific types of child care settings.

(5) Payment shall be issued within fifteen days of the date the properly completed invoice is submitted to the CCAP administrator.

(b) **Payment Calculations**

(1) Payments for the service month shall be calculated based upon submission of the completed invoice. The amount of the CCAP payment shall be determined by adding or subtracting the amounts listed in subdivisions (2) and (3) of this subsection to the lesser of the following amounts:

(A) the approved cost of care calculated in subdivision (a)(3) of section 17b-749-13 of the Regulations of Connecticut State Agencies; plus

(B) any supplemental payments authorized for the provider under subsection (a) and subdivision (b)(4) of section 17b-749-16 of the Regulations of Connecticut State Agencies; or

(C) the provider's actual charges for the service month.

(2) Incentives for accreditation and professional development authorized under subsection (d) of section 17b-749-13 of the Regulations of Connecticut State Agencies that are paid as a percentage increase in the payment shall be added to the amount calculated in subdivision (1) of this subsection. Lump sum and flat rate incentives may be issued together with the regular monthly payment or paid separately.

(3) The allocated monthly fee determined in subsection (f) of section 17b-749-13 of the Regulations of Connecticut State Agencies and any reductions due to the recoupment of an overpayment or mandated withholding shall be deducted from the sum of the amounts calculated in subdivisions (1) and (2) of this subsection. The resulting total shall be the CCAP payment amount. Payments shall be prorated if the child is eligible for payment for only part of the month. Parents shall be responsible for any costs not covered by CCAP.

(c) **Payee**

(1) Unless otherwise specified in this section, benefit payments shall be made to the order of the child care provider or to the provider's fiduciary if the provider is a subcontractor or part of a network of child care providers. Benefit payments shall be mailed to the provider's home or business address or issued through direct deposit, except that the department shall have the option of paying the parent directly for care that is provided in the child's own home. In such cases, the benefit payment shall be issued to the parent's home address. If the department elects to make benefit payments through direct deposit, parents and providers shall cooperate in establishing a bank account as a condition of payment eligibility.

(2) Benefit payments issued by mail may be sent to a post office box address under the

following conditions:
(A) if the provider is not a relative or in-home provider, and the provider's business address is a post office box; or
(B) if the parent or provider has submitted adequate verification of residence and the postal authority confirms that mail is not delivered to the home address.
(3) Benefit payments may be issued to an alternate payee under the following conditions if the individual acting on the behalf of the provider can verify that services were provided:
(A) if the provider is deceased at the time the payment is issued, payment shall be issued to the fiduciary of the provider's estate appointed by the probate court; or
(B) if the provider becomes incapacitated or incompetent, payment shall be issued to a conservator appointed by probate court or other individual acting with power of attorney.
(4) Benefit payments may be issued to the parent on an exception basis if an administrative error caused payment to be delayed for three or more months and the parent was required to pay the provider for the full cost of care while waiting for the department to correct the error. The parent and provider shall be required to verify that the parent has already reimbursed the provider for the services and that payment should be remitted to the parent rather than the provider.
(d) **Stale Dated Checks**
Checks issued as payment for child care services shall become void if they are not cashed within sixty days.
(e) **Lost, Stolen or Destroyed Checks**
(1) The payee may request replacement of a lost, stolen or destroyed check within ninety days of the date the original check was issued. If the CCAP administrator determines that the original check was signed or cashed by the provider, the parent or a member of the family, no replacement check shall be issued. Payments issued through direct deposit shall not be replaced under any conditions.
(2) The payee shall be required to submit a notarized affidavit using a form specified by the CCAP administrator prior to replacing the lost, stolen or destroyed check, unless the check has been returned and has not been transacted. The payee shall also file a police report if requested by the CCAP administrator, and cooperate with any investigations conducted by the department or the police.
(3) The CCAP administrator may withhold replacement checks for up to fourteen days from the date the affidavit is submitted if payment of the original check could not be stopped or if the original check has not been recovered or has been cashed. In the event of an ongoing investigation, the replacement check may be withheld indefinitely pending completion of the investigation.

(Adopted effective July 10, 2001)

Sec. 17b-749-16. Supplemental payments
(a) **Supplements for Additional Hours of Care**
(1) Parents shall be entitled to request a supplemental payment for increased care with

the same provider when the child care needs temporarily exceed the authorized hours of care reflected on the certificate by more than twenty hours in a calendar month as the result of the following circumstances and the parent is charged for the additional hours:

(A) school closes for vacation or other reasons;

(B) the child is required to attend child care instead of school for three or more consecutive days due to illness or other reasons;

(C) there is a temporary increase in work hours or the hours of an employment services activity; or

(D) there is a temporary change in the availability of a parent who usually provides care.

(2) Supplemental payments for the additional hours of child care with the same provider shall be approved if all of the following conditions are satisfied:

(A) the additional hours of care needed exceed the authorized hours as determined in subsection (b) of section 17b-749-13 of the Regulations of Connecticut State Agencies by more than twenty hours in a calendar month; and

(B) the hours of care fall within the work or employment services activity schedule including travel time; and

(C) the hours do not coincide with hours covered by an existing certificate of payment; and

(D) the additional charges reflect the provider's customary policy for all children attending the program.

(3) In addition to supplemental payments authorized under subdivision (1) of this subsection, the CCAP administrator may approve payments for a temporary alternate child care provider for up to twenty hours in a calendar month if the parent is required to use a different provider for the following reasons:

(A) the child does not attend school due to illness or other reasons and the child's regular provider can not provide the care;

(B) a temporary increase in work hours or the hours of the employment services activity that fall outside the normal operating hours of the child's regular provider; or

(C) during holiday vacations or periods during which the child's normal provider is closed or does not offer care.

(4) The parent shall submit a child care agreement form for the alternate provider and have the provider enrolled pursuant to the requirements of section 17b-749-12 of the Regulations of Connecticut State Agencies.

(5) In any calendar month, the parent shall be responsible for all costs associated with the first twenty hours of additional care. Payment shall be authorized only for the additional hours of care with the same or alternate provider that exceed twenty hours separately or in combination. The additional hours may be rounded to the nearest half hour.

(6) The amount of the supplement shall be calculated by multiplying the additional needs in excess of the twenty hours by the special hourly supplemental payment rate. The hourly supplemental payment rate shall be the weekly payment rate for full-time care established in subdivision (c) of section 17b-749-13 of the Regulations of Connecticut State agencies,

divided by forty. The payment amount shall be the lower of the calculated amount or the amount of the provider's additional charges.

(7) The total number of regularly authorized hours plus the additional hours shall not exceed sixty-five hours per calendar week or two hundred eighty hours in a calendar month. Once the approved additional hours of care exceed twenty hours, the additional hours approved for that month shall be eligible for payment.

(8) Parents shall request supplemental payments by contacting the CCAP administrator by phone or in writing, except during periods of extended school vacations where the CCAP administrator shall have the discretion to authorize payments based on information submitted by the provider for a school age child already in the provider's care. To be eligible for payment, all requests for supplemental payments shall be made within thirty days following the end of the month in which the additional hours were provided. The parent and provider shall submit any verification requested as a condition of payment eligibility. The CCAP administrator shall have thirty days to process the request for a supplemental payment once all required documentation has been submitted.

(b) **Supplemental Payments for Children with Special Needs**

(1) Parents shall be entitled to request additional payments for an eligible child with special needs pursuant to section 17b-749-11 of the Regulations of Connecticut State Agencies. Supplemental payments shall be approved to the extent the provider cannot serve the child in his or her regular program after implementing reasonable accommodations as may be required by the Americans with Disabilities Act, 42 U.S.C. § 12132 *et. seq*.

(2) Payments shall not be made for services provided by a program operated by any state or local government agency. The parent shall apply and take steps necessary to receive assistance from such programs upon the request of the CCAP administrator. The request for a special needs supplement shall be denied if the parent does not apply and take the necessary steps to obtain services.

(3) An increase in the payment rate may be granted if the child's condition requires a marked increase in the amount of care or supervision needed or special care, including but not limited to the use of special equipment, assistance with movement, feeding, toileting or the administration of medications that require specialized procedures. The child's special needs shall be clearly documented to the satisfaction of the CCAP administrator by an Individualized Education Program (IEP), or an Individualized Family Service Plan (IFSP), the child's physician or another certified health care professional who is directly involved with the child. Additional documentation may be required as necessary to establish the need for special care in the child care setting. The amount of the increase shall be equal to fifteen percent of the payment rate for a child with no special needs as determined in subsection (c) of section 17b-749-13 of the Regulations of Connecticut State Agencies. The supplement shall be included in the approved cost of care as determined in subsection (a) of section 17b-749-13 of the Regulations of Connecticut State Agencies for the purpose of calculating the monthly payment.

(4) A child with special needs may be eligible for supplemental payments for identifiable

costs charged to the parent by the provider for services specifically associated with the provision of child care to the individual child. Payments for identifiable costs shall be in addition to any increase in the payment rate authorized pursuant to subdivision (3) of this subsection. Services and costs that may be eligible for payment shall include, but not be limited to the following:

(A) rental of equipment needed to provide appropriate care, such as maintenance apparatus that assists in breathing, feeding or toileting as prescribed by a therapist, physician or other state certified specialist and that is not transportable and cannot be provided by the parent;

(B) special furniture, materials or supplies used on a routine basis as prescribed by a therapist, physician or other certified specialist and that are not provided by the parent; and

(C) a personal child care attendant for prescribed periods;

(D) specialized training needed to care for the child that is not otherwise available without charge.

(5) Supplemental payments for identifiable costs shall not be approved for special transportation services, special education, therapeutic services or other costs not directly related to the provision of child care, the cost of diapers, supplies or other items provided by the parent, facility improvements, equipment, materials or expenses for services or accommodations that are or would be available to all children enrolled in the facility and that cannot be categorized as assistance to the parent.

(6) The maximum payment for identifiable costs in any month shall not exceed twenty percent of the standard payment rate for a child of the same age and approved hours of care with no special needs as determined in subsection (c) of section 17b-749-13 of the Regulations of Connecticut State Agencies. Any costs incurred during a month that exceed twenty percent of such rate shall be the responsibility of the parent and shall not carry over as billable charges to the department in subsequent months. The commissioner may disapprove payments for identifiable costs where the cost of supporting the child in the child care setting is determined unreasonable or excessive relative to services available from other similar providers, vendors or through other means.

(7) The parent and provider shall submit a written request to the CCAP administrator that includes a description of the additional services, why they are needed, verification of the cost of the services and the payment schedule where applicable. The request shall be co-signed by the parent.

(Adopted effective July 10, 2001)

Sec. 17b-749-17. Payment adjustments

(a) **Child's Attendance**

(1) Occasional absences from care shall not affect the amount of the payment unless the provider charges less due to the reduced hours. Providers shall, however, report the number of days the child attended care and any reduction in charges due to absence. Providers shall charge parents in accordance with the provider's customary attendance policy for children

who do not receive CCAP assistance.

(2) Parents may be required to document the reason the child did not attend care if the child is frequently absent for twenty-five percent or more of the scheduled days. Continued absences equal to or exceeding the twenty-five percent threshold may cause the approved hours of care to be recalculated based on the child's utilization pattern if the absences continue for two or more months. The approved hours shall be readjusted if the condition that caused the recurring absences changes.

(b) **Liens, Overpayment Recoupments and Child Support Wage Executions**

The CCAP administrator shall reduce payments as necessary to fulfill legal responsibilities related to properly filed liens, overpayment recoupments and child support wage executions. Overpayments shall be recouped in accordance with the requirements of section 17b-749-20 of the Regulations of Connecticut State Agencies.

(c) **Discretion to Withhold for Employment Related Obligations**

(1) Parents shall be informed that there may be state and federal requirements to withhold employment related obligations from wages paid by parents to in-home child care providers to the extent the provider is not considered to be self-employed or a self-contractor, and is considered to be the employee of the parent.

(2) The CCAP administrator may, if requested by commissioner, deduct amounts for employment related obligations from benefit payments for in-home child care services if parent of the child for whom the benefit is paid is determined to be the employer of the provider. Any amounts withheld shall be properly deposited with the appropriate federal or state agency. Parents and providers shall receive notice of all deductions made in accordance with this subdivision.

(Adopted effective July 10, 2001)

Sec. 17b-749-18. Continued eligibility

(a) **Optional Monthly Verification of Participation in Activities**

(1) The commissioner may require parents to submit verification of their activity schedules monthly. The decision to require more frequent verification of participation in activities shall be based on the following criteria:

(A) CCAP case error profiles; or

(B) whether the activity schedule or the parent's history of participation fluctuates in a manner that requires frequent or continuous monitoring.

(2) Verification shall be due on the tenth day of each month. The requirement may be waived in the redetermination month based on verification submitted with the redetermination. Families not submitting verification by the end of the month shall become ineligible.

(3) The CCAP administrator shall issue a reminder notice to all parents who did not submit verification by the tenth day of the month. The notice shall inform parents that assistance will be discontinued if the verification is not received by the last day of the month. Discontinued families who submit the required verification within ten days of the

discontinuance date shall be reinstated retroactive to the date of discontinuance if continued eligibility is established.

(b) **Redeterminations**

(1) Eligibility shall be redetermined at intervals not to exceed six months from the month assistance is granted or from the last redetermination. The CCAP administrator shall establish the length of the redetermination period based on the stability of family circumstances and may conduct unscheduled reviews due to anticipated changes in household circumstances. Eligibility shall terminate at the end of the redetermination month unless the redetermination is completed and the family is determined eligible.

(2) Parents shall complete a new application using a form specified by the CCAP administrator and shall submit verification and have their redeterminations processed in the same manner as at the time of initial application. Parents shall not be required to re-verify circumstances that have already been verified and are not questionable or subject to change.

(3) Parents and their child care provider(s) shall be notified of the redetermination between forty-five and sixty days prior to the last day of the redetermination month. Parents shall have a minimum of fifteen days from the date the redetermination form is mailed to return the form to the CCAP administrator. The redetermination form shall be due on the first day of the redetermination month.

(4) Redeterminations forms submitted timely shall be processed by the end of the redetermination month. Redetermination forms submitted after first day of the redetermination month shall be considered late and shall be processed in the same manner as a new application. The CCAP administrator shall have thirty days from the date the form is received to process a redetermination that is submitted late, unless processing is delayed in accordance with the requirements of subsection (c) of section 17b-749-09 of the Regulations of Connecticut State Agencies. Parents shall be issued a reminder notice if the redetermination is not submitted on time. The CCAP administrator shall give priority to processing redeterminations forms that are submitted late.

(5) Families who submit redeterminations forms late, but by the tenth day following end of the redetermination month, shall not be assigned to the wait list if the CCAP program is closed to the family's priority group at the time eligibility is determined. If eligible, the family shall be approved for participation. Families who are denied shall be entitled to have their redeterminations reopened in accordance with the requirements of subsection (e) of section 17b-749-09 of the Regulations of Connecticut State Agencies. Redeterminations are denied and later reopened shall be granted retroactive to the first day of the month following the end of the prior redetermination period if the family is eligible.

(6) Parents and providers shall be notified of the results of the redetermination.

(Adopted effective July 10, 2001)

Sec. 17b-749-19. Changes in eligibility or benefits

(a) **Reporting and Processing Changes**

(1) Parents shall report changes in household circumstances and child care arrangements

to the CCAP administrator within ten days of the date of the change. Changes may be reported by phone, in writing, or electronically as authorized by the department.

(2) Program and payment eligibility shall continue in accordance with the requirements of this section. Families shall remain eligible until the parent withdraws from the program or until the family no longer meets the eligibility requirements of the CCAP program. Providers shall remain eligible as long as they meet the requirements of section 17b-749-12 of the Regulations of Connecticut State Agencies.

(3) Changes in eligibility or benefits shall be processed in accordance with the requirements of this section and sections 17b-749-02 to 17b-749-23 of the Regulations of Connecticut State Agencies, inclusive. Prompt action shall be taken to determine the effect of a change whenever the CCAP administrator becomes aware that a change has occurred. To be considered prompt, action shall be taken within ten days of the date of the CCAP administrator becomes aware of the change in circumstances.

(b) **Termination of Program Eligibility**

(1) Eligibility for the program shall end if the family no longer meets the CCAP eligibility requirements, if eligibility cannot be established because the parent did not provide requested information or if the parent did not comply with the eligibility or quality control processes. Eligibility for the program shall end on the last day of the month in which the change occurs, unless advance notice is required pursuant to subsection (c) of section 17b-749-07 of the Regulations of Connecticut State Agencies. If advance notice is required, program eligibility shall end on the last day of the month in which the notice of adverse action expires.

(2) Families who were granted assistance without an approved provider shall become ineligible for CCAP if they do not submit the information needed to determine payment eligibility for at least one child within thirty days pursuant to the requirements of subdivision (c)(4) of section 17b-749-09 of the Regulations of Connecticut State Agencies. Eligibility shall end at the end of the month in which the thirtieth day falls.

(c) **Determinations of Provider Ineligibility by the Department**

(1) Eligibility for payment shall end if the department determines that the child care provider does not meet the requirements specified in section 17b-749-12 of the Regulations of Connecticut State Agencies. Eligibility for payment shall terminate on the date the parent and provider are notified of the change. Any outstanding payments to the provider may be withheld pursuant to subdivision (c)(4) of section 17b-749-12 of the Regulations of Connecticut State Agencies.

(2) A provider shall be considered ineligible as of the date the provider did not meet the eligibility requirements established for providers. Payments issued during a period when the provider was ineligible shall be considered overpayments and shall be subject to recoupment pursuant to the requirements of section 17b-749-20 of the Regulations of Connecticut State Agencies.

(3) Parents shall be given thirty days from the date of notification to submit a child care agreement form for the new provider. Payment for the new provider may begin retroactive

to the date the services started if the information needed to enroll the provider is submitted timely. If the information is not submitted timely, payment shall begin on the date the information is submitted or the date the services begin, whichever is later. Eligibility for the program shall end on the last day of the month in which the thirtieth day falls if the child care agreement form is not submitted by the end of that month and there are no other children in the family who are eligible for payment.

(d) **Decreasing Benefits or Terminating Payments**

(1) Changes that cause payments to be reduced or terminated shall take effect on the following dates, unless otherwise specified in this section:

(A) the date the action is taken if advance notice is not required; or

(B) the day after the notice of adverse action expires if advance notice is required; or

(C) within ten days of the date of an administrative hearing decision if action was delayed pending the hearing, and the department's decision is upheld.

(2) Increased fees shall take effective on the first day of the family's next redetermination period pursuant to subsection (f) of section 17b-749-13 of the Regulations of Connecticut State Agencies.

(3) If benefits are terminated because a child reaches the maximum age limit for the program, payments shall end on last day of the month in which the child turns age thirteen, or age nineteen for a child with special needs. Eligibility shall continue for the family unless there are no other eligible children in the home.

(e) **Adding Children and Increasing Payments**

(1) With the exception of benefit increases that are due to a reduction in the family fee, changes that result in increased payments or payment eligibility for a new child shall take effect on the date the change is reported if the change is verified timely. If the change is not verified timely, the change shall take effect on the date the change is verified unless good cause exists for not providing timely verification pursuant to subsection (e) of section 17b-749-06 of the Regulations of Connecticut State Agencies. The parent shall not be eligible for a supplemental payment to replace any benefits that would otherwise have been paid if the parent had submitted the verification timely.

(2) Decreases in fees shall be implemented in accordance with the requirements of subsection (f) of section 17b-749-13 of the Regulations of Connecticut State Agencies.

(f) **Changing Providers**

(1) Parents may change providers at any time. The certificate of payment for the current provider shall expire on the date services ended or the date the CCAP administrator issues written notice to the provider if the change is reported after services ended. Payments for the new provider shall not begin prior to the date the current certificate of payment expires. To avoid a lapse in coverage, parents shall report changes in providers to the CCAP administrator at least ten days in advance of the date of the change.

(2) Parents who change providers shall be given fifteen days to submit a child care agreement form for the new provider. Eligibility shall terminate at the end of the month in which the fifteenth day falls if the child care agreement form is not submitted by the end of

that month and there are no other children in the family who are eligible for payment. If the child care agreement form is submitted late but before eligibility is terminated, the change shall be effective on the date the form is submitted or the date services began, whichever is later. Good cause provisions shall not apply. If eligibility is terminated, the parent shall reapply for the program.

(g) **Extended Program or Payment Eligibility**

(1) Otherwise eligible families who timely report the loss or interruption of employment, an employment services activity or attendance in a high school program shall, upon request, be granted an extended period of program eligibility pursuant to the requirements of this subsection. To qualify, the parent shall report the change to the CCAP administrator within ten days of the date of the interruption without exception. Eligibility for payments during the extended eligibility period shall be determined separately in accordance with the requirements of subdivision (6) of this subsection.

(2) If employment is terminated or unpaid leave is taken due to pregnancy, an additional four months of program eligibility shall be granted if the parent intends to return to work by the end of the four month period.

(3) If employment is terminated or leave is taken due to an extended illness or other circumstances covered under the Family and Medical Leave Act, an additional three months of program eligibility shall be granted if the parent intends to return to work on a regular basis by the end of the three month period.

(4) If the activity is interrupted when school closes for the summer vacation, an extended period of program eligibility shall be granted to cover the period of time school is closed.

(5) In all other circumstances where a parent timely reports a temporary interruption in employment or an employment services activity, an additional month of program eligibility shall be granted under the following conditions:

(A) if the parent is expected to resume the activity by the end of the month following the month in which the interruption occurred; or

(B) if the parent terminated employment and is actively seeking a new job or has received a bona fide offer of employment that is scheduled to begin by the end of the month following the month in which the prior activity ended; or

(C) if the parent is expected to begin a new employment services activity by the end of the month following the month in which the current activity ended and the parent continues to receive TFA cash assistance during this period; and

(D) if the parent is capable of participating in the activity.

(6) Parents who meet the conditions specified in subdivision (5) of this subsection shall be eligible for payments during the period of extended eligibility if the parent verifies that payment is needed to prevent the loss of a slot in a school-based child care program or a licensed child care setting and the child continues to attend child care. Payments shall not be approved for families granted extended program eligibility pursuant to subdivisions (2) through (4) of this subsection, if the child does not attend care, or if care is given in a setting that is not school-based or licensed.

(7) Otherwise eligible families who timely report the loss of the need for care during the summer while their children attend temporary no cost alternative child care, such as a summer camp, shall remain eligible for the program for up to three calendar months if assistance will be needed by the end of the summer period.

(h) **Changes during Extended School Vacations or Affecting the General Caseload**

The department may establish special procedures for processing changes that occur as the result of school vacation periods or other changes that affect the general caseload, including specific reporting deadlines, timeframes for processing changes and issuing payments. The CCAP administrator shall provide adequate notice to parents and providers of any actions they are required to complete under this subsection.

(Adopted effective July 10, 2001)

Sec. 17b-749-20. Benefit errors

(a) **Underpayments and Overpayments**

(1) The CCAP administrator shall take prompt action in accordance with the requirements of this section whenever an error occurs that causes benefits to be underpaid or overpaid.

(2) Underpayments occur when the parent does not receive all the benefits to which the family is entitled due to an administrative error made by the department, the CCAP administrator or upon submission of satisfactory documentation of an error made by the Department of Labor or its designee for a family participating in an employment services activity. The evidence shall clearly demonstrate that an administrative error occurred. Errors caused by the family or the provider shall not be considered underpayments, except when a provider makes a billing error on an invoice and the CCAP administrator is notified of the error within thirty days of the date the payment is issued to the provider.

(3) Overpayments occur whenever the amount paid exceeds the benefit that would have been paid if the payment had been calculated correctly based on accurate information that was reported, verified and acted on in a timely manner. The cause of each overpayment shall be classified as administrative, parent or provider caused. Parent and provider caused overpayments shall be further classified as intentional or unintentional.

(4) No overpayment shall exist if the difference between the benefits paid on behalf of the family and the correct benefit amount is less than ten dollars in any month.

(b) **Administrative Errors**

(1) An overpayment or underpayment shall be classified as an administrative error if the error was caused solely by actions taken by the department, the CCAP administrator or the Department of Labor or its designee. Administrative errors shall include, but not be limited to the following types of errors:

(A) errors caused by delays in processing applications or taking prompt action on changes that were reported timely;

(B) errors in determining eligibility, the benefit amount or the payment authorization period;

(C) data entry errors;

(D) errors caused by the incorrect application of state regulations, policy or procedures; and

(E) fraud committed by an individual who works for the CCAP program.

(c) **Errors Caused by Parents and Providers**

(1) Overpayments that are not due to administrative error shall be classified as parent or provider caused.

(2) Overpayments caused by the parent shall include, but not be limited to errors caused by reporting false or inaccurate information, delays in reporting changes in household circumstances or provider arrangements, or excess payments made as the result of a request to continue benefits pending an administrative hearing.

(3) Overpayments caused by the provider shall include, but not be limited to the following types of errors:

(A) inaccurate reporting of information concerning licensing status, age or other provider eligibility requirements;

(B) inaccurate reporting of the provider's relationship to the child or the location at which care is given;

(C) inaccurate reporting of household circumstances;

(D) committing an illegal act, such as cashing a replacement check after falsely claiming that the original check was lost, stolen or destroyed;

(E) inaccurate reporting of actual charges, attendance or dates of service; and

(F) any other false claim for goods or services provided as enumerated in section 53a-290 of the Connecticut General Statutes.

(4) The error shall be classified as both parent and provider caused if the parent and the provider both had knowledge and actively participated in the action that caused the overpayment to occur.

(5) The CCAP administrator shall make a preliminary determination of whether the overpayment was intentional or unintentional pursuant to guidelines established by the department. Overpayments shall be classified as intentional if the parent or provider knowingly withheld or provided false information on matters affecting eligibility, benefits or a claim for services. An overpayment shall be considered unintentional under the following circumstances:

(A) if there was clearly no intent to commit fraud or to obtain benefits or payments under false pretenses;

(B) if the parent or provider did not purposefully withhold or provide erroneous information;

(C) if illness, a family emergency or other good cause reasons exist for not reporting information timely or accurately; or

(D) if the error was due to a delay in taking action as the result of an administrative hearing request.

(6) Where the CCAP administrator makes a preliminary determination that a parent or

provider may have committed fraud, the case may be referred as appropriate to the Office of the Attorney General, the Office of the Chief State's Attorney or for an administrative disqualification hearing. Administrative disqualification hearings shall be conducted in accordance with the requirements of section 17b-749-22 of the Regulations of Connecticut State Agencies.

(7) A final determination that an error was intentional shall be made only as the result of a decision by a court or administrative hearing official, or if the parent waives his or her right to an administrative hearing. If the error was intentional, the CCAP administrator shall disqualify the family or the provider from participating in CCAP for the period specified in subsection (h) of this section.

(d) **Calculating the Error**

(1) Benefit errors shall be calculated by comparing the benefits paid during the applicable benefit period to the payment that would have been payable if eligibility and payment had been calculated correctly. The difference between the correct benefit and the amount actually paid shall be the amount of the error.

(2) If benefits are underpaid due to an administrative error, the amount owed shall be paid within sixty days of the date the error was discovered, unless information needed to calculate the correct payment is pending or if the family or provider has an outstanding overpayment. The amount of the underpayment shall first be used to offset an outstanding overpayment.

(3) Underpayments shall be corrected regardless of whether the family's case is active or closed. The parent and provider shall be notified of the determination.

(4) For overpayments caused by the parent or provider that are unintentional, the error shall begin on the first day of the month following the month in which the circumstances that caused the overpayment occurred.

(5) For administrative overpayments, the overpayment shall begin on the first day of the month following the month in which the circumstances that caused the overpayment occurred, unless action would have been taken after that date due to a required period of advance notice. If advance notice would have been required, the overpayment shall begin on the day after the period of notice of adverse action would have expired. To determine this date, the CCAP administrator shall assume that the notice of adverse action would have been issued on the day sufficient information existed to warrant taking the proposed action.

(6) For intentional errors, the overpayment shall begin on the date the circumstances that caused the overpayment occurred without regard to advance notice requirements. If the CCAP administrator fails to take timely action to correct the overpayment following discovery of the error, any benefits overpaid as the result of the administrative delay shall be considered administrative error.

(e) **Responsibility for Repayment**

(1) The parent shall be responsible for repaying the overpayment unless the overpayment was caused solely by the provider. If the parent is responsible for the overpayment and recoupment is initiated by reducing the parent's monthly benefits, the provider may require

the parent to pay the difference between the regular payment and the reduced amount.

(2) If the provider is solely responsible for the error, the provider shall repay the overpayment. Providers shall not increase charges for children subsidized by CCAP to compensate for the loss of income due to the recoupment of an overpayment caused by the provider.

(f) **Notice of Overpayment**

The party responsible for the overpayment shall be provided with advance notice of the overpayment, the amount and repayment options. The responsible party shall be asked to select a repayment method as outlined in subsection (g) of this section. If the parent is responsible for repaying the overpayment, the provider shall be notified in advance of the proposed change in benefits. Written notice to the parent shall not be required if the provider is responsible for repaying the overpayment.

(g) **Methods of repayment**

(1) If the recoupment method and rate has not been set by a court, the CCAP administrator shall first attempt to recover overpayments by a lump sum repayment or by offsetting the amount of the overpayment against any benefits owed as the result of an underpayment. If the parent or provider does not agree to a lump sum repayment, the CCAP administrator shall reduce the parent's or the provider's ongoing payments by the lessor of the following amounts until the overpayment has been recouped:

(A) ten percent of the parent's monthly benefits or the provider's monthly payment if the overpayment was due to an administrative or unintentional error; or

(B) twenty-five percent of the parent's monthly benefits or the provider's monthly payment if the overpayment was due to an intentional error.

(2) The percentage reduction shall be applied to each child for whom the parent receives CCAP assistance or who are in the provider's care. Recoupment shall be initiated automatically if the parent or provider does not respond to the advance notice.

(3) If the parent or provider do not actively receive CCAP payments, the department shall attempt to recover the overpayment by establishing a monthly billing schedule.

(4) If the parent or provider does not comply with the repayment plan, the commissioner may, to the extent allowed by law, take whatever action deemed appropriate to recover such overpayment.

(h) **Disqualification Penalties in Fraud Cases**

(1) Parents who are overpaid due to an intentional error may be referred to an administrative disqualification hearing or to a court of appropriate competent jurisdiction if the CCAP administrator determines that the parent may have committed fraud. Child care providers shall not have the right to an administrative hearing.

(2) The CCAP administrator shall impose a disqualification penalty on the family if the parent is found to have knowingly committed fraud in connection with obtaining benefits from CCAP. A penalty shall be imposed only after a final determination that the parent committed fraud has been made pursuant to the requirements of subsection (a) of section 17b-749-22 of the Regulations of Connecticut State Agencies.

(3) For the first finding of fraud committed by a parent, the period of ineligibility shall be three months from the date the notice of disqualification is issued or from the date the family's benefits are discontinued, whichever is later. For the second finding of fraud, the disqualification period shall increase to six months. For any subsequent finding, the disqualification period shall be one year for each occurrence.

(4) Child care providers convicted of committing vendor fraud by an appropriate court of competent jurisdiction shall be permanently disqualified from participation pursuant to the requirements of sections 17b-99 and 53a-290 of Connecticut General Statutes.

(5) Parents may reapply and be approved for assistance at the conclusion of the disqualification period.

(Adopted effective July 10, 2001)

Sec. 17b-749-21. Administrative hearings

(a) **Hearing Authority**

Administrative Hearings shall be conducted by the department in accordance with the provisions of Chapter 54 of the Connecticut General Statutes.

(b) **Right to an Administrative Hearing**

(1) Parents shall have the right to request an administrative hearing if they are aggrieved by an action taken by the department, except in situations specified in subdivision (d)(2) of this section. Child care providers shall not have the right to an administrative hearing. A parent may request an administrative hearing if the parent is aggrieved by an action taken against a child care provider to the extent such action was not the result of a decision by the Department of Public Health to deny, suspend or revoke the provider's license.

(2) The request for an administrative hearing shall be made within sixty days of the date the parent was provided with written notice of the action.

(c) **Aid Continuing Pending a Hearing**

(1) Action to discontinue or reduce benefits shall be delayed until the administrative hearing decision is rendered under the following circumstances:

(A) if the parent requests a hearing within ten calendar days of the date the notice of adverse action is issued;

(B) if the action being taken is subject to an administrative hearing;

(C) if the action does not involve termination of payments due to the ineligibility of the child care provider; and

(D) if the parent requests benefits to continue.

(2) If the administrative hearing officer rules in favor of the Department, any benefits paid in error as the result of the delayed action shall be subject to recoupment.

(d) **Reasons for Requesting an Administrative Hearing**

(1) An administrative hearing may be requested if the family disagrees with any of the following actions, except where otherwise specified in subdivision (2) of this subsection:

(A) an application is denied or not acted upon timely;

(B) benefits are denied, reduced or discontinued;

(C) the receipt of benefits is adversely affected in any way;
(D) an eligibility requirement is imposed incorrectly;
(E) the amount of the income, fee or benefit calculation is incorrect;
(F) disapproval of an in-state child care provider for a reason not related to a violation of the Department of Public Health licensing requirements;
(G) a request for replacement of a lost, stolen or destroyed check was refused; or
(H) a requested good cause exemption of the child support requirements was denied.
(2) Families shall not be entitled to an administrative hearing for the following actions:
(A) when changes required by state or federal law are implemented that affect the general caseload or a specific priority group;
(B) if benefits are affected due to a change in the sliding fee scale or changes in the regional payment rates;
(C) if the commissioner opens or closes the wait list for a specific priority group or removes a priority group from the wait list;
(D) if the commissioner denies payment for a provider located in an adjoining state; or
(E) if the CCAP program is closed.
(e) **Notice Requirements**
(1) Parents shall be informed in writing of the following information any time action is taken to grant, deny, discontinue or modify benefits:
(A) the right to request an administrative hearing and the method by which an administrative hearing can be requested;
(B) that action may be delayed if a hearing is requested within ten days of the date the notice of adverse action is issued, and that any benefits paid in error as the result of the delay will be subject to recoupment if the administrative hearing official upholds the department's decision;
(C) that the family may represent itself or be represented by legal counsel, a relative, friend, or other spokesperson;
(D) the right to request resolution of the issue through someone not directly involved with the parent's case; and
(E) the availability of legal services and the toll free telephone number of statewide legal service organizations.
(2) The administrative hearing official shall notify the parent and the parent's representative of the following information:
(A) the time and place of the administrative hearing;
(B) the department's contact person;
(C) circumstances under which the hearing request may be dismissed;
(D) administrative hearing procedures; and
(E) the right to examine the case record prior to and during the administrative hearing.
(3) The CCAP administrator shall prepare a written summary of actions over which the parent is aggrieved and the reason for taking the action. The summary shall be distributed at least three business days prior to the date of the scheduled hearing to the administrative

hearing officer and the parent or the parent's representative.

(f) **Scheduling and Location of the Administrative Hearing**

(1) The department shall schedule the administrative hearing within thirty days of the date the request is received. One continuance shall be granted to the parent for good cause as determined by the administrative hearing official. Additional continuances may be granted at the discretion of the administrative hearing official. The deadline for issuing a decision shall be extended by the length of the continuance.

(2) If the issue is resolved prior to the administrative hearing, the hearing shall be held unless the parent or his or her representative withdraws the request in writing or through other communication with the administrative hearing official.

(g) **Delegation of Authority to an Administrative Hearing Official**

(1) The commissioner may delegate authority to conduct administrative hearings, find facts, reach conclusions and make final decisions on his behalf to a discrete unit of the department or other person not personally involved in the decision that is the subject of the administrative hearing. The commissioner may limit the scope of the delegated authority in a directive that the authority is limited to conducting an administrative hearing.

(2) The administrative hearing official shall be an employee of the department who has not personally acted as an investigator in the contested case, including an eligibility supervisor, caseworker or other individual with a personal interest in the case. The role of the administrative hearing official shall consist of scheduling the hearing and conducting the hearing, facilitating the hearing process and rendering a decision on behalf of the department.

(3) If the administrative hearing issue concerns a medical condition, disability or a child with special needs, the hearing official may order an independent medical assessment or evaluation from a source mutually satisfactory to the parent and the department. The department shall be responsible for paying for the independent assessment.

(h) **Rights at an Administrative Hearing**

(1) Subject to the limitations specified in subsection (e) of section 17b-749-02 of the Regulations of Connecticut State Agencies, the parent or his or her representative shall have the right to examine the case record and all documents to be used by the department at the administrative hearing before and during the administrative hearing.

(2) The parent may present his or her case or have it presented by legal counsel or another person representing the family.

(3) The parent shall have the opportunity to question or refute testimony, to present evidence, to confront and cross-examine adverse witnesses or to bring witnesses.

(4) The parent shall have the opportunity to present an argument without undue interference.

(i) **Attendance at the Hearing**

(1) The hearing shall be attended by an individual representing the department, the parent or the parent's representative pursuant to section 17b-60 of the Connecticut General Statutes.

(2) Both parties may call witnesses, except the administrative hearing official may restrict

attendance when necessary to protect confidentiality.

(j) **The Administrative Hearing Record**

(1) The administrative hearing record shall consist of the hearing request, notices issued by the administrative hearing official, the transcript or recording of testimony, exhibits, all papers and requests filed in the proceeding and the hearing decision.

(2) The administrative hearing record shall be made available to the parent at a reasonable time for copying and inspection.

(k) **Hearing Decision**

(1) A decision shall be rendered within sixty days of the close of the hearing record based exclusively on evidence introduced at the hearing and contained in the hearing record.

(2) The decision shall be issued in writing to the parent, the parent's representative and to the CCAP administrator.

(3) The decision shall be considered binding upon the department, unless the department elects to reconsider the decision as described in subsection (*l*) of this section.

(4) The decision shall serve as a final resolution to the issue unless the parent appeals to a court of competent jurisdiction within forty-five days of the date the decision is issued pursuant to subsection (n) of this section.

(5) The hearing record shall be available for public inspection and copying, subject to the limitations of subsection (e) of 17b-749-02 of the Regulations of Connecticut State Agencies.

(*l*) **Reconsideration of the Decision**

(1) The parent or his or her representative shall have fifteen days from the date the hearing decision is issued to request the commissioner or his designee to reconsider the decision. Pursuant to section 4-181a of the Connecticut General Statutes, an administrative hearing decision shall warrant reconsideration if an error or fact of law should be corrected, if new evidence is discovered that materially affects the merits of the case which was not presented at the administrative hearing for good reason or if there is other good cause for reconsidering the decision.

(2) The commissioner or his designee shall have twenty-five days from the date the request is received by him to decide whether reconsideration is warranted.

(3) The Department may on its own initiative decide to reconsider the decision within forty days of the date of the decision was issued.

(4) If reconsideration is warranted, the parent and his or her representative shall be notified that the department plans to conduct additional proceedings as may be necessary to render a new decision.

(m) **Implementation of Administrative Hearing Decision**

(1) The department shall implement the appropriate changes or corrections within the timeliness standards for processing changes, unless otherwise specified by the administrative hearing official. Any benefits owed to the family shall be promptly restored.

(2) If the department is upheld, action shall be taken to recover any benefits that the family may have improperly received.

(n) **Appealing the Decision**

The parent or his or her representative has the right to appeal an administrative hearing decision to superior court in accordance with the requirements of section 17b-61 of the Connecticut General Statutes.

(Adopted effective July 10, 2001)

Sec. 17b-749-22. Administrative disqualification hearings

(a) **Hearing Process**

(1) The department shall have the option of referring a case for an administrative disqualification hearing if the CCAP administrator determines that an overpayment was caused as the result of an intentional error by the parent to commit fraud in obtaining benefits from CCAP. The purpose of the administrative disqualification hearing is to determine if the error was intentional. The standard of proof that the administrative hearing officer shall use in making his or her decision is by clear and convincing evidence. The administrative disqualification hearing process shall be conducted in the same manner as an administrative hearing and is subject to requirements of section 17b-749-21 of the Regulations of Connecticut State Agencies, except as otherwise stated in this section.

(2) The CCAP administrator shall treat overpayments caused by the parent as unintentional until an appropriate authority has confirmed the preliminary decision that the error was intentional. The CCAP administrator shall not impose a disqualification penalty until the decision that the error was intentional becomes final. The decision that the error was intentional shall become final under the following conditions:

(A) if a court of competent jurisdiction finds that the parent has committed fraud or grants accelerated rehabilitation; or

(B) if an administrative hearing officer determines that the error was intentional; or

(C) if the parent waives his or her right to an administrative disqualification hearing.

(3) If the administrative hearing officer determines that the error was not intentional, the overpayment shall be treated as unintentional or as an administrative error based on the results of the hearing. If the parent is found to have committed an intentional error, the family shall be subject to a disqualification penalty as specified in subsection (h) of section 17b-749-20 of the Regulations of Connecticut State Agencies.

(b) **Cases Referred for Administrative Disqualification Hearings**

(1) A parent's case may be referred for an administrative disqualification hearing under the following circumstances:

(A) if a preliminary determination has been made that the parent knowingly and willfully intended to commit fraud to obtain benefits from CCAP; and

(B) if the case is not being referred to the state police, a prosecuting authority or to the attorney general; or

(C) if the case was referred and has been rejected for prosecution.

(2) The parent's case shall not be referred for an administrative disqualification hearing while the case is under consideration for referral to the state police, a prosecuting authority

or the attorney general, or if a court of competent jurisdiction has determined that the parent is not guilty or has dismissed the case.

(c) **Notification**

(1) The administrative hearing official shall notify the parent in writing that an administrative disqualification hearing has been scheduled. The notice shall be sent to the parent by certified mail at least thirty days prior to the scheduled hearing date. Notice shall be assumed to have been given unless the certified mail return receipt is returned stamped as "undeliverable as addressed" or "forwarding address has expired."

(2) The notice shall contain the following information:

(A) the time, date, and place of the hearing;

(B) a statement of the reasons for the hearing;

(C) a summary of the evidence upon which the hearing is being held and how and where the evidence can be examined;

(D) a warning that the decision will be based solely on the information provided by the CCAP administrator if the parent does not appear at the hearing;

(E) a statement of the parent's administrative hearing rights;

(F) a statement that the hearing does not preclude additional civil or criminal action;

(G) a statement of the availability of free legal representation;

(H) a statement of the availability of a new hearing in the event there is good cause for the individual not to attend the scheduled hearing; and

(I) an invitation to contact the department if additional information is needed.

(d) **Pre-Hearing Interview**

(1) The CCAP administrator shall send parents referred for an administrative disqualification hearing a notice scheduling a pre-hearing interview and a waiver of administrative disqualification hearing form. The pre-hearing interview shall be conducted by the CCAP administrator at an office of the department closest to where the parent lives. The CCAP administrator shall make a reasonable attempt to accommodate a request made by the parent with regard to the hearing date and time.

(2) The purpose of the pre-hearing shall be to provide the parent with the opportunity to review the evidence supporting the CCAP administrator's allegations, to receive an explanation of the hearing process and to dispute the CCAP administrator's findings. The CCAP administrator shall provide the parent with a detailed explanation of the following information:

(A) the evidence supporting the overpayment and the determination that the error was intentional;

(B) the administrative hearing process and the parent's administrative hearing rights;

(C) the waiver process, including that the parent's right to waive the hearing, the right to change the decision to waive the hearing within 10 days, and the fact that signing the waiver is not an admission of guilt; and

(D) the recoupment or disqualification penalty that will be applied if the parent signs the waiver.

(3) Failure to appear at the pre-hearing interview shall not serve as a basis for delaying the administrative disqualification hearing. A parent who does not appear at the pre-hearing interview shall be sent a formal notice of the scheduled hearing, unless the parent has submitted a signed waiver of his or her right to a hearing.

(e) **Waiver of Right to Administrative Disqualification Hearing**

(1) The parent shall have the option to waive his or her right to an administrative disqualification hearing. Waiver of the right to a hearing shall result in the same penalties as would be imposed if a determination of guilt had been rendered by an administrative disqualification officer or a court of law, including benefit reduction and discontinuance penalties. The CCAP administrator shall provide the parent with a waiver form. The form shall include the following information:

(A) the date by which the waiver shall be signed and returned to the department;

(B) the address where the form shall be returned;

(C) a statement of the right of the individual to remain silent and avoid self-incrimination;

(D) an option to select admission or denial of guilt;

(E) a place for the parent's signature and date;

(F) that a benefit reduction or disqualification penalty will automatically be imposed if the waiver is signed, even if the parent does not admit guilt;

(G) that waiver of the right to an administrative disqualification hearing results in the same penalties as would be imposed in the event of a determination of guilt by an administrative disqualification hearing officer or a court of law, regardless of whether or not the waiver form indicates an admission of guilt;

(H) the fact that the individual may withdraw the waiver within 10 days of the date signed; and

(I) telephone numbers for additional information and for free legal services.

(2) The parent may withdraw the waiver by submitting a written statement to the administrative hearing officer within ten days of the date the waiver form was signed. If the parent does not withdraw the waiver in a timely manner, the department shall proceed with scheduling the hearing.

(f) **Time Limits**

(1) The hearing shall be held and a decision rendered within ninety days from the date the notice of the hearing is mailed to the parent, barring continuances and extensions of the close of the hearing record.

(2) The parent or the parent's representative may request and receive a postponement of the scheduled hearing for good cause as determined by the administrative hearing official. The hearing shall not be postponed for more than thirty days.

(g) **Consolidation of Administrative Hearings with Administrative Disqualification Hearings**

(1) The administrative hearing officer may combine an administrative hearing and an administrative disqualification hearing into a single hearing if the factual issues arise out of the same or related circumstances and the parent receives prior notice that the hearings

will be combined.

(2) If the single hearing is held for the purpose of settling the amount of the overpayment as well as determining whether intentional recipient error occurred, the parent shall not be entitled to a separate hearing to contest the amount of the overpayment.

(h) **Hearing Format**

(1) The hearing shall be conducted in accordance with the requirements of section 17b-749-21 of the Regulations of Connecticut State Agencies.

(2) The hearing official shall advise the parent or the parent's representative of the right to remain silent during the hearing.

(3) If the parent or the parent's representative cannot be located or fails to appear at a hearing without good cause, the hearing shall be conducted without the parent being represented. If the parent does not appear at the hearing and is not represented by another person, the hearing official shall make a decision based on the evidence presented.

(i) **Good Cause for Failure to Appear at Hearing**

(1) A new hearing shall be scheduled if the parent had good cause for failing to appear. The parent or his or her representative shall submit a good cause request to the administrative hearing official within ten days of the date of the original hearing.

(2) Good cause reasons for not appearing at the hearing shall include, but not be limited to illness of the individual or immediate family member, a family emergency, severe weather or the unavoidable loss of transportation where there was no alternative immediately available.

(3) The administrative hearing official shall decide if good cause exists and enters the decision into the hearing record. If good cause exists, the administrative hearing official who presided at the initial hearing shall schedule a new hearing. The decision reached as the result of the original hearing shall be rendered null and void when a new hearing is scheduled.

(j) **Hearing Decision**

(1) The administrative hearing official shall issue a written decision within ninety days from the date the notice scheduling the hearing was mailed to the parent. The decision shall identify the evidence used to make the decision, specifies the reasons for the decision, cites relevant policy or regulation, responds to the reasoned arguments made by the parent or his or her representative and specifies the penalty.

(2) If a disqualification penalty is imposed, the effective date and length of the disqualification period shall be specified.

(k) **Appealing the Decision**

(1) The parent shall be entitled to an administrative hearing to dispute an intended action to reduce or terminate benefits or if the parent disagrees with the recoupment plan. The parent shall not be entitled to an administrative hearing to dispute the findings of the administrative disqualification hearing official or the penalty imposed.

(2) The parent may contest the hearing official's decision by appealing to the Superior Court within forty-five days of the date the hearing official issues the decision. The

disqualified individual shall follow the appeal procedures described in subsection (n) of section 17b-749-21 of the Regulations of Connecticut State Agencies concerning appeals of administrative hearing decisions.

(3) If a court reverses the finding of guilt of an intentional recipient error, the CCAP administrator shall reinstate the case if the family is currently eligible and issues payments for any underpayment that may have occurred.

(Adopted effective July 10, 2001)

Sec. 17b-749-23. Implementation

The requirements of sections 17b-749-01 to 17b-749-22 of the Regulations of Connecticut State Agencies, inclusive, shall take effect on January 1, 2002. Families who apply for benefits prior to January 1, 2002 shall be subject to the requirements of the regulations that are in effect on the date eligibility is determined. Families determined eligible prior to January 1, 2002 shall receive the same benefits as would have been received under the regulations in effect prior to January 1, 2002, until the next eligibility determination conducted on or after January 1, 2002.

(Adopted effective July 10, 2001)

Agency
Department of Social Services

Subject
Security Deposit Program

Inclusive Sections
§§ 17b-802-1—17b-802-12

CONTENTS

Sec. 17b-802-1. Definitions
Sec. 17b-802-2. Eligibility criteria
Sec. 17b-802-3. Verification of eligibility
Sec. 17b-802-4. Elements of application
Sec. 17b-802-5. Application filing
Sec. 17b-802-6. Application review and notification
Sec. 17b-802-7. Security deposit, claim for damages and refund
Sec. 17b-802-8. Assistance limitations
Sec. 17b-802-9. Security deposit guarantee and claim for damages
Sec. 17b-802-10. Subsequent security deposit guarantee or security deposit
Sec. 17b-802-11. Landlord participation
Sec. 17b-802-12. Fair hearings

Security Deposit Program

Sec. 17b-802-1. Definitions

As used in sections 17b-802-1 through 17b-802-12, inclusive, of the Regulations of Connecticut State Agencies:

(1) "Applicant" means a person who has completed, signed and submitted an application to the department or to any entity so designated under section 17b-802-5 of the Regulations of Connecticut State Agencies to obtain a security deposit guarantee or security deposit that, if approved, will allow the person to move into a dwelling unit.

(2) "Application" means the forms prescribed by the commissioner to be used by applicants to apply for a security deposit guarantee or a security deposit. The application forms, which may be modified from time to time, shall contain information that the commissioner deems necessary to determine whether the applicant should be granted a security deposit guarantee or security deposit.

(3) "Catastrophic event" means a situation that arises due to a natural or man-made disaster that results in destruction or loss of housing, as determined by appropriate local or state officials or by the department.

(4) "Commissioner" means the Commissioner of Social Services.

(5) "Current income status" means the household's gross income for, at a minimum, the thirty (30) days preceding the date of application.

(6) "Department" means the state Department of Social Services.

(7) "Dwelling unit" means any house or building, including a mobile manufactured home in a mobile manufactured home park as defined in section 21-64 of the Connecticut General Statutes, or portion thereof, which is occupied, is designed to be occupied, or is rented, leased or hired out to be occupied as a home or residence of one or more persons.

(8) "Emergency housing" means a temporary residential facility, other than an emergency shelter, such as a hotel, motel, hospital, state institution or shelter for victims of domestic violence. Emergency housing also includes the private residence of a friend or relative which temporarily houses individuals or families displaced within the past sixty (60) days due to an eviction, catastrophic event or domestic violence.

(9) "Emergency shelter" means a privately or publicly supported structure designed to shelter homeless persons on a temporary basis pending relocation to permanent housing.

(10) "Eviction" means one of the following:

(A) The applicant is forced to relocate after receiving a legal notice to quit;

(B) The applicant is a sublessee or is sharing the dwelling unit with the lessee and the lessee has received a legal notice to quit or has been evicted through court action;

(C) The applicant is either an owner or a tenant of a dwelling unit and is being forced to relocate as a result of a foreclosure judgment in a foreclosure action completed in court; or

(D) The applicant is illegally locked out of the dwelling unit by the landlord and the applicant has filed a police complaint concerning such lockout.

(11) "Gross income" means the total annual income of all household members, before deductions, derived from earned and unearned income. Earned income includes any

compensation payable by an employer to an employee for personal services and includes wages, salaries, tips, commissions, bonuses and earnings from self-employment or contractual agreements. Unearned income includes, but is not limited to: pensions, annuities, dividends, interest, rental income, estate or trust income, royalties, social security or supplemental security income, unemployment compensation, workers' compensation, alimony, child support and cash assistance from federal or state funded assistance programs.

(12) "Household" means one or more individuals living together as a unit.

(13) "HUD" means the federal Department of Housing and Urban Development.

(14) "Landlord" means the owner, lessor or sublessor of: the dwelling unit, the building of which the dwelling unit is a part, or the premises on which the dwelling unit is located. "Landlord" includes a licensee, permittee or any person who owns, operates or maintains a mobile manufactured home park.

(15) "Recipient" means any individual or household that has received a security deposit guarantee or a security deposit by meeting the criteria as set forth in section 17b-802-2 of the Regulations of Connecticut State Agencies.

(16) "Security deposit" means a security deposit as defined in section 47a-21 of the Connecticut General Statutes.

(17) "Security deposit guarantee" means a written agreement in lieu of paying the security deposit directly to the landlord that is executed between the commissioner or his or her designee or agent and the landlord.

(18) "Tenant" means the lessee, sublessee or person entitled under a rental agreement to occupy a dwelling unit or premises to the exclusion of others, or as is otherwise defined by law.

(Adopted effective May 24, 2004)

Sec. 17b-802-2. Eligibility criteria

To participate in the security deposit guarantee or security deposit program an applicant shall satisfy the department that all of the following criteria are met:

(a) The applicant meets one of the following requirements of financial eligibility:

(1) The applicant is a current recipient of temporary family assistance (TFA), diversion assistance pursuant to section 17b-112g of the Connecticut General Statutes, state-administered general assistance (SAGA), refugee assistance, aid to the aged, blind or disabled (AABD), food stamps, Safety Net services pursuant to section 17b-112e of the Connecticut General Statutes, or Medicaid or

(2) The annual gross income of the applicant and his or her household, excluding assets, does not exceed 150% of the federal poverty income guidelines (for the household's size) as established by the federal Department of Health and Human Services.

(b) The applicant meets one of the following requirements of categorical eligibility:

(1) The applicant holds a federal Section 8 housing choice voucher or holds a certificate from the Rental Assistance Program, the Transitionary Rental Assistance Program or any other rental assistance program operated by the department, that was issued while the

applicant was on the waiting list of any of the aforementioned rental assistance programs within the six months prior to filing a security deposit guarantee or security deposit application pursuant to section 17b-802-5 of the Regulations of Connecticut State Agencies, or

(2) The applicant is currently residing in emergency housing or an emergency shelter in Connecticut, or

(3) The applicant cannot remain in permanent housing because:

(A) The applicant has received a notice to quit, or a judgment has been entered against the applicant in a summary process action instituted pursuant to chapter 832 of the Connecticut General Statutes, provided the action was not based on criminal activity, or a judgment has been entered against the applicant in a foreclosure action pursuant to chapter 846 of the Connecticut General Statutes and the time limit for redemption has passed;

(B) The applicant has left his or her permanent housing to escape domestic violence;

(C) A catastrophic event, such as a fire or flood, has occurred within the 60 days prior to the application date and has made the permanent housing uninhabitable or the applicant has been ordered to vacate the permanent housing by a local code enforcement official within said 60 days;

(D) The applicant has been issued a new federal Section 8 housing choice voucher or a new certificate from the Rental Assistance Program, the Transitionary Rental Assistance Program or any other rental assistance program operated by the department because the applicant resides in a unit assisted under any of the aforementioned rental assistance programs which has failed a housing quality standards inspection when that failure was the responsibility of the owner and the owner refused to correct the conditions causing the failure;

(E) The applicant shares a dwelling unit with a primary tenant who is being evicted or who engages in criminal activity;

(F) The applicant was illegally locked out by the landlord and has filed a police complaint concerning the lockout;

(G) The applicant has been living with a tenant who received a preliminary notice under section 47a-15 of the Connecticut General Statutes or a notice to quit because of termination of a rental agreement for lapse of time; or

(H) The applicant has left the permanent housing because a child in his or her family who resided in the dwelling unit with the applicant has been found to have a level of lead in the blood equal to or greater than twenty micrograms per deciliter of blood or any other abnormal body of lead and the local director of health has determined, after an epidemiological investigation pursuant to section 19a-111 of the Connecticut General Statutes, that the source of the lead poisoning was the dwelling unit in which the child resided with the applicant.

(c) The applicant has found a rental dwelling unit in Connecticut of which the applicant and the landlord conduct an inspection, which the landlord represents to the department to meet local housing code enforcement laws, and which is intended to be occupied as

permanent housing.
(d) The department determines that the applicant's household can reasonably be expected to afford the monthly rental charge of the dwelling unit.
(e) The applicant is precluded from occupying the otherwise affordable dwelling unit due to a security deposit requirement which is beyond the current financial means of the applicant.

(Adopted effective May 24, 2004)

Sec. 17b-802-3. Verification of eligibility
(a) Any applicant seeking eligibility based on financial need pursuant to section 17b-802-2(a)(2) of the Regulations of Connecticut State Agencies shall verify his or her household's income in a manner that is acceptable to the department. Forms of verification include, but are not limited to:
(1) Current wage stubs;
(2) Federal or state income tax filing forms;
(3) A department form W-35 for disclosure of gross wages, salary or commission paid;
(4) A copy of a Social Security check or any other benefit check;
(5) A statement from an employer or other sources of documentation which clearly establish gross income; or
(6) An IRS Form W-2 or W-2p.
(b) The applicant shall provide the following documentation as it is relevant to the applicant:
(1) Evidence that the applicant holds a federal Section 8 housing choice voucher or holds a certificate from the Rental Assistance Program, the Transitionary Rental Assistance Program or any other rental assistance program operated by the department, in conformance with section 17b-802-2 of the Regulations of Connecticut State Agencies;
(2) Documentation or other evidence that the applicant is staying at an emergency shelter, which may include verbal or written verification from an appropriate official of an emergency shelter;
(3) Documentation that the applicant occupies emergency housing; or
(4) Documentation of the reason why the applicant cannot remain in permanent housing. Such documentation may include, but is not limited to:
(A) Notice to quit and any other summary process paperwork addressed either to the applicant or the primary tenant with whom he or she lives. A copy of a judgment entered against the applicant in a summary process action instituted pursuant to chapter 846 of the Connecticut General Statutes;
(B) Confirmation of domestic violence, which may include a sworn statement by the victim or any evidence of such violence available to the applicant, which may include: police, government agency or court records; documentation from a shelter worker, legal, medical, clerical or other professionals from whom the applicant has sought assistance in dealing with domestic violence; or a statement from an individual with knowledge of the

circumstances which provide the basis for the claim of domestic violence. For purposes of this section, allegations of domestic violence by a victim may be sufficient to establish domestic violence where the department has no independent reasonable basis to find the applicant not credible;

(C) Confirmation, whether verbal or written, from appropriate authorities such as state officials, police, fire or local code enforcement officials regarding a catastrophic event;

(D) Evidence that the applicant was issued a federal Section 8 housing choice voucher or a certificate from the Rental Assistance Program, the Transitionary Rental Assistance Program or any other rental assistance program operated by the department when the applicant resided in a unit assisted under any of the aforementioned rental assistance programs, and that unit failed a housing quality standards inspection when that failure was the responsibility of the owner and the owner refused to correct the conditions causing the failure;

(E) A sworn statement by the applicant that the primary tenant with whom he or she resides engages in criminal activity;

(F) A sworn statement by the applicant that he or she has been illegally locked out of his or her dwelling unit; or

(G) Evidence that a child in the applicant's family resides with the applicant and has a level of lead in the blood equal to or greater than twenty micrograms per deciliter of blood or any other abnormal body of lead and the local director of health has determined, after an epidemiological investigation pursuant to section 19a-111 of the Connecticut General Statutes, that the source of the lead poisoning was the dwelling unit in which the child resided with the applicant.

(Adopted effective May 24, 2004)

Sec. 17b-802-4. Elements of application

A completed application requesting the equivalent of up to two (2) month's rent as a security deposit guarantee, or the equivalent of up to one (1) month's rent as a security deposit and up to one (1) month's rent as a security deposit guarantee, pursuant to section 17b-802-8 of the Regulations of Connecticut State Agencies, includes:

(1) A completed security deposit guarantee or security deposit application form signed by the applicant and the department's worker. The application form shall stipulate that the applicant agrees to notify the department within thirty (30) days of vacating the dwelling unit for which payment is being requested;

(2) Any documents set forth in section 17b-802-3 of the Regulations of Connecticut State Agencies, or any other documents that the department determines are necessary to determine eligibility; and

(3) A written agreement between the department and the prospective landlord which shall include one or both of the following:

(A) A written security deposit guarantee signed by the prospective landlord and the department's designee. The written guarantee shall stipulate that the department shall pay

the landlord for any damages suffered by the landlord due to the tenant's failure to comply with such tenant obligations as defined in section 47a-21 of the Connecticut General Statutes, provided the amount of any such payment shall not exceed the amount of the security deposit guarantee; or

(B) A waiver form completed and signed by the prospective landlord. The waiver form shall stipulate that if the tenant for whom a security deposit payment is made vacates the dwelling unit, any return of the security deposit or accrued interest to which the tenant is entitled, shall be paid directly to the department.

(Adopted effective May 24, 2004)

Sec. 17b-802-5. Application filing

Applications for security deposit guarantees or security deposits may be made either to the department at one of its regional offices or to any entity under contract with the department to operate an emergency shelter or other emergency housing facility for individuals or families. An applicant shall have sixty (60) days to complete an application once she or he initiates the application process by filing any part of the application with the department or with any entity under contract with the department to operate an emergency shelter or other emergency housing facility for individuals or families. An applicant may request one or more sixty (60) day extensions to the time limit for completing an application. Such extensions may be granted in writing by department staff or by the staff of any entity under contract with the department to operate an emergency shelter or other emergency housing facility for individuals or families when the applicant has demonstrated a reasonable effort to locate a rental unit.

(Adopted effective May 24, 2004)

Sec. 17b-802-6. Application review and notification

The department shall review the application and shall notify the applicant in writing of the approval or denial of his or her eligibility within ten (10) days from the date the department is in receipt of the completed security deposit guarantee or security deposit application form signed by the applicant and the department's worker, and any documents set forth in section 17b-802-3 of the Regulations of Connecticut State Agencies, or any other documents that the department determines are necessary to determine eligibility, provided all documentation necessary to make a determination of eligibility has been submitted. If an application for a security deposit guarantee or security deposit is denied at this stage, the applicant shall be notified in writing within the ten-day period noted above of the reason for the denial and of his or her right to request a fair hearing from the department. Further, once the department is in receipt of a written agreement between the department and the prospective landlord, signed by both parties, the department shall review the written agreement and shall notify the applicant in writing of the approval or denial of his or her application within five (5) days from the date the department is in receipt of the completed application, including a written agreement between the department and the

prospective landlord, provided all documentation necessary to make a determination has been submitted. If an application for a security deposit guarantee or security deposit is denied at this stage, the applicant shall be notified in writing within the five-day period noted above of the reason for the denial and of his or her right to request a fair hearing from the department.

(Adopted effective May 24, 2004)

Sec. 17b-802-7. Security deposit, claim for damages and refund

(a) If the landlord claims the right to withhold any portion of any security deposit that the department has paid directly to the landlord, he or she shall comply with all of the provisions of Connecticut General Statutes section 47a-21, as well as subdivisions(a) (1) and (2) of this section. Any notice regarding any security deposit that the landlord or his agent sends to the tenant shall also be sent on the same day to the department.

(1) No later than thirty (30) days from the date of the termination of the tenancy, the landlord shall submit to the department the balance of the security deposit paid by the department plus accrued interest, after deduction for any damages suffered by such landlord by reason of the tenant's failure to comply with the tenant's obligations as defined in section 47a-21 of the Connecticut General Statutes. The landlord is also obligated, not later than thirty (30) days after the termination of the tenancy, to submit to the department written documentation supporting any deduction for damages, including evidence of actual costs of required repairs. If such deposit and documentation are not submitted, and if a civil action is necessary to collect the balance of the deposit, the landlord shall pay the costs associated with such civil action and shall be subject to double damages, pursuant to section 47a-21 of the Connecticut General Statutes.

(2) The department may inspect the dwelling unit to determine the extent of any damages.

(b) The rights of the tenant to the refund of the security deposit shall be subrogated to the department.

(Adopted effective May 24, 2004)

Sec. 17b-802-8. Assistance limitations

(a) Security deposit guarantee applications and security deposit applications from individuals or households shall be considered in the order in which they are received by the department in completed form in accordance with sections 17b-802-4 and 17b-802-5 of the Regulations of Connecticut State Agencies. The approval of an application is subject to the availability of funds. In the absence of funds, the department may determine that applications should not be accepted until such funds become available.

(b) Security deposit guarantee applications and security deposit applications for recipients aged sixty-two (62) years and older shall be limited to the equivalent of one (1) month's rent pursuant to Connecticut General Statutes section 47a-21(b)(2).

(c) Security deposit guarantees for all recipients under the age of sixty-two (62) shall be

limited to the equivalent of two (2) month's rent, except in the circumstance where the commissioner has determined that the health, safety or welfare of a child who resides with the applicant is threatened due to an emergency, in which case the security deposit guarantee shall be limited to the equivalent of one (1) month's rent combined with a security deposit that is limited to the equivalent of one (1) month's rent.

(Adopted effective May 24, 2004)

Sec. 17b-802-9. Security deposit guarantee and claim for damages

(a) No later than thirty (30) days from the date of the termination of the tenancy, the landlord shall submit to the department written documentation supporting the claim for damages, including evidence of actual costs of required repairs for damages suffered by such landlord by reason of the tenant's failure to comply with the tenant's obligations as defined in section 47a-21 of the Connecticut General Statutes.

(b) The department may inspect the dwelling unit to determine the extent of any damages.

(c) When a claim for damages is received by the department, written notice of such claim shall be sent to the tenant not later than five (5) days from the date of receipt of the claim by DSS. Such notice shall include the opportunity for the tenant to request an administrative review to dispute the claim. A request for an administrative review shall be in writing and received by the department not later than ten (10) days after the notice is sent to the tenant. Upon receipt of a timely request, payment of the claim shall be withheld pending the outcome of the review. The review shall be scheduled in a timely manner upon receipt of the request. The reviewer shall issue a written decision of his or her findings and mail a copy of the decision to the tenant (a) and to the landlord.

(Adopted effective May 24, 2004)

Sec. 17b-802-10. Subsequent security deposit guarantee or security deposit

(a) A person shall be eligible for a second or subsequent security deposit guarantee or security deposit if, at the time of re-application, the person meets the criteria for eligibility as set forth in section 17b-802-2 of the Regulations of Connecticut State Agencies.

(b) A person shall be eligible for a security deposit guarantee or security deposit only once within an eighteen (18) calendar month period, except for the circumstance identified in subsection (c) of this section.

(c) A person who applies for a second or subsequent security deposit guarantee or security deposit within eighteen (18) calendar months of the date of completion of an application for a previous security deposit guarantee or security deposit which was approved shall obtain approval from the commissioner for said second or subsequent security deposit guarantee or security deposit. For a person who applies for a second or subsequent security deposit guarantee or security deposit within eighteen (18) calendar months of the date of any payment to a landlord for damages claimed to have been caused by the person, the amount of a second or subsequent security deposit guarantee or security deposit shall be

reduced by:

(1) Any amount of the previous security deposit which has not been returned to the department pursuant to Connecticut General Statutes section 47a-21; and

(2) The amount of any payment made by the department to the landlord for damages.

(Adopted effective May 24, 2004)

Sec. 17b-802-11. Landlord participation

A landlord who engages in program fraud, misrepresentation or a violation of any aspect of his or her written agreement with the department shall be subject to civil or criminal penalties to the extent authorized by the law. The commissioner, at his or her discretion, may decline to enter into an agreement with a landlord under the security deposit guarantee program if the commissioner is of the opinion that the landlord has failed to comply with the provisions of the security deposit guarantee program.

(Adopted effective May 24, 2004)

Sec. 17b-802-12. Fair hearings

(a) A person aggrieved by a denial of a security deposit guarantee or security deposit shall be given an opportunity for a fair hearing. A person aggrieved by a reduction in the amount of a second or subsequent security deposit guarantee or security deposit shall be given an opportunity for a fair hearing.

(Adopted effective May 24, 2004)

Agency

Department of Social Services

Subject

Transitionary Rental Assistance Program

Inclusive Sections

§§ 17b-811a-1—17b-811a-8

CONTENTS

Sec. 17b-811a-1. Definitions
Sec. 17b-811a-2. Program administration and description
Sec. 17b-811a-3. Eligibility requirements
Sec. 17b-811a-4. Family referral, application and selection process
Sec. 17b-811a-5. Approval of tenancy and payment of benefits
Sec. 17b-811a-6. Computation of assistance amount
Sec. 17b-811a-7. Reporting requirements and audits
Sec. 17b-811a-8. Appeals

Transitionary Rental Assistance Program

Sec. 17b-811a-1. Definitions

As used in sections 17b-811a-1 to 17b-811a-8, inclusive, of the Regulations of Connecticut State Agencies:

(1) "Adjusted gross income" means the gross income of all adults residing in the dwelling unit less allowable deductions in accordance with section 17b-811a-6 of the Regulations of Connecticut State Agencies;

(2) "Agent" means any entity designated by the department to operate the transitionary rental assistance program;

(3) "Commissioner" means the Commissioner of the Department of Social Services;

(4) "Contract rent" means the total monthly rent payable to the owner for the dwelling unit. The contract rent is the sum of the tenant contribution plus the transitionary rental assistance payment to the owner;

(5) "Department" means the state of Connecticut Department of Social Services;

(6) "Dependent" means a member of the family household (excluding foster children) other than the family head or spouse, who is under 18 years of age or is disabled or is a full-time student 18 years of age or older;

(7) "Dwelling unit" means any house or building, including a mobile manufactured home in a mobile manufactured home park as defined in section 21-64 of the Connecticut General Statutes, or portion thereof, which is occupied, is designed to be occupied or is rented, leased or hired out to be occupied, as a home or residence of one or more persons;

(8) "Eligible family" means a family which meets the eligibility requirements set forth at 17b-811a-3 of the Regulations of Connecticut State Agencies;

(9) "Eligible housing" means privately owned rental housing located in any municipality in the state, which meets federal housing quality standards as cited in 24 CFR 982.401, and local and state health, housing, building and safety codes;

(10) "Gross rent" means the sum of the contract rent and any allowance for utilities established by the commissioner;

(11) "Income" means gross income (from whatever sources derived);

(12) "Owner" means any person(s) or entity having the legal right to lease or sublease housing and includes an owner's designated representative;

(13) "Request for tenancy approval" means the document submitted by the eligible family to the department or its agent requesting approval of a dwelling unit for tenancy by the family;

(14) "TFA" means the temporary family assistance program established under section 17b-112 of the Connecticut General Statutes;

(15) "TFA payment standard" means the monthly amount of cash assistance received by a family with no income that is collecting TFA subject to the twenty-one month time limit;

(16) "Tenant contribution" means the amount payable monthly by the family as rent to the owner; and

(17) "Transitionary rental assistance certificate" means the document issued by the

department or its agent that defines the terms, conditions and eligibility requirements for participation in the transitionary rental assistance program.

(Adopted effective March 9, 2006)

Sec. 17b-811a-2. Program administration and description

(a) Subject to the availability of funds, the commissioner shall implement and administer a transitionary rental assistance program for families that meet the eligibility requirements of section 17b-811a-3 of the Regulations of Connecticut State Agencies.

(b) An eligible family, whether or not it has received a transitionary rental assistance certificate, shall not receive assistance under this program if funds are not available.

(c) The department may administer the transitionary rental assistance program directly or it may designate one or more agents to administer the program. If an agent is designated to administer the program, the department shall enter into a contract with that agent. Such agent shall be required by contract to keep records in accordance with applicable state requirements.

(d) The commissioner may provide, on a one-time basis, up to twelve consecutive months of transitionary rental assistance.

(e) The department or its agent shall make transitionary rental assistance payments directly to an owner on behalf of an eligible family. No payment shall be made until (1) a lease has been executed by the family and the owner; (2) tenancy has been approved by the department or its agent; (3) the dwelling unit has passed a housing quality standard inspection; and (4) the department or its agent and the owner have entered into and executed a transitionary rental assistance contract. An eligible family shall make a monthly tenant contribution directly to the owner pursuant to an executed lease. The amount of the tenant contribution shall be determined in accordance with section 17b-811a-6 of the Regulations of Connecticut State Agencies.

(f) The commissioner shall develop a schedule of maximum allowable rent. Except as provided in section 17b-811a-6 (c) of the Regulations of Connecticut State Agencies, the department or its agent shall not grant a request for tenancy approval if it determines that the proposed rent under the lease is greater than the amount allowed pursuant to the schedule of maximum allowable rent. In developing the schedule, the commissioner shall consider the cost of rent in the different municipalities in which rental property is located; the type of housing (e.g., single family, apartment building); and the number of, and size of, bedrooms in the dwelling unit. The maximum allowable rent shall include a utility allowance that the commissioner shall develop. Said utility allowance shall include an allowance for all utilities paid by the eligible family except telephone service. The department or its agent shall use the utility allowance when determining the tenant contribution pursuant to section 17b-811a-6 of the Regulations of Connecticut State Agencies.

(g) Administrative responsibilities for the transitionary rental assistance program shall include family selection, family and landlord briefings, family and landlord outreach, family mobility counseling, promotion of housing choice and encouragement of racial and

economic integration, dwelling unit inspection for compliance with housing and health codes, income and rent verifications, maintenance of records and other responsibilities as required by the commissioner.

(h) Participation by a landlord and by the department or its agent in the transitionary rental assistance program shall require compliance with all applicable federal and state fair housing law, rules and regulations.

(i) In accordance with section 17b-811a-3(a) of the Regulations of Connecticut State Agencies, a family may be eligible for transitionary rental assistance if an adult member is employed at the time the family leaves the TFA program and either; (1) has income which exceeds the TFA payment standard or (2) is employed for a minimum of 12 hours per week. The commissioner may determine at any time, in his discretion, that funding limitations require a priority to be established for allocating limited transitional assistance benefits. In such an eventuality, families with income that exceeds the TFA payment standard shall be afforded priority over families with an adult member who is employed for a minimum of 12 hours per week.

(Adopted effective March 9, 2006; Amended June 1, 2010)

Sec. 17b-811a-3. Eligibility requirements

(a) A family shall be eligible for transitionary rental assistance if an adult member is employed at the time the family leaves the TFA program and either: (1) has income which exceeds the TFA payment standard or (2) is employed for a minimum of twelve hours per week. A family whose income does not exceed fifty percent of the median family income for the area of the state in which such family lives shall be eligible as determined by the commissioner. A family that has left the TFA program may submit an application for transitionary rental assistance not more than six months after leaving TFA. Transitionary rental assistance benefits shall not be provided before the first day of the month following the month during which the family's TFA benefits end.

(b) To maintain eligibility for transitionary rental assistance, a family shall:

(1) supply information that is accurate and complete to the department or its agent;

(2) comply with the provisions of the transitionary rental assistance certificate;

(3) supply information that the department or its agent requests to determine the household composition and the income of any household member;

(4) provide social security numbers of household members and provide social security cards for verification;

(5) sign and submit consent forms that allow the department or its agent to obtain relevant information about household members;

(6) supply any information that the department or its agent requests concerning whether the family is living in the dwelling unit or information related to a family's absence from the unit;

(7) promptly notify the department or its agent in writing when the family is away from the dwelling unit for four or more continuous weeks;

(8) allow the department or its agent to inspect the dwelling unit at reasonable times and after reasonable notice;

(9) notify the department or its agent and the owner in writing before moving out of the dwelling unit or terminating or amending a lease;

(10) pay utility bills and supply appliances that the owner is not required to pay for or supply under the terms of the lease;

(11) give the department or its agent a copy of any eviction notice it receives; and

(12) use the dwelling unit as its sole residence.

(c) To maintain eligibility for transitionary rental assistance, a family (including each household member) shall not:

(1) own or have any interest in the dwelling unit; however, a family shall not be ineligible for assistance if it has an ownership interest in a cooperative, or if it owns a manufactured home for which it leases a manufactured home space;

(2) commit any serious or repeated violation of the lease;

(3) commit fraud, bribery or any other corrupt or criminal act in connection with the transitionary rental assistance program;

(4) participate in any illegal drug or violent criminal activity in the dwelling unit or on the premises on which the dwelling unit is located;

(5) sublease or rent the dwelling unit to another party, assign or transfer the lease of the dwelling unit to another party;

(6) receive transitionary rental assistance while receiving another housing subsidy for the same dwelling unit or a different dwelling unit under any other state, federal or local housing assistance program;

(7) willfully damage the dwelling unit or premises or cause serious or repeated damage to the dwelling unit or premises through negligence or permit any guest to willfully damage the dwelling unit or premises or permit any guest to cause serious or repeated damage to the dwelling unit or premises through negligence; or

(8) receive TFA.

(d) If the department or its agent determines that a family or household member receiving transitionary rental assistance has violated any subdivision of subsections (b) or (c) of this section, it may terminate the family's participation in the transitionary rental assistance program.

(Adopted effective March 9, 2006)

Sec. 17b-811a-4. Family referral, application and selection process

(a) Any family approaching the end of the twenty-one month time limit on TFA is scheduled to have an interview conducted under section 17b-112 (f) of the Connecticut General Statutes during month twenty for the purpose of being informed of services that may continue to be available to them. Any family in a six month extension of TFA after the twenty-one month time limit is scheduled to have an interview conducted under section 17b-112 (f) of the Connecticut General Statutes during month five for the aforementioned

purpose.

(b) A transitionary rental assistance certification and referral form shall be issued to any family that is determined to be potentially eligible, or appears at the time of the interview conducted pursuant to section 17b-811a-4(a) of the Regulations of Connecticut State Agencies to be potentially eligible, for participation in the transi-tionary rental assistance program by way of meeting initial eligibility criteria. Other families leaving TFA may also apply for transitionary rental assistance. For any such family that appears eligible, the department shall assist the family in filling out an application form. This application form shall include, but not be limited to, information on family size and composition and the amount and sources of all current income for all family members who will reside in the dwelling unit which the family will occupy. The department or its agent shall obtain verification of the family's income prior to that family's receipt of transitionary rental assistance.

(c) The department or its agent shall accept an application for transitionary rental assistance from a family provided it is received by the department or it's agent no later than six months from the date the family has been discontinued from TFA.

(d) If an application for transitionary rental assistance from a family that appears to meet initial eligibility criteria is substantially completed, as determined by the department or its agent, the department or its agent shall accept the application and place the family in the pool for selection of transitionary rental assistance program participants.

(e) If an application for transitionary rental assistance is not substantially completed, the department or its agent shall notify the applicant in writing or telephonically of the information that is needed to complete the application. After such notification, the applicant shall respond to the department or its agent not later than twenty business days after the date on which the applicant was notified. If the applicant fails to respond, the department or its agent shall deem said application to have been withdrawn and the department or its agent shall notify the applicant in writing no later than five business days after said application has been deemed withdrawn. The applicant may request, in accordance with section 17b-811a-8 of the Regulations of Connecticut State Agencies, that the department or its agent review its determination that an application has been withdrawn. The department or its agent shall not provide transitionary rental assistance payments before a family's application is completed.

(f) If the department or its agent denies an application for transitionary rental assistance, it shall notify the applicant in writing of the reasons for the denial no later than five business days after the denial. The applicant may request the department or its agent to review the denial in accordance with section 17b-811a-8 of the Regulations of Connecticut State Agencies.

(g) The department or its agent shall, on a monthly basis and dependent on the amount of funds available and the number of referrals made, conduct a lottery to select a pre-determined number of families to participate in the program. Families not selected shall remain in the pool for a period not to exceed six months. Selected families shall be issued

a transitionary rental assistance certificate. Such certificate allows a family to locate a dwelling unit and submit a request for tenancy approval to the department or its agent. Neither the department nor its agent shall approve tenancy for a family that is not in receipt of a valid certificate. The department or its agent shall not provide transitionary rental assistance unless tenancy has been approved in accordance with section 17b-811a-5 of the Regulations of Connecticut State Agencies.

(h) A transitionary rental assistance certificate shall be valid for sixty calendar days. The first day of the sixty days shall begin on the calendar day following the day that the department or its agent issued the certificate. The department or its agent may extend the certificate's validity, in one or more increments, by up to sixty additional days. The department or its agent may extend the certificate's validity for more than one-hundred-twenty total days if it determines that good cause existed for the family's failure to locate a dwelling unit or submit a request for tenancy approval.

(i) No day shall count toward the sixty-day or subsequent limit if the department or its agent is in receipt of a submission by a certificate holder of a request for tenancy approval. If tenancy is not approved the department shall give the family prompt notice by mail or telephonically. The first calendar day following the day of department notification of its non-approval shall be the first day on which the sixty-day or subsequent limit shall resume.

(Adopted effective March 9, 2006)

Sec. 17b-811a-5. Approval of tenancy and payment of benefits

(a) The department shall develop a "request for tenancy approval" form and shall provide each applicant for transitionary rental assistance with five copies of the form at the time the applicant receives his or her transitionary rental assistance certificate. In addition to any other information required by the commissioner, the form shall include: (1) a statement that the applicant requests approval of tenancy; (2) a statement indicating that the owner agrees to rent the dwelling unit to the applicant; and (3) a place for the signatures of the owner and the applicant.

(b) When an eligible family has located an available rental dwelling unit and the owner is willing to rent the dwelling unit to the family, the family shall submit to the department or its agent a request for tenancy approval that is signed by the applicant and the owner, along with the proposed lease. The lease that the family submits to the department or its agent shall be for a term of twelve consecutive months and for the rental of a dwelling unit that qualifies as eligible housing as defined in section 17b-811a-1(9) of the Regulations of Connecticut State Agencies.

(c) Prior to approving tenancy, the department or its agent shall inspect the dwelling unit for compliance with the standards as cited in 24 CFR 982.401, and local and state health housing, building and safety codes. If there are defects that require correction, the department or its agent shall advise the owner of the work required to be done. If defects are claimed to be corrected, the dwelling unit shall be re-inspected and tenancy approved before a contract is executed.

(d) The department or its agent shall not approve tenancy if the owner of the dwelling unit resides in the available rental dwelling unit.

(e) An eligible family may submit a request for tenancy approval for the dwelling unit that it already occupies if the unit qualifies as eligible housing as defined in section 17b-811a-1(9) of the Regulations of Connecticut State Agencies.

(f) If the department or its agent grants a request for tenancy approval, the department or its agent shall notify the owner and the family of its approval of tenancy no later than five business days after approval. The department or its agent shall provide the owner with: (1) two copies of a transitionary rental assistance contract, which shall be a written and binding agreement between the department or its agent and the owner that contains the terms and conditions under which the owner shall rent the dwelling unit to an eligible family and under which the department or its agent shall make monthly transitionary rental assistance payments directly to the owner on behalf of the eligible family in a specified amount; and (2) a copy of the lease between the eligible family and the owner, which has been approved by the department and specifies any and all of the terms and conditions under which the owner shall rent to the eligible family and specifies the contract rent. The owner shall execute both contracts and return them to the department or its agent along with a copy of the executed lease between the owner and the eligible family. The department or its agent shall execute the transitionary rental assistance contracts and provide the owner and the eligible family with one copy each.

(g) The department or its agent shall provide transitionary rental assistance payments to the owner in accordance with the rental assistance contract for the dwelling unit under the lease. These payments shall cover the difference between the contract rent and the tenant contribution. However, the amount may not exceed the maximum allowable rent established by the commissioner pursuant to section 17b-811a-2 of the Regulations of Connecticut State Agencies, except as provided in 17b-811a-6 of the Regulations of Connecticut State Agencies.

(Adopted effective March 9, 2006)

Sec. 17b-811a-6. Computation of assistance amount

(a) The amount of monthly transitionary rental assistance that the department or its agent provides on behalf of an eligible family shall be the difference between the tenant contribution and the contract rent.

(b) The tenant contribution shall be ten percent of the family's monthly income or forty percent of the family's monthly adjusted gross income less a utility allowance, whichever is greater. A family's monthly adjusted gross income shall be reduced by the following deductions, up to maximum amounts that the commissioner establishes:

(1) a deduction for dependents;

(2) childcare costs paid by and not reimbursed to, or on behalf of, the certificate holder which enable one or more adults in the family to work, to attend school or to actively seek employment;

(3) unreimbursed medical expenses which exceed three percent of the family's annual income;

(4) allowable disability assistance expenses deducted for attendant care or an auxiliary apparatus for person(s) with disabilities if needed to enable the individual or an adult family member to work, when these are paid by, and not reimbursed to or on behalf of, the transitionary rental assistance certificate holder; and

(5) any other deduction that the commissioner may establish.

(c) Notwithstanding section 17b-811a-4 of the Regulations of Connecticut State Agencies, the gross rent for the unit shall not exceed the maximum allowable rent, as determined by the commissioner, unless the transitionary rental assistance certificate holder decides to remain in his or her current dwelling unit and the owner agrees to participate in the transitionary rental assistance program. If the transitionary rental assistance certificate holder decides to remain in his or her current dwelling unit, the new contract rent shall not exceed the rent paid by the tenant holding the transitionary rental assistance certificate prior to the beginning of the transitionary rental assistance contract term.

(d) An eligible family that receives transitionary rental assistance may, during the term of said family's lease, request that the department or its agent conduct a re-determination of its contribution to the gross rent because of changes in its income or household composition.

(Adopted effective March 9, 2006)

Sec. 17b-811a-7. Reporting requirements and audits

(a) Any agent designated by the department to administer this program shall submit monthly financial and program reports to the department in accordance with the terms specified in its contractual agreement with the department.

(b) An entity that has been designated as an agent of the department to administer this program shall be subject to an audit of all books and records related to this program. Audits shall be performed by independent public accountants registered to practice in the state of Connecticut or by qualified department personnel. All audits shall be in accordance with procedures and timetables established by the department.

(Adopted effective March 9, 2006)

Sec. 17b-811a-8. Appeals

(a) The department or its agent shall give transitionary rental assistance program applicants prompt written notice of a decision denying assistance to an applicant, and shall give families participating in the program prompt written notice of a decision changing the terms of, or denying continued assistance to, a participant. This notice shall contain a brief statement of the reason(s) for the decision, shall state that the applicant or family participating in the program may request an informal conference to review the decision and shall describe how to obtain such an informal conference.

(b) A written request for an informal conference shall be made to the department's agent

where the program is locally administered or, if there is no such agent, to the department. The request shall be postmarked no later than seven days after the date of the notice of the decision from the administering agent or the department. The department's agent, if in receipt of such a request, shall forward a copy to the department's Housing Services Unit.

(c) The department or its agent shall continue to provide rental assistance as provided in the transitionary rental assistance contract to those families who have requested an informal conference to review a decision changing the terms of, or discontinuing, their assistance until a report has been issued following such conference, provided: (1) the request for the informal conference is received or postmarked no later than seven days after the date of notice from the department or its agent; (2) the program has sufficient funds to provide such assistance and; (3) the decision under review is not one that affects all program applicants or families participating in the program equally. Under no circumstances shall more than twelve months of benefits be provided under this subsection.

(d) The department or its agent shall schedule an informal conference no later than thirty days from the receipt of the request and shall inform the applicant or family participating in the program of the conference by written notice. The notice of informal conference shall include the date, time and place for the conference; a reference to the particular sections of the statutes and regulations involved; and a short and plain statement of the matters asserted. The informal conference shall be conducted by any person or persons designated by the department or its agent, other than a person who recommended or approved the decision under review or a subordinate of such person.

(e) In lieu of holding an informal conference, the department or its agent may take one of the following actions:

(1) Acceptance of a withdrawal of the request by the person who made it. This action shall be voluntary and may be made at any time before the informal conference by a written statement of withdrawal addressed to the department or its agent;

(2) dismissal of the request by the department or its agent. This action shall be taken if:

(A) The applicant or family participating in the program who has requested the informal conference fails to appear at the designated time and place for the conference; or

(B) the issue is resolved prior to the informal conference.

(f) Not later than thirty days from the date of the informal conference, the department or its agent shall issue a written report of its findings, which may modify the decision that was reviewed by the conference. Factual determinations relating to the individual circumstances of the applicant or family participating in the program who requested the informal conference shall be based on information presented at the informal conference. A copy of the report shall be provided promptly to the applicant or family participating in the program who requested the informal conference and shall include copies of any documents presented at the informal conference.

(g) If, following an informal conference and report, the decision is unchanged, the department shall provide a desk review of the report, upon written request of the applicant or family participating in the program, to ensure compliance with an agent's contractual

obligation. The applicant or family participating in the program shall request said desk review not later than ten days after the decision has been rendered. No new information which could have been presented at the informal conference shall be used by the department for the purposes of such desk review. Requests shall be sent to:

Commissioner, Department of Social Services
25 Sigourney Street
Hartford, CT 06106
Attn: Housing Services Unit

(Adopted effective March 9, 2006)

Agency

Department of Social Services

Subject

Rental Assistance Program

Inclusive Sections

§§ 17b-812-1—17b-812-14

CONTENTS

Sec. 17b-812-1. Definitions
Sec. 17b-812-2. Program administration
Sec. 17b-812-3. Repealed
Sec. 17b-812-4. Supportive housing; eligibility and selection of owner participants
Sec. 17b-812-5. Notice, application process, selection of eligible families and issuance of rental assistance certificates; special considerations
Sec. 17b-812-6. Computation of rental assistance payments
Sec. 17b-812-7. Eligible housing
Sec. 17b-812-8. Request for tenancy approval
Sec. 17b-812-9. Reexamination of family income
Sec. 17b-812-10. Disbursement of rental assistance payments
Sec. 17b-812-11. Reporting requirements and audit
Sec. 17b-812-12. Family obligations
Sec. 17b-812-13. Denial or termination of assistance
Sec. 17b-812-14. Notice, appeals and hearings

Rental Assistance Program

Sec. 17b-812-1. Definitions

As used in sections 17b-812-1 to 17b-812-14, inclusive, of the Regulations of Connecticut State Agencies:

(1) "Adjusted gross income" means the gross income of all adults residing in a dwelling unit less the allowable deductions listed in subsection (d) of section 17b-812-6 of the Regulations of Connecticut State Agencies;

(2) "Agent" means any entity designated by the department to operate the rental assistance program;

(3) "Commissioner" means the Commissioner of Social Services;

(4) "Contract rent" means the total monthly rent payable to the owner for the dwelling unit;

(5) "Department" means the Department of Social Services;

(6) "Dependent" means a member of a family, other than a head of household, spouse or foster child, who is under eighteen years of age or is disabled or is a full-time student eighteen years of age or older;

(7) "Disabled person" means a person who has a disability as defined in the Americans with Disabilities Act, 42 USC 12102;

(8) "Dwelling unit" means a house, building or mobile manufactured home in a mobile manufactured home park, as such terms are defined in section 21-64 of the Connecticut General Statutes, or any portion of a house, building or mobile manufactured home in a mobile manufactured home park, that is occupied, designed to be occupied or rented, leased or hired out to be occupied as a home or residence of one or more persons;

(9) "Elderly person" means a person sixty-two years of age or older;

(10) "Eligible family" means a household consisting of one or more persons, with income that does not exceed fifty per cent (50%) of the median family income for the area of the state where the family lives, as determined by the commissioner. An eligible family shall include at least one citizen or eligible non-citizen;

(11) "Eligible housing" means privately owned rental housing, located in any municipality in the state, that meets federal housing quality standards as cited in 24 CFR 982.401, and local and state health, housing, building and safety codes;

(12) "Eligible non-citizen" means a person who meets the qualification requirements established in subsection (a) of 42 USC 1436a;

(13) "Gross rent" means the sum of the contract rent and any utility allowance established by the commissioner;

(14) "Income" means gross income from whatever sources derived;

(15) "Maximum allowable rent" means the maximum amount of monthly rent that is payable under the rental assistance program, as determined by the commissioner;

(16) "Mixed family" means a household consisting of one or more persons who are citizens or eligible non-citizens and one or more persons who are ineligible non-citizens or who elect not to state that they have eligibility status;

(17) "Occupancy policy" means the standards established by the commissioner for determining the appropriate number of bedrooms for families of different sizes;

(18) "Owner" means a person or entity having the legal right to lease or sublease housing;

(19) "Pre-application" means the form disseminated by the department or its agent by which an applicant submits his or her name into a lottery for establishing the waiting list for the Rental Assistance Program;

(20) "Project-based rental assistance" means rental assistance that is attached to a specific dwelling unit and is non-transferable;

(21) "Rental agreement" means all agreements, written or oral, and valid rules and regulations adopted under section 47a-9 of the Connecticut General Statutes, embodying the terms and conditions concerning the use and occupancy of a dwelling unit and premises between the owner and the tenant;

(22) "Rental assistance certificate" means the document issued by the department or its agent to the tenant that defines the terms, conditions and eligibility requirements for participation in the Rental Assistance Program;

(23) "Rental assistance contract" means a written agreement between the department or its agent and the owner or the owner's designated representative that contains the terms and conditions under which the owner or the owner's designated representative will rent the dwelling unit to an eligible family, and the amount of rental assistance payments to be made by the department or its agent to the owner or the owner's designated representative on behalf of such eligible family;

(24) "Rental assistance payment" means the amount paid by the department on behalf of the tenant to the owner of the dwelling unit toward the contract rent;

(25) "Request for tenancy approval" means the document submitted by an eligible family to the department or its agent requesting approval of a dwelling unit for tenancy by the family;

(26) "Supportive housing" means rental housing, funded by tenant-based rental assistance or project-based rental assistance, that also provides support services to individuals and families experiencing, or at significant risk of, long-term homelessness;

(27) "Tenant" means an eligible family that is leasing a dwelling unit from an owner;

(28) "Tenant-based rental assistance" means rental assistance payments provided to eligible families that are retained by the eligible family even if they subsequently move to another dwelling unit;

(29) "Tenant contribution" means the amount of the monthly contract rent payable by the eligible family to the owner;

(30) "Tenant selection plan" means a plan submitted to the department by a supportive housing provider that specifies the uniform methodology the provider shall use to select tenants for its supportive housing units including, but not limited to, specific eligibility factors, occupancy policy, and application and tenant screening procedures; and

(31) "Utility allowance" means the estimated monthly cost, as determined by the commissioner, for an eligible family for heat and other utilities, excluding telephone, that

are not supplied or paid for by the owner of the dwelling unit rented by the family. The utility allowance is added to the contract rent to calculate the gross rent.

(Effective March 21, 1996; Amended February 9, 2000; Amended May 31, 2007; Amended December 28, 2012)

Sec. 17b-812-2. Program administration

(a) The commissioner shall implement and administer a non-entitlement program that provides rental assistance for low-income families living in privately owned rental housing, allowing eligible families to afford decent, safe and sanitary housing.

(b) The commissioner or the commissioner's agent shall limit the issuance of rental assistance certificates to eligible families based upon the availability of funds. A certificate does not guarantee a family the right to participate in the program. The commissioner or the commissioner's agent may suspend or cancel an issued certificate if a change in an applicant's circumstances results in ineligibility prior to execution of the rental assistance contract. The commissioner may suspend or cancel issued certificates based on lack of funds.

(c) The department shall administer and oversee the rental assistance program. The department may directly administer the financial assistance provided or may designate one or more agents to administer the program.

(d) Administrative responsibilities for this program, whether undertaken by the department or its agent, shall include: Tenant selection, tenant and landlord briefings, landlord and tenant outreach, mobility counseling, promotion of housing choice, encouragement of racial and economic integration, annual unit inspection for compliance with housing and health codes, initial and annual re-examination of tenant income and rent adjustments, maintenance of records, and other duties as required by the commissioner.

(e) The commissioner may designate a portion of available rental assistance funding under the rental assistance program for supportive housing units. To the extent practicable, rental assistance for supportive housing shall adhere to the requirements of the federal Housing Choice Voucher program, set forth in subsection (o) of 42 USC 1437f, relative to the tenant's share of the rent to be paid. Selection for tenant-based and project-based rental assistance shall be in accordance with subsection (a) of section 17b-812-5 of the Regulations of Connecticut State Agencies or subject to a tenant selection plan approved by the commissioner that designates rental assistance to eligible families who are homeless, or at risk of homelessness, and who would benefit from the support services provided. Such services are provided by programs other than the rental assistance program and include those intended to address mental health disorders, substance use disorders, AIDS and AIDS related disorders and other factors contributing to homelessness. The availability of support services shall be a factor considered by the commissioner for the purposes of tenant selection and site location.

(Effective March 21, 1996; Amended February 9, 2000; Amended May 31, 2007; Amended December 28, 2012)

Sec. 17b-812-3. Repealed

Repealed December 28, 2012.

Sec. 17b-812-4. Supportive housing; eligibility and selection of owner participants

(a) The commissioner may select municipalities, housing authorities, private organizations or nonprofit organizations to participate in the supportive housing program based on criteria that shall include, but not be limited to, the following:

(1) Demonstration of the need for housing for low income families in the geographic area served by the municipality, housing authorities, private organization or nonprofit organization;

(2) demonstration of the availability of rental units in the geographic area served by the municipality, housing authorities, private organization or nonprofit organization; and

(3) availability of other public or private funds.

(b) Eligible municipalities, housing authorities, private organizations and nonprofit organizations may participate in other municipal, state or federal housing repair, rehabilitation or financing programs, including the programs of the Connecticut Housing Finance Authority.

(c) Criteria for selecting municipalities, housing authorities, private organizations or nonprofit organizations for the supportive housing portion of the rental assistance program shall include:

(1) Any needs outlined in the five year housing advisory plan;

(2) local housing assistance plans, if in existence;

(3) any statistical data on housing need and marketability;

(4) suitability of the proposed site and project;

(5) the apparent capability of the municipality, housing authority, private organization or nonprofit organization to manage the project;

(6) the availability of funds from sources other than the rental assistance program; and

(7) the availability of funding for support services from other programs.

(d) Any rental assistance payments provided under the supportive housing portion of the rental assistance program shall be provided to the municipality, housing authority, private organization or nonprofit organization through a contract with the department to make one or more dwelling units affordable to low-income families. These dwelling units shall continue to be made available to eligible families for the term of the contract entered into between the department and the municipality, housing authority, private organization or nonprofit organization, so long as funds are available for such purposes.

(e) Rental assistance provided to an eligible family under the supportive housing portion of the rental assistance program is non-transferable and shall remain with the dwelling unit.

(Effective March 21, 1996; Amended February 9, 2000; Amended May 31, 2007; Amended December 28, 2012)

Sec. 17b-812-5. Notice, application process, selection of eligible families and issuance of rental assistance certificates; special considerations

(4) protecting witnesses to a crime;

(a) The department shall provide notice to the public in newspapers of general circulation when the waiting list for the rental assistance program will be opened. The notice shall include information regarding where pre-applications can be obtained and submitted, and the dates when the department will be accepting pre-applications. After the period for accepting pre-applications has concluded, the department or its agent shall conduct a lottery using all pre-application forms received. The department or its agent shall place a predetermined number of applicants on the waiting list for the rental assistance program in the order in which they were randomly selected by the lottery.

(b) If selected from the lottery, an eligible family shall complete a rental certificate application form that shall include, but not be limited to, information on family size and composition and the amount and sources of all income. The commissioner or the commissioner's agent shall verify the family's income.

(c) When the department or its agent determines that a family is eligible for rental assistance, the department or its agent shall issue the family a rental assistance certificate. The department or its agent shall inform the family of the family's obligations under the program as well as the responsibilities of the owner of the dwelling unit, and shall provide the family with applicable forms and information that may assist the family in finding a suitable dwelling unit.

(d) The rental assistance certificate shall be used within ninety days of issuance. The department or its agent may extend the expiration date of the certificate in one or more increments, such extensions not to exceed a total of ninety days. The certificate holder shall have a maximum of one hundred eighty days to locate a suitable dwelling unit unless the department or its agent finds good cause to extend the maximum period.

(e) The ninety day time limit stops running on the day the department or its agent receives a request for tenancy approval. If for any reason the dwelling unit cannot be approved, then the certificate holder shall be notified and the time limit shall resume running on the date notice is mailed.

(f) If it is determined that an applicant is ineligible to participate in the rental assistance program, the department or its agent shall notify the applicant, in writing, of the reason why he or she was determined to be ineligible. The applicant shall have the right to appeal this decision in accordance with section 17b-812-14 of the Regulations of Connecticut State Agencies.

(g) The commissioner shall have discretion to grant rental assistance payments, within available funding, to individuals who may or may not be on the waiting list but who are otherwise eligible, and are homeless, have been displaced by governmental action, whose dwelling unit has been extensively damaged or destroyed as a result of a disaster declared or otherwise formally recognized pursuant to federal disaster relief laws, or are participants in programs approved by the commissioner. Programs approved by the commissioner may

include, but are not limited to, programs for:

(1) Assisting individuals residing in nursing facilities or public institutions to leave such facilities or institutions;

(2) preventing individuals from becoming institutionalized;

(3) providing housing for children with severe disabilities and their families;

(4) protecting witnesses to a crime; or

(5) addressing the housing needs of individuals and families where lack of housing results in a significant threat to the health or safety of such persons.

(Effective March 21, 1996; Amended February 9, 2000; Amended May 31, 2007; Amended December 28, 2012)

Sec. 17b-812-6. Computation of rental assistance payments

(a) The amount of rental assistance paid by the department on behalf of eligible families shall be the difference between the tenant contribution and the contract rent. The tenant contribution shall be ten per cent (10%) of the family's monthly income or forty per cent (40%) of the family's monthly adjusted gross income less a utility allowance, whichever is greater.

(b) The contract rent plus utility allowance for the unit shall not exceed the maximum allowable rent, as determined by the commissioner.

(c) Notwithstanding the basic formula under subsection (a) of this section, the tenant contribution for elderly or disabled persons shall be ten per cent (10%) of the family's monthly income or thirty per cent (30%) of the family's monthly adjusted gross income less a utility allowance, whichever is greater.

(d) The commissioner shall determine the amount of the following allowable deductions, which shall be deducted from a family's income to determine adjusted gross income:

(1) Each dependent;

(2) unreimbursed child care costs that enable all adults in the household to work, to attend school or to actively seek employment. The department or its agent may make exceptions for one or more adults in the household who are precluded by disability from working, attending school or actively seeking employment;

(3) for households with a head of household or spouse who is an elderly or disabled person, annual unreimbursed medical expenses that exceed three per cent (3%) of the family's income;

(4) unreimbursed disability assistance expenses for attendant care or auxiliary apparatus for a household family member with disabilities if such expenses are needed to enable the disabled person or an adult household family member to work; and

(5) any other deduction that the commissioner may establish.

(e) An eligible family that receives rental assistance may, during the term of such family's rental agreement, request that the department or its agent conduct a redetermination of its contribution to the gross rent because of changes in its income or household composition.

(f) The department shall offer pro-rated assistance to a mixed family. The department

shall calculate pro-rated assistance by determining the amount of assistance payable if all family members were eligible and multiplying such amount by the percent of family members who are eligible.

(Effective March 21, 1996; Amended February 9, 2000; Amended May 31, 2007; Amended December 28, 2012)

Sec. 17b-812-7. Eligible housing

(a) Dwelling units contracted for under the rental assistance program shall meet the definition of eligible housing provided in section 17b-812-1 of the Regulations of Connecticut State Agencies.

(b) A family with a rental assistance certificate is responsible for finding a dwelling unit within the state that suits the needs of the family. A family may select the dwelling unit that it already occupies if the dwelling unit meets the department's occupancy policy and the provisions of section 17b-812-8 of the Regulations of Connecticut State Agencies.

(c) The owner of the dwelling unit shall not reside in the same dwelling unit for which a rental assistance payment is being paid to the owner.

(Effective March 21, 1996; Amended February 9, 2000; Amended May 31, 2007; Amended December 28, 2012)

Sec. 17b-812-8. Request for tenancy approval

(a) An eligible family that has located an available dwelling unit for rent shall submit a request for tenancy approval to the department or its agent. The request for tenancy approval shall be signed by the owner or the owner's designated representative and the eligible family. The family shall also submit a copy of the proposed rental agreement between the owner and the family.

(1) The department or its agent shall determine whether the proposed contract rent is in accordance with the schedules established by the commissioner.

(2) Before approving tenancy, the department or its agent shall inspect the dwelling unit for compliance with the standards provided in section 17b-812-7 of the Regulations of Connecticut State Agencies. The department or its agent shall notify the owner of any defects that require correction and shall reinspect the dwelling unit after the owner represents that the identified defects have been corrected. The department or its agent shall not approve tenancy until the dwelling unit is in compliance with the department's occupancy policy for eligible housing.

(b) The term of the rental agreement between the tenant and the owner shall be not less than one year.

(c) The department or its agent shall notify the owner or the owner's designated representative and the family if the request for tenancy is approved. The department or its agent shall provide the owner with two copies of a rental assistance contract. The owner or the owner's designated representative shall sign and return both copies of the rental assistance contract to the department or its agent as well as a copy of the rental agreement

signed by the owner or the owner's designated representative and the tenant. The department or its agent shall sign the rental assistance contracts and return one copy to the owner or the owner's designated representative.

(Effective March 21, 1996; Amended February 9, 2000; Amended May 31, 2007; Amended December 28, 2012)

Sec. 17b-812-9. Reexamination of family income

(a) The department or its agent shall conduct an annual reexamination of the income and family composition of families participating in the rental assistance program. The department or its agent shall adjust the amount of each family's assistance payment at the time of the annual reexamination to reflect changes in the family's adjusted gross income.

(b) During the term of the eligible family's rental agreement, the eligible family shall report changes in income or any change in family composition to the department or its agent within thirty days.

(Effective March 21, 1996; Amended February 9, 2000; Amended May 31, 2007; Amended December 28, 2012)

Sec. 17b-812-10. Disbursement of rental assistance payments

The department or its agent shall pay rental assistance payments directly to the owner or the owner's designated representative. The rental assistance payment shall be the amount stated in the rental assistance contract between the department and the owner.

(Effective March 21, 1996; Amended February 9, 2000; Amended May 31, 2007; Amended December 28, 2012)

Sec. 17b-812-11. Reporting requirements and audit

(a) Any agent designated by the department to administer this program shall submit monthly financial and program reports to the department in accordance with the terms specified in its contractual agreement with the department.

(b) An entity that has been designated as an agent of the department to administer this program shall be subject to audit of all books and records related to this program. Audits shall be performed by independent public accountants registered to practice in the state of Connecticut or by qualified department personnel. All audits shall be in accordance with procedures and timetables established by the department.

(Effective March 21, 1996; Amended February 9, 2000; Amended May 31, 2007; Amended December 28, 2012)

Sec. 17b-812-12. Family obligations

(a) A family shall comply with subsections (b) and (c) of this section in order to continue participating in the rental assistance program. Failure to comply may result in termination from the program.

(b) A family shall:

(1) Provide information that is true and complete and in compliance with the provisions of the rental assistance certificate;

(2) provide all forms and documents necessary for use in a regularly scheduled reexamination or interim reexamination of family income and composition;

(3) provide the social security numbers of all household members and sign and submit forms that will allow the department or its agent to obtain information to determine eligibility;

(4) not later than thirty days after a request by the department or its agent, provide the department or its agent information to verify that the family is living in the dwelling unit or information related to family absence from the dwelling unit;

(5) notify the department or its agent in writing before any planned absence of thirty days or more, or on or before the thirtieth consecutive day of any unplanned absence. If the entire family is absent from the unit for more than ninety consecutive days, the department shall consider the unit vacated and shall terminate rental assistance, unless the family has notified the department or its agent on or before the thirtieth day of any absence and can show good cause for the extended absence on or before the ninetieth day of any absence. If the family shows good cause, the department or its agent may permit the family to be absent for up to sixty additional days before considering the unit to be vacated;

(6) notify the department or its agent in writing not later than thirty days before moving out of the dwelling unit or terminating the lease;

(7) use the dwelling unit as the family's sole residence;

(8) notify the department or its agent in writing of the birth, adoption or court-awarded custody of a child, not later than thirty days after such birth, adoption or court-awarded custody;

(9) request written approval from the department or its agent before adding any other adult family member as an occupant of the dwelling unit;

(10) notify the department or its agent in writing if any member no longer lives in the dwelling unit, not later than thirty days after such member leaves;

(11) allow the department or its agent to inspect the dwelling unit at reasonable times and after reasonable notice as part of regularly scheduled reexaminations, interim examinations and on other occasions deemed necessary by the department or its agent;

(12) immediately notify and forward to the department or its agent a copy of any notice to quit received by the tenant; and

(13) pay utility bills and supply appliances that the owner is not required to provide under the rental agreement.

(c) The family, including each family member, shall not:

(1) Own or have any interest in the dwelling unit other than in a cooperative, or as the owner of a mobile manufactured home leasing space in a mobile manufactured home park, as such terms are defined in section 21-64 of the Connecticut General Statutes;

(2) commit any serious or repeated violation of the rental agreement;

(3) commit fraud, bribery or any other corrupt or criminal act in connection with the

rental assistance program;
(4) participate in any illegal drug or violent criminal activity leading to the individual's conviction;
(5) sublease the dwelling unit;
(6) receive rental assistance while receiving another housing subsidy for the same dwelling unit or a different dwelling unit under any other state, federal or local housing assistance program; or
(7) willfully damage the dwelling unit or premises or cause serious or repeated damage to the dwelling unit or premises through negligence, or permit any guest to willfully damage the dwelling unit or premises or cause serious or repeated damage to the dwelling unit or premises through negligence.

(Adopted effective February 9, 2000; Transferred from § 17b-812-11a, May 31, 2007; Amended May 31, 2012; Amended December 28, 2012)

Notes: Section history note reworded. Former note read: "Adopted as § 17b-812-12, effective March 21, 1996; amended February 9, 2000; renumbered and amended May 31, 2007; amended December 28, 2012." (October 14, 2014)

Sec. 17b-812-13. Denial or termination of assistance
The department or its agent may deny program assistance to an applicant or terminate assistance to a participant for any of the following reasons:
(1) A household family member fails to comply with the provisions of section 17b-812-12 of the Regulations of Connecticut State Agencies;
(2) a household family member fails to sign or submit required forms;
(3) a family with a rental assistance certificate fails to locate an approved dwelling unit within one hundred eighty days and does not demonstrate good cause for extending the expiration date of the rental assistance certificate;
(4) a household family member has been terminated from a department rental assistance program in the last three years;
(5) a household family member refuses to enter into a repayment agreement for monies owed to the department or its agent as a result of a program violation;
(6) a household family member currently owes rent or other monies to the department or its agent in connection with a rental subsidy program;
(7) a household family member has engaged in or threatened abusive or violent behavior towards the department or its agent's personnel;
(8) a family fails to report income that results in rental assistance overpayment in excess of two thousand five hundred dollars; or
(9) a household family member is subject to a registration requirement under a state or federal sex offender registration program.

(Adopted effective March 21, 1996; Transferred from § 17b-812-11a, May 31, 2007; Amended May 31, 2012; Amended December 28, 2012)

Sec. 17b-812-14. Notice, appeals and hearings

(a) The department or its agent shall give program applicants prompt written notice of a decision to deny assistance to an applicant, and shall give program participants written notice of a decision to change the terms of assistance or to discontinue assistance to a participant. Such notice of decision shall: (1) contain a brief statement of the reasons for the decision; (2) state that any person aggrieved by a decision of the commissioner or the commissioner's agent pursuant to the program may request an administrative hearing in accordance with the provisions of section 17b-60 of the Connecticut General Statutes; and (3) describe how to request an administrative hearing. A notice of decision changing the terms of assistance or discontinuing assistance shall be issued not less than thirty days prior to the effective date of the proposed action.

(b) A participant or applicant may make a written request for an administrative hearing to the department's Office of Legal Counsel, Regulations and Administrative Hearings. Such request shall be faxed or postmarked not later than sixty days from the date printed on the notice of decision issued by the department or its agent.

(c) If an aggrieved participant requests an administrative hearing due to a decision to deny assistance, change the terms of assistance or discontinue assistance, the department shall continue to provide rental assistance payments as provided in the participant's rental assistance certificate until a decision has been issued following such hearing, provided: (1) the request for an administrative hearing is faxed or postmarked not later than ten days from the date printed on the notice of decision issued by the department or its agent; (2) the program has sufficient funds to provide such assistance; and (3) the decision under review is not one that affects all program applicants or participants equally. If an aggrieved participant requests an administrative hearing but the participant's grievance is not due to a decision to deny assistance, change the terms of assistance or discontinue assistance, the department shall continue to provide rental assistance payments as provided in the rental assistance certificate until a decision has been issued following such hearing.

(d) An administrative hearing shall be scheduled by the Office of Legal Counsel, Regulations and Administrative Hearings not later than thirty days from the receipt of the request for an administrative hearing. The Office of Legal Counsel, Regulations and Administrative Hearings shall notify the applicant or participant and the department or its agent of the administrative hearing by written notice issued not less than ten days in advance of the scheduled hearing. The notice of administrative hearing shall include the date, time and place for the hearing; reference the particular sections of the statutes and regulations involved; make a short and plain statement of the matters asserted; and advise the participant of the right to be represented by counsel. The administrative hearing shall be conducted by a hearing officer designated by the department.

(e) In lieu of holding an administrative hearing, the Office of Legal Counsel, Regulations and Administrative Hearings may take one of the following actions:

(1) Accept a withdrawal of the request by the person who made it. This action shall be voluntary and may be made at any time before the administrative hearing by a written

statement of withdrawal addressed to the Office of Legal Counsel, Regulations and Administrative Hearings; or

(2) dismiss the request if:

(A) The applicant or recipient who has requested the administrative hearing fails to appear at the designated time and place without good cause; or

(B) the point at issue is resolved prior to the administrative hearing.

(f) Not later than sixty days from the date of the administrative hearing, the Office of Legal Counsel, Regulations and Administrative Hearings shall issue a written report of its findings which may order a change to the original decision of which review was sought. Factual determinations relating to the individual circumstances of the applicant or recipient who requested the administrative hearing shall be based on information presented at the administrative hearing. A copy of the decision shall be provided promptly to the applicant or recipient who requested the administrative hearing.

(Effective December 28, 2012)