State of Connecticut
Regulation of
Department of Social Services
Concerning
The Acquired Brain Injury Waiver Program

The Regulations of Connecticut State Agencies are amended by adding sections 17b-260a-1 to 17b-260a-18, inclusive, as follows:

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

The Acquired Brain Injury (ABI) waiver program is established pursuant to sections 17b-260a(a) and 17b-260a(b) of the Connecticut General Statutes and 42 USC 1396n(c). The ABI waiver program provides, within the limitations described in sections 17b-260a-2 to 17b-260a-18, inclusive, of the Regulations of Connecticut State Agencies, a range of nonmedical, home and community-based services to individuals 18 years of age or older with an ABI who, without such services, would otherwise require placement in a hospital, nursing facility (NF), or Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID). The intention of the ABI waiver program is to enable such individuals, through person-centered planning, to receive home and community-based services necessary to allow such individuals to live in the community and avoid institutionalization.

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

Sections 17b-260a-1 to 17b-260a-18, inclusive, of the Regulations of Connecticut State Agencies set forth the requirements for eligibility and payment of services to eligible individuals participating in the ABI waiver program. These regulations also describe program requirements; services available; service requirements; department, provider and individual responsibilities; residential setting requirements; and limitations under the ABI waiver program.

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

As used in sections 17b-260a-1 to 17b-260a-18, inclusive, of the Regulations of Connecticut State Agencies:

(1) "Acquired brain injury" or "ABI" means the combination of focal and diffuse central nervous system dysfunctions, immediate or delayed, at the brainstem level or above. These dysfunctions may be acquired through physical trauma, oxygen deprivation, infection, or a discrete incident that is toxic, surgical, or vascular in nature. The term "ABI" does not include disorders that are congenital, developmental, degenerative, associated with aging, or that meet the definition of intellectual disability as defined in section 1-1g of the Connecticut General Statutes;

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

(3) "Acquired Brain Injury waiver program" or "ABI waiver program" or "the program" means the programs administered by the Department of Social Services and established pursuant to sections 17b-260a(a) and 17b-260a(b) of the Connecticut General Statutes, as described in Medicaid waivers approved by the Secretary of the United States Department of Health and Human Services pursuant to 42 USC 1396n as amended from time to time, for the provision of home and community-based services to individuals with acquired brain injury;

(4) "ABI Waiver I" means the Acquired Brain Injury waiver administered by the Department of

Social Services, as authorized by section 17b-260a(a) of the Connecticut General Statutes and approved by the Secretary of the United States Department of Health and Human Services with an initial effective date of January 1, 1999;

(5) "ABI Waiver II" means the Acquired Brain Injury waiver administered by the Department of Social Services, as authorized by section 17b-260a(b) of the Connecticut General Statutes, and approved by the Secretary of the United States Department of Health and Human Services with an initial effective date of December 1, 2014;

(6) "Acquired Brain Injury waiver services" or "ABI waiver services" means all or some of the services provided to individuals in the ABI waiver program;

(7) "Activity of daily living" or "ADL" means an activity or task that is essential to an individual's health, welfare, and safety, including, but not limited to, bathing, dressing, eating, transfers, and bowel and bladder care;

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

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

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

(11) "Applied income" means the portion of the individual's income that remains after all deductions and disregards are subtracted and that may be applied to the cost of waiver services;

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

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

(14) "Commissioner" means the Commissioner of Social Services;

(15) "Cost-effective" or "cost-effectiveness" means the department's determination that payments for the individual's total service costs do not exceed either the individual caps or available funding for the ABI waiver program;

(16) "Countable income" means all sources of income not excluded under the Medicaid program;

(17) "Department" or "DSS" means the state of Connecticut Department of Social Services or its agent;

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

(19) "Fiscal intermediary" means an agent or agents under contract with the department that is responsible for: paying providers for services delivered; registering providers; providing training and outreach to individuals and providers of services under the ABI waiver program; and performing other administrative functions requested by the department;

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

(21) "Home and community-based services" means Medicaid services provided to an individual in that individual's own home or other community-based setting;

(22) "Home and community-based setting" has the same meaning as provided in 42 CFR 441.301(c)(4)-(5), as amended from time to time;

(23) "Hospital" has the same meaning as provided in 42 CFR 440.10, as amended from time to

time;

(24) "Household employee" means a provider who performs ABI recovery assistant I, ABI recovery assistant II, chore, companion, homemaker, independent living skills training, or respite services, and who is employed by the individual and not an agency;

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

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

(27) "Integrated work setting" means a work setting where people with disabilities work alongside people without disabilities, for at least minimum wage.

(28) "Intermediate care facility for individuals with intellectual disabilities" or "ICF-IID" has the same meaning as provided in 42 CFR 440.150, as amended from time to time, and is a facility licensed by the Connecticut Department of Developmental Services for the care and treatment of persons with intellectual disabilities;

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

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

(31) "Level of care" means the type of facility, as determined by a care manager or designated agent of the department, needed to care for an individual if the individual were not receiving services under the ABI waiver program. The types of facilities include: a nursing facility, ABI NF, CDH, or ICF-IID;

(32) "Medicaid" or "Medicaid program" means medical and health-related services administered by the state of Connecticut Department of Social Services pursuant to Title XIX of the Social Security Act;

(33) "Medicaid Provider Enrollment Agreement" has the same meaning as provided in section 17b-262-523(23) of the Regulations of Connecticut State Agencies, except that such agreement may include addenda specific to the ABI waiver program;

(34) "Neuropsychological evaluation" has the same meaning as provided in section 17b-262-468(17) of the Regulations of Connecticut State Agencies;

(35) "Nursing facility" or "NF" has the same meaning as provided in 42 CFR 440.40 and 42 CFR 440.155, as amended from time to time;

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

(37) "Other medical services" means services that are normally included in the department's payments to NFs, ABI NFs, CDHs, and ICF-IIDs, and that the individual requires, in addition to ABI waiver services, to live in the community. Other medical services include: home health care; nursing services; physical therapy; speech therapy; and occupational therapy;

(38) "Person-centered plan" means a service plan developed by the person-centered team that meets the requirements of 42 CFR 441.301(c)(1)-(3), inclusive, as amended from time to time;

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

(40) "Provider" means an agency provider, household employee or self-employed provider who meets the qualifications established by the department to provide home and community-based services under the ABI waiver program, has signed the Medicaid Provider Enrollment Agreement,

and is enrolled in the ABI waiver program;

(41) "Qualified neuropsychologist" means a psychologist who meets the qualifications of section 17b-262-468(16) of the Regulations of Connecticut State Agencies;

(42) "Rehabilitation hospital" means a facility performing rehabilitative outpatient hospital services in accordance with the provisions of 42 CFR 440.20(a).

(43) "Representative" means a person who is not a legal representative, and who is acting in support of an individual;

(44) "Self-employed provider" means a person who does not work for an agency, is not a household employee, and meets the qualifications listed in 17b-260a-8 of the Regulations of Connecticut State Agencies to provide certain services under the ABI waiver program;

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

(46) "Supervision or cueing" means daily support such as monitoring, observing, verbal or gestural prompting, verbal coaching and gestural or pictorial cueing that is required in order for the individual to accomplish an ADL. Supervision and cueing must be required on a contemporaneous basis with the performance of the ADL, and does not include a reminder or request to perform an ADL when the individual does not need support beyond such reminder or request in order to accomplish the ADL.

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

(48) "Waiting list" means a record maintained by the department that includes the names, and dates of completed ABI waiver applications, of all individuals who have submitted completed applications for ABI waiver services and whose applications have been screened and found to be functionally eligible for the program.

(NEW) Sec. 17b-260a-4. Not an Entitlement

The ABI waiver program is not an entitlement program. Services, waiver slots and access to services under the ABI waiver program may be limited based on available funding and program capacity.

(NEW) Sec. 17b-260a-5. Eligibility

(a) An applicant may be eligible to receive coverage for the cost of the services specified in section 17b-260a-8 of the Regulations of Connecticut State Agencies, through the department's ABI waiver program, if:

(1) The applicant's countable income is less than 300% of the benefit amount that would be payable under the federal Supplemental Security Income program to an applicant who lives in the applicant's own home and has no income or resources;

(2) The applicant is otherwise eligible to participate in the department's Medicaid program, including any applicable asset requirements, under either the working disabled or long-term care eligibility criteria;

(3) The applicant meets the programmatic requirements of subsection (c) of this section; and

(4) The applicant is not ineligible for coverage under subsections (d) or (e) of this section.

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

(1) The applicant's countable income and assets for purposes of eligibility are determined using the same methodologies the department employs in determining the countable income and assets of

an institutionalized applicant for Medicaid, including, but not limited to, the spousal impoverishment rules and spousal post-eligibility rules under section 1924 of the Social Security Act, 42 U.S.C. § 1396r-5, for individuals with a community spouse.

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

(3) Payment for ABI waiver services is reduced by the individual's applied income, which is calculated by determining the amount of the applicant's countable income remaining after the deduction of an allowance for the personal needs of the individual equal to 200% of the federal poverty level, as well as any applicable community spouse's or family allowance, and amounts for incurred medical or remedial care expenses not subject to payment by a third party, as specified in 42 CFR 435.726.

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

An individual shall:

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

(2) Have an ABI, as defined in section 17b-260a-3(1) of the Regulations of Connecticut State Agencies;

(3) Meet the criteria for one of the level-of-care categories described in subsection 17b-260a-9(d) of the Regulations of Connecticut State Agencies;

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

(5) Voluntarily choose to live in the community by participating in the ABI waiver program;

(6) Wish to utilize ABI waiver services;

(7) Develop, in consultation with the person-centered team, a service plan that provides assistance that reasonably addresses and mitigates identified risks;

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

(9) Understand and acknowledge, or the individual's legal representative shall understand and acknowledge, that the individual is the employer of any household employees, as defined in section 17b-260a-3(24) of the Regulations of Connecticut State Agencies, and shall sign a written document accepting full responsibility as the employer of such providers;

(10) Maintain eligibility for Medicaid;

(11) Need waiver services, which means that the individual needs a minimum of two waiver services, on at least a monthly basis;

(12) Have a total service plan cost that does not cause the ABI waiver program's expenditures to exceed total appropriated funding limits for the ABI waiver program;

(13) Have a total service plan cost that does not exceed the individual cap that applies to the individual, as set forth in sections 17b-260a-10(a) and (b); and

(14) Agree to pay, if applicable, any applied income toward the cost of services rendered under the waiver, as required under section 17b-260a-11(b).

(d) Notwithstanding subsections (a), (b) and (c) of this section, an individual shall not be eligible for ABI waiver program services if:

(1) The individual:

(A) Receives services under any other Medicaid waiver program;

(B) Has received and benefited from ABI waiver services, no longer requires the services, no longer meets level-of-care criteria, and can continue to reside in the community without the support of ABI waiver program services;

(C) Has a cognitive or behavioral dysfunction due solely to an intellectual disability or chronic mental illness, rather than an ABI, as determined by a licensed medical professional;

(D) Requires inpatient care in an acute care hospital, NF, ABI NF, ICF-IID or CDH, or who is otherwise institutionalized for a period of ninety days or more, provided, however, such durational limitation may be extended for an additional thirty days upon submission of documentation from a medical professional indicating that the applicant's discharge is expected within thirty days;

(E) Demonstrates consistent and extreme physical, verbal, or sexual aggression toward others;

(F) Demonstrates behaviors that violate the law or are contrary to community integrated living;

(G) Is currently incarcerated, and not expected to be returned to the community within ninety days;

(H) Lacks mental capacity to participate in the program;

(I) Refuses services that are vital to health, welfare, and safety; or

(J) Behaves in ways that are detrimental to the individual's health, welfare, and safety, which includes, but is not limited to:

(i) Participating in illegal or criminal activity;

(ii) Using, or threatening to use, weapons, chemicals, or firearms for the purpose of causing harm or injury to self or others; or

(iii) Compromising the safety of caregivers, staff, and others in the home or community.

(2) The conditions at the individual's home or on the grounds of the home are hazardous due to:

(A) Illegal or criminal activity;

(B) The presence of animals that are dangerous or not properly secured or maintained;

(C) Poor sanitation; or

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

(3) Persons who either reside in, or have regular access to, the individual's home are:

(A) Engaging in illegal or criminal activity;

(B) Behaving in a manner that is dangerous or jeopardizes the safety, health, or well-being of the individual, providers, or others;

(C) Interfering with the provider's delivery, or the individual's receipt, of services or acting in any way that affects a provider's access to the individual; or

(D) Threatening the individual verbally, physically, or sexually; or

(4) In the opinion of the department, a service plan that is both cost-effective and reasonably ensures the health, welfare, and safety of the individual cannot be developed or implemented.

(e) Individuals who are actively participating in the ABI waiver program and who turn 65 years of age shall be offered the choice of (1) remaining on the ABI waiver program; (2) accessing institutional placement; or (3) transitioning to the Connecticut Home Care Program for Elders.

(NEW) Sec. 17b-260a-6. Person-centered planning process

(a) The service plan shall be developed based on a person-centered planning model, as described in 42 CFR 441.301(c), as amended from time to time. The individual shall lead the planning process where possible, and in accordance with section 17b-260a-11(a) of the Regulations of Connecticut State Agencies.

(b) In addition to being led by the individual receiving services and supports, the person-centered planning process shall:

(1) Include people chosen by the individual, provided the inclusion of such persons is not otherwise prohibited herein;

(2) Provide necessary information and support to ensure that the individual directs the planning process to the maximum extent possible, and is able to make informed choices and decisions;

(3) Be timely and occur at dates, times, and locations of convenience to the individual;

(4) Be conducted in a manner that reflects cultural considerations of the individual; provides information in plain language; and is accessible to the individual and persons with limited English proficiency;

(5) Include strategies for conflict-resolution or solving disagreements within the process, including clear conflict-of-interest guidelines for all participants;

(6) Prohibit providers of waiver services for the individual, or those who have an interest in or are employed by a provider of waiver services for the individual, from providing care management or participating in the development of the person-centered service plan;

(7) Offer informed choices to the individual regarding the types and providers of services and supports that are available;

(8) Include a method for the individual to request updates to the plan as needed; and

(9) Record the alternative home and community-based settings that the individual considered.

(NEW) Sec. 17b-260a-7. Home and community-based setting requirements

(a) Prior to an individual accessing any services under the ABI waiver program, the department shall assess each home and community-based setting in the service plan to determine whether such setting complies with 42 CFR 441.301(c)(4)-(5), as amended from time to time.

(b) If, upon initial assessment of the individual's service plan, or any time thereafter, the department determines that a setting does not comply with 42 CFR 441.301(c)(4)-(5), the department shall inform the individual that the setting does not comply, and inform the individual of alternative settings that comply with these requirements. If the individual elects to remain in, or receive services at, a setting that does not meet these requirements, and the provider has not complied with the department's corrective action plan for meeting such requirements, the individual shall not remain eligible to receive services under the ABI waiver program.

(c) The department shall assess compliance with 42 CFR 441.301(c)(4)-(5) as part of its process for credentialing and re-credentialing providers.

(NEW) Sec. 17b-260a-8. Home and community-based services available under the ABI waiver program

(a) General principles

(1) ABI waiver services shall be furnished under a written service plan that is based on a person-centered planning process, as described in section 17b-260a-6 of the Regulations of Connecticut State Agencies, and subject to approval by the department.

(2) Except as set forth in subsection (b) of this section, ABI waiver services may be provided alone or in combination with other services, in accordance with the specific functional needs of the individual.

(3) The ABI waiver services provided at any given time, in combination with other available medical and community-based services, constitute the individual's service plan. The need for each specific ABI waiver service shall be documented in the service plan.

(4) The ABI waiver services documented in the service plan may be purchased from agency providers, household employees, or self-employed providers that the department's fiscal intermediary has determined are eligible to participate in the Medicaid program, are enrolled with the department

as a provider, and agree to accept Medicaid payment as payment in full for services authorized and performed under the program.

(5) The department shall not pay for ABI waiver services provided by the individual's conservator, power of attorney, or a family member of such conservator or power of attorney, or an agency provider owned by the individual's conservator or power of attorney.

(6) The department shall pay only for ABI waiver services that are provided in settings that meet the requirements of 42 CFR 441.301(c)(4), as amended from time to time.

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

(8) The rate paid to service providers does not include payment for transportation services, unless specified in subsection (b) of this section.

(9) The department's fiscal intermediary, prior to the start of services and bi-annually thereafter, shall verify that providers are qualified to provide services.

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

(1) ABI Group Day Habilitation Services, which are services and supports that: lead to the acquisition, improvement, or retention of skills and abilities necessary for an individual to maintain health, wellness, and self-care; prepare an individual for work or community participation; or support meaningful socialization and leisure activities. ABI Group Day Habilitation services shall be provided only:

(A) By an agency provider or a rehabilitation hospital outpatient department that meets the requirements of subsection (a) of this section, and all applicable training, state licensure, or certification requirements; and

(B) For a time period that does not exceed eight hours per day.

(2) ABI Recovery Assistant I Services, which are services to promote the individual's strengths and abilities to maintain and foster community living skills, in accordance with therapeutic goals outlined in the individual's service plan. Services may include improvement of socialization, self-advocacy, and the development of natural supports. Services also include communication and coordination with service providers and others who support the individual. Although not a primary function, a provider performing ABI Recovery Assistant I services may provide assistance with ADLs and cueing with respect to medications with support of a medication box.

(A) This service shall be provided only to individuals on ABI Waiver II; and

(B) This service shall be provided by an agency provider or a household employee who meets the requirements of subsection (a) of this section, and all applicable training, state licensure, or certification requirements.

(3) ABI Recovery Assistant II Services, which are non-medical and safety monitoring services to assist an individual with activities of daily living (both hands-on and cueing) and integration into the community.

(A) This service shall be provided only to individuals on ABI Waiver II;

(B) This service shall be provided by an agency provider or a household employee who meets the requirements of subsection (a) of this section, and all applicable training, state licensure, or certification requirements.

(4) Adult Day Health Services, which are services provided in a group setting that include a variety of health and social services, including, but not limited to: personal care, health care, recreation, socialization, nursing services, transportation services, and hot meals and snacks that meet the individual's nutritional needs and dietary restrictions. Adult Day Health services shall:

(A) Be provided only to individuals on ABI Waiver II;

(B) Be provided by an agency provider that meets the requirements of subsection (a) of this section, and all applicable training, state licensure, or certification requirements;

(C) Be provided one or more days per week, four or more hours per day, on a regularly scheduled basis; and

(D) Include transportation to and from the Adult Day Health Center, a meal, and snacks.

(5) Care Management Services, which are services provided to assist the individual to implement the service plan and to assure on-going effective coordination, communication, and cooperation among all sources of support and services to the individual. Care management services include, but are not limited to, the following: assistance identifying the individual's home and community-based service needs; promotion of participation in activities that may increase the individual's independence, inclusion in the community and life satisfaction; arrangement of daily living supports and services to be delivered to the individual; assistance identifying and accessing entitlements and other possible funding sources; advocacy for the individual when necessary to ensure the receipt of needed services; and referral for crisis intervention services and monitoring, as necessary and appropriate. Care management services shall be provided by a care manager that meets all the requirements of subsection (a) of this section, and all applicable training, state licensure, or certification requirements, and that:

(A) Does not provide any other home and community-based services to the individual; and

(B) Does not have an interest in, or is not employed by, a provider of home and community-based services for the individual.

(6) Chore Services, which are services needed to maintain the individual's home in a clean, sanitary, and safe condition. Chore services include, but are not limited to, heavy household chores, such as washing floors, windows, and walls, and moving heavy items of furniture in order to provide safe access and egress.

(A) Chore services shall be provided by an agency provider or household employee who meets the requirements of subsection (a) of this section, and all applicable training, state licensure, or certification requirements;

(B) Chore services shall not be covered if:

(i) The individual or anyone else living in the household is capable of performing or paying for the services;

(ii) A relative, caretaker, community agency or other entity is capable of, or responsible for, providing the services; or

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

(7) Cognitive-Behavioral Services, which are individual interventions designed to increase an individual's cognitive and behavioral capabilities and to further the individual's adjustment to successful community engagement. These services include, but are not limited to: comprehensive assessment of cognitive strengths and liabilities, quality of adjustment, and behavioral functioning; development and implementation of cognitive and behavioral strategies; development of a structured cognitive-behavioral intervention plan; ongoing or periodic consultation with the individual and the person-centered planning team concerning cognitive and behavioral strategies and interventions specified in the cognitive-behavioral intervention plan; ongoing or periodic assistance with training of the individual and person-centered planning team concerning cognitive and behavioral strategies and interventions; and periodic reassessment and revision, as needed, of the cognitive-behavioral intervention plan.

(A) Cognitive-behavioral services may be provided in the individual's home or in the community, and shall be performed by an agency provider or a self-employed provider who is a licensed psychologist, physical therapist, speech therapist, or occupational therapist, a qualified neuropsychologist, or another type of provider authorized to perform cognitive-behavioral services

under the ABI waiver program, and who meets the requirements of subsection (a) of this section, and all applicable training, state licensure, or certification requirements.

(B) Intervention plans shall be updated at least annually, or more frequently as clinically indicated. Intervention plans shall include the following components:

(i) Long-term, measurable goals mutually agreed upon by the individual, or the individual's legal representative, and the provider;

(ii) Shorter-term, measurable objectives to reach those goals;

(iii) The individual's strengths and challenges, and a description of how strengths are to be used in achieving goals;

(iv) Skills or tasks that need to be developed by the individual or the family;

(v) Input by the individual into the intervention plan commensurate with the level at which the individual is able to participate; and

(vi) A description of how positive reinforcement, rather than punitive measures, will be used to support the individual.

(C) Providers of cognitive-behavioral services shall be paid for face-to-face encounters and also for non-face-to-face encounters.

(i) Face-to-face (in-person) encounters are in-person meetings with the individual, and meetings with the individual's family, supporters, or providers, even when the individual is not present. The provider must have an in-person meeting with the individual at least quarterly.

(ii) Non-face-to-face (not in-person) encounters are telephonic or other secure electronic forms of communication, including video telephony services such as Skype. A provider may also be paid at the non-face-to-face rate for activities such as reviewing the individual's record and writing the plan of care, even if the individual is not present.

(8) Community Living Support Services, which are support services that provide supervised living in the individual's residence for up to 24 hours per day, including overnight supervision, to a minimum of two, or a maximum of three, individuals at once who require support and supervision, in a supervised community residential setting for either a half-day (12 hours) or full day (24 hours).

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

(i) Self-care;

(ii) Medication management;

(iii) Interpersonal communication;

(iv) Socialization;

(v) Sensory and motor skills;

(vi) Mobility;

(vii) Utilizing transportation services;

(viii) Problem-solving;

(ix) Money management; and

(x) Household management.

(B) Assessment and training services are provided as part of this service.

(C) Room and board is not included as part of this service.

(D) The provider shall develop a plan that demonstrates the provider's ability to work with the individual and to provide services that are consistent with the therapeutic goals of the individual's service plan.

(E) Upon the individual's request or improvement in the individual's ability to live more independently, the provider and the care manager shall work together, with the individual, to develop and implement a plan to transition the individual to greater independence in the community.

(F) Community living support services shall be provided by an agency provider or rehabilitation

hospital that meets the requirements of subsection (a) of this section, and all applicable training, state licensure, or certification requirements.

(9) Companion Services, which are nonmedical services that are provided in accordance with a therapeutic goal included in the service plan, including the following: supervision and socialization services; assistance with or supervision of meal preparation; assistance with laundry that is being performed by the individual; and light housekeeping tasks that are incidental to the care of the individual.

(A) Companion services shall be provided by an agency provider or a household employee who meets the requirements of subsection (a) of this section, and all applicable training, state licensure, or certification requirements.

(B) Companion services shall not entail the provision of hands-on care or household management tasks, as these tasks are provided by personal care assistants and chore services providers, respectively, in accordance with subdivisions (6) and (15) of this subsection.

(10) Consultation Services, which are services provided to assist a team and individuals to address service-implementation issues that have presented a barrier to resolution. This service aids in the development of individual interventions designed to decrease an individual's severe maladaptive behaviors, which jeopardize the individual's ability to remain integrated in the community.

(A) Consultation services shall be provided:

(i) Only to individuals on ABI Waiver II;

(ii) In a team meeting at the individual's home or community location; and

(iii) By an agency or self-employed provider who is a licensed psychologist, clinical social worker, speech pathologist, speech therapist, occupational therapist, physical therapist, registered nurse, or dietician/nutritionist, a qualified neuropsychologist, or a certified rehabilitation counselor or substance abuse specialist, and who meet the requirements of subsection (a) of this section and all applicable training, state licensure, or certification requirements.

(11) Environmental Accessibility Adaptation ("EAA") Services, which are physical changes made to an individual's home that are necessary to ensure the health, welfare, and safety of the individual, or enhance and promote greater independence, without which the individual would require institutionalization.

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

(i) Installation of ramps;

(ii) Widening of doorways;

(iii) Modifications to meet egress requirements;

(iv) Modification of bathroom facilities; and

(v) Addition of specialized electrical and plumbing devices.

(B) All EAA services shall be provided by agency providers or private contractors or businesses in accordance with applicable state and local building codes.

(C) EAA services do not include: carpeting; central air conditioning; roof repair; house adaptations that add to the square footage of the home; or any other physical improvement to the home not of direct benefit to the individual's health, welfare, and safety, or ability to live independently.

(D) EAA services shall not be provided to adapt units that are owned or leased by providers of waiver services.

(12) Homemaker Services, which are general household activities, including meal preparation and routine household chores.

(A) The department shall pay for homemaker services when the person regularly responsible for homemaking activities is temporarily absent or unable to manage the home and care for the individual or others in the home, or when the individual is unable to learn such skills.

(B) Homemaker services shall be provided by an agency provider or a household employee that meets the requirements of subsection (a) of this section, and all applicable training, state licensure, or certification requirements. Homemaker services shall not be provided by a member of the individual's family, the individual's conservator, or a member of the conservator's family.

(13) Home-Delivered Meals, which is the preparation and delivery of one or two meals per day to an individual who is unable to prepare or obtain nourishing meals on the individual's own, or for an individual who normally has someone who is responsible for preparing and delivering meals, but that person is temporarily absent or unable to perform this service.

(14) Independent Living Skills Training ("ILST"), which is a training service designed for, and delivered to, an individual to improve that individual's ability to live independently in the community and to carry out strategies developed in cognitive/behavioral programs.

(A) ILST may include, but is not limited to, teaching the individual the following skills:

(i) Self-care;

(ii) Medication management;

(iii) Task completion;

(iv) Interpersonal communication skills;

(v) Socialization skills;

(vi) Sensory/motor skills;

(vii) Mobility and community transportation skills;

(viii) Problem solving skills;

(ix) Money management skills; and

(x) Household management skills.

(B) ILST shall be provided by an agency provider or household employee that meets the requirements of subsection (a) of this section, and all applicable training, state licensure, or certification requirements.

(15) Personal Care Assistant services, which are services that provide the individual with assistance with the following: eating, bathing, dressing, personal hygiene, and other activities of daily living that are performed by a provider in the individual's home or community; or supervision and cueing of these activities without actual hands-on assistance. Personal care assistant services shall be provided only:

(A) If the individual's physical ability to perform activities of daily living is impaired, or if the individual's cognitive or behavioral impairments interfere with the individual's ability to perform these tasks;

(B) To individuals on ABI Waiver II; and

(C) By an agency that meets the requirements of subsection (a) of this section, and all applicable training, state licensure, or certification requirements.

(16) Personal Emergency Response System ("PERS"), which is an electronic device connected to an individual's telephone that enables an individual at high risk of institutionalization to secure help in an emergency.

(A) A PERS is available only to an individual who:

(i) Lives alone;

(ii) Is alone for significant parts of the day and who does not have providers; or

(iii) Would otherwise require extensive routine supervision.

(B) A PERS shall be provided by an agency provider that sells and installs PERS equipment.

(17) Prevocational Services, which are time-limited services that provide learning and work experience, including volunteer work, where the individual can develop general non-job-task-specific strengths and skills that contribute to employability in paid employment in an integrated work setting. Services are intended to develop and teach general skills, such as the ability to: communicate

effectively with supervisors, co-workers, and customers; comply with generally accepted community workplace conduct and dress; follow directions; attend to tasks; develop strategies to solve problems at the workplace; and comply with general workplace safety and mobility training. Prevocational services are designed to be a pre-cursor to integrated employment.

(A) The following time limits shall apply to prevocational services:

(i) For individuals enrolled in ABI Waiver I, effective December 1, 2015, a two-year time limit for this service shall be applied prospectively. This two-year limit may be extended up to a maximum of four years upon a determination by the department that additional time is needed for an individual to achieve the person-centered goal of attaining supported employment. Annual redeterminations of eligibility for such services shall be made after an initial two years of such services.

(ii) For individuals enrolled in ABI Waiver II, this service is limited to two years. Upon strong justification of progress toward employment goals, the department may authorize the service for a maximum total of three years.

(iii) This service is limited to 40 hours per week.

(B) Services shall be provided in the individual's home or in an integrated work setting, based on the individual's needs and preferences.

(C) The individual shall have employment-related goals in the person-centered service plan;

(D) Prevocational services shall be provided by an agency provider that meets the requirements of subsection (a) of this section, and all applicable training, state licensure, or certification requirements.

(18) Respite Care Services, which are services provided to individuals who are unable to care for themselves, and when the person normally performing such services is absent or in need of relief.

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

(B) Services shall be provided by an agency or household employee who meets the requirements of subsection (a) of this section, and all applicable training, state licensure, or certification requirements;

(19) Specialized Medical Equipment and Supplies, which include devices, controls, or appliances that enable an individual to increase the individual's ability to perform ADLs, or to cognitively perceive, control, or communicate in the individual's environment within the community; items necessary for life support and those ancillary supplies and equipment that are necessary for the proper functioning of such items; and durable and non-durable medical equipment that is not available as a covered medical service under the Medicaid state plan.

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

(B) Specialized medical equipment and supplies shall be provided by a medical equipment vendor, durable medical equipment provider, or pharmacy that meets the requirements of subsection (a) of this section, and all applicable training, state licensure, or certification requirements.

(20) Substance Abuse Program Services, which are individually designed interventions to reduce or eliminate the individual's use or abuse of alcohol or drugs when such use or abuse interferes with the individual's ability to remain in the community.

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

(i) Performing an in-depth assessment of the relationship between the individual's use or abuse of alcohol or drugs and the individual's brain injury;

(ii) Performing a learning and behavioral assessment;

(iii) Developing and implementing a structured treatment plan;

(iv) Providing ongoing education and training of the individual, family members, and other service providers concerning support needs of the individual;

(v) Developing individualized strategies to avoid relapse;

(vi) Conducting periodic reassessment of the treatment plan; and

(vii) Providing ongoing support to the individual.

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

(C) Substance abuse program services shall be provided by either agency providers (i.e, substance abuse diagnostic and treatment centers, or rehabilitation hospitals) or individual providers (i.e., self-employed providers, licensed psychologists, or certified drug and alcohol counselors) that meet the requirements of subsection (a) of this section, and all applicable training, state licensure, or certification requirements.

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

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

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

(21) Supported Employment services, which are services provided to individuals who, because of their disabilities, need intensive on-going support to perform in a work setting. The intended outcome of this service is sustained paid employment or self-employment in the general workforce in a job that: (1) meets the individual's personal and career goals; (2) pays a wage level at or above the minimum wage; and (3) pays at a wage and benefit level that is not less than the customary wage and benefit level paid by an employer for the same or similar work performed by individuals without disabilities.

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

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

(C) Transportation between the individual's residence and supported employment site is required as a supported employment service, and is included in the rate paid to the provider.

(D) Supportive employment services shall be provided by agency providers that meet the requirements of subsection (a) of this section, and all applicable training and state licensure, or certification requirements.

(22) Transitional Living Services, which are short-term, individualized, residential services providing support to an individual transitioning into a community living situation. These services and supports are designed to improve the individual's skills and ability to live in the community.

(A) Transitional living services:

(i) Are available only to individuals on ABI Waiver I;

(ii) Shall be provided for only one transitional period;

(iii) May be provided up to 24 hours per day;

(iv) Shall be provided only when the individual is unable to be supported in a permanent residence and is in need of intensive clinical interventions provided by this service; and

(v) Shall be provided by an agency provider or rehabilitation hospital that meets the requirements

of subsection (a) of this section, and all applicable training, state licensure, or certification requirements;

(B) Prior to discharge from transitional living services, the provider shall work with the individual and the care manager to develop a plan of care. Upon discharge, other ABI services shall become available to the individual in accordance with the plan of care.

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

(D) Transitional living services shall not be provided with any ABI services other than care management, environmental modifications, specialized medical equipment and vehicle modifications.

(23) Transportation Services, which are services offered in accordance with the individual's service plan to allow the individual to access services that do not qualify for non-emergency medical transportation under 42 CFR §440.170(a).

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

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

(C) Transportation services shall be provided by a livery service or individual provider licensed by the State of Connecticut, with a valid Connecticut driver's license and evidence of automobile insurance.

(24) Vehicle modification services, which are alterations to a vehicle when such alterations are necessary to improve the individual's independence and inclusion in the community, and to enable the individual to avoid institutionalization.

(A) The vehicle shall be the individual's primary means of transportation.

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

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

(D) Vehicle modification services do not include: adaptations or improvements to a vehicle that are of general utility and not of direct medical or remedial benefit to the individual; payments for the purchase or lease of a vehicle; or regularly scheduled upkeep and maintenance of a vehicle, except for upkeep and maintenance of the modifications.

(E) The total individual cost limit for vehicle modifications is $10,000.00.

(F) Vehicle modification services shall be provided by a provider approved by the State of Connecticut as a vehicle modification vendor.

(NEW) Sec. 17b-260a-9. Pre-screen, waiting list and assessment

(a) The department shall review completed applications that it receives in the order in which they are received. Acceptance to the ABI waiver program shall be on a first-come, first-served basis, except that individuals transitioning from the Money Follows the Person program or Department of Mental Health and Addiction Services Acquired Brain Injury Services to the ABI waiver program shall have priority for reserved spaces.

(b) The department shall conduct a pre-screen of the applicant following the receipt of the application, and prior to placing the applicant's name on the waiting list, to determine whether the applicant (1) meets the financial and programmatic requirements described in section 17b-260a-5 of the Regulations of Connecticut State Agencies, and (2) requires one of the level-of-care categories described in subsection (d) of this section.

(c) Applications shall be pre-screened based upon the information contained in the completed

application, as well as information obtained from: the individual; a neuropsychological examination report prepared by a qualified neuropsychologist; and any other clinical personnel who are familiar with the individual's case and history. In order to be considered, the neuropsychological examination report must have been completed no more than two years prior to the application date, provided, however, that the department retains the discretion to increase this time limitation on a case-by-case basis. The neuropsychological examination report shall be submitted to the department no later than six months following the application date, except that the department may extend this deadline for an additional 90 days if a neuropsychological examination appointment has been scheduled. Failure by the individual to meet this deadline shall result in the denial of the application.

(d) To qualify for services under the ABI waiver program, the individual shall meet one of the following institutional level-of-care categories:

(1) Category I (NF level of care): If the individual were not receiving services under the ABI waiver program, the individual would require care in a NF. The individual is considered to require care in a NF if the individual resides in such a facility and the department or its agent determines that the individual currently requires such level of care, or if the individual does not reside in such a facility but has impaired cognition and, due to physical or cognitive deficits, requires physical assistance, supervision or cueing, as described in section 17b-260a-3(46) of the Regulations of Connecticut State Agencies, with two or more ADLs, including, but not limited to, eating, bathing, dressing, toileting, and transferring;

(2) Category II (ABI NF level of care): If the individual were not receiving services under the ABI waiver program, the individual would require care in an ABI NF. The individual is considered to require care in an ABI NF if the individual resides in such a facility and the department or its agent determines that the individual currently requires such level of care, or if the individual does not reside in such a facility but has impaired cognition, impaired behavior requiring daily supervision or cueing, as described in section 17b-260a-3(46) of the Regulations of Connecticut State Agencies, with two or more ADLs, and a mental illness that manifested itself before the brain injury occurred;

(3) Category III (ICF-IID level of care): If the individual were not receiving services under the ABI waiver program, the individual would require care in an ICF-IID. The individual is considered to require care in an ICF-IID if the individual resides in such a facility and the department or its agent determines that the individual currently requires such level of care, or if the individual does not reside in such a facility but has impaired cognition, an ABI that occurred before the age of 22 and, due to physical deficits, requires physical assistance with two or more ADLs; or

(4) Category IV (CDH level of care): If the individual were not receiving services under the ABI waiver program, the individual would require care in a CDH. The individual is considered to require care in a CDH if the individual resides in such a facility and the department or its agent determines that the individual currently requires such level of care, or if the individual does not reside in such a facility but has impaired cognition and impaired or abnormal behavior, and, due to physical or cognitive deficits, requires physical assistance, supervision or cueing, as described in section 17b-260a-3(46) of the Regulations of Connecticut State Agencies, with two or more ADLs. For purposes of this category, "impaired or abnormal behavior" means that one or more behaviors is consistently severely impaired or abnormal, and requires the availability of intensive and ongoing behavior intervention to the extent that the individual would require care in a CDH if the individual were not receiving services under the ABI waiver program. Behaviors that may meet this definition include: engaging in inappropriate sexual activity; causing injury to others or self, or damage to property; demonstrating physical or verbal aggression; demonstrating a consistent ongoing pattern of wandering or elopement; engaging in socially offensive behavior; demonstrating withdrawal, susceptibility to victimization, impulsivity, intrusiveness, agitation or pica; or engaging in criminal activity after the brain injury occurred.

(e) The applicant shall be placed on the waiting list if the applicant is determined by the department, based on the information provided during the pre-screening, including the neuropsychological examination report, to meet the financial and programmatic requirements described in section 17b-260a-5 of the Regulations of Connecticut State Agencies and the applicant requires one of the levels of care described in subsection (d) of this section.

(f) The department shall notify the applicant in writing when, based on the applicant's waitlist position, an opening is reasonably expected to become available to the applicant within 90 days. Once notified, a care manager shall meet with the individual, complete a comprehensive assessment of the individual's needs, including the level of care, and develop a proposed service plan. A care manager and the individual, in conjunction with the person-centered team, shall then develop, if feasible, a cost-effective service plan as determined pursuant to section 17b-260a-10(d). Services shall not be authorized until the department determines that the individual's Medicaid coverage is active.

(g) The department shall re-evaluate the level of care for each individual at least annually.

(NEW) Sec. 17b-260a-10. Development of the service plan and evaluating cost-effectiveness

(a) Applicants enrolled in ABI Waiver I shall have a total individual service plan cost limit no greater than 200% of the annualized alternative institutional care cost.

(b) Applicants enrolled in ABI Waiver II shall have a total individual service plan cost limit no greater than 150% of the annualized alternative institutional care cost.

(c) The department shall not approve a total individual service plan that exceeds the individual service plan cost caps or funding limitations established in the approved waiver.

(d) To determine the cost-effectiveness of the individual's service plan, the department shall:

(1) Obtain the annualized alternative institutionalized care costs for the individual. For each level of care listed in subsection (d) of section 17a-260a-9 of the Regulations of Connecticut State Agencies, the annualized alternative institutional care cost is equal to the state's weighted average cost for the specified facility type, as annually developed and published by the department, minus the average applied income;

(2) Determine the individual's total service cost by aggregating each of the following costs:

(A) The annualized cost of each covered service that will be provided to the individual, based on the department's established rates for such services;

(B) The annualized cost of the ABI waiver home and community-based services, as described in section 17b-260a-8 of the Regulations of Connecticut State Agencies, to be provided to the individual under the proposed service plan;

(C) The annualized cost of any other medical services covered by Medicaid, as described in section 17b-260a-3(37) of the Regulations of Connecticut State Agencies, provided in the individual's home that the individual may require in order to live in the community, to be calculated by multiplying the expected frequency of utilization of these services by the Medicaid rates established by the department for such services; and

(D) The annualized cost of any other community-based services, as described in section 17b-260a-3(36) of the Regulations of Connecticut State Agencies, that the individual may require in order to live in the community; and

(3) Compare the individual's total service cost to the applicable individual limit set in subsections (a) and (b) of this section to determine if the total service cost exceeds the applicable individual limit.

(e) To promote cost neutrality in accordance with 42 USC1396n(b), every reasonable effort shall be made to provide services below the maximum dollar amount level, and in the most cost-effective manner possible. The department shall not exceed the funding limitations established in the approved waiver when determining whether an individual can be accepted into the program.

(NEW) Sec. 17b-260a-11. Responsibilities of the individual

(a) Person-Centered Planning and Selecting Providers

(1) To the extent feasible, the individual shall lead the person-centered planning process. If the individual has a legal representative, the legal representative may participate in the planning process, making decisions for the individual, as necessary to ensure the best interests of the individual. The department may seek assistance from a court of probate if:

(A) The department determines that the legal representative is not acting in the best interests of the individual and is hindering the person-centered planning process; or

(B) There is a conflict between the individual and the legal representative.

(2) The individual or the individual's legal representative, or both, shall:

(A) Choose the team to participate in the person-centered planning process;

(B) Collaborate with the person-centered team;

(C) Select, from a list of providers, the providers who will deliver the services specified in the service plan;

(D) Supervise the services that are provided to the individual in accordance with the service plan;

(E) Notify the department if a provider is not performing satisfactorily;

(F) Terminate the employment of a household employee or the services of a self-employed provider, as necessary; and

(G) Select new providers, as necessary.

(b) Financial Responsibilities

(1) An individual whose gross income exceeds 200% of the federal poverty level shall be required to contribute toward the cost of services rendered under the waiver. The amount contributed shall be calculated according to section 5035 of the Uniform Policy Manual, or any other applicable law or policy of the department.

(2) The individual shall agree to pay directly to the department's fiscal intermediary the portion of income calculated to be contributed to the individual's cost of care. This agreement shall be documented in the individual's service plan.

(c) Responsibilities of the Individual as the Employer of Household Employees

An individual who is the employer of household employees, as defined in section 17b-260a-3(24) of the Regulations of Connecticut State Agencies, shall be responsible for:

(1) Compliance with all applicable state and federal requirements, including, but not limited to, those related to workers' compensation, unemployment compensation, minimum wage rates, and income tax withholding; and

(2) Hiring and termination of the employment of household employees, as necessary.

(d) Critical Incident Reporting

(1) The individual, or the individual's legal representative, shall comply with the department's critical incident reporting protocol for instances where an individual experiences a perceived or actual threat to the individual's health or welfare, or to the individual's ability to remain in the community.

(NEW) Sec. 17b-260a-12. Department responsibilities

The department or its agent shall:

(a) Inform eligible individuals that they have the choice whether to receive home and community-based services through the ABI waiver program, or to receive institutional care;

(b) Establish eligibility for the ABI waiver program by performing an assessment of the individual's needs;

(c) Coordinate the development of a service plan designed to deinstitutionalize or divert the individual from institutional placement;

(d) Assist with implementation of an approved service plan by coordinating services provided to the individual;

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

(f) Review and reassess, at least every 12 months, and whenever there is a significant change in the individual's ability to function in the community, the individual's service plan and level of care;

(g) Lead team meetings in conjunction with the individual;

(h) Maintain records for at least 7 years.

(i) Advise the individual of the individual's right to an administrative hearing in accordance with sections 17b-60 and 17b-61 of the Connecticut General Statutes if the individual is aggrieved by the department's decision with respect to the individual's application or eligibility for the ABI waiver program, or if services are reduced, denied or terminated;

(j) Maintain a waiting list of individuals who have applied for and been pre-screened for ABI services;

(k) Establish provider qualifications and, through its fiscal intermediary, establish and maintain a directory of providers;

(*l*) Establish payment rates for all services offered under the ABI waiver program;

(m) Pay for approved ABI waiver services delivered by providers on behalf of the individual; and

(n) Maintain, and comply with, a critical incident reporting protocol for instances where an individual experiences a perceived or actual threat to the individual's health or welfare, or to the individual's ability to remain in the community.

(NEW) Sec. 17b-260a-13. Provider responsibilities

(a) All providers shall:

(1) Comply with any critical incident reporting protocols developed by the department for instances where an individual experiences a perceived or actual threat to the individual's health or welfare, or to the individual's ability to remain in the community.

(2) Report their arrest, or any arrest of an employee, to the department within 10 business days. The failure of a provider to report any such arrest may result in termination of the provider from the ABI waiver program.

(3) Complete a state and federal criminal background check, at the expense of the applicant or provider.

(4) Accept payment only for services that were actually provided to the individual and that do not violate the rules, regulations, standards, or laws governing the Medicaid program in accordance with sections 17-83k-1 to 17-83k-7, inclusive, of the Regulations of Connecticut State Agencies. A provider may be suspended or terminated from participation in the program for accepting payment for services not provided or for violating the rules, regulations, standards, or laws governing the program.

(b) Agencies that employ providers shall:

(1) Ensure that all staff, volunteers, interns or other persons employed by, supervised by, or representing the agency who may have direct contact with individuals receiving ABI waiver funding, meet and maintain all criminal background standards and requirements as set forth in subsection (a)(3) of this section.

(2) Have policies in place regarding the provision of language services to individuals while receiving ABI waiver services, and shall not rely on the assistance of individuals' friends, family or

others.

(3) Deliver training to staff members regarding the provision of services that are person-centered and culturally competent.

(4) Have policies and procedures in place regarding employee standards of conduct. Such policies and procedures shall include, but are not limited to, the following topics:

(A) The need for providing person-centered services;

(B) The importance of respecting individuals' rights, including privacy and self-determination;

(C) The prohibition against neglect, abuse, and harassment of individuals;

(D) The prohibition of the use of drugs or alcohol, or of being under the influence of drugs or alcohol, while providing services to individuals;

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

(F) Critical incident reporting requirements.

(5) Establish a quality assurance plan. Such plan is subject to approval by the department and shall include random checks of staff performance.

(NEW) Sec. 17b-260a-14. Provider participation

(a) It shall be a certification requirement of the department for all service specialties that, in order to participate in the ABI waiver program and receive payment from the department, all providers:

(1) Enroll with the department as a provider in the Medicaid program and sign the Medicaid Provider Enrollment Agreement, as directed by the department, which agreement may include addenda specific to the ABI waiver program and may be amended from time to time;

(2) Comply with all applicable state and federal statutes and regulations, including, but not limited to, sections 17b-262-522 et seq. of the Regulations of Connecticut State Agencies, the Medicaid Provider Enrollment Agreement and any applicable addenda, and all departmental policies, as amended from time to time

(3) Comply with all of the provisions and requirements of applicable Medicaid waivers, as amended from time to time;

(4) Deliver, document, and bill only for those services that are outlined in the individual's service plan; and

(5) Comply with the requirements of any corrective action plan imposed by the department.

(b) The commissioner shall have the discretion to refuse to list a provider in the provider directory, remove the provider's name from the provider directory, or refuse payments to a provider, if the provider performing the services poses a threat to the health or safety of individuals participating in the ABI waiver program, or has been convicted in this state or any other state of a felony, as defined in section 53a-25 of the Connecticut General Statutes, involving: forgery under sections 53a-137of 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; sexual assault under sections 53a-70, 53a-70a, 53a-70b, 53a-71, 53a-72a, 53a-72b, 53a-73a of the Connecticut General Statutes; or assault under sections 53a-59, 53a-59a, 53a-60, 53a-60a, 53a-60b, and 53a-60c of the Connecticut General Statutes; or has been convicted in this state or any other state of an offense, as defined in section 53a-24 of the Connecticut General Statutes, involving: cruelty to persons under section 53-20 of the Connecticut General Statutes; vendor fraud under sections 53a-290 to 53a-296, inclusive, of the Connecticut General Statutes; or the abuse of an elderly, blind or disabled person, or a person with intellectual disability under sections 53a-320 to 53a-323, inclusive, of the Connecticut General Statutes.

(NEW) Sec. 17b-260a-15. Corrective action and provider cooperation

(a) If a provider fails to comply with sections 17b-260a-1 to 17b-260a-18, inclusive, of the Regulations of Connecticut State Agencies, other applicable state or federal statute or regulation, or any provision of the Medicaid waivers or Medicaid Provider Enrollment Agreement, the department may require the provider to comply with a corrective action plan.

(b) The provider shall cooperate fully with any department, state, or federal audit or investigation, and shall correct any deficiencies identified in the course of such audit or investigation.

(NEW) Sec. 17b-260a-16. Provider fiscal responsibility

(a) For purposes of this section:

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

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

(b) The provider shall not engage in or commit fraud or abuse, including, but not limited to:

(1) Billing for services not rendered;

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

(3) Billing for services not medically necessary;

(4) Falsely identifying the person who actually performed a service, including billing for services performed by an individual who is not credentialed;

(5) Failing to adequately document all services that are billed;

(6) Billing for services for ABI waiver participants who are institutionalized at the time in which the service has been billed as having been rendered; or

(7) Violating Medicaid policies, procedures, rules, regulations, or statutes.

(NEW) Sec. 17b-260a-17. Client documentation and provider reporting

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

(1) Provider's name and signature;

(2) Dates of service;

(3) Start time for each visit;

(4) End time for each visit;

(5) A description of duties performed or items provided;

(6) Client goals and documentation of progress toward meeting those goals; and

(7) Unless otherwise described in the provider's applicable Medicaid Provider Enrollment Agreement and any addenda thereto, the individual's name and the signature of the individual or the individual's legal representative.

(b) Upon written request presented to the provider, the department or its authorized agent shall be given immediate access to, and permitted to review and copy, any and all records and documentation used to support claims billed to Medicaid. For purposes of this subsection, "immediate access" means access to records at the time the written request is presented to the provider.

(c) The provider shall submit written reports on the individual's status and progress for each of the first three months of the individual's participation in the program, and quarterly thereafter, to the care manager in a manner that is set forth by the department.

(NEW) Sec. 17b-260a-18. Provider termination, suspension or disqualification

(a) Failure to comply with any requirements in sections 17b-260a-1 to 17b-260a-18, inclusive, of the Regulations of Connecticut State Agencies, other applicable state or federal statute or regulation, or any provision of the Medicaid waivers or Medicaid Provider Enrollment Agreement, may result in the nonpayment of services, suspension or termination from participation in the ABI waiver program, or any other sanction available under state or federal law.

(b) The department may suspend or terminate the provider from participation in the ABI waiver program immediately and without prior notice if it has reason to believe that a provider poses a threat to, or has acted in a manner that posed a threat to, the health, safety or welfare of an individual participating in the ABI waiver program, or has engaged in fraudulent or abusive program practices.